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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: Axel West Pedersen

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1 Executive Summary

A major pension reform started to take effect from January 1. 2011. The main idea of the reform is to safeguard economic sustainability by both putting a break of future expenditure and by stimulating more labour supply. The reform consists of three main elements: 1) The introduction of a completely flexible age of retirement has been introduced from the age of 62 to age 75, based on the condition of actuarial neutrality. The take-up of pension benefits and work can be freely combined. 2) At the same time a system for automatic longevity adjustment of retirement benefits is put in place. Cohorts born after 1944 will have their benefits reduced in proportion to increases in life-expectancy compared to the life-expectancy of the 1943 cohort. 3) The third cornerstone of the pension reform is the introduction of a new system of the accrual of pension rights that is proportional to lifetime earnings. A high minimum pension is maintained, however, in the form of an individually targeted Guarantee Benefit. This new system for the accrual of pension rights will be implemented more gradually and only individuals born after 1963 will have their old age pensions fully decided by the new system.

It is still too early to tell whether the reform will produce the desired results in terms of higher labour force participation throughout the life-cycle and in particular in particular in later years. One effect of the reform has however materialised already and been a source of concern. A very large share of those who are now offered the opportunity to start drawing a pension from the age of 62 have in fact chosen to do so, in many cases in combination with continued full time working. The main reason for this is a new system of taxation for pensioners that appears to favour an early take-up – whether combined with continued full-time or part-time work or not.

A clear setback for the reform efforts has been the failure to adapt the occupational pension schemes for public sector employees in line the main principles of the national pension reform. There is still no indication that the public sector unions will be either persuaded (or forced) to come back to the bargaining table. A proposal for a new set of regulations for defined benefits schemes in the private sector are expected before the summer that will be fully compatible with the reformed National Insurance system, and this might trigger a debate also about the public sector schemes.

By the end of 2011 Parliament finally decided on an important and highly controversial aspect of the reform – the treatment of people who become disabled before reaching the early retirement age. The solution implies that disability pensioners will not be forced to start drawing their old age pension before the age of 67 but the accrual of new old age pension rights will be stopped at age 62. It has been further decided that disability pensioners will be partly shielded from the effect of the longevity adjustment.

From January 1st 2012 the so-called Coordination Reform of the public health care and long-term care system started to take effect. It redefines the division of labour between the state owned secondary health service and the municipal primary health care and long-term care service. One of the most concrete measures taken in connection with the reform is to let the municipalities take part in the financing of in-hospital care, and in this way give the municipalities an incentive to invest in preventive measures and to avoid an excessive use of in-hospital care for their inhabitants.

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

2.1 Overarching developments

The Norwegian economy is almost entirely unaffected by the continued problems that haunts the world economy in general and the Eurozone in particular. After a modest recession in 2009 the economy is growing with 1.6% in 2011 and an expected 2.2 in 2012, as shown in Table 1. The unemployment rate was down to 3.3 in 2011 and is expected to increase slightly to 3.4 in 2012.

Table 1: Macro-economic indicators (in %)

	2008	2009	2010	2011	2012*
GDP-growth	0	-1.7	0.7	1.6	2.2
Unemployment	2.6	3.2	3.6	3.3	3.4

*Source: Statistics Norway. * Prognosis*.

In an effort to cope with the economic downturn in the wake of the financial crisis, the Norwegian Government implemented a series of expansionary fiscal policies and it thereby consciously broke the self-imposed fiscal policy rule to limit the spending of petroleum revenues to the equivalent amount of a 4% real return on the financial assets held in the petroleum fund (its present official name is the Government Pension Fund Global). However, the Government committed itself to work hard to reduce public spending and increase revenues in order to secure a relatively swift return to a situation in accordance with the rule. In late 2009 it was expected that this commitment would require a tough effort to curb public expenditure in the following years. It turned out, however, that the Norwegian economy recovered much faster and much more which has resulted in automatically increasing revenues and reduced spending on unemployment benefits, and already in 2011 the spending of oil revenues is already in accordance with the rule. Norwegian fiscal policy is presently more constrained by worries about a potential overheating of the economy, than by the requirements set out in the fiscal policy rule.

Discussions about a need for cuts in social security benefits – like sickness benefits and disability benefits – that went high particularly in 2010, have now disappeared almost entirely from the agenda.

In February 2012 the Governor of the Norwegian National Bank raised his voice to challenge the fiscal policy rule saying that it is too lax as it rests on an assumption that the long-term real return on the petroleum fund will be 4%. Instead the Governor argued that a more realistic assumption would be a long-term real return of 3% and that the rule should be adapted accordingly.[1] If this advice was to be followed it would once again require cuts in public spending and put a much stronger demand on fiscal discipline. However, the suggestion was immediately rejected by Norwegian politicians including both the Prime Minister, the Finance Minister and leading spokesmen for the opposition. In April 2012 the Ministry of Finance published a White Paper on the management of the Petroleum Fund where the analysis by the Governor of the National Bank was rejected and an argument was made about the realism of the target of a 4% real return.[2]

[1] http://www.norges-bank.no/pages/88046/arstale_2012.pdf.

[2] Stortingsmelding nr. 17 (2011–2012) Forvaltningen av Statens pensjonsfond I 2011 http://www.regjeringen.no/nb/dep/fin/dok/regpubl/stmeld/2011-2012/meld-st-17-20112012.html?id=676409.

Having put this discussion to rest there is at present no indication that social policy will be changed dramatically in the immediate future.

2.2 Pensions

2.2.1 The system's characteristics and reforms

From January 1st 2011 a structural reform of the Norwegian public pension system started to be implemented. However, only parts of the reform take immediate effect and for a long transition period the pre-reform and the reformed systems will coexist.

The pre-reform system

The pre-reform National Insurance pension system is a traditional defined benefit scheme combining a universal flat-rate benefit with an earnings-related second tier. To qualify for full earnings-related benefits you need a 40 year contribution record and benefits are calculated on the basis of the twenty best years of an individual's earnings career.

An important feature of the system (both pre- and post-reform) is the generosity of minimum protection offered to old age pensioners. The minimum benefit for a single pensioner is currently (from May 2011) fixed at just above NOK 158,400. Since a pensioner who receives this minimum benefit will not pay taxes, the effective minimum benefit is quite high and currently equivalent to almost 50 % of the net (after tax) value of an average full time wage (Christensen et al. 2009).

Another important feature of the pre-reform system is that the benefits (as well as accrued pension rights) are indexed with the development in average wages. Although the indexation mechanism has never been fully automatic, development in pension benefits and accrued pension rights has – particularly over the last decade – been roughly in line with the development of average wages.

The pre-reform system is based on pay-as-you-go financing and the system is fully integrated in the general state budget. Current public expenditure on old-age pensions is surprisingly low when measured against the total size of the economy, and about on par with notorious low-spenders like UK and the US. In 2007, for instance, public expenditure on old-age pensions amounted to no more than 4.7% of GDP in Norway compared to an OECD-average of 7.0% (OECD 2011). Four factors contribute to the comparatively low expenditure level: the high GDP, the comparatively high formal retirement age, the incomplete maturation of the scheme, and the relative modesty of replacement rates offered by the existing scheme to average and high income earners (while the level of minimum protection and replacement rates for low income earners are high).

In the absence of a substantive pension reform, Norway was expected to move from being a low spender to one of the top spenders in the OECD-area. In addition to the purely demographic factors, expenditures are expected to grow as a result of continued maturation of the earnings-related second tier. The maturation period has been prolonged as a result of growing female labour force participation since the 1970s. The influx of women into the labour market has so far provided more shoulders to carry the costs of current pension expenditures, but when these economically active female cohorts eventually retire, they can claim much higher benefits than previous generations of female pensioners. According to a projection made by the Pension Commission that prepared a proposal for the contemporary reform, public expenditure on old-age pensions was expected to more than triple its share of GDP over the coming five decades to reach 14.8% of GDP in the year 2050.

The expected consequences for the tax load on future tax-payers were less dramatic, however. Thanks to booming oil revenues, Norway has from the mid-1990s run huge surpluses on the state budget that have been transferred to the so-called "State Petroleum Fund" and invested in international capital markets. Since 2001 the build of this fund has been regulated by a self-

imposed fiscal policy rule linked to the balance of the general state budget. The rule basically says that all state revenues from the petroleum sector will be set aside in the fund, while only an amount corresponding to a 4 % real return on the financial assets is allowed to be consumed annually.

In 2009 the accumulated assets in this fund surpassed the value of GDP, and in March 2012 the total value is about 3,500 billion NOK.[3] The continued build-up of this fund over the coming decades is expected to help smooth out the financial burden associated with population ageing.

