Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

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Author: Jon Kvist

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1 Executive Summary

The Danish policies of pensions, health care and long-term care are all under strain and a certain extent of reform, albeit perhaps not as dramatic as in most other EU countries and also coming from a different level. The changes in train are in part due to economic and demographic developments and in part due to political changes.

In 2011 there was a change of government. After a parliamentary election on 15 September 2011 the Social Democrats formed a coalition government with the Socialist Peoples Party and the Social Liberals thereby taking over from the Liberal-Conservative coalition government that had ruled since 2001. This led to changes in health care policies, but not in pensions or long-term care.

In health care, the Budget 2012 agreements of November 2011 reached between the coalition and the Red-Green Alliance led to abolishing the tax favourable treatment of private health insurance, more funds to preventive initiatives and increases of duties on alcohol, tobacco and on sodas, chocolate and ice cream.

Health care is also subject to re-organisation with digitalisation and new hospitals being built and old ones closed down, merged and specialised.

In pensions there have not been any new marked changes. The agreement on retirement reform reached in May 2011 between the then government, the Danish Peoples Party and the Social-Liberals was confirmed. The main elements are phasing in a gradual increase of retirement ages in the national old age pension and voluntary early exit benefit earlier than originally planned, reduction of the maximum benefit period on voluntary early exit benefit and various income-testing mechanisms making it less attractive for middle and high income groups to retire early.

In June 2011 the agreement between the government and the regions and municipalities did not change the fundamental conditions for long-term care in 2012. However, general economic problems in municipalities also impact on long-term care with the number of employed in this sector going down in the last year.

The on-going debates and discussions are not least framed by the debt crisis, globalisation and ageing populations. A key element in the attempt to increase labour supply and decrease social expenditures is reform of the disability pension with parliamentary negotiations probably coming to a conclusion this spring. Another key element is the use of technology in welfare provision and administration.

There are no signs of marked impact of the EU on policies in pensions, health care or long-term care. The Danish government support the europact being drafted these months.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The adverse general economic situation did not improve in the last year. The unemployment rate was 7.5% in fourth quarter of 2011 compared to 7.4% a year earlier and 3.2% in the second quarter of 2008. In the fourth quarter of 2011 the number of full-time employed was 2,158,477 compared to 2,166,511 a year earlier and 2,293,079 in the second quarter of 2008 (STATISTICS DENMARK 2012). The activity rate was stable at 78.9% in the fourth quarter of 2011 compared to 78.8% a year earlier and 80.1% in second quarter of 2008.

The adverse economic situation is reflected in less tax revenues and more outlays to social security. The public finances moved from a surplus of 3.2% of GDP in 2008 to a deficit of 2.7% in 2009 and 2.6% in 2010 (STATISTICS DENMARK 2012). Based on an expected deficit of more than 3.0% in 2011, the EU made a recommendation on 12 May 2010 to end the deficit on public budgets (EUROPEAN COMMISSION 2010).

The government that came into office September 2011 made some changes to policies. In the Budget 2012 that was backed by the Red-Green Alliance the tax privilege of private occupational health insurance was withdrawn and more money was allocated to preventive measures and more duties imposed on sugar, alcohol and other products. No changes were made to national old age pensions or long-term care. For 2011 the Ministry of Finance expects the public deficit to become 4.0% of GDP and 5.5% in 2012 to 2.6% in 2013 (FINANSMINISTERIET 2011).

National debates concern not least the sustainability of the social protection system. In the short term the dual challenge is to overcome the economic crisis and adapt to ageing populations.

2.2 Pensions

2.2.1 The system's characteristics and reforms

In this section we first describe the characteristics of the Danish pension system and afterwards the reforms that will be implemented. These reforms concern withdrawal from the labour market and thus concern not only the national old age pension but also the voluntary early exit benefit scheme (efterløn) that is not officially a pension but which nevertheless is an important exit route out of the labour market for older workers.

The pension system consists of a national old age pension (folkepension) in the first pillar, labour market pension schemes in the second pillar and a variety of individual saving vehicles in the third pillar. Also there are two supplementary pension schemes – ATP and SUPP[1] – that cannot unambiguously be categorised as either first or second pillar schemes. In Table 2 below these schemes are therefore placed under the pillar they have most commonalities with.

[1] See page 5 for details.

Table 1. The Danish pension system according to the three pillar categorisation[2]

	First pillar	Second pillar	Third pillar
Goal	Prevent poverty	Maintain income	Additional savings
Sector	Public	Private	Private
Basis	Universal (residence)	Mostly compulsory membership through collective agreements	Voluntary payments
Benefit formulae	Flat-rate benefits to all, means-tested or guaranteed minimum income	Earnings-related benefits	Flexible
Financing	Taxes, pay-as-you-go	Contributions, fully funded	Contribution based
Danish pension schemes	National old age pension	Labour market pensions	Individual pension savings
	ATP and SUPP		

Source: ANR (2011).

The Danish national old age pensions consist of a basic amount, a supplementary amount and the supplementary pension benefit. The basic amount is the same for everybody, i.e. DKK 68,556 annually or DKK 5,713 monthly (all amounts for 2012).[3] The supplementary amount varies for single persons and others. For single persons the supplementary amount is DKK 71,196 or DKK 5,933 monthly and for others DKK 33,416 annually or DKK 2,868 monthly. The supplementary pension benefit is DKK 11,200 annually, paid out as a 'cheque' once a year.

All amounts of the Danish national old age pensions are taxable.

The basic amount and the supplementary amounts are automatically indexed each year according to wage and price developments. The level of the supplementary pension benefit, popularly called the Elderly Cheque, has from its introduction in 2003 been set politically (for more details, see ANR 2010).

Often the national old age pension is portrayed as a universal scheme. In reality, citizens residing in Denmark earn 1/40 national old age pension for each year they stay in Denmark between the age of 15 and 65 years. Persons residing for less than 40 years in this period of their life are entitled to a fraction of the full national old age pension, e.g. 33/40 of the full pension for a person having resided in Denmark for 33 years between being 15 and 65 years of age.

The virtue of the Danish national old age pension is that it constitutes a good minimum pension effectively combating poverty in old age. Especially this is the case because virtually all benefits in kind for elderly are free of charge (except institutional care).

[2] The three pillar system misses out on two important policy programmes for early exit: The first is the scheme for workers above 60 years of age, the voluntary early exit benefit, and the second is the disability pension which is for workers and non-workers alike and disregarding age.

[3] EUR 100 = DKK 745.0529, yearly average for 2011 (NATIONALBANKEN 2012).

However, the national old age pension does not provide good income maintenance for middle and high income earners. The supplementary labour market pension, ATP (Arbejdsmarkedets Tillægs Pension), does not significantly change this picture. The ATP provides a supplement to the national old age pension which is significant for groups with low to middle earnings but less important for middle to higher income groups expressed by its share of their income in retirement. In 93 of the 98 Danish municipalities the national old age pension and the ATP are more important sources of income than private pensions as their share of average pensions is greater (ATP 2011a).

Contributions to the ATP scheme and thus the ATP benefit in retirement depend on the working time, but are independent of the size of earnings. To partly compensate for the growth in labour market pensions that do not benefit person not in a job, claimants of temporary social security benefits are also paying mandatory contributions to the ATP scheme with public authorities paying the 'employer part'. Typically, these are larger than the ordinary contributions to ATP (see ANR 2010).

Persons outside the labour market on more permanent basis also have the possibility of an ATP like scheme, namely the Supplementary Labour Market Pension for Disability Pensioners (Supplerende arbejdsmarkedspension for førtidspensionister - SUPP). The rationale of SUPP is to partly compensate for the lack of an ordinary labour market pension. Unlike the ATP contributions made for persons on temporary social security benefits, the SUPP scheme is voluntary. SUPP gives persons on disability pensions the possibility to contribute to supplementary labour market pension scheme. The insured person and the municipality pay, respectively, DKK 157 monthly and DKK 314 monthly to SUPP.

Because of the relatively low compensation rates for middle and high income groups provided by the national old age pension and ATP, there was a pressure for many years to introduce new supplementary pensions that paid out higher benefits. This resulted in 1990 in a big expansion of supplementary pensions that were negotiated as part of collective agreements, i.e. varying across sectors on the labour market.

These supplementary pension schemes called labour market pensions (arbejdsmarkedspensioner) are fully funded and defined-contribution schemes with benefits reflecting the contributions made and the return of investments.

Private pensions in the form of occupational pensions have become gradually larger as schemes established in the early 1990s are gradually maturing and as contribution rates to these schemes have gone up as part of collective agreements. As private pensions become more salient, there will be smaller differences between the working and the retired population but greater inequalities among the retired.

Reforms

There were no changes to the public pension schemes as part of the Budget 2012. However, the coalition government did agree with the Red-Green alliance to reduce the tax-exempted payments to third pillar pension schemes with periodical payments over typically ten years (ratepensioner) to DKK 55,000 annually and to abolish the tax allowance for pension fund management (FINANSMINISTERIET 2011).

However, reforms are under way. The Welfare Reform of 2006 increased the pension age from 60 to 62 years of age in the early exit benefit (efterløn) between 2019 and 2022 and from 65 to 67 years in the national old age pension and ATP from 2024 to 2027. The Reform of 2006 also meant that pension age will be indexed with increases in life expectancy.

Finally, on 21 December 2011 a reform of the early exit benefit was passed. This reform was in fact agreed on by a number of political parties already on 13 May 2011, i.e. ahead of the election on 15 September 2011, who said they would pass the reform if they got the majority of seats in Parliament after the election. And they did. The interesting political aspect is that the parties encompass both opposition parties (Conservatives and the Liberal party) and the Social Liberals (Radikale Venstre) from the coalition government. The main elements of the reform were:

- Reduction of the possible time on the early exit benefit from five to three years.
- From 2014 to 2023 a gradual increase of the age of retirement on early exit benefit and the national old age pension from, respectively, 60 year today to 64 years and from 65 years today to 67 years (and higher for persons born 1963 or later, e.g. a person born in 1967 may retire on early exit benefit at age of 64 years and on national old age pension at age 69 years).
- Greater income-testing of the early exit benefit with income from pensions making it less attractive for persons with large pensions to retire.
- Continued possibility to earn a tax-free premium if retirement is postponed.
- Insured persons under 60 years of age can withdraw from the early exit benefit and receive their contributions tax-free and in cash between April and October 2012.

Moreover, when average longevity increase so will retirement ages in both the early exit and the national old age pension (for more details on the scheme, Welfare Reform of 2006 and the last reform, see ANR 2011).

2.2.2 Debates and political discourse

There are no debates or other signs that indicate there will be marked changes in the national old age pension system in the medium term. In general, there is a political discourse that the pension system meets the criteria of adequacy, sustainability and of being modern. According to the prevailing belief the national old age pension provide adequate benefits that in combination with extensive social services for the elderly enable elderly persons to make ends meet. However, the debates on social protection reforms in general concern labour supply and thus even further increases in retirement ages cannot be ruled out.

However, in the short and medium term reforms to increase labour supply are more likely to be in other areas of the social protection system than old age pension. Indeed the next reform of pensions will concern the disability pension (Førtidspension). The political parties seem to agree that there is no need to change the size of national old age pensions or further raise the pension age. Also the political parties seem to agree that there is a need for a new reform of the disability pension even though the last reform was made not even ten years ago. Because influx remains high and entitlements are increasingly given due to mental factors rather than physical the most likely key element is likely to be a temporary development benefits. For a long period political debate has been going on behind closed doors between both sides of the political spectrum as well as with the social partners. The government announced its proposal for a disability reform on 29 February 2012. The Conservative and the Liberals are positive towards the proposal. Negotiations are likely to result in a reform based on a broad range of parties in Parliament.

2.2.3 Impact of EU social policies on the national level

There is so far little impact of EU social policies on pensions in Denmark. There is little, if any, mentioning of the Social OMC or of the EU2020 in relation to pensions. Out of 45 contributions to hearings, including 17 on economic issues like pensions, that the DaneAge Association (Ældresagen) has made over the last few years only one concerned the EU, namely an EU hearing on traffic.

Some may argue that the EU has had an impact on the recent retirement reform because the EU has at various occasions suggested reforms of the voluntary early exit benefit. However, many actors – including Danish experts, The Economic Council, and various commissions as well as international organisations such as the OECD – have for many years suggested a retirement reform and, in particular, a reform of the voluntary early exit benefit.

The importance of the EU coordination of social security increase as the world becomes more global with still more people living in different places during their life. The number of persons receiving the Danish national old age pension abroad more than doubled over the last decade from 15,000 in 2000 to nearly 39,000 in 2010 (ATP 2011b, nr. 94 & PENSIONSSTYRELSEN 2011). However, looking at where these pensioners reside shoots down two myths about, respectively, export of Danish pensions by third country nationals and of Danish pensioners living in the sunny parts of the EU.

The debate about immigrants and descendants of immigrants taking the Danish pension back to their countries of origins is currently not backed by big numbers. Five out of six pensioners abroad live in other EU/EAS countries. In 2010 643 persons received their national old age pension in Turkey, Iraq, Iran, Lebanon, Bosnia-Hercegovina and Pakistan. This constitutes less than 2% of people receiving the national old age pension abroad.

Table 2. Top 10 countries – number of Danish national old age pensioners abroad according to country, 2010

Country	Number of national old age pensioners
1. Sweden	11,638
2. Norway	4,723
3. Germany	4,704
4. Spain	3,496
5. France	2,124
6. United Kingdom	2,062
7. Australia	1,523
8. Canada	1,425
9. USA	905
10. Switzerland	803

Source; ATP (2011b, nr. 94; PENSIONSSTYRELSEN 2011)

By far the largest groups of pensioners receive their national old age pensions in neighbouring countries of Sweden, Norway and Germany, see Table 2 above. In Sweden alone there are more pensioners living than in all the Mediterranean countries together. In other words, it is a myth that most retirees abroad have gone to the sunny coasts of France and, especially, Spain.

2.2.4 Impact assessment

The crisis affects pensions in many ways. In a multi-pillar system like the Danish with a relatively large role for private, defined contribution schemes, the current low interest rates have severe implications for the saving needed to ensure a certain income in old age. Calculations by the ATP (2012, 100) shows that a 25 year old person today must save nearly twice as much as the person who is 65 years old today. During 40 years of work the 65 year old should have saved DKK 1,500 to have a pension of DKK 10,000 monthly. Because of lower interest rates the 25 year old should save DKK 2,550 monthly to have a pension of DKK 10,000 monthly. And because of longer longevity the 25 year old must add DKK 400 monthly.

The first pillar with a basic pension made up by the national old age pension and the ATP is - and will most likely remain - an important means of provision in old age, especially for women. On average the basic pension makes up 67.6% of pension income, but 74.0% for women and 60.5% for men (ATP 2012). In 97 of the 98 municipalities women receive less than half their pension income from the basic pension. There are twelve municipalities where men receive less than half their pension income from the basic pension.

The risk of poverty or social exclusion was 18.3% in 2010 compared to 23.4% for the EU27. This indicator shows a small increase from 16.3% in 2008 and 17.6% in 2009.

The at-risk-of-poverty rate for persons older than 65 years was 17.7% in 2010 down from 20.1% in 2009 and 18.1% in 2008. These fluctuations are more likely to be caused by changes in labour markets than in pensions. Measured as persons with an income below 60% of the median income there are thus between one in five and one in sex persons older than 65 years of age. However, this measure of adequacy does not take into account the non-monetary benefits that elderly are eligible for. In particular, social and health care are almost exclusively free of charge.

Another problem, seen from a Danish perspective, is that the at-risk-of-poverty rate takes 60% of the median income as the threshold where the full national old age pension is just a little below that line.

In 2009 around 8.3% of persons above 65 years of age were in persistent-at-risk-of-poverty as measured as having less than 60% of median earnings in one year and also in at least two of the preceding three years.

Few, 2.7% of the total population in Denmark was seriously materially deprived (EUROSTAT 2012).

The national old age pension is an important source of income even high up in the income deciles. Also the basic package of the national old age pension and the ATP makes up the largest source of income for pensioners in 93 out of 98 municipalities (ATP 2011).

In a comparative perspective the Danish pensions are not particularly lavish. The aggregate replacement ratio was 0.44 in 2010 compared to 0.53 for EU27 (EUROSTAT 2012). At 0.46 the aggregate replacement ratio for men is higher than 0.42 for women. Indeed, the national old age pension contributes to equality between rich and poor and between men and women (DET ØKONOMISKE RÅD 2011). Because the national old age pension flat-rate amount is income-tested with work income above a certain amount low-income pensioners gain more in relative terms than high-income pensioners. Because the supplementary amount is income-tested earned, capital and pension income, high income groups with such income have their national old age pension reduced unlike lower income groups.

An analytical report from the Danish Association of Insurance looked into the maturation of the Danish multi-pillar pension system for various occupational groups (NIELSEN 2011). The

focus is on pensions paid out in the second and third pillar from 1995 to 2009 and through projections until 2030. The composition of pensions and their net replacement rates helps assess to what extent the pension system can be said to be matured for various groups in the labour market. The analysis finds that the maturation of the pension system cannot yet be seen in the aggregate pension payments, but that there is wide differences in the payments from pillar two and pillar three among occupations depending on how long they have been covered by supplementary pensions (arbejdsmarkedspensioner). The projections show that payment from pillar two and pillar three will increase over the next thirty years to become larger than the national old age pension by 2030.

This analytical report builds on new data on contributions into and payments from supplementary pensions, i.e. including both pillar two schemes operationalised as employer-administered schemes and the pillar three schemes operationalised as individual private schemes. Former studies have built on combinations of surveys and register data at specific points in time. The new data has the advantage that it is regular and that it can be broken down on gender, age, education, socio-economic status, regional place of residence, and ethnic origins. As described above Denmark has defined contribution schemes, so it is crucial to pay in a certain amount or percentage of earnings to save for old age. Let us illustrate this by looking at contributions for different socio-economic groups.

Table 3 below shows the total contributions to both pillar two and pillar three schemes according to socio-economic status from 1995 to 2009. One can identify three groups. The first group consists of persons out or work – unemployed, disability pensioners and persons outside the labour market. Not surprisingly they have markedly lower contributions than groups of persons inside the labour market because they are not covered by supplementary employer schemes and limited means to arrange their own schemes. Over the last fifteen years these contributions have even fallen, including for disability pensions that have possibility of supplementary pensions (SUPP) described earlier. Self-employed pay about twice as much into pensions, a share that has remained relatively stable. Wage earners at the basic level include skilled and unskilled labour that got covered with new supplementary pension in the early 1990s and who saw their contributions rates increase gradually over the years as results of collective bargaining. This can be seen in their contributions that are now nearly twice as big as in 1995 and a little more than for the self-employed. The last group consists of wage earners that are high level or top managers who generally had supplementary schemes in the early 1990s but also saw the contribution rates increase over the 1990s.

Table 3. Contributions to supplementary pension according to socio-economic status, 1995-2009, percentage of gross earnings

	1995	2000	2005	2009
Self-employed	9.3	8.6	10.6	10.0
Wage earner, top manager	9.9	10.5	12.9	14.5
Wage earner, high level	10.3	11.0	12.8	14.3
Wage earner, middle level	9.5	9.9	11.7	12.9
Wage yearner, basic level	6.3	7.7	9.9	11.0
Unemployed	5.3	4.5	4.5	4.1
Disability pensioners	7.5	6.5	6.4	4.5
Persons outside the labour market	6.6	5.0	5.1	4.5

Source: FORSIKRING & PENSION (2012).

However, there are even bigger differences across socio-economic status if we look at the composition of pillar two and pillar three schemes and if we look at the contributions in absolute terms rather than in relative terms. This is shown in Table 4 below.

Table 4. Contributions to supplementary pension according to employer-administered pension schemes (pillar two) and private signed pension schemes (pillar 3) and socio-economic status, 1995-2009, DKK

	1995	2000	2005	2009
Employer pensions (pillar two)				
Self-employed	2,647	3,793	3,778	4,547
Wage earner, top manager	35,088	46,272	65,255	81,834
Wage earner, high level	23,489	33,136	45,760	59,378
Wage earner, middle level	19,049	25,203	35,682	45,177
Wage yearner, basic level	9,188	15,356	24,050	30,853
Unemployed	938	2,372	3,492	5,346
Disability pensioners	189	283	934	4,053
Persons outside the labour market	816	1,286	3,697	4,816
Private individual pensions (pillar three)				
Self-employed	23,201	25,695	40,061	38,665
Wage earner, top manager	12,581	8,719	8,929	8,334
Wage earner, high level	9,573	6,795	6,880	6,766
Wage earner, middle level	4,918	3,850	4,535	4,704
Wage yearner, basic level	4,227	3,978	4,575	4,565
Unemployed	6,144	4,854	4,759	3,511
Disability pensioners	7,760	7,440	9,182	3,763
Persons outside the labour market	6,776	5,307	5,049	4,114

Source: FORSIKRING & PENSION (2012).

The administration of social security payments will be transferred from municipalities to a central unit, Payment Denmark (Udbetaling Danmark) that is part of the ATP administration (for a brief description see UDBETALING DANMARK 2011). Economic austerity and future shortages of labour have led to an intense search for areas where technology, administrative re-organisation or both can lead to more efficient and less labour intensive solutions. For that reason the task of 2,000 caseworkers in 98 municipalities will be transferred in 2012 to Payment Denmark that will set up five centres nationwide (and two temporary ones). The plan is that 1,500 full-time persons will move to the ATP and by 2014 the number should be reduced to 1,000 full-time persons leading to a total saving of close to DKK 300 million. 500 full-time persons will stay in the municipalities to be case-workers on areas where the municipalities are still responsible authorities, undertake holistic guidance in areas where Payment Denmark is authority, and to assist citizens with special needs unable to make use of digital solutions.