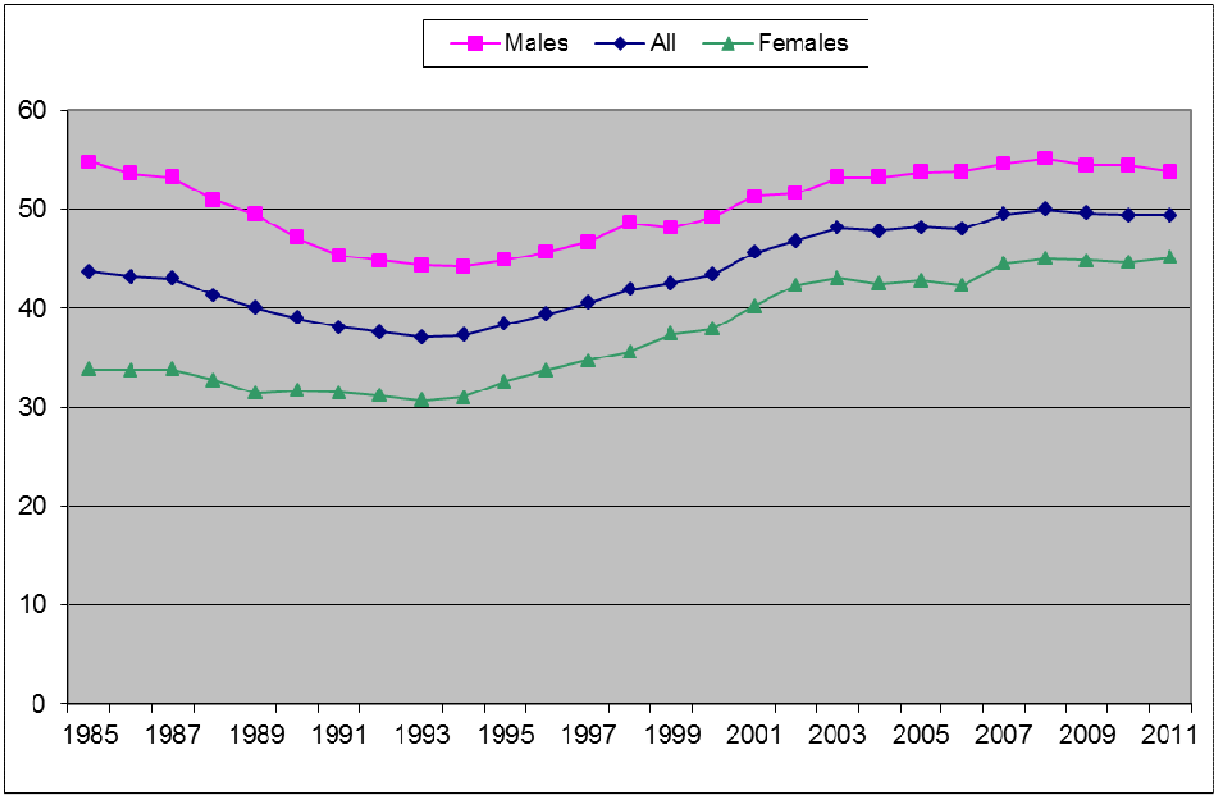
The normal age of retirement in the National Insurance scheme has for several decades been fixed at the age of 67, but from 1988 a negotiated early retirement scheme has allowed employees in the unionised sectors of the economy to withdraw earlier – since 1998 from age 62. The so-called AFP-scheme was financed partly by employers and partly by a government subsidy. Among the older cohorts who are about to enter the relevant age span, it has been estimated that coverage was close to 80% (Midtsundstad 2004, see also Christensen et al. 2009). For those covered the scheme provided a fairly strong incentive to retire early as there were no actuarial penalties for taking up early retirement benefits between age 62 and 67.

Somewhat surprisingly, labour force participation among elderly cohorts in Norway has remained fairly stable over the last decades.[4] As can be seen in Figure 1, since the mid 1990s there has even been a slight increase in participation rates among the population 55+. A tight labour market and low unemployment rates for most of the period are likely to be the major explanation for this. In 2009 we could for the first time in many years observe a small drop in participation rates – most likely as the result of a slight weakening of the labour market due to the financial crisis - but the situation appears to have stabilised again from 2010. The introduction of a flexible retirement age on actuarially neutral terms from the beginning of January 2011 that will be described below does not appear to have led to dramatic changes in this time-series.

[3] http://www.nbim.no/no/Investeringer/markedsverdi/, March 15. 2012.

[4] One should note however that the labour force rates portrayed in Figure 1 include also very short part-time work, and the development in full-time equivalents is likely to have been somewhat weaker over this period.

Figure 1: Labour force participation among the population aged 55-74[5]



Finally it should be noted that the Norwegian pension system comprises a fairly comprehensive system of occupational pension schemes. All employees in the public sector (state and municipalities) have since the early 1960s been covered by generous occupational pension schemes offering a gross replacement rate of 67% of the final salary after a minimum of 30 years of active service.

In the private sector, coverage with occupational pensions has been less widely diffused and the quality of the schemes varies strongly. The establishment and running of private occupational schemes has largely remained the prerogative of individual employers – and not a subject for negotiations with trade-unions, and tax rules for occupational pension schemes have traditionally followed the so-called "EET" formula, implying that both contributions and returns are exempt from taxation while benefits are subject to income taxation. Also the private sector schemes have traditionally been of the defined benefit type, with only the most generous of the private occupational schemes being on par with the public sector schemes. During the 1980s coverage with occupational pensions in the private sector increased (Pedersen 2001), but by the late 1990s coverage was estimated to have stabilised at about 50% of the private sector workforce.

In 2001 a new comprehensive legislation on private sector occupational pensions was put in place, allowing for the first time favourable tax treatment to be extended to defined contribution schemes (either of an insurance type or the pure savings type). In the following years coverage with occupational pensions only expanded slowly but many employers have reacted to the new legislation by replacing existing defined benefit schemes with new defined contribution schemes.

[5] Source: Statistics Norway, http://statbank.ssb.no/statistikkbanken/, March 10. 2012.

In connection with the process to reform the public pension system a new law on occupational pension schemes was introduced in 2006 making it obligatory for all private sector employers to run an occupational pension scheme of minimum quality for their employees – either of the defined benefits or the defined contribution type. The law specifies a minimum requirement for the level of contributions at 2% of the wage. Obviously this has made the coverage with occupational pension schemes almost universal also among private sector employees, but it has been shown that almost all new schemes that have been established as a consequence of the law, are of the defined contribution type and with contributions set at the minimum level required (Veland 2008).

The reformed system

The Norwegian pension reform is strongly inspired by the innovative Swedish (and Italian) pension reforms from the previous decade. It can be described as consisting of 4 main elements:

- The introduction of a new (NDC-inspired) system for the accrual of pension rights
- The introduction of an actuarially "neutral" flexible retirement between age 62 and 75
- The introduction of an automatic longevity adjustment factor
- Less than full wage indexation of pension benefits

The three last features have taken effect from January 1st 2011 while the new system for accrual of pension rights will only be fully implemented for cohorts born in 1964 or later while it will partly implemented for the cohorts born between 1954 and 1963. Older cohorts will have their benefits decided entirely by the rules of the old (pre-reform) system.

The new system for the accrual of pension rights

The new National Insurance system old-age pensions will consist of two types of benefits. An Income Pension that is designed to be strictly proportional to life-time earnings and a Guarantee Pension taking care of minimum protection.

For each year in gainful employment an amount equivalent to 18.1% of the yearly earnings will be credited to a "notional" pension account. The pension wealth on the notional account is supposed to accumulate over the economically active life, and it will be converted to a life annuity when the individual decides to start drawing benefits. Yearly earnings (and self-employment income) up to a ceiling of 7.1 times the Base Amount (NOK 562,000 from May 2011) count, and pension accrual can start from the age of 13 and continue to the age of 75. Accrued pension rights will be automatically indexed with the development in average wages. This approach guarantees direct proportionality between life-time earnings (below the yearly earnings ceiling) and accumulated pension rights.

Individuals who do not participate in gainful employment for particular (politically sanctioned) reasons are also secured the accrual of pension rights. Parents with small children (under the age of six) are guaranteed a minimum pension accrual equivalent to an earnings level of 4.5 Base Amounts (NOK 356,000 2011/12). Young people doing military service will receive pension rights equivalent to an earnings level of 2.5 Base Amounts. For social security recipients, social security benefits are as the main rule counted as earnings, while recipients of unemployment benefits will have their pension accrual calculated on the basis of previous earnings up to an income equivalent to 6 Base Amounts.