2.2.5 Critical assessment of reforms, discussions and research carried out

The by far largest on-going discussion concerns how to increase the effective retirement age. This is not a new discussion, but has increased in intensity where politicians following up on some of the proposals of the Welfare Commission in 2006 signalling a shift also towards more political initiatives. Table 6 list some of the initiatives taken since 2004 to increase the retirement age. As can be seen all initiative have taken the form of positive measures as seen from the perspective of the person. They have been given carrots in the form of rewards to people who retire later by deferring the national old age pension, the ATP and private and occupational pensions and through tax breaks for pensioners having work on the side. They have been given new possibilities for working longer by abolishing age limits for civil servants and by extending the age limit in discriminatory practise.

Table 5. Initiatives to increase employment for person above 65 years of age

Initiative	Content
Deferred national old age pension	Since 2004 it has been possible to defer the national old age pension and get a larger pension in return. The work demand of 1,500 hours annually was reduced to 1,000 hours by 2008.
Deferred ATP	Since 2007 it has been possible to defer the start of payment of the ATP from 65 years up to 75 years.
Increase of age limit	From 2008 age conditional cease of work as stipulated in the law on discrimination was increased from 65 years to 70 years.
New basic tax allowance	From 2008 a special tax allowance ensures that national old age pensioners can earn up to DKK 30,000 annually without having their pension or supplements reduced.
Civil servants law	From 2008 the general, obligatory retirement age of 70 years for civil servants was abolished (with the exception of few groups of civil servants).
Deferred of private and occupational pensions	As part of the Spring Package 2009 (see ANR 2010) it became possible to increase the age of starting payment of private and occupational pensions from 70 to 75 years.
Campaigns	A series of campaigns have aimed to increase the retirement age, including "A few more years make a difference" (2006), "Senior talents" (2009).

Source: ATP (2010) and updates.

One key change has pushed in the opposite direction on the employment activity of those aged 65 to 67 years, i.e. the lowering of the eligible age for the national old age pension gradually phased in from 67 years in 2004 to 65 years in 2006.

No changes have penalised people retiring early.

In any case there have been little effects so far of the attempts so far to increase the working age and to have more elderly people working. This may be explained by a wide range of factors. First, many people have retired before the age of 65 years, thus making the potential of initiatives targeted at people aged 65 years and above smaller. There has been no trend of un-retiring in Denmark. For the Federation of Employers, this is an argument of removing early exit schemes as the efterløn (see interview in ATP 2010). Second, the labour market and employers may not be considerate about special needs and preferences of their older employees. For the Trade Unions this is an argument for making special allowances for older workers at their work places such as weekly days of, reduced time, exemption for night shifts etc. (see interview in ATP 2010). With increased wealth in general among elderly it may become increasingly difficult to make them substitute leisure with work.

How can the retirement age then be increased? A recent study by ATP (2011c, nr 99) may give some leads. The study shows that in nearly 50% of couples both partner retire with less than one year between them. This can be explained by two factors. First, retirement is often not an individual decision, but taken in the household. Second, the Danish scheme with old age pensions and voluntary early exit schemes have enabled partners to coordinate their exit from the labour market. When the reform on withdrawal from the labour market has become implemented it will be more difficult to coordinate retirement, thus leading to less coordination,

later retirement or a combination of the two. In short, attempts to reduce incentives to retire early may benefit of taking into account that decisions often are made in the households, rather than on an individual level, and that either the economic incentives have to be very large or possibilities to retire early have to be abolished or dramatically altered.

Thus, reducing possibilities to retire earlier or making it more difficult to coordinate in the household is one way of increasing the effective retirement age.

Another way is to provide incentives to stay longer in the labour market. This can done in various ways where rewarding persons who retire later is one way. The possibility of a deferred national old age pension works along these lines.

A recent evaluation from the Danish Association of Insurance of the Danish deferred national old age showed that 15,233 people signed up since the deferred pension scheme gentile introduction first July 2004 until and through 2009, that average length of deferral was close to two years, 3.7% of a cohort enrolled and 14.1% among those in work in the age of 64, the majority of those deferring the pension have high incomes, long education and good health as well as a spouse who have not retired either (EJSING 2011). In 2009 the share of persons aged 66 in work was 4.6% for persons with a deferred pension and nearly 7% without. As part of the retirement reform made in May 2011 (described earlier and in ANR 2011), the employment requirement for the deferred pension was further reduced to 750 hours per year. Most likely this will lead to more people taking the deferred pension and thus continue working, although the reduction of the work demand also means that some will choose to work fewer hours than today. On a critical note one may argue that the deferred national old age pension to some extent rewards those who would have continued to work anyhow and that these groups are those privileged in the labour market in the first place and thus least in need of extra income.

How can the national old age pension system be improved and what other recommendations can be made? Obviously, the gradual maturation of the second pillar schemes will result in better old age pensions for most persons due to the very high employment-population rates and thereby coverage. However, because they defined contributory schemes the final payments will depend not only on the amount of contributions made but also on the economic development, especially the rate of return on contributions. Such uncertainty and chance of modest pensions underline the need for a good basic pension provided in the first pillar. Also the differentials of the labour market are to a large extent now continued into old age and aspirations of redistribution must therefore be ensured in the first pillar. Another recommendation is to continue work on making the population more financial literate even from early ages as very few persons exercise choice in pension provision and because many do not save sufficiently to avoid a serious income drop in old age.

2.3 Health Care

2.3.1 The system's characteristics and reforms

In this section we first describe the Danish health care system and then the most recent reforms.

The Danish health care service can for practical purposes be divided into two sectors: Primary health care and the hospital sector.

The primary health care sector deals with general health problems and its services are available to all. This sector can be divided into two parts: One which chiefly deals with treatment and care: general practitioners, practising specialists, practising dentists, physiotherapists etc. (the practice sector) and district nursing;

The other part is predominantly preventive with preventive health schemes, health care and child dental care.

In case of illness, the citizen normally first comes into contact with primary health care.

The hospital sector deals with medical conditions which require more specialised treatment, equipment and intensive care.

In addition to the treatment of patients, both general practitioners and hospitals are involved in preventive treatment as well as in the training of health personnel and medical research. In the health care service, the general practitioners act as "gate-keepers" with regard to hospital treatment and treatment by specialists. This means that patients usually start by consulting their general practitioners, whose job it is to ensure that they are offered the treatment they need and that they will not be treated on a more specialised level than necessary. Normally, it is necessary to be referred to both hospitals and specialist treatment by the general practitioner.

The general practitioners also refer patients to other health professionals working under agreement with the health care service, and arrange for home nursing to be provided.

Like Denmark as a whole, the health care sector has three political and administrative levels: the state, the regions and the municipalities (national, regional and local levels). The health care service is organised in such a way that responsibility for services provided by the health service lies with the lowest possible administrative level. Services can thus be provided as close to the users as possible.

With the local government reform, which came into effect on 1 January 2007, the old system of 15 counties (including the metropolitan area) and 271 municipalities was replaced by five regions primarily focused on the health care sector and 98 municipalities responsible for a broad range of welfare services.

The municipalities have a number of tasks, of which health is one part. In the health field, the municipalities are responsible for home nursing, public health care, school health service, child dental treatment, prevention and rehabilitation. The municipalities are also responsible for a majority of the social services, some of which (subsidised housing for older people in the form of non-profit housing, including homes for elderly people with care facilities and associated care staff) have to do with the health care service.

As the running of hospitals requires a larger population than that of the majority of the municipalities, this responsibility lies with the five regions. The regions organise the health service for their citizens according to regional preferences and available facilities. Thus, the individual regions can adjust services within the financial and national legal limits according to needs at the different levels.

The task of the state in health care provision is first and foremost to initiate, coordinate and advise. One of the main tasks is to establish the goals for a national health policy. The Ministry of Health, in its capacity of principal health authority, is responsible for legislation on health care. This includes legislation on health provisions, personnel, hospitals and pharmacies, medicinal products, vaccinations, pregnancy health care, child health care and patients' rights.

The Ministry of Health's legislation covers the tasks of the regions and the municipalities in the health area. The Ministry also sets up guidelines for the running of the health care service. This is mostly done through the National Board of Health. Moreover, the Ministry of Health supports efforts to improve productivity and efficiency by e.g. the dissemination of experience and the professional exchange of information and by the introduction of economic incentives and activity-based payment.

Reforms

The perhaps most important reforms in health care came as a direct consequence from the change of government. As described in ANR 2010 and ANR 2011 the Conservative-Liberal government from 2001 to 2011 stimulated a marked rise of private health insurance through tax privileges and a marked rise of private hospitals through guarantees on waiting time, free choice of hospital and favourable payments to private hospitals for their treatments. The latter had been addressed by the Audit of State Accounts and led to a renegotiation of rates of payments to private hospitals (for an analysis of the determinants of private health insurance coverage in Denmark see the PhD dissertation of economist Astrid Krill (2011)).

The incoming Social Liberal-Socialist-Social Democratic government had as one of its flagships "a better and more equal health care system". In the Budget 2011 agreements with the Red-Green Alliance this resulted in a series of changes abolishing, redirecting or even reversing that direction of policy reforms made the previous governments. Most notably this includes measures under the headings of free and equal access to health care and stronger preventive initiatives:

Free and equal access to health care

- abolishing tax exemption of employer paid health insurance and health treatments expected to give DKK 500 million in extra revenues;
- abolishing user payments for fertility treatment and the area of fertility treatment allocated DKK 213 million per year equal to cuts made;

Stronger preventive initiatives

- abolishing planned cuts worth DKK 24 million;
- abolishing planned cuts worth DKK 300 million in the Prevention Fund (Forebyggelsesfonden) in 2012 and 2013;
- social partners and partners behind the Budget 2012 agree on finding more means to fund The Danish Working Environment Authority (Arbejdstilsynet);
- increase of duties on sodas, chocolate, candy, and ice cream giving an extra revenue of DKK 636 million in 2012 and DKK 1,660 million in 2013;
- increase of duties on beer and wine giving an extra revenue of DKK 625 million in both 2012 and 2013;
- increase of duties on tobacco with an average of DKK 3 per package of 20 cigarettes and an intention among the partners behind the Budget to further increase the price on cigarettes with DKK 10;
- introduction of a duty on work injuries with an estimated revenue of DKK 100 million in 2012 and DKK 300 million in 2013. (FINANSMINISTERIET 2011).

Next to these changes there are a number of reforms under way or in the pipeline. The treatment of cancer received top priority also under the previous government. In general cancer treatment in Denmark apparently lack behind that of other countries as cancer is a more prevalent cause of death in Denmark than in neighbouring countries (OECD 2011).

Another reform that is that of digitalising the public sector where health care is one of the most crucial.

Finally, there is a series of new hospitals being planned and built in these years (for more see ANR 2011 and section 2.3.5. below).

2.3.2 Debates and political discourse

The location of the new hospitals was subject for a fierce debate in 2010. In 2011 the discussion has centered more on what hospitals are to be closed down.

The increase of duties on sweets, alcohol and tobacco has also been subject to fierce debates before the election and after the duty increases were announced. An ideological current can be found in arguments, typically from the parliamentary opposition that the state should not try to regulate what people eat, drink and smoke more than is the case already. Also it has been said that the duties have a regressive effect in that people from less socio-economic groups tend to spend a larger part of their income on sweets, alcohol and tobacco. Finally, experts have argued that the design of the duties is not smart enough to actually reduce the consumption of the "bad fat".

2.3.3 Impact of EU social policies on the national level

There is no marked impact of EU social policies on national health policies. The debate on the impact of patient mobility in 2010 on the sustainability of the health care system and on the rights of patients disappeared from the headlines in 2011. The OMC Health has not appeared in the political debates. The year of active ageing is still to make its imprint on the national debates on health. This is not to say that there is no debate on how to improve the health care sector, also in areas that this touched upon in the OMC Health like involving the profession and patient organisation or in active ageing like preventive measures.

2.3.4 Impact assessment

The debt crisis is about public finances and therefore also affects the public sector. After having reached its peak in the second and third quarter of 2010 public employment has gradually gone down in the three core welfare areas – health care, education and social care – that together made up 78.4% of the public sector employment in third quarter of 2011 (DANMARKS STATISTIK 2011, nr. 599). In health care employment fell with 1.6% or 2,800 full-time persons from the third quarter of 2010 to the third quarter of 2011 (DANMARKS STATISTIK 2011, nr. 599).

The debt crisis also affects the level and distribution of health. So far no studies have examined such links and consequences.

2.3.5 Critical assessment of reforms, discussions and research carried out

The Audits of the State Accounts have made no less than three reports on the health care system concerning, respectively, the building of new hospitals, cancer treatment and quality initiatives. These reports give a good sense of recent developments and discussion on the health sector in Denmark.

Over the next few years a series of so-called superhospitals are to be built. The Audit of State Accounts has looked into their planning which is the responsibility of the regions and the Ministry of Health. The new hospitals will get a larger number of hospital functions and ensure a more efficient health care system providing service of a higher quality, see also ANR 2011. The audit finds that the Ministry and the regions have not properly planned the building (RIGSREVISIONEN 2011a). In particular, this concerns the biggest of the hospitals, namely the new University Hospital in Aarhus. The Ministry gave approval of this new hospital without the basic preconditions being clear and the Ministry and the region MidtJylland has yet to come to terms with this. The audit finds that there is a high risk that the hospital cannot be built with the money set aside. Already now the Region MidtJylland expects the building of the

hospital to cost DKK 1,250 million more than allocated. The audit recommends the Ministry to monitor the process better and that the regions make a better management of risks to ensure the buildings are made with the money set aside.

Cancer treatment has been pivotal in Danish health policy for shifting governments at least since 2000 when the first national cancer plan was made. From 2007 to 2010 DKK 6.8 billion has been allocated to combat cancer (RIGSREVISIONEN 2012). As can be seen in Box 1 the Cancer Plan I aimed to expand the fight against cancer through better equipment and personnel. Cancer Plan II dealt with prevention, organisation and operations. Finally, in 2010 the national Cancer Plan III was made including a wide number of initiatives.

Box 1. Cancer Plan I, II and III
2000: The Cancer Plan I is about expanding health efforts against cancer and focussed primarily on the radiotherapy, increased capacity to scan and personnel training.
2005: The Cancer Plan II has recommendations for the entire cancer area with special focus on preventing smoking, organise better patient treatment and strengthen the cancer surgery.
2007: Board of Health conduct a follow-up of Cancer Plan II on the basis of contributions from the regions and the professional players on the field.
2010: The Cancer Plan III focuses on early detection, early diagnosis, prevention, rehabilitation and palliation and contains a variety of initiatives, which will enter into force when they are fully developed and ready for deployment.

Another element of the fight against cancer happened in 2007 when key actors contributed to a broad evaluation. The most important result of this exercise was the introduction of so-called "packet sequences" for cancer patients that aims to give patients an optimal diagnoses and treatments and thereby increase their survival chances and life quality. A packet sequence describes the tests and treatments as a standard patient must receive from suspicion of a cancer over cancer treatment to aftercare. The packet sequences are based on the most recently updated clinical guidelines. Pathways are disease-specific and thus vary for different types of cancer.

The Audit of State Accounts finds that the Cancer Plans, the "packet sequences" and the extra funding have and all levels of health care work hard to enhance cancer treatment. However, the Audit finds that the Ministry of Health should make more explicit demands to the regions on concrete results in the cancer field. Clear goals and a continuous follow-up can, according to the audit create more managerial attention and make it possible to assess whether the transferred funds and the many initiatives actually lead to a better quality of care, shorter time from referral to treatment and increasing survival rates (RIGSREVISIONEN 2012).

The final Audit of State Accounts concerns the initiatives taken to improve quality in health care. The Audit aims to investigate whether nation-wide quality initiatives help to ensure and develop quality in hospitals. Following the guidelines of WHO the study in the Audit distinguishes between the three types of quality:

 the clinical quality, i.e. that concerning the treatment of disease, medications and care of the patient

 the patient-directed quality, i.e. the quality experienced by the patient in the encounter with sewing and inpatient units and has a special focus on patient safety

 the organisational quality, i.e. what concerns the organisation of work, guidelines for the work etc.

The Audit identifies 17 nationwide initiatives with the Danish Quality Model being the far largest, see Box 2. In conclusion the Audit finds a good deal of support from the nationwide initiatives to the regional work on improving quality. As the scale of initiatives is big further coordination may be warranted and can be supported by more IT solutions. The Audit also finds that the Ministry of Health and the Regions could do a better job monitoring whether the objectives of in particular the Danish Quality Model are served.

Box 2. The Danish Quality Model (DDKM)
DDKM is an accreditation model for all Danish hospitals - and eventually the entire health care system. DDKM is a common framework for quality development decided on by the Ministry of Health, regional and onsrådene and local councils. The model is interdisciplinary and specially designed for the Danish health care system. There are also developed versions of DDKM for pharmacies, municipal health services and the prehospital field. From 1 January 2013 it is planned to launch standards for general medical practitioners.

DDKM is the common denominator for a large part of the quality initiatives that the Ministry of Health and the regions manage. The aim is that as a national and cross-cutting quality system will help to:
- a continuous quality improvement in health care
- consistently high quality in all health care
- consistency of patient care
- transparency and visibility of quality in health care.

Institute for Quality and Accreditation in Health Care was established in 2005 to develop and manage the model. DDKM is based on data, knowledge and legislation by the authorities and a wide range of quality development and quality assurance projects.

As part of the National Documentation Projects (De Nationale Dokumentationsprojekter) information is collected on the usage of hospitals, home help and institutional care for elderly. Based on the numbers of hospital discharges and days in hospital beds an indicator has been made on average number of days in hospital beds per discharge for various diagnoses (Indicator 6 – Days in hospital for persons above 67 years of age). Based on information on admissions of persons that falls within 30 days of discharge another indicator measures average readmissions for various diagnosis (Indicator 7 - Readmissions for persons above 67 years of age). Such information can guide policy-making both at the regional level concerning hospital management but also municipal government.

What improvements can be made to the Danish health care sector in times of austerity and ageing populations? The three reports of the State of Audits highlight some of the needs. First, there is an acute need to monitor the building and budgets of the new hospitals. Second, the continued specialisation of cancer treatment in superhospitals can be supported and the setting of targets can be made more clear and monitored. Third, the work on improving quality has no doubt had a large positive impact, but it is important to avoid unnecessary standards and procedures to increase effectiveness and avoid staff becoming de-motivated.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

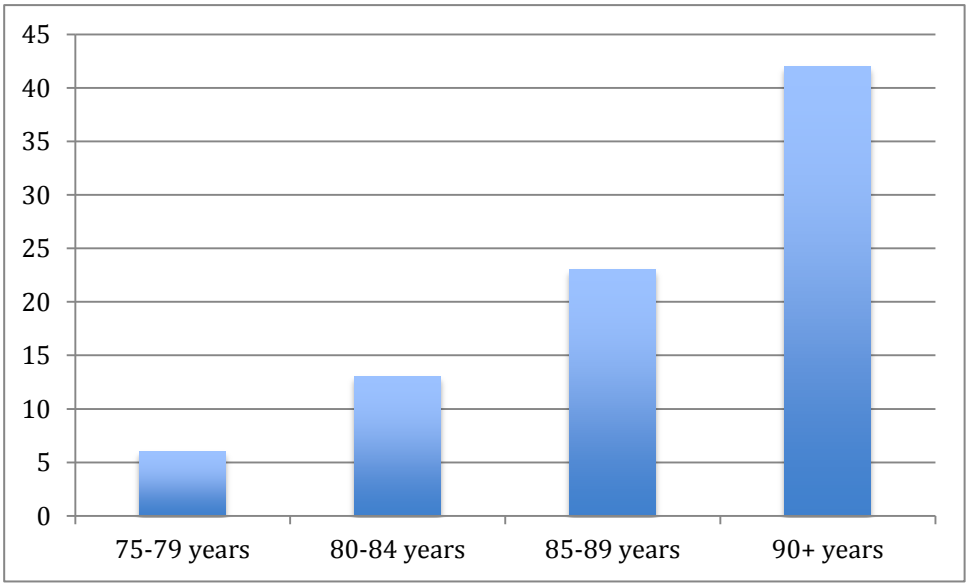
Denmark has perhaps the most extensive system of long-term care, at least for the elderly. The goal of long-term care is to increase the quality of daily life for persons in need of such care and to increase their possibilities to take care of themselves. The Danish system of long-term care is organised locally in the 98 municipalities. Long-term care may be provided by way of residing in institutional care facilities, or special housing typically with nurses attached, or home help.

In particular the scope of home help is relatively encompassing. In 2010, 177,000 persons received permanent home help (DANMARKS STATISTIK 2011, nr. 177). In total these persons received 656,000 hours of home help per week or on average 3.7 hours of home help per week.

In total 77,400 persons live in nursing homes (plejeboliger) and homes for the elderly (ældreboliger) (DANMARKS STATISTIK 2011, nr. 573). Five thousand are under 60 years of age and 14,900 are between 60 and 75 years. 34,700 live in nursing homes and 33,700 in homes for the elderly. Women make up 67% of people living in nursing home and homes for the elderly. Women amount to 65% of recipients of home help, but men receive on average more hours of help than women do. On average men receive 4.1 hours of help compared to 3.5 hour for women. Men particularly receive more personal help than women. Except for persons above 90 years of age men receive more help than women. At the same time, there is a larger share of men in all age groups who do not receive any home help at all. For example, among men 60.2% aged 85-89 years and 31.7% aged 90 years and above do not receive home help compared to, respectively, 37.0% and 8.2% of women (DANMARKS STATISTIK 2011, nr. 573).

The share of the population in nursing and elderly care increase with age. 42% of persons 90 years or older live in nursing and elderly care, 23% of those aged 85-89 years, 13%of those aged 80-84 years and 6% of those 75-79 years, see Figure 1 below.

Figure 1. Share of elderly in nursing and elderly housing, April 2011, percentage of age group.



Source: DANMARKS STATISTIK (2011, nr. 573).