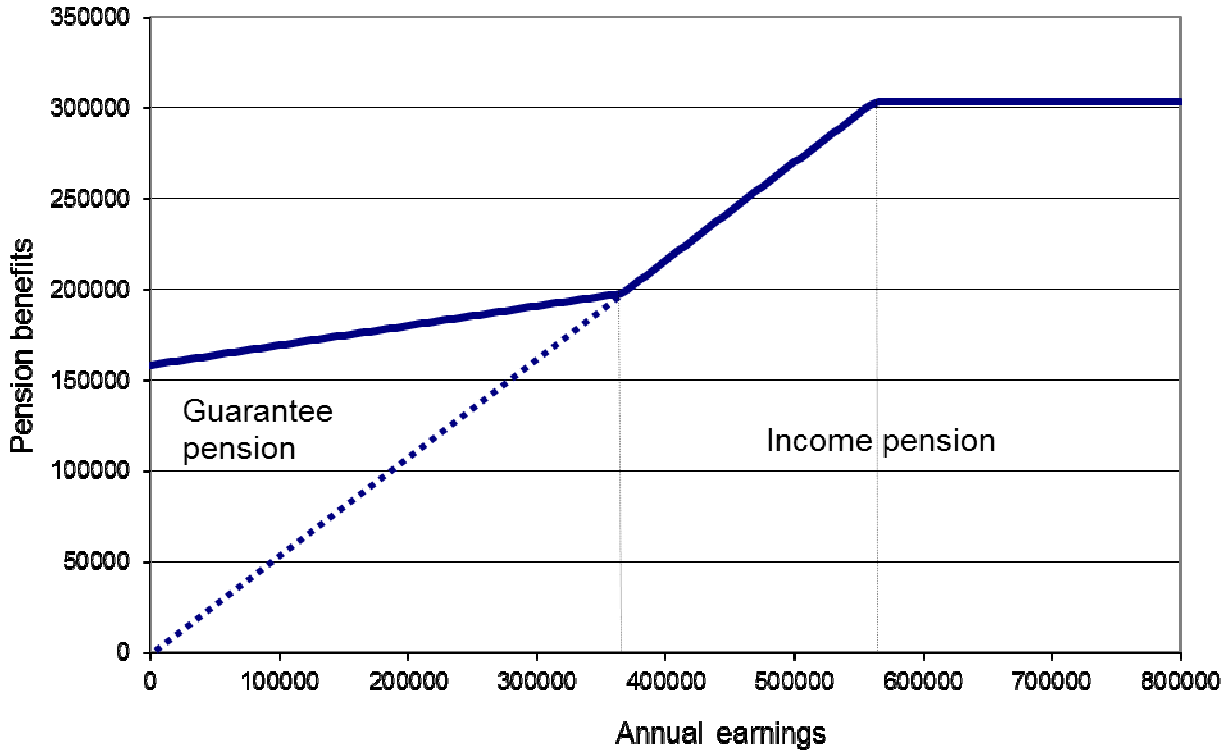
Minimum protection will be provided by a Guarantee Pension. The level of the Guarantee Pension has been fixed at the same level as the existing minimum pension, and it will be indexed with the same wage index as accrued pension rights in the Income Pension system. The Guarantee Pension will be tapered against Income Pensions by 80%. This ensures that people with rights to Income

Pensions are always allowed to keep at least part of their advantage vis-a-vis individuals with no earned pension rights what-so-ever.

The compound profile of the new system is shown in Figure 2 in the stylised case of a (single) worker with 40 years of stable earnings/contributions to the system. It shows that the formal proportionality of the Income Pension system is strongly modified in the long tapering interval of the Guarantee Pension that in this case stretches to a yearly earnings level of NOK 367,000 – which is more than ¾ of an average full time wage.

In other words, the strong link between earnings and benefits that characterises the income pension system, only applies in practice to a relatively narrow section of the earnings distribution. Due to the tapering of the Guarantee Pension, the marginal effect of increased earnings/contributions to the system are very modest for wage earners who can expect to end up with less than average lifetime earnings.

Figure 2: The benefit profile of the reformed old-age pension system. Single pensioner with a stable 40 year contribution record (NOK 2012)



Source: Author's own compilation

The compound benefit profile of the new system does not deviate dramatically from the old system. It is - like in the old system - strongly progressive, offering very high replacement rates in the bottom parts of the earnings scale and declining replacement rates in the intervals well above average wages.

The progressivity of the benefit profile has been reinforced by a revision of pensioner taxation that was passed by Parliament in connection with the 2011 budget (Prop. 1 LS (2010-2011) Skatter og avgifter). The main purpose of the revision is to make sure that pensioners, who receive the minimum benefit only, will continue to be complete exempt from income taxation. While the

general tax rules of old age pensioners will be normalised (by removing a general tax-allowance to all old age pensioners), poorer pensioners will be given a tax credit that is tapered off against pension income (but not earnings) in excess of the minimum pension level. The taper is relatively mild (17%) which means that the credit will benefit a significant share of the pensioner population.

Flexible retirement between 62 and 75 on actuarially neutral terms

From January 1st 2011 the retirement age in the National Insurance system has become flexible between age 62 and 75, based on the principle of actuarial neutrality. The principle of neutrality implies that each individual carries the full costs associated with the timing of retirement. The introduction of neutrality is followed up by a complete removal of all earnings and work tests. It is now possible to draw a full old-age pension from age 62 while continuing to work full time and an almost continuous range of options to draw a partial pension are available.

One should note, however, that the right to start drawing old-age pensions at age 62 is made conditional on having enough accumulated pension rights so that the actuarially reduced benefit is at least as high as the Minimum Pension. The requirement has been installed in order to avoid that people are tempted to spend the pension wealth too early and hence having to cope on a benefit that is insufficient to maintain a decent living standard throughout retirement.

The AFP scheme that used to offer a heavily subsidised early retirement option, has for employees in the private sector been completely transformed into a kind of (additional) occupational pension scheme paying life-long benefits as a supplement to National Insurance benefits. Benefits from the new private sector AFP-scheme can be drawn from age 62 on flexible and neutral terms just like the National Insurance benefits. Also AFP benefits can be drawn alongside full-time or part-time work. For those private sector workers who are covered by the new AFP-scheme it represents a substantial addition to the pension wealth they accumulate in the Nation Insurance scheme and the wealth accumulated in the standard occupational pension schemes.

In 2009 the Government tried to achieve a similar consistent implementation of the principle of actuarial neutrality also for public sector employees but the attempt failed due to strong resistance from public sector unions. Instead employees in the state and municipal sector have kept their existing AFP-scheme more or less intact, i.e. as an early retirement scheme with strong subsidies for those who choose to withdraw early.

Longevity adjustment and indexation of benefits

The reform contains two retrenchment measures of which the first – longevity adjustment – is by far the most important. The idea is basically that old-age benefits in the future will be reduced in proportion to an increase in longevity compared to the situation in 2010.[6] In practice this is achieved as the accumulated pension wealth is turned into an annuity upon retirement. The annual benefit will be calculated on the basis of a stylised projection of the remaining life expectancy for the particular cohort at different age levels. For each cohort a table of remaining life-expectancy figures will be produced as the cohort turns 61 and the figures will be calculated on the basis of historical mortality rates for the preceding cohorts. In other words, the actuarial adjustment to the timing of retirement and changes in longevity are done in the same operation and both are incorporated in the annuity divisor. Also the level of the Guarantee Pension will be subject to longevity adjustments, while being otherwise indexed with wages.

[6] More precisely the remaining (average) lifeexpectancy at age 61 for the 1943 cohort is estimated on the basis of mortality statistics from the 10 preceeding years, and used as an anchor for the longevity adjustment for future cohorts for whom similar lifeexpectancy estimates are calculated at age 61.

According to the favoured projection by Statistics Norway, longevity after age 62 is expected to increase with about 1 year in every ten years (Brunborg & Texmoen 2011). If this turns out to be the case, the longevity adjustment will result in a 20% reduction of pension benefits for the cohorts retiring around 2050. The saving for the National Insurance scheme will be of an equivalent magnitude. The introduction of this measure removes a very important growth factor in public expenditure on pensions and a source of uncertainty about the future financial burden. The burden is instead transferred to each pensioner cohort. With a flexible retirement age, pensioners can in principle compensate for the reduction in yearly benefits by working longer, and about eight months of continued work will as the main rule be enough to compensate for a one year increase in longevity.

The other retrenchment measure is to let pension benefits – once they have started running – be subject to indexation rules that do not offer full wage adjustments. In practice it has been decided to let running pension benefits be indexed with wages minus a fixed factor of 0.75 percentage points. It is estimated that this measure will in the long run achieve a reduction in pension expenditures of about 7% compared to full wage indexation.