There are 16,000 adults with handicaps living in special housing either for longer or temporary periods of time (DANMARKS STATISTIK 2011, nr. 118). About half have a psychological functional reduction, 30% are mentally ill, about 12% have a physical functional reduction and the remainder have social problems. There are no marked shifts in the number of residents in such housing from 2009 to 2010, albeit a small decrease of longer stays and similar increase of shorter stays.

Municipalities are responsible for long-term care for the elderly. Home help is provided by municipalities. There were no elements with a direct bearing on long-term care in the Budget 2012 (FINANSMINISTERIET 2011).

2.4.2 Debates and political discourse

In view of ageing populations there has over the past many years been a debate about how to turn 'cold hands' into 'warm hands' in the provision of welfare to citizens. This is not least the case of long-term care. The debate deals with, at least, three issues. One issue is how to decrease the share of management vis-à-vis the share of workers in face-to-face contact with citizens. The second issue is how to enable those that are in contact with citizens to spend their time taking care of these citizens rather than spending time filling out paper work or adhering to other bureaucratic procedures that are of little direct value to the citizen. These two issues concern the organisation of long-term care. The third issue is about technology and how this may help in both reducing time spent on administration and on, especially, practical help to allow for more personal help.

New statistics may help monitor progress in this regard. As can be seen from Table 6 below there are 159,812 full-time person working with long-term care in terms of both care, nursing and pedagogues and thus not only long-term care of elderly but more broadly social offers in municipalities and regions. Health care and dentists are not included and so far the statistics does not encompass private providers of home help.

Table 6. Personnel in care, nursing and pedagogues, 2010, % share and full-time persons

	Full-time persons	%
Total	159,812	100.0
Management	1,448	0.9
Nurses	9,184	5.7
Physiotherapists	2,387	1.5
Dietist and others	3,999	2.5
Ergo therapists and others	3,048	1.9
Teachers	683	0.4
Pedagogues	26,140	16.4
Psychologists	735	0.5
Social workers and others	2,066	1.3
Administrative workers	3,423	2.1
Office and secretary work	2,922	1.8
Estate inspectors and janitors and others	2,412	1.5
Pedagogue assistants and others	2,495	1.6
Social- and health helpers and others	56,424	35.3
Social- and health assistants	36,157	22.6
Cleaning and others	5,565	3.5
Assistants in kitchens and others	724	0.5

Source: STATISTICS DENMARK (2012), Statistikbanken, RES10.

The information can be disaggregated according to municipalities and other relevant dimensions. Over the next years, it will become possible to develop time series and thereby access the composition of the work force in long-term care.

2.4.3 Impact of EU social policies on the national level

One cannot trace a marked impact of EU social policies on long-term care. There may be other effects from the EU on national long-term care in Denmark than those deriving from EU social policies.

2.4.4 Impact assessment

The economic crisis affects the financial sustainability of the public sector and this leads to cuts either through direct dismissals or through not hiring new workers when older workers retire. Because long-term care and health care employ the lion's share of public employees there is also reduction of people working in these areas. The most recent figures are for the third quarter of 2011. According to the labour force at that time 2,664,000 people were in employment, 219,000 were unemployed, and 728,000 were not in the labour force (STATISTICS DENMARK 2012, statistikbanken, arbejdskraftundersøgelsen). Although not exactly comparable, there were 750,400 full-time persons working in the public sector, including 175,100 in health care and 254,200 in social protection which encompass long-term care (DANMARKS STATISTIK 2011, nr. 599).

Compared to the previous quarter employment in public administration and service fell with 0.5% equivalent to a fall of 3,900 full-time persons (DANMARKS STATISTIK 2011, nr. 599). Employment in the public administration and service reached its peak in the second and third quarter of 2010 and has been falling since. Employment falls in the three largest welfare areas when compared to the same quarter one year earlier. The biggest fall of employment was 4.5% equal to 12,000 full-time persons in social protection that includes long-term care.

The impact of the crisis can also be seen in the scope of home help provided. Although there is no hard evidence there seems to be a tougher visitation to home help. The number of recipients has also fallen from 182,000 persons in 2009 to 177,000 persons in 2010 (DANMARKS STATISTIK, nr. 177). The average number of home help received per week remained 3.7 hours from 2008 to 2010 with 0.9 hours being for practical help and an increase in personal help from 5.6 weekly hours 2008 over 5.7 in 2009 to 5.8 hours in 2010 (STATISTICS DENMARK, statistikbanken, ældreområdet indikatorer).

2.4.5 Critical assessment of reforms, discussions and research carried out

There has only been a limited number of research reports on long-term care over the last 12 months.

One study examined the principle of self-help in home care. Increasingly municipalities provide practical and personal care with the purpose of making the recipient able to provide better or at least to take care of as many tasks as possible. However, a series of barriers limits the extent to which elderly can be self-reliant (HANSEN, ESKELINEN & DAHL 2011). One of the main barriers is that the elderly who have been visited home help do not understand that they are supposed to do anything themselves. Another barrier is that it takes more time initially to involve the elderly person. To overcome such barriers it may be good to focus on improving the communication to the elderly person so that it becomes clear for the recipient that he or she must take part in the home care tasks. Also it may be advantageous to allocate more time in the first period of home care until the elderly is familiar and capable of doing his or her part without too long instruction and other help from the home carer.

Fortunately we can in certain areas assess developments in long-term case based on the new National Documentation Projects (De Nationale Dokumentationsprojekter) that contain some information on home help and institutional care for elderly.

One of the indicators concerns user satisfaction. The Table below shows that in 2011 87% in their own home are satisfied with their practical care and 91% with their personal care which was almost the same as in 2009 where the similar figures were, respectively, 86% and 92%, and only slightly better than in 2007 with 84% and 87%.

Table 7. User satisfaction with the quality of home care according to housing situation and type of care, percentage share, 2007-2011.

	Own home				Nursing home or service home			
	Practical care		Personal care		Practical care		Personal care	
	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory
2007	47	37	52	35	41	47	44	47
2008	44	39	52	43	57	31	50	40
2009	54	32	55	37	58	29	60	29
2011	51	36	52	39	54	35	56	36

Source: Statistics Denmark (2012). Note: Indicator 1 – Quality of help.

User satisfaction is also very high and stable for people living in nursing homes and service homes. In 2011 89% expressed satisfaction with their practical care 92% with their personal care, i.e. slightly up from 87% and 89% in 2009 and slightly below the 88% and 91% in 2007.

User satisfaction is also high on other aspects. The Table 8 below shows that user satisfaction is high for both personal and practical care both for persons living in their own home and for persons living in nursing homes or service homes. Between 75% and 87% are either satisfied or very satisfied with care being delivered on the time agreed. The share of satisfied recipients are slightly lower among persons living in nursing and service home than among persons living in their own home.

Table 8. User satisfaction with the stability of home care according to housing situation, type of care, and aspect of care, 2009 and 2011, % share of recipients.

		Own home				Nursing home or service home			
		Practical		Personal care		Practical care		Personal care	
		Satis-factory	Very satis-factory	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory
Delivered on time	2009	48	36	54	31	56	31	51	24
	2011	49	36	53	29	50	36	48	27
Uniformity of services	2009	50	25	56	27	59	16	62	22
	2011	49	25	60	24	46	32	55	26
Number of helpers	2009	42	25	46	23	55	14	56	20
	2011	40	28	50	20	46	22	53	21

Source: Statistics Denmark (2012). Note: Indicator 2 – Stability of help and Indicator 3 – Number of different helpers.

The majority of recipients also find that services are the same, uniform, from time to time. Between 75% and 84% find that services are uniform, at least they express that they are either satisfied or very satisfied with the uniformity of services.

The lowest level of satisfaction can be found for the dimension of number of helpers. Between 67% and 76% express that they are either satisfied or very satisfied with the number of helpers delivering their home care service. The smallest share of satisfied recipients of care is for practical help in own home and the largest share of satisfied for personal care in nursing homes or service homes.

Free choice of types of services and providers has been high on the agenda of the current government that came into office in 2002. People living in their own homes that are eligible for home care can chose between municipal and private providers of practical care, personal care and both personal and practical care. Also people in living in their own homes that are eligible for home care can under certain conditions choose between different benefits and services within practical care, personal care, and within both personal and practical care. However, part of the discussion on long-term care has been on whether people know about their free choices and whether they can indeed process such information. The Table below shows the share of recipients of home care in their own homes that have knowledge of free choice of providers and of flexible home care.

Table 9. Share of recipients of home help in their own home who has knowledge of free choice of providers and flexible home care, 2007-2011, percentage share.

	2007	2008	2009	2011
Free choice of provider	66	68	65	71
Flexible home care	42	37	32	33

Source: Statistics Denmark (2012). Note: Indicator 4 – Knowledge of free choice and Indicator 5 – Knowledge about flexible home care.

Seven out ten recipients of home care in their own home know that they have the right to choose between the municipal provider of care and a private provider of care. This share is stable across the five years observed. Much fewer persons know about their possibility of choosing between benefits and services, the flexible home care. Also the share knowing about flexible home care is becoming smaller quickly. In 2007 42% of home care recipients knew about flexible home care compared to 33% in 2011, see Table above. Although not reported here knowledge of free provider of home care and flexible home care become smaller with age.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Despite the official pension age of 65 the average exit age from the labour market was 62.3 in 2009. Compared with 61.4 years for the EU27 this looks good, but this is not the case when compared to neighbouring Sweden that has an age of 64.8. Women retire a bit earlier than men. Women's average exit rate is 62.4 and men's is 63.2. One factor explaining the earlier exit of the labour market by women is that couples tend to retire at the same time and since women are often two-three years younger than their partner, this means that fewer elderly people are at work when compared to other groups (ATP 2011).

The mirror pattern can be seen in employment rates. The total employment rate is 57.6 which is higher than the 46.3 for EU27 and lower than the 70.5 in Sweden. The male employment rate is 62.7 and the male is 52.5.

In other words social protection has over the last three years not been promoting active ageing when seen as having large shares of the elderly population in work.

2.5.2 Participation in society

However, social protection helps active ageing in other ways. Thus, elderly people are generally well-integrated into society. The size of pensions and particularly the wide range of free or strongly subsidised services and medicine enables an active and decent standard of living for most senior citizens. The universal free home care described above gives many elderly a large degree of autonomy from their families and from institutional types of care. The costs of care for the elderly is 1.7% of GDP only surpassed in the EU 27 by Sweden at 2.3% (EUROSTAT 2011).

Even elderly receiving home care are increasingly becoming integrated in the home care provision, i.e. activated. Municipalities sometimes call this form of home care for 'everyday rehabilitation' (see HANSEN, ESKELINEN & DAHL 2011 for an evaluation study).

Denmark has a Grundtvigian tradition of adult learning that many elderly take advantage of. 24% of persons aged 55-64 participate in training and education over a year which is by far the largest share in the EU 27 where Sweden comes second with 15% (EUROSTAT 2011).

Less than 5% of the population agree that they feel left out of society which is only larger than in Spain and Luxemburg of the EU 27 countries (EUROSTAT 2011).