Financial structure

The new system of accumulating pension rights resembles closely the reformed Swedish pension system that in the international literature has been referred to a Notional Defined Contribution (NDC) system. Also the new Norwegian system will be based mainly on pay-as-you-go financing and the accounts used for the accumulation of pension rights will indeed be "notional". However, contrary to the Swedish system, the reformed Norwegian pension system is not autonomous and self-financing and the 18.1% accrual rate does not correspond to an earmarked contribution to the pension system of a similar magnitude. The new Norwegian system will (as before) be fully integrated in the general state budget, and the existing system of financing through a mixture of general social security contributions, pay-roll taxes and general taxation will be continued.

2.2.2 Debates and political discourse

A number of issues related to the implementation of the pension reform were not fully settled when the reform took effect from January 1. 2011. The first and one of the most controversial is concerned with the way the old-age pension reform is implemented for disability pensioners.

Old- age benefits to former disability pensioners

The old age pension reform has made it necessary to modify the disability benefit system. Today disability benefits are modelled on the existing old age pension system, but this will no longer be possible when the accrual of old-age pensions is changed towards the NDC-formula. In addition to decide on a new formula for disability benefits, important decisions have to be made on the conditions under which disability benefit recipients shall accrue old-age pension rights. Since about 40% of a cohort of new old age pensioners comes from the disability system, this is an extremely important and potentially very controversial aspect of the entire old age pension reform.

A commission appointed by the Government to deal with these issues published its report already in 2007 (NOU 2007:4). However, the Government was slow to follow up on the commission's proposal and a solution was not ready when the reform started to take effect. Finally the Government has in May 2011 presented its proposal for new legislation that is supposed to take effect from January 2015 (Prop. 130 L (2010–2011): Ny uføretrygd og alderspensjon til uføre).

In line with the proposal from the commission the Government has suggested to tighten the conditions for the accrual of pension rights for disability pensioners compared to the present system. Today disability pensioners are transferred to the old-age pension system at the normal retirement age of 67, and they earn pension rights based on their pre-disability earnings level up

until that age. This rule is viewed as problematic when from 2011 the non-disabled can start taking up old-age pensions at 62 with a heavy actuarial penalty. On this background the Government endorses a compromise saying that disability pensioners should be allowed to continue drawing disability benefits until they reach 67 (just like today), but that their accrual of earnings-related old-age benefits is stopped at age 62.

Even more controversial is the question whether the general longevity adjustment should be applied with equal force to people entering retirement from the disability system. These individuals do not have the opportunity to compensate for the longevity adjusts by working longer, and this has been seen as a powerful argument for giving the disabled some sort of protection. On the other hand, if the disabled should be fully shielded from the effects of longevity adjustment, a significant part of the overall retrenchment effect will be lost and both negative legitimacy and incentive effects are foreseen if it appears that coming into old-age via the disability system is particularly attractive.

The Government's suggestion for a compromise on this very difficult issue has been to implement mechanism for a partial shielding of disability pensioners who will retirement in the coming years (putting a limit to the adjustment effect of 0.25 percentage points per year). This mechanism will later be evaluated in light of developments in the retirement behaviour of the non-disabled. If it turns out that most people choose to adapt to the longevity adjustment by working longer, the disabled will be shielded to a higher degree, while they will not be shielded if most people do not work longer and simply accept lower annual benefits as a result of longevity adjustment.

The proposal from the Government on these issues was finally accepted by Parliament in December 2011 with support from the opposition parties. This means that one of the most important issues that were left pending after the bulk of the reform took effect in 2010/2011 has been settled.[7]

The adaptation of occupational pension schemes

In the private sector the AFP-scheme has been adapted entirely in line with the Government's (and Parliament's) preference for an actuarially neutral system for the drawing of pension rights. The more technical issues related to the adaptation of the private sector occupational pension schemes have not yet been solved, however. An expert committee dealing with this issue published a report in May 2010 (NOU 2010:16). Here they suggest a number of technical changes to the legislation on defined contribution schemes that will ensure compatibility with the reformed National Insurance system, but the committee found it necessary to postpone the much more complicated issues related to the adaptation of defined benefit schemes. The committee is expected to publish a report before the summer of with a proposal for a comprehensive new legislation concerning private sector occupational pension schemes that is intended to bring these schemes in line with the reform of National Insurance.

One problem that the social partners in the private sector are likely to be struggling with in the coming years is the coordination between the existing occupational schemes (either defined benefit or defined contribution) and the new reformed AFP-scheme – which, as already mentioned, has now been transformed into another occupational pension scheme. For workers that are already covered by a good occupational pension scheme the total compensation rate (given that they continue to work till age 67) could become extremely high, and many private sector employers are likely to see this as an opportunity to reduce benefit levels in their occupational pension scheme.

In the public sector the situation is very different. In addition to upholding the existing AFP-scheme the public sector unions also managed in 2009 to shield older cohorts of public employees

[7] http://www.stortinget.no/PageFiles/312141/vedtak-201112-030.pdf.

from the effects of another crucial aspect of the National Insurance reform, the longevity adjustment, and to uphold a system where the total pension benefits of public employees is determined by their final salary and a full pension is earned after 30 years – see Prop. 107 L (2009-2010) for a description of the concrete legislation. This means that crucial aspects of the general pension reform – life-time accrual of pension rights, a flexible and actuarially neutral retirement age – do not apply to the about 1/3 of the workforce employed in the public sector. In the implementation of the 2009 agreement, the Government has chosen a set of rules that even severely weakens work incentives for public sector employees between the age of 67 and 70. The counterintuitive and counterproductive effects of these rules came under media-scrutiny in the Fall of 2011, but only to spur a surge of blame avoidance between the Government and public sector unions.[8]

While a minority of the unions that took part in the negotiations in 2009 have signalled that they are willing to revise this settlement, the majority appear stern in their commitment not to open up for a renegotiation. This means that there is no immediate change in sight that could bring the pension system for public sector employees more in line the principles of the general pension reform.

Little impact of the financial crisis

The financial crisis has been extremely mild in Norway and it has had very little effect on the pension policy discourse. The fall in stock market values and the low interest rates in wake of the credit crunch in 2008, did give heavy losses for the State pension fund and it was felt in the occupational pension sector. However, the State pension has regained most of the losses, and occupational pension schemes – both of the defined benefit and the defined contribution type – have not been seriously disrupted by the crisis. The fact that most defined contribution accounts are still in a very early phase of build-up, explains why there has been fairly little debate in the media over potential losses, even when share prices were at their lowest in first half of 2009. The low rates of return on pension capital to be expected for a foreseeable future does add to the pressures on existing defined benefit schemes and give strong incentives to employers for converting their schemes to the defined contribution type.

2.2.3 Impact of EU social policies on the national level

It is very difficult to find traces of an impact of EU social policies on the Norwegian pension reform process. As a non-member Norway does not participate in any of the OMC processes. The OMC on pensions with its policy guidelines and recommendation is not mentioned in any of the central policy documents in the field, and has not received any media coverage. The same is true for the EU Green Paper on pensions.

It is a longstanding practice in Government commission reports and in green and white papers to have chapter with description of relevant policies in other countries – the other Nordic countries and other Northern European countries like Germany and the UK are used in this way as sources of inspiration and reference points. This practice has been maintained in recent policy documents on pensions.

EU hard law does occasionally appear as an influence on very specific parts of pension legislation. One example here is a case where the occupational pension scheme for public sector employees (Statens pensjonskasse) for a number of years operated with more favourable rules for widows as opposed to widowers. This practice has on more than one occasion been deemed in violation of the equal treatment principles of the treatises, and the Government was forced to pay out compensation to the widowers who were subject to discrimination.

[8] http://www.aftenposten.no/jobb/article4258105.ece.

2.2.4 Impact assessment

The goals of the pension reform was to achieve an increase in the effective retirement age, secure the long term financial sustainability of the pension system and a more simple and coherent system from the view of individual wage earners. It is of course far too early to tell whether the two first goals will be fulfilled.

Concerning the retirement age Norway has over the last decades had comparatively high effective retirement ages. Since the mid1990s there have even been tendencies for an increase in labour force participation of people age 60+ and in effective retirement ages but this tendency turned to a slight decrease in 2009 and 2010 (Haga and Lien 2011).

From January 2011 the two phenomena – withdrawal from the labour market and the drawing of a pension – will in principle be separated with the new flexible system of retirement. The political interest is concentrated on the first: will individuals age 60+ increase their labour supply and postpone the age of actually withdrawing from the labour market in response to the new flexible system that gives strong incentives to continue working?

If people choose to postpone retirement it will give a welcome boost to total labour supply, and for the state coffers it will have a positive effect due to higher tax payments. Attempts to estimate the retirement behaviour of Norwegian workers based on historical data with a structural model have indicated that the introduction of actuarial premiums will have a very substantial positive effect on the labour supply of workers age 62+ (see Hernæs and Iskhakov 2009 and Hernæs and Jia 2012). However one should note that these estimations do not take into account the fact that the new flexible system does not apply among public sector employees who make up between a 1/4 and a 1/3 of the entire workforce. Also it has been pointed out that for those groups that were not covered by the old AFP-scheme, the reform has in fact opened up a new possibility to withdraw from the labour market and take up a pension from age 62, and it is a general finding in research on retirement behaviour that some individuals will retire at the earliest possible date – despite any incentives to stay on (Lien 2009).

Possible changes to the timing of the start to draw a pension is not associated with the same interest – simply because the new flexible system implies that an early take-up of benefits will result in lower annual benefits and the effects for the pension system in the steady state should in principle be nil. However it would not be particularly desirable if everybody choose to exploit the new possibility to start drawing old age pensions at age 62. First of all this would produce a one-off loss for the state coffers that will never be regained unless the trend is turned, and from a social policy perspective it is a source of worry if too many people use up too much of the total pension wealth early and enter the later stages of their retirement carrier being dependent on a low annual benefit. It has been pointed out that the new system of pensioner taxation contains a stimulus for many people to take out their pensions early (while continuing to work full- or part-time), and there is reason to expect that this practice could become rather widespread (Pedersen 2010, Fredriksen & Stølen (2011a; 2011b).

By the end of 2011 it turns out that the rate of take up of early old-age retirement benefits has exceeded all earlier prognoses to reach 30,000 new claimants (Dahl and Lien 2011). However, the first estimation of changes in the labour force participation of people in the eligible age groups (Dahl & Lien 2011) confirms that employment rate among people aged 55+ have simultaneously increased in line with the more long-term trend (see Figure 1 above). It appear that as long as Norway is back to a situation of virtually full employment there is little reason to expect a strong negative development in the labour supply of older workers. The increased take-up of old-age pensions is therefore a strong indication that the decisions to take-up benefits and to retire from the labour market have in effect been detached from each other.

2.2.5 Critical assessment of reforms, discussions and research carried out

The pension reform is in an initial phase of implementation. The content of the reform has undergone significant changes and amendments since the first outline was sketched by a Government commission in 2004. The overall distributive profile of the reform was modified by decisions made in the recent years to significantly improve the level of minimum protection.

Since the level of minimum benefits will in the future be indexed with wages – but adjusted to increases in longevity – relative poverty rates among the elderly are likely to remain very low and only slowly increase in the long run as a result of longevity adjustments.

The strong emphasis given to distributive concerns in the last phase of the reform process means that the overall system will not provide as powerful incentives to participate in gainful employment throughout the life-course as was the original intention (Pedersen 2010; Fredriksen & Stølen 2011a; 2011b). The Government has announced that it will commission a large research based evaluation of all aspects of the reform, and this evaluation will hopefully show what impact the reform has had on economic and political outcomes.

The surprisingly high take-up rates that have been observed among people aged 62-67 since January 1st 2011 when the new flexible system was first introduced, is a source of worry from a number of different perspectives. High take-up rates at early ages produces a one-off hike in pension expenditure and an associated weakening of the state finances will never be recovered unless the tendency is reversed sometime in the future. Secondly the observation that the propensity to take out benefits early is particularly high among low wage earners (see Dahl 2011) is a cause of worry from a distributive point of view since it must be expected to lead to higher income inequality over the remaining retirement phase. Finally, the observation that take-up rates are much higher among eligible males than females (Dahl 2011) could be an indication of strategic behaviour where men have realised that their shorter life-expectancy could make it profitable to take out benefits early – (see however Lien 2012).

Arguably, the most serious weakness of the entire reform package is the failure to adapt the occupational and early retirement schemes for public sector employees to the main principles of the reform. This clearly weakens the reform both in terms of its expected economic effects and in terms of its political legitimacy. The incompatibility of the occupational pension schemes in the two sectors creates new problems for labour mobility between public and private enterprises.

The Government has decided to commission a large research based evaluation of all aspects of the reform. The first part of this evaluation will concentrate on the political decision making process and the efforts undertaking to inform the general public about the content of the reform and its consequences for the individual, while later parts will comprise a comprehensive evaluation of the effects on labour force participation and other pertinent outcome variables.[9]

2.3 Health Care

2.3.1 The system's characteristics and reforms

In line with Scandinavian traditions, the provision of health services is in Norway predominantly a public responsibility, and public health care is provided on the basis of the principle of universal access for all legal residents in the country. A number of laws regulate the rights of citizens to receive adequate health care and the terms under which these services are delivered.

The administrative responsibility for delivering health care services is divided between the municipalities and the state. Primary health care is the responsibility of the municipalities. Under

[9] See: http://www.forskningsradet.no/prognett-evapen/Home_page/1253961246164.

the "Municipal health services act" (Lov om helsetjenesten i kommunene), the municipalities in addition have the obligation to deliver a range of preventive activities and services. The responsibility for providing specialised health services (and here most importantly hospital services) has since the year 2002 been transferred to the state.

Private health insurance is still a relatively marginal phenomenon in Norway and commercially run private hospitals are almost non-existing. Commercially provided health services are mostly found in the area of specialised outpatient treatment and simple surgical procedures.

In the beginning of the 2000s two important reforms of the Norwegian health services were implemented. The first introduced a new principle on the provision of primary health care, while second changed the organisation of specialised care.

In 2001 the municipal primary health care system was rearranged in line with the basic principles of British National Health Service and in line with the organisation in other neighbouring Scandinavian countries. The population is offered the opportunity to register with a general practitioner (fastlege) who provides access to all publicly financed primary and secondary health care. This general practitioner is self-employed but operates under a contract with the municipality. Before this system was installed, patients in Norway could shop around between general practitioners, with or without a contract with the municipality, and gain direct access to specialists whose services were subsidised by the state through a system of reimbursements for the services provided.

Under the present system patients are obliged to stick to one general practitioner at a time, and they are only allowed to change two times per year. In addition patients are offered the right to have a second opinion by another doctor, in the case that a conflict arises with their current practitioner. The introduction of this system was originally rather controversial and met with scepticism from part of the medical profession. One of the objectives of the reform was to achieve a more effective regulation of the access to expensive specialised services, and another was to secure more continuity in the patient-doctor relationship, which was believed to be particularly useful for people suffering from chronic diseases. The reform was subject to a thorough research based evaluation over the period 2001-2005, and the main conclusions of the evaluation were positive.

A second major health reform took effect from the beginning of 2002. It implied that the responsibility for owning and running the secondary health service including the hospitals were transferred from the counties, to the state. In one sense the reform entailed a strong centralisation of the responsibility for hospital care. On the other hand, hospitals were restructured under the ownership of four regional health enterprises that were given wide autonomy to run their business under supervision from the Norwegian Directorate of Health and the Ministry of Health. These new regional health enterprises are non-profit organisations.

One of the main motives of the reform was to achieve a higher degree of specialisation and hence efficiency in the production of hospital services. First of all the counties were deemed too small to allow for a sufficiently efficient specialisation and secondly the reform is a reflection of ideas inspired by New Public Management, with its emphasis on the establishment of quasi markets and more autonomy to corporate management. There has since the reform was enacted, been a continuous discussion about whether it has succeeded in improving efficiency. A research based evaluation of the reform published in 2007 produced a rather mixed picture.

Despite the emphasis of public financing user charges do play a role in some parts of the public health service. Both in primary health care and in specialised care and outpatient treatment patients are charged modest user fees. Patients also have to pay for pharmaceutical products but when prescribed by a doctor to treat a chronic illness they are strongly subsidised by the state.

Individual expenditures on user charges and pharmaceutical products are further limited by a scheme that secures reimbursement of expenditures in excess of a specified ceiling. When it comes to treatment inpatient treatment in hospital, there is no user charges in the Norwegian system.

The "coordination reform"

From January 1st 2012 a new health care reform is being implemented. The reform process started in June 2009 when the Government launched a White paper on a comprehensive reform agenda for both health services and elder care services in Norway. The White paper was titled: 'The coordination reform' and the main thrust of the document was to improve integration and coordination between primary and secondary health care (hospital care and outpatient specialist treatment) and between health care and elderly care (St.meld. nr. 47 (2008-2009).

An important aspect of this reform agenda is to achieve a better coordination between health services run and financed by the state and services run and financed by the municipalities (primary health care and elder care).