2.5.3 Healthy and autonomous living

Measured by longevity Danes have not been doing quite as well as their neighbours, especially women have had shorter average life expectancy than their sisters in many other European countries.

As described above the fight against cancer has been intensified over the last 12 years. This slowly but surely lead to longer longevity and more quality of life years.

The elderly feel comparatively safe in Denmark. One in four feel unsafe or very unsafe but this share is only smaller in four other EU 27 countries (EUROSTAT 2011).

When we turn to autonomous living the study by EUROSTAT (2011) on active ageing does not provide information on the household status of Danish elderly. However, based on statistics from Statistics Denmark it is possible to find information on this as this is available for individuals on an age basis (year by year, i.e. 60 years of age, 61 years of age etc.).

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RIGSREVISIONEN (2011), Beretning til Statsrevisorerne om sygehusbyggeriet, Report of the Audits of the State Accounts, date, Copenhagen, retrieved on 12 February 2012 at www.rigsrevisionen.dk.

RIGSREVISIONEN (2011), Beretning til Statsrevisorerne om kvalitetsindsatser på sygehusene, Report of the Audits of the State Accounts, date, Copenhagen, retrieved on 12 February 2012 at www.rigsrevisionen.dk.

RIGSREVISIONEN (2012), Beretning til Statsrevisorerne om mål, resultater og opfølgning på kræftbehandlingen, Report of the Audits of the State Accounts, January, Copenhagen, retrieved on 12 February 2012 at www.rigsrevisionen.dk.

UDBETALING DANMARK (2011), Sådan etablerer vi Udbetaling Danmark, brief, Hillerød, retrieved on 12 February 2012 at www.atp.dk.

3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R2; R5] EJSING, Ann-Katrine & Andreas Østergaard NIELSEN (2011), Finansiel forståelses betydning for privatøkonomien, Analytical report 2011:11, Copenhagen, retrieved from: http://www.forsikringogpension.dk.

"The importance of understanding financial matters for the household economy "

The analysis is based on a questionnaire survey conducted in late 2010. A total of 2,967 persons between 18-74 years answered the questions and the response rate was 59.1%. The analysis differs from most other international studies by linking survey data with public records. Many international surveys have self-reported background variables. The analysis shows that Danish financial literacy are distributed equally over low, medium and high financial literacy, where education is an important source for explaining levels. People with higher education have significantly higher financial literacy over those with lower education levels. Financial literacy as part of their education further contributes to a higher level of financial literacy. The report also shows that low financial literacy may mean that you are unable to manage your personal finances in a responsibly way, result in more expensive debt and increases the likelihood of becoming poor.

[R3; R5] EJSING, Ann-Katrine (2011), Arbejde i pensionsalderen, Analyserapport 2011:5, , Copenhagen: The Danish Insurance Association, retrieved from: http://www.forsikringogpension.dk.

"Work in the pension age"

This analysis evaluate the employment effects of the deferred national old age pension. The analysis is based on data from Kommunedata (KMD) and Statistics Denmark. KMD collects information about who joins deferred state pension, and when registered. Data available for the period 1 July 2004 to 31 January 2010. The descriptive and statistical analyses are based on a full count of the Danish population from Statistics Denmark registers. The study finds that the deferred pension has positive effects on employment. 3.7% of a cohort and 14.1% of those aged 64 register for a deferred pension, but of those continuing to work there may also be a reduction of working hours.

[R2; R5] NIELSEN, Andreas Østergaard (2011), Modning af pensionssystemet, Analytical Report, Copenhagen: The Danish Association of Insurance, retrieved from: www.forsikringogpension.dk.

"The maturation of the pension system"

[H7] THOMSEN, Lars Brink & Jan HØGELUND, Handicap og beskæftigelse, research report, March 2011, Copenhagen: SFI, retrieved from: http://www.sfi.dk.

"*Disability and employment*"

This is a study on the development between 2002 to 2010 on the labour market situation of persons with disabilities. The study examines the employment situation of persons with disabilities with a focus on the general knowledge about employment-oriented schemes for persons with disabilities and the attitudes toward persons with disabilities on the labour market. The study finds that markedly fewer persons report that they have a disability and that the employment of persons with disabilities has fallen to the same extent as for persons without disabilities. Compared to earlier times, the study also finds that more persons with disabilities are employed on special terms, that the knowledge of the possibility of personal assistance for persons with disabilities has increased, and that there are more people today who have a positive attitude towards persons with psychiatric illness. The study is based on the labour force interviews in 2002, 2005, 2008 and 2010 as well as register data.

[R3, R4, H7] JACOBSEN, Joannes & Maia LINDSTRØM, Lokal integration af førtidspensionister, research report, February 2011, Copenhagen: SFI, retrieved from: http://www.sfi.dk.

"*Local integration of disability pensioners*"

This study maps living conditions for a broad group of disability pensioners. The study also identifies a group of disability pensioners who wants more social interaction and activities in the daily life. The group of disability pensioners is very heterogeneous with respect to social exclusion and social vulnerability. More than one in five can be said to belong to a particular vulnerable group. Nearly one in four wants a more active life making up a target group of about 37,000 persons who may be interested in local integration projects. Equally large shares of the vulnerable disability pensioners and the more socially included disability pensioners wants a more active life. Based on in-depth interviews the study finds that many persons need a helping hand to get started with socially inclusive activities. The study is based on 1,753 survey interviews and seven qualitative interviews.

[H] Health care

[H3] BJERREGAARD, Peter (2011), Inuit health in transition – Greenland survey 2005-2010. Population sample and survey methods, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"Inuit health in transition – Greenland survey 2005-2010. Population sample and survey methods"

This is a general health study of the situation of adults in Greenland. The report contains a description of the population group and the prevalence of illness and health. The report also contains a description of the methods used.

[H3] BJERREGAARD, Peter & Inger Katrine DAHL-PETERSEN (2011), Sundhedsundersøgelsen i Avanersuaq 2010, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"The Health survey in Avanersuaq"

This report on the health in Avanersuaq in North Greenland is initiated by the Department of Health, Government of Greenland to map the incidence of various diseases and causes of death and to compare morbidity and mortality pattern in Avanersuaq with the rest of Greenland. This happens because the people of Avanersuaq have observed an increased incidence of such cancer, skin disorders and unexplained deaths, and because many are worried about whether this new disease pattern may have something to do with a possible radioactive contamination following an accident in 1968, when a B-52 bombers with nuclear weapons crashed on the ice near the Pituffik. The study was paid for by the Danish government and implemented by the National Institute of Public Health in collaboration with the Department of Health, Government of Greenland. The study does not aim to demonstrate or reject a causal relationship between exposure to plutonium and certain diseases. Furthermore, for statistical analysis to show robust results the population of Avanersuaq is too small and the expected exposure too low for results. Moreover, there are no diseases that can safely be attributed to plutonium.

[H1] BJERRUM KOCH, Mette, Michael DAVIDSEN, Knud JUEL (2011), De samfundsmæssige omkostninger ved rygsygdomme og rygsmerter i Danmark, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"The societal costs of back diseases and back pain in Denmark"

The report highlights the social costs among people with back disorder and back pain in the adult Danish population. It shows how much people with back disorder and back pain contributes to the cost of the hospital sector, primary sector and in the form of transfers from general fund and production losses due to absenteeism from work. The report uses survey data from the national representative National Health Interview survey from 2005. Additionally the information from the questionnaire was combined with information from certain public records.

[H3] CHRISTENSEN, Anne Illemann, Michael DAVIDSEN, Ola EKHOLM, Stig Eiberg HANSEN, Maria HOLST & Knud JUEL (2011), Den Nationale Sundhedsprofil 2010 - Hvordan har du det?, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"The National Health Profile 2010 - How are you?"

This is the annual reporting of the large-scale health profile project described in more detail in ANR 2011. The country's five regions, Health Authority and NIPH conducted in 2010 a survey of the adult population's health and morbidity, where 177,639 adult citizens participated. The study was conducted on the basis of an agreement between the Danish Regions, Local Government Association, the Ministery of Interior, the Ministry of Health and the Ministry of Finance.

[H3] EKHOLM, Ola & Knud JUEL (2011) National Sundhedsprofil Unge 2011, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"National health profile of youth 2011"

The report is based on responses from about 12,000 young people aged 16-20 years. The study looked at young people's health and behavior in relation to diet, smoking, alcohol, exercise, social relationships and illicit drugs. The report also shows the correlations between these various factors. Data on the 16-20-year-olds was collected in connection with the large population study "The national health profile 2010 - How are you?" implemented by the Board of Health in conjunction with the Regions and the National Institute of Public Health, SDU.

[H2, H4] GOHR, Camilla & Anne Sofie BÆK-SØRENSEN (2011), Erfaringer med kort alkoholintervention i kommunale sundhedscentre, University of Southern Denmark, Institute for Public Health & the Tryg Foundation, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"Experience with brief alcohol intervention in municipal health centers"

This report reports the findings of an evaluation of brief alcohol intervention. The study is based on qualitative interviews with 27 health consultants in five municipal health centers that took a course on alcohol and treatment of alcoholism. The report communicated the research project experience to municipalities and other stakeholders who are considering or already facing the need to initiate preventive alcohol interventions. This report is intended as inspiration to get started and before becoming aware of the opportunities and barriers that may be associated with addressing the prevention of alcohol drinking.

[H2, H3] HANSEN, Tina Birgitte, Michael DAVIDSEN, Ann-Dorthe ZWISLER (2011), Danske hjerteregister – årsberetning 2010, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"The Danish Heart Registry – Annual Report 2010"

The Danish Heart Registry (DHR) is a clinical quality database that collects data from cardiac centers and satellites for all patients in Denmark referred to coronary diagnostics, invasive cardiology and cardiac surgery. With this systematic registration, it is possible to monitor the

activity on areas and the quality of operations. The Annual Report 2010 only contains figures from 2010 as other information has not been transferred to the Analysis Portal.

[H2] HOLSTEIN, Bjørn E., Mogens Trab DAMSGAARD, Pia Wichmann HENRIKSEN, Charlotte KJÆR, Charlotte MEILSTRUP, Malene Kubstrup NELAUSEN, Line NIELSEN, Signe Boe RAYCE og Pernille DUE (2011), Psykisk mistrivsel blandt 11-15-årige, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"Psychosocial failure to thrive among 11-15-year-old - school children's mental health"

The report is based on data from SIF's schoolchildren study 2010. It describes the failure to thrive among 11-15-year-olds, the development of mental failure to thrive over the past 10-20 years, and variations in psychological job dissatisfaction in relation to gender, age, family structure, ethnicity, social class, social integration, and differences between schools and between Nordic countries. Psychosocial failure to thrive defined as not to feel good about themselves and others.

[H3, H4] KILL, Astrid (2012), Private health insurance in a universal tax-financed health care system – an empirical investigation, PhD thesis, Institute of Public Health, University of Southern Denmark, retrieved from: www.sdu.dk.