The white paper identified three main weaknesses of the present system:

- The needs of patients who require both health and care services are not effectively met. One symptom of this is the practice of hospitals to release patients who need long- term care, without making sure that the needed care service is actually available in the municipality – or vice-versa examples of hospitals that keep patients longer than required because no adequate care service is available.
- There is too little emphasis on prevention in the overall system.
- Mechanisms securing cost containment and efficiency in the delivery of services are too weak.

The reform agenda contains proposals to rearrange the division of responsibilities between municipalities and the state and between primary health services and specialised services. The main idea is to strengthen the role of the municipalities in the overall system. Arguably this approach faces the obstacle that many Norwegian municipalities are extremely small and therefore it is questionable whether they are capable of filling a more important role as co-financiers, providers and gatekeepers in the overall health care system.

Among the more radical and also politically controversial aspects of the reform is the initiative to let the municipalities take part in the co-financing of hospital and specialist treatment. This in essence involves the introduction of economic incentives as a means to control the gate-keeping behaviour of the municipalities and the general practitioners.

Another aspect of the reform is to integrate the general practitioners more in the Municipalities' health plan and put a lower limit on the number of patients they are allowed to treat. This part of the reform has been met with strong opposition from the medical profession.

After extensive rounds of consultations with stakeholders and parliamentary debates the Government presented its proposal for a concrete legislative follow-up in April 2011 (Prop. 91 L (2010-2011)) and the main components of the reform were finally passed by Parliament in the summer of 2011.

The final legislation contains a long list of measures to clarify the division of labour between the municipalities and the health enterprises and the responsibilities they have vis-à-vis different groups of patients. One important aspect of the reform is an attempt to make the legal responsibility for providing services more neutral in terms of the professions that are involved in

the provision. This particular aspect of the reform has been met with resistance from doctors' and nurses' associations.

The municipalities are given a stronger role in health care financing. First of all the municipalities are given full responsibility for patients that are ready to be discharged from hospital treatment. Also a modified version of the radical and controversial idea to introduce co-financing of secondary health care services by the municipalities has been implemented in practice. In accordance with the Government's proposal the co-financing arrangement will be restricted to include medical treatment of hospital patients only and not include any types of surgical treatment. This restriction is meant to help limit the risks and financial obligations of municipalities. The rate of co-financing has been set to 20%. This municipal co-financing will form part of the activity based financing of the regional health services which amounts to 50% of the total revenue, while the remaining 50% will still be provided as block grants to the regional health authorities.

The reform was passed with broad support in Parliament despite reluctance from several opposition parties who have argued that many Norwegian municipalities are too small to shoulder the bigger administrative and financial responsibilities that will follow from the reform.

2.3.2 Debates and political discourse

One of the aspects of the present system that have been widely debated is the system of financing. The regional health enterprises are presently financed by a combination of fixed basic grants that are distributed according to a priory assessment of needs (about 50% of their revenue) and a detailed system of activity dependent reimbursements related to the treated diagnoses. However, a number of examples have appeared in the media of goal replacement where hospitals and enterprises have consciously manipulated its use of diagnoses in order to maximise reimbursement payments from the state, and it has recently been suggested to modify the system for assessing variation in needs that determines the distribution of the fixed basic grants.

Waiting lists for hospital treatment and the problems with the fulfilment of patient rights to immediate treatment for serious illnesses is a continuous source of dissatisfaction and controversy. In a number of cases it has been revealed that public hospitals have manipulated their patient registers in an effort to hide breaches of treatment guarantees and to avoid obligations to finance treatment in private clinics in cases where the treatment cannot be provided by the public hospital itself.

As mentioned, private health insurance and private health care plays a very modest role in Norway. The former center-right government (Bonnevik II) introduced a system of favourable tax rules for private companies that pay directly for treatment of their employees or purchase health insurances. This led to a rapid expansion of the coverage with supplementary health insurance coverage among private sector employees, but this development was stalled when the present red-green government in 2006 removed these tax concessions (Aarbu 2010). From January 1st 2012 the Government has removed a special tax allowance for expenditures related to ill health and this has been met with criticism from private health providers and from the opposition parties.

2.3.3 Impact of EU social policies on the national level

EU policies in the area of health are completely absent from the Norwegian debate. Also in this field there are points where EU law impacts on the development of Norwegian health services – i.e. the right to seek adequate treatment in another EEA country, free movement of health professionals – but they remain fairly marginal.

2.3.4 Impact assessment

Norway ranks among the OECD-countries with the highest total (public and private) expenditure on health per capita when measured in absolute terms, and almost all the Norwegian health expenditure is almost entirely publicly financed. When measured relative to GDP, however, Norway does not stand out as a particular high spender. Total health expenditure amounted to about 9% of GDP in 2005 which puts Norway in the middle of the OECD league. When Norway's high and growing revenues from oil and gas are excluded from the picture, and health expenditures are measured relative total public and private consumption, Norway is clearly ranked among the high spenders. In terms of manpower resources Norway ranks high as well. It is no. 1 among the OECD-countries in terms of the number of nurses per capita and 8 in terms of the number of doctors (St.meld. Nr. 9 (2008-2009) p. 79).

The high growth in health expenditures over the last decades is only partly explained by demographic changes (ageing). However, like in most other OECD countries the age adjusted demand for and expenditure health services is constantly rising – partly related to technological innovations and partly as a result of generally rising prosperity.

Projection about future demand and expenditures

The financial burden related to an expected increase in public health care expenditure has been a cause for concern in a number of official policy documents. Most recently these issues are thoroughly discussed in a Government white paper on the long term prospects for the Norwegian economy (St. meld, nr. 9 (2008-2009)).

One of the most hotly debated issues both in academic research and in official policy documents concerns the relationship between longevity and morbidity. Will increasing longevity be associated with an increase in morbidity and frailty and hence in the number of years an individual needs intensive health care and long-term care, or will increasing longevity simply result in a postponement of the phase with high morbidity and frailty? If the latter should turn out to be the case, the future growth in the need for health services and elderly care will be less dramatic than one would be led to think based on the more conventional assumption that the demand for these services in each age span is constant (Holmøy and Nielsen 2008 and St. meld. nr. 9 (2008-2009)).

Health outcomes

On a range of public health indicators Norway scores comparatively high (infant mortality, life expectancy, self-reported general health, obesity and smoking) – see Norwegian Directorate of Health (2008). It is unclear however whether and to what extent this can be attributed to the quality of the preventive and curative efforts of the health service. There is general agreement among epidemiologist and health sociologists that more general societal factors are likely to be as important for health outcomes. One hypothesis that has received considerable attention is the claim that the modest degree of economic inequality found in Norway and the other Nordic countries might be conducive to aggregate public health (see Kravdal 2008 and Mæland et al. 2009). This hypothesis has recently found support in a study that looks at the relationship between regional inequality and regional mortality. The study confirms that there is a robust statistical association in the expected direction and that this is primarily connected higher mortality rates among working class males in regions with high income inequality (Elstad 2010 and 2011a).

One somewhat disturbing fact is, however, that social (relative) inequalities in health outcomes appear to be higher in Norway and the other Scandinavian countries than they are in Central and Southern European countries – see for instance Mackenbach (2006) and Bambra (2011). There is, in other words, a comparatively strong social gradient in health outcomes in Norway. Part of the explanation might be a very strong social gradient in smoking and other health-related behaviours, and it has been suggested that the information campaigns that have helped to reduce smoking and

other harmful behaviours among the middle classes have not yet succeeded in changing the behaviour of lower status segments of the population.

2.3.5 Critical assessment of reforms, discussions and research carried out

The state owned regional health enterprises are a source of continuous controversy. One of the issues that these enterprises have to deal with is the distribution of hospital services across their region. Concerns for cost efficiency and the quality of specialised services put centralisation on the agenda in many of the regions. However, suggestions to close smaller local hospitals and concentrate services in larger units is always met with fierce resistance from local politicians and the employees whose jobs are in danger of being moved. In line with New Public Management thinking, the regional enterprises have been granted a high degree of autonomy from the political authorities of central government to deal with these types of structural issues based on technical/professional considerations, but they have difficulties handling critique from unions and local politicians because the enterprises lack an independent democratic base of legitimacy. Therefore, critique of this sort is often directed towards the political leadership of the Ministry of Health that owns the enterprises and the Government in general, and the Government is constantly under pressure to interfere in these types of conflicts.

Also many of the regional health enterprises are currently running huge deficits and their efforts to balance the budget by cutting expenditure are met with strong resistance from unions and the public, who ask the Government to intervene and provide more money. Also here there are signs that the present governance structure based on technocratic leadership with arms-length distance to politicians is difficult to sustain as it tends to breed tensions and frustration.

The "coordination reform" is still in a very early phase of implementation. Like in the case of the pension reform the Government has announced that it will commission a comprehensive research based evaluation of the reform – both in terms of its implementations and its effects on quantifiable outcome variables.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

While up until the 1980s Norway was somewhat of a laggard in the development of services for the elderly compared to the other Scandinavian countries, this is no longer the case. Today Norway has a strongly developed system for providing both home-help, nursing and institution based elder care.

In 2009 2.0% of GDP was spent on services to the elderly - compared to 5.6% on cash benefits (old-age pensions), see NOSOSCO (2012). Like ordinary health care, long term care is provided as a universal right to all residents that is inscribed in the law. Long term care is the responsibility of municipalities, and the right to receive care is stated in the Municipal health services act.

Traditionally, voluntary organisations have played a significant role in owning and running nursing homes for the elderly. However, while there still are quite a few privately owned nursing homes in Norway, most have been fully integrated in the public system and completely dependent upon public financing. While the municipalities provide most the financing of elder care given within and outside institutions, income related user charges are levied on the recipients of the services – particularly on the inhabitants in long-term care institutions. In 2007 user charges covered 7.5% of the total costs devoted by the municipalities to long term care (St. meld. nr. 9 (2008-2009), p. 89).

The growth in the provision of long-term care for the elderly has been associated with reforms in the mode of provision. Two important reform tendencies can be identified since the 1980s. While the counties used to have responsibility for nursing homes, the responsibility was transferred to the municipalities in 1988. The municipalities finance these services out of their tax revenue and general grants from the state. Previously a major part of the state's financial support for a range of municipal services was given in the form of earmarked reimbursements, but over the last decades a clear priority has been to increase municipal autonomy by giving general grants instead. To compensate for the loss of a direct influence through earmarked financing the state has instead put emphasis on steering through legal obligations and contractual agreements with the confederation of municipalities.

The building of nursing homes of a high quality happened somewhat later in Norway than in Denmark and Sweden. Only in the latter part of the 1990s was the securing of single rooms as the standard solution in nursing homes achieved in Norway. Like in the other Nordic countries, emphasis the last years has been stronger on providing nursing and practical help outside the institutions – either in the recipient's ordinary home or in so-called service housing: extra care housing where the physical environment is adapted to the needs of elderly and frail people and where nursing and other services are more easily provided.

2.4.2 Debates and political discourse

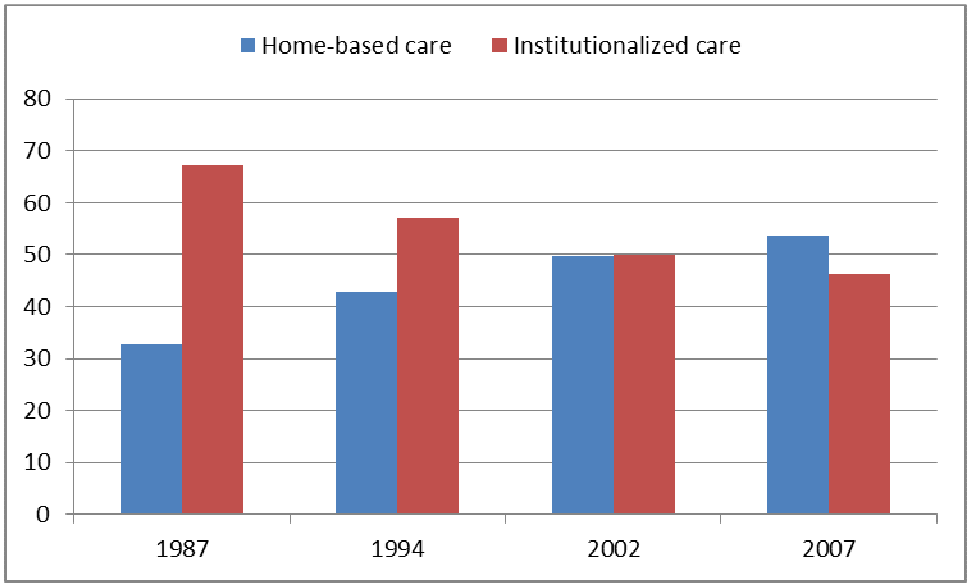
Over the last decade there has been a continuous debate on the desirability of competition in the delivery of care services. The role for private companies in the provision of elderly care is one of the few social policy issues with a very clear confrontation along the traditional left-right axis. There is general agreement that the financing of services should be a public responsibility, but the parties to the right of the political spectrum call for different forms of privatisation of the delivery, while the parties the left (that make up the present Government) prefer that the municipalities should maintain their virtual monopoly as providers of both institutionalised and home-based elderly care. In some of the largest municipalities – like Oslo – there has in recent years been a tendency to let contracts for the running of nursing homes and home-help serviced be decided by a competition between public (municipal) and private (non-profit and for-profit) providers. A few for-profit companies have managed to win these competitions and take the running of nursing homes on behalf of the municipalities that provide the financing. In the municipality of Oslo, individual users of home help services are offered the opportunity to choose between different providers – public and private (Vabø 2011b). Even so, the private contribution to elderly care is still fairly modest compared to the situation in Denmark and Sweden.

The attempt to build a larger private care sector in Norway suffered a severe setback in early 2011 when it was revealed that one of the big commercial actors (the multinational company Adecco) had consciously violated the Norwegian law on labour protection in its running of nursing homes in Oslo. The result has been that city government of Oslo, that has been a spearhead in the promotion of more private providers, decided to terminate the contract with this actor and is now running these nursing homes directly by the municipality.

Also publicly run nursing homes are continuously being criticised for offering and inadequate number of places and for not living up to official standards – in terms of time spent with the elderly, the quality of nutrition, medical attention etc. The present government has promised to strengthen the long term care sector very significantly to overcome both the quantitative problem of an insufficient number of places in nursing homes and problems of poor quality in the delivery of both institution-based and home-based services. However the existing governance structure where the municipalities have responsibility for providing these services - financed out of non-earmarked block grants - makes it difficult for the central political authorities to ensure that national targets of in terms of resource spent and service output are actually met. There are

continuous debates whether the municipalities are actually delivering on the promised increase in the provision of long term care (Huseby & Paulsen 2009).

Figure 3: Number of man-years in institutions and home based care in selected years between 1987-2007



Source: Vabø 2011a.

As shown in Figure 3 there has since the late 1980s been a shift in the balance between man-hours provided through institution-based services (nursing homes) and home-based services. This has been the result of a deliberate policy to shift the emphasis more in the direction of home-based care for frail elderly - inspired by the even more pronounced shift in Denmark (Godager, Hagen & Iversen 2011). However, it seems clear that the potential for substituting nursing homes with home based care has been exhausted, and that the decline in the number of man-hours devoted to nursing homes must be reversed if the supply of services should meet the strong increase in demand that is driven by ageing.

2.4.3 Impact of EU social policies on the national level

There is generally little impact of EU policies in this field on Norwegian policy debates and developments, except for the indirect effects of competition law etc. However the European Year for Active Ageing does gain attention from the Government and NGO's in the field as well as the Centre for Senior Policy. The Year for Active Ageing is explicitly mentioned in a new report from a Government appointed commission on innovation in eldercare (NOU 2011:11). The commission strongly recommends that Norway participates actively in the various initiatives and activities launched under this heading in Europe in 2012.

2.4.4 Impact assessment

To keep pace with increased demand for long term care that follows from the rapid growth of the elderly population is a continuous challenge. As can be seen from Table 2 over the five years from 2002 to 2006 the share of elderly people at different age intervals who live in nursing homes has decreased somewhat despite a constant number of available places for the country as a whole. The share of people aged 80+ who live in nursing homes has seen a marked decrease over these few years – a period in which political attention to the issue has been very high. A plausible partial explanation for the decrease can be found in the stronger emphasis on home-based care that has

already been mentioned. Also there has in this period been a rapid development in the supply of extra care housing for elderly people who are too frail to stay on living in their ordinary home but too well functioning to need the intensive care offered in a traditional nursing home.