[H2, H4] NORMAN, Kasper, Marie BERGMANN, Micael MIKKELSEN, Tina Drud DUE & Astrid BLOM (2011), Patientrettet forebyggelse i kommunerne En kortlægning af patientrettede forebyggelsestilbud (rehabilitering) til borgere med type 2-diabetes, hjerte-kar-sygdom og kronisk obstruktiv lungesygdom i alle danske kommuner, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"Patient-targeted prevention in municipalities - A survey of patient-oriented prevention interventions (rehabilitation) for individuals with type 2-diabetes, cardiovascular disease and chronic obstructive lung disease in all Danish municipalities"

Data for the survey was obtained through telephone interviews with representatives from each municipality. The 98 interviews were conducted from late September to November 2010. A large proportion of the interviewees were at managerial level or in a managerial position (53 people) and the remaining 45 were either health and course coordinators, project managers, physiotherapists or nurses.

[H3] PLAUBORG, Rikke & Karin HELWEG-LARSEN (2011), Evaluering af mandecentrene - En karakteristik af brugerne og en beskrivelse af deres oplevelser af forløbet i centret, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"Evaluation of male centers, A characterisation of users and a description of their experiences of the course at the Centre"

This report presents the results of an evaluation of man centers in Copenhagen and Aarhus in the spring of 2011. Male centers offer free and anonymous counseling to men in crisis because

of relationship problems or divorce. Results and conclusions are based on a survey and focus group interviews among users of male centers and interviews with employees.

[H3] RASMUSSEN, Mette & Pernille DUE (eds.) (2011), Skolebørnsundersøgelsen 2010, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"School children health 2010"

In 2010 School Children survey carried out for the eighth time. 4,922 students in fifth, seventh and ninth grade at 73 of its schools have participated. The report describes children and young people according to their health behavior, symptoms and damage, ability to function in relation to family, school and peers, being at school and in the immediate surroundings. The study is also the Danish contribution to the international research project Health Behavior in School-aged Children (HBSC) of the World Health Organisation. The study is based on comparative studies of large representative sample of 11 -, 13 - and 15-year-old school with approx. four years apart in a large number of countries. In 2010, 41 countries participated in the study.

[H1, H4] RIGSREVISIONEN (2011), Beretning til Statsrevisorerne om sygehusbyggeriet, Report of the Audits of the State Accounts, date, Copenhagen, retrieved on 12 February 2012 from: www.rigsrevisionen.dk.

"Hospital construction projects"

The Audit aims to assess how the Health Ministry and the regions have planned the building of new hospitals. The Audit finds that the Ministry and the regions have not properly planned the building, and, in particular, this concerns the biggest of the hospitals, namely the new University Hospital in Aarhus. The study is based on information from an expert panel, the Ministry of Health, regions and the Association of Danish Regions. Information from the expert panel includes assessments of regional funding applications, consultancy of the panel and the panel's recommendations on the commitment of the grant. Information from the Ministry of Health include its dialogue with the regions, assessment of funding applications, work on developing a management framework and other materials which the Ministry has obtained during the evaluation and supervision. From the regions and Association of Danish Regions information include involvement of finance applications, accounts for how the overall preparation has been completed, reports on budget assumptions and documentation of how the management of hospital building work is being prepared.

[H4] RIGSREVISIONEN (2011), Beretning til Statsrevisorerne om kvalitetsindsatser på sygehusene, Report of the Audits of the State Accounts, date, Copenhagen, retrieved on 12 February 2012 from: www.rigsrevisionen.dk.

"Quality initiatives on hospitals"

The Audit aims to investigate whether nation-wide quality initiatives help to ensure and develop quality in hospitals. The Audit identifies 17 nation wide initiatives with the Danish Quality Model being the far largest. There is a good deal of support from the nation wide initiatives to the regional work on improving quality. As the scale of initiatives is big further coordination may be warranted and can be supported by more IT solutions. The Audit finds that the Ministry of Health and the Regions could do a better job monitoring whether the objectives of in particular the Danish Quality Model are served. The Audit is based on information from

the Ministry of Health, Health Protection Agency, Patients Rights Organisation (Patientombuddet), Medicines Agency, Association of Danish Regions and the individual regions through and interviews, questionnaires and documents and statistics. For one hospital in each region interviews were made with hospital directors and 2 Department managements, there are a total of 5 medical (including 2 neurologic) departments and 5 surgical wards. There is also conducted 9 group interviews with health professionals (doctors, nurses, medical secretaries and therapists) on the wards. The questionnaire for individual hospital departments indicate which quality standards and procedures they have worked with in the period. Documentation from the Ministry of Health, Association of Danish Regions, the five regions, 5 hospitals and 10 departments concern work to ensure and develop quality such as the regional quality strategies, hospital quality policies, contracts between hospitals and regions, notes on building quality organisations, notes about the various interventions and evaluations.

[H4] RIGSREVISIONEN (2012), Beretning til Statsrevisorerne om mål, resultater og opfølgning på kræftbehandlingen, Report of the Audits of the State Accounts, January, Copenhagen, retrieved on 12 February 2012 from: www.rigsrevisionen.dk.

"Objectives, results and follow-up on cancer treatment"

The study aims to assess whether the Ministry of Health has set targets for cancer treatment and whether the Ministry and the regions monitor the results of cancer treatment. The audit finds that the Ministry should become better at setting targets and the regions in monitoring treatment. The study is based on examination of three types of cancer: lung, colon and rectal cancer and ovarian cancer. The audit is based on: interviews with civil servants at the Ministry of Health and the Regions and with managers and clinicians in a hospital in each region (Aalborg Hospital, Aarhus University Hospital, Odense University Hospital, Herlev Hospital, Herlev Hospital), meetings with researchers in the cancer area, Cancer Society and Danske Regions; data from clinical databases are discussed with the relevant clinicians; financial statements, activity statements and data for patient survival and time from the referral is received at the hospital for initial treatment; latest annual reports from the 3 clinical databases (Danish Lung Cancer Registry, National database for cancer of the colon and rectum, and the Danish Gynaelogically Cancer Database; and the annual report on lung cancer from the National Indicator Project.

[H2, H3] VIDEBÆK, Jørgen, Lisbeth Vestergaard ANDERSEN & Joan BENTZEN (2011), Dansk Hjertestatistik 2010, University of Southern Denmark, Institute for Public Health, retrieved on 12 February 2012 from: www.si-folkesundhed.dk.

"Danish Heart Statistics 2010"

The report provides a comprehensive overview of cardiovascular diseases nationwide and in individual regions and municipalities. Besides basic data on population including age distribution, education and ethnicity, the report contains data on mortality, hospitalisations, medication use and costs of cardiovascular disease in all municipalities, regions and nationwide.

[L] Long-term care

[L] ROSTGAARD, Tine, Liv BJERRE, Kresta SØRENSEN & Niels RASMUSSEN, Omsorg og etnicitet: Nye veje til rekruttering og kvalitet i ældreplejen, May 2011, Copenhagen: SFI, page/retrieved from: www.sfi.dk.

"Ethnicity and care"

Over the past years there have been campaigns aimed at attracting ethnic minority groups to undertake elderly care. Nowadays, one in ten persons working in elderly care is of another ethnic background than Danish and they expect to continue working with elderly care. All employed in elderly care express that working with people is one of the essential reasons for working in elderly care. Workers with an ethnic non-western background are also attracted by the short, practice-oriented education to become a social worker, the possibility to make a carrier, and the wage and job status are also of larger importance than for workers from an ethnic western background. Workers with an ethnic western background emphasise workingconditions and that the preconditions, especially time, allow them to provide a decent care for elderly. Management expectations of a better elderly care through more diversity and inclusion of workers from a cultural background where elderly are perhaps more respected than in Denmark is not reflected among the workers in elderly care nor in the result of the study. Language and racism on the part of the recipients (i.e. elderly) are among the challenges for new workers in the care sector. Workers with a non-western background put less emphasis on the importance of communication just as they work less towards help-to- selfhelp which is one of the principles in Danish elderly care. In short, more diversity in elderly care work gives management new challenges. The study is based on qualitative interviews and a survey among social workers and management in 10 municipalities.

[L], HANSEN, Eigil Boll, Leena ESKELINEN and Hanne Marlene DAHL, Hjælp til selvhjælp eller service i hjemmeplejen Hvordan er praksis, og er der en virkning? November 2011, page/retrieved from: www.akf.dk.

"Home Care: Help for Self-help or Service-oriented Help"

The aim of this study was to identify whether there is a preventive effect on older people's physical functioning and mental well-being of the municipal home care focuses on providing self-help compared with service-oriented help. The authors expected a priori that self-help could help to maintain elderly's ability to perform activities of daily living, while we did not have a clear expectation about the effect on mental well-being of one or the other principle. Two municipalities (Høje Taastrup and Varde) represent a principle of self-help and two municipalities (Brønderslev and Fredericia) represent a service-oriented principle. Municipalities, which represents self-help, had completed or were currently implementing projects specifically directed toward enabling and train recipients of practical assistance and care to help boost their self-reliance. Data comes from social and health care assistants (SOSU) perception and practice, focus group interviews and observations of the performance of aid to the elderly. To study the impact on senior citizens' physical functioning and mental well-being a survey among recipients of aid in the autumn of 2009 and a follow up survey in autumn 2010 among those who had answered the questionnaire in 2009. The recipients of such help was asked if they can perform a variety of daily activities without help, and how they have had it in the past four weeks. On this basis, the development from 2009 to 2010 in physical functioning and mental well-being among older recipients of aid compared in the four municipalities. A total of 1,693 elderly claimants of respondents in both 2009 and 2010. Finally, information

about the level of assistance granted in the two years were obtained from the municipalities, and changes in volume were compared.

4 List of Important Institutions

AE Arbejderbevægelsens Erhvervsraad - Economic Council of the Labour Movement
Address: Reventlowsgade 141, DK-1651 Copenhagen K
Contact: + 45 33 55 77 10
Webpage: www.aeraadet.dk
Think thank associated with the labour movement.

Akademikernes Centralorganisation, AC - The Danish Confederation of Professional Associations, AC
Address: Nørre Voldgade 29, DK-1017 Copenhagen K
Contact: + 45 33 69 40 40
Webpage: www.ac.dk
AC is an umbrella organisation for its trade union member organisations. These organisations offer service to professional and managerial staff graduated from universities and other higher educational institutions.

ATP-Arbejdsmarkedets Tillægspension - ATP-Labour Market Supplementary Pension
Address: Nørre Voldgade 29, DK-1017 Copenhagen K
Contact: -
Webpage: www.atp.dk
ATP administers not only the ATP scheme but also a series of other labour market schemes, including the Special Pension (Særlig Pensionsopsparing, SP), the holiday money (FerieKonto) and the Labour Market Occupational Disease Fund (AES). As of 2012 ATP will take over the payment of almost all social security benefits through its new agency, Payment Denmark (Udbetaling Danmark), located in five regional offices.

AKF-Anvendt Kommunal Forskning - AKF-Applied Municipal Research
Address: Nyropsgade 37, DK-1602 Copenhagen K
Contact: + 45 4222 3400
Webpage: www.akf.dk
AKF is an applied research institute that undertakes studies focusing on the large role played by local and regional authorities in Denmark.