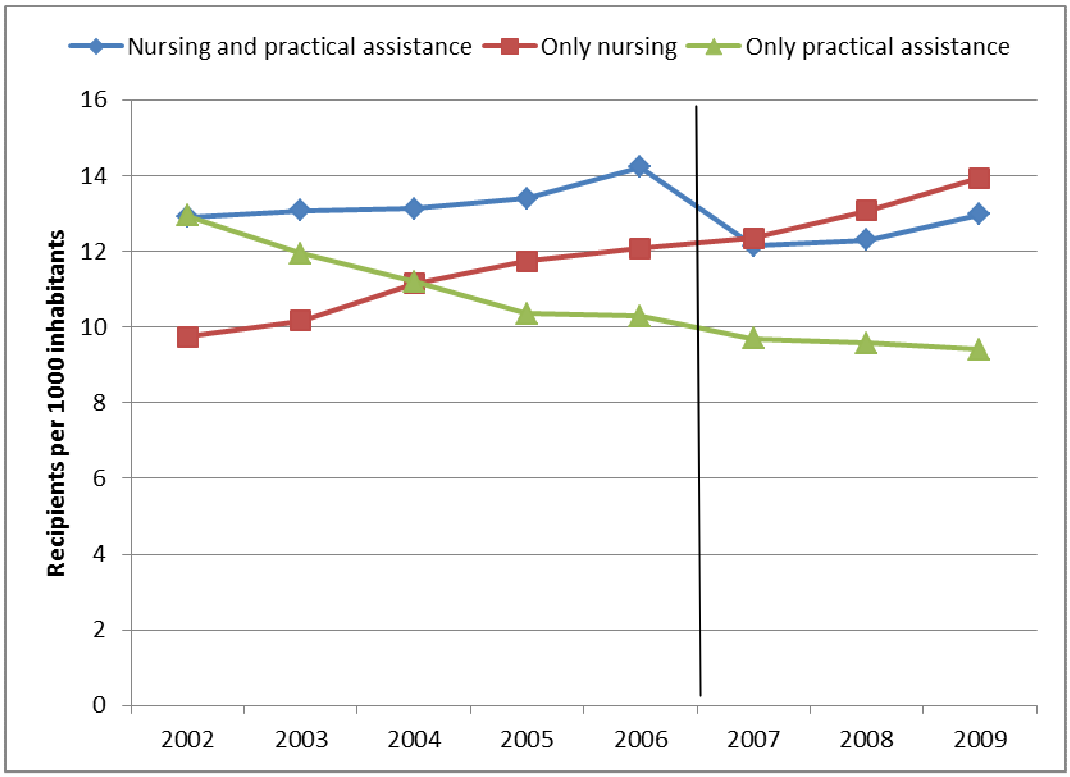
Table 2 The number of elderly people living in nursing homes, per 1000 inhabitants in the respective age brackets. 2002-2006

	2002	2003	2004	2005	2006
Age 67-74	12	12	12	11	11
Age 75-79	38	36	36	34	34
Age 80-84	86	83	83	80	79
Age 85-89	185	178	172	165	159
Age 90+	366	351	337	343	338

Source: http://statbank.ssb.no/statistikkbanken/, June 2011.

Between 2002 and 2009 there has been an increase in the recipiency rate of home based services that involve nursing – as can be seen from Figure 4. There is a break in the time series between 2006 and 2007 so that the apparent decline in the rate of receiving a combination of nursing and practical assistance is likely to be an artifact. The recipience rate for practical services only seems to be declining, however.

Figure 4. The number of recipients of home based care serviced per 1000 inhabitants.



Source: http://statbank.ssb.no/statistikkbanken/, March 2012.

A further breakdown of the recipiency of home care services according to age, reveals however that the absolute number of elderly recipients has remained fairly constant while there has been a rapid growth in the number of young recipients. The very substantive growth in the number of non-elderly recipients is likely to be related to reforms from this period that have attempted to de-institutionalise care for long-term psychiatric pasients and the mentally retarded (Vabø 2011a).

A more universal overview of the take up of both institution-based and home-based care for the year 2008 is provided in Table 3 which is adopted from Otnes (2011). These figures confirm that a very substantial fraction of the elderly in Norway does receive some form of publicly financed care service and that this fraction is increasing very rapidly with age. Among people above the age of 80 50% receive care services – almost evenly distributed between home-based and some form of institution based services including extra care housing.

The general impression that the overall coverage rates with care services for given age intervals has stagnated over the last decade – despite a very strong political commitment to strengthen elder care – does not necessarily imply that there is a constant or growing gap with respect to actual needs in line with improvements in life expectancy. According to a recent study (Moe & Hagen 2011) the increasing life expectancy of the elderly appears to go hand in hand with decreasing morbidity and improvements in health and functionability. In other words: the elderly remain healthier at higher ages and hence the demand for care services does not increase despite increasing longevity.

Table 3: Take up rates according to type of service and age (%).

	67+	80+	90+
1. Nursing home	6	14	36
2. Extra care housing	5	11	22
3. Sum out of home (1+2)	11	25	57
4. Home based care	12	24	33
5. Sum all types of care (3+4)	24	49	90

Source: Otnes (2012:71)

2.4.5 Critical assessment of reforms, discussions and research carried out

The "coordination reform" mentioned in the section on health care also has important implications for the general elderly care. One of the main ideas is to avoid cost-shifting between municipal elderly care and state financed hospital care. As mentioned, the reform is intended to give the municipalities full responsibility for taking care of patients that are ready to be discharged from hospital. It is an open question, however, whether all coordination problems will be solved by this.

Giving the municipalities a co-financing obligation for in-hospital medical care could easily have unintended negative effects their behaviour and priorities vis-à-vis a large group of elderly patients. One could worry, for instance, whether this could lead to a higher threshold before sending elderly patients to hospital treatment.

In view of the very strong demographic changes that will take place over the coming decades, the financing of elder care is a matter of concern together with health care and old-age pensions. Arguably, however the biggest challenge in connection with the future of care services in Norway is related to problems to recruit sufficient manpower. Salaries in the relevant occupations have traditionally been relatively low, and it is an open question whether it will be possible to mobilise sufficient manpower to meet the growing demand in a rapidly ageing society. Immigrants from Non-Western countries provide a growing share of the manpower that produces these services, and it has been speculated whether import of trained personnel and increased immigration more generally can be the only way to solve the projected shortages of manpower in this sector. This argument, however, is at odds with the rather widespread resistance towards labour immigration from the political authorities and social partners – including (somewhat surprisingly) the peak employers' association, NHO.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Norway has one of the highest labour force participation rates for people above 60 in Europe. As described in the section on pensions, one of the key goals of the pension reform in general and the introduction of flexible retirement on neutral terms that was introduced in 2011 is to encourage prolonged working life, and in particular to allow for a flexible and gradual withdrawal from the labour market.

Flexibility and the provision of incentives in the pension system is neither a necessary nor sufficient condition for allowing elderly workers to continue working as long as they can.

Mandatory retirement ages play an important role too, and adjustments to regulations on mandatory retirement are being discussed in connection with the pension reform. In Norway, the Work Environment Act gives very strong employment protection but only to the age of 70. This gives an employer the right to cancel the employment contract simply on the grounds that the employee has reached the age of 70. Norwegian courts have also in a number of cases recognised the rights of employers to lay off an employee already when reaching 67, provided that the company has secured the employee a satisfactory occupational pension from this age to top up benefits from the National Insurance system. Finally, a number of occupations – particularly in the public sector – face special lower mandatory retirement ages: e.g. military personel, policemen, nurses, pilots etc.

It is currently being discussed whether to raise the general mandatory retirement age to 70, or perhaps even to abandon it entirely and make any age discrimination illegal like it has been done in countries like the US and Denmark. Although the more radical solution of making employment protection unrelated to age has some support among the political parties (the liberal party "Venstre" in particular), it is being strongly opposed by the social partners, who appear to agree in their support for maintaining a general age limit for employment protection at age 70. The employers fear that abandoning the mandatory retirement age in the Norwegian context with a general high level employment protection will just add to the rigidities of the Norwegian employment relations and make it impossible to get rid of less productive older workers. Presumably a total ban on age discrimination is likely to work better in the context of rather weak employment protection – a hire-and-fire labour market, if you like - that is found in countries like the US and Denmark.

A more likely development in Norway would be to gradually raise the age limit from 70 in line with development in longevity and the associated longevity adjustment factor that has been introduced in the pension system. The right to lay off employees already at age 67 if the company has provided a generous pension plan that has been developed through case law, is also likely at some point to be removed by explicit legislation. Finally the system of special mandatory retirement ages for different occupation groups is under revision, and in the cases where there are no strong public security reasons for maintaining a lower mandatory retirement age, there is likely to be a strong political interest to remove the special regulations. However, the employee associations will strongly resist any changes, and it is an open question whether the present or future Governments are ready to enter a head on battle with the trade unions and professional organisations involved.

As described in the pensions section, the new flexible pension age from age 62 is completely flexible with respect to any combinations of full-time and part-time work and pension take-up. So far we have seen a high take up pension benefits combined with stable or increased employment rates