Beskæftigelsesministeriet – The Ministry of Employment
Address: Ved Stranden 8, 1061 København K, Denmark
Contact: +45 7220 5000
Webpage: http://www.bm.dk
The Ministry of Employment has the overall responsibility for measures in relation to all groups of unemployed persons, i.e. both unemployed persons on social assistance as well as unemployed persons receiving unemployment benefits. In addition, the Ministry of Employment is responsible for the framework and rules as regards employment and working conditions, safety and health at work and industrial injuries, financial support and allowances to all persons with full or partial working capacity as well as placement activities, services in relation to enterprises and active employment measures.

Center for Velfærdsstatsforskning - CWS - Centre for Welfare State Research, Department of Political Science, University of Southern Denmark
Address: Campusvej 55, DK-5230 Odense M
Contact: + 45 65 50 00 00
Webpage: http://www.sdu.dk/Om_SDU/Institutter_centre/C_Velfaerd.aspx
Small research centre placed at the University of Southern Denmark that focus on the Danish welfare state in a comparative and historical perspective.

CEPOS - CEPOS, Liberal think tank
Address: Landgreven 33. sal, DK-1301 Copenhagen K
Contact: + 45 33 45 60 30
Webpage: www.cepos.dk
The most vocal liberal think thank is CEPOS.

Danmarks Statistik - Statistics Denmark
Address: Sejrøgade 11, DK-2100 Copenhagen Ø
Contact: + 45 39 17 39 17
Webpage: www.dst.dk
Statistics Denmark publishes statistical information on the Danish society.

Dansk Arbejdsgiverforening - Danish Federation of Employers
Address: Vester Voldgade 113, DK-1790 Copenhagen V
Contact: + 45 33 38 90 00
Website: www.da.dk

Danske Handicaporganisationer, DH - Danish Handicap Organisations, DH
Address: Kløverprisvej 10 B, DK-2650 Hvidovre
Contact: + 45 36 75 17 77
Website: www.handicap.dk
The umbrella organisation for interest organisations for persons with handicaps.

Danske Regioner - Danish Regions
Address: Dampfærgevej 22, DK-2100 Copenhagen Ø
Contact: + 45 35 29 81 00
Website: www.regioner.dk
Danish Regions is the national association of the five regions in Denmark.

Den Centrale Videnskabsetiske kommitte - The National Committee on Biomedical Research Ethics
Address: Slotsholmsgade 12, DK-1216 Copenhagen K
Contact: + 45 72 26 93 70
Website: www.cvk.sum.dk
The committee acts as an appeals committee in connection with findings in the regional committees, issues guide lines, considers submission of recommendations to the Minister for Health and Prevention regarding specific new fields of research etc.

Det Økonomiske Råd – The Economic Council
Address: Amaliegade 44, DK-1256 København K
Contact: +45 33 44 58 00
Website: www.dors.dk
The Economic Council is chaired by three leading macro economists, the so-called 'economic wise men' of which one is the 'economic over wise man'. The board consists of representatives from the social partners. However, it is the Secretariat of the Economic Council which writes the biannual reports. These reports consist of two parts. The first part is always a survey of the economy and the second part is on a special theme.Both parts are accompanied by policy recommendations.

Etisk Råd - The Danish Council of Ethics
Address: Ravnsborggade 2-4, DK-2200 Copenhagen N
Contact: + 45 35 37 58 33
Website: www.etiskraad.dk
The Council gives advice to the Parliament and public authorities on the ethical issues related to genetic engineering and biotechnology and it also initiates debates in the public.

Finansministeriet - Ministry of Finance
Address: Christiansborg Slotsplads 1, DK-1281 Copenhagen K
Contact: + 45 33 92 40 88
Website: www.fm.dk
The Ministry of Finance is as elsewhere an important player and publish the national reform programme among other publications.

Forsikring og Pension - Danish Insurance Association
Address: Amaliegade 10, DK-1256 Copenhagen K
Contact: + 45 33 43 55 00
Website: www.forsikringogpension.dk
The Danish Insurance Association, DIA, is the trade association of non-life and life insurance and multi-employer pension funds in Denmark.

Frivillighedsrådet - Council for Volunteers and Volunteering in the Social Field
Address: Nytorv 19, 3. sal, DK-1450 Copenhagen K
Contact: + 45 33 93 52 93
Website: www.frivilligraadet.dk
The Council for Volunteers and Volunteering is a NGO active in the social field arranging debates, campaigns and meetings.

Funktionærernes og Tjenestemændenes Fællesråd, FTF -FTF - Confederation of Professionals in Denmark
Address: Niels Hemmingsensgade 12, Postboks 1169, DK-1010 Copenhagen K
Contact: + 45 33 36 45 00
Website: www.ftf.dk
FTF is the trade union confederation for 450,000 public and private employees, making it the second biggest of Denmark's three main trade union confederations. Three out of four members work in the public sector. FTF has approximately 90 affiliated organisations. The five largest calculated by number of members are: The Danish Union of Teachers (Danmarks Lærerforening), The Danish Nurses Organisation (Dansk Sygeplejeråd), The Danish National Federation of Early Childhood Teachers and Youth Educators (BUPL), The Financial Services

Union (Finansforbundet), and the Danish Association of Social Workers (Dansk Socialrådgiverforening).

HK Danmark - HK Denmark
Address: Weidekampsgade 8, Postboks 470, DK-0900 Copenhagen K
Contact: + 45 33 30 44 15
Website: www.hk.dk
Trade union of office workers.

Institute for Quality and Accreditation in Health Care
Address: Olof Palmes Allé 13, 1. th., DK-8200 Aarhus N
Contact: + 45 87 45 00 50
Website: www.kvalitetsinstitut.dk
The Institute is an independent institution which administers and develops the Danish health care quality assessment model.

Institut for Folkesundhed - The National Institute of Public Health, University of Southern Denmark
Address: Øster Farimagsgade 5 A, DK-1399 Copenhagen K
Contact: + 45 39 20 77 77
Website: www.si-folkesundhed.dk
The primary purpose of NIPH is research into the health and morbidity of the Danish population and the functioning of the health care system. NIPH also carries out reviews and consultancy for public authorities and participates in postgraduate education. The institute also regularly publish The Public Health Report.

Kommunernes Landsforening - Local Government Denmark
Address: Weidekampsgade 10, P.O. Box 3370, DK-2300 Copenhagen S
Contact: +45 33 70 33 70
Website: www.kl.dk
Local Government Denmark is the national association of municipalities in Denmark.

Konkurrencestyrelsen - The Danish Competition Authority
Address: Nyropsgade 30, DK-1780 Copenhagen V
Contact: + 45 72 26 80 00
Web site: www.ks.dk
The Danish Competition Authority monitors the state of affairs with regard to competition.

Landsorganisationen i Danmark, LO - Danish Trade Union Confederation
Address: Islands Brygge 32 D, Postbox 340, DK-2300 Copenhagen S
Contact: + 45 35 24 60 00
Website: www.lo.dk
Danish trade union confederation.

Lægemiddelstyrelsen - The Danish Medicines Agency
Address: Axel Heides Gade 1, DK-2300 Copenhagen S
Contact: + 45 44 88 95 95
Website: www.dkma.dk
The Danish Medicines Agency administers legislation relating to medicines, pharmacists, and medical devices.

Indenrigs- og Sundhedsministeriet - Ministry of Domestic Affairs and Health
Address: Slotsholmsgade 10-12, K-1216 Copenhagen K
Contact: + 45 72 26 90 00
Website: www.sum.dk

Patientklagenævnet - The Patients' Complaints Board
Address: Frederiksborggade 15, DK-1360 Copenhagen K
Contact: + 45 33 38 95 00
Website: www.pkn.dk
The Patients' Complaints Board deals with complaints against health care professionals.

Patientforsikringen - The Patient Insurance Association
Address: Nytorv 5, DK-1450 Copenhagen K
Contact: + 45 33 12 43 43
Website: www.patientforsikringen.dk
The Patient Insurance Association makes decisions regarding compensation claims from patients injured in connection with treatment etc. in the health service or injured by a drug.

Patientskadeankenævnet - The Patients' Injury Appeals Board
Address: Vimmelskaftet 43, DK-1161 Copenhagen K
Contact: + 45 33 69 00 44
Website: www.patientskadeankenaevnet.dk
The Patients' Injury Appeals Board functions as a board of appeal for decisions made by

SFI-Det nationale center for forskning i velfærd - SFI-The Danish National Centre for Social Research
Address: Herluf Trolles Gade 11, DK-1052 Copenhagen K
Contact: + 45 33 48 08 00
Website: www.sfi.dk
SFI is an applied research institute that undertakes a large number of commissioned studies for especially the Ministry of Welfare and the Ministry of Employment.

Statens Seruminstitut - State Serum Institute
Address: Artillerivej 5, DK-2300 Copenhagen S
Contact: + 45 32 68 32 68
Website: www.ssi.dk
The State Serum Institute is a public enterprise, which prevents and controls infectious diseases, biological threats and congenital disorders. The institute produces vaccines and blood products.

Sundhedsstyrelsen - The National Board of Health
Address: Islands Brygge 67, P.O. Box 1881, DK-2300 Copenhagen S
Contact: Tel: + 45 72 22 74 00
Website: www.sst.dk
The National Board of Health assists the Ministry of Health and Prevention and other authorities with professional consultancy on health issues. In addition, the National Board of Health performs a number of administrative tasks, including supervision and inspection.

Videns- og Forskningscenter for Alternativ Behandling (ViFAB) - ViFAB - Knowledge and Research Center for Alternative Medicine

Address: Jens Baggesens Vej 90 K, 2. sal, DK-8200 Aarhus N
Contact: + 45 87 39 15 30
Website: www.vifab.dk

The centre is an independent institution under the Ministry of Health and Prevention. Its purpose is to increase knowledge of alternative treatment and its effect, to promote research and dialogue between authorised health personnel and alternative therapists and users.

The Danish Medical Research Council - c/o Danish Agency for Science Technology and Innovation

Address: Bredgade 40, DK-1260 Copenhagen K
Contact: +45 35 44 62 00
Website: www.fist.dk

DMRC provides research-based advice within the council's scientific area of expertise and it funds specific research activities based on researchers' own initiatives.

Velfærdsministeriet - Ministry of Welfare

Address: Holmens Kanal 22, DK-1060 Copenhagen K
Contact: + 45 33 32 93 00
Contact: vfm@vfm.dk
Website: http://www.ism.dk/Sider/Start.aspx

This Ministry is responsible for pension and long-term care for the elderly, among other policy programmes.

3F, Faglige Fælles Forbund - 3F

Address: Kampmannsgade 4, DK-1780 Copenhagen K
Contact: + 45 70 30 03 00
Website: www.3f.dk

3F is the largest trade union in Denmark with 352,588 members. 3F organises skilled and unskilled workers in many sectors and industries in the private as well as the public sector, including transport, building & construction, manufacturing industries, agriculture, forestry, horticulture and gardens, cleaning, hotel & restaurants.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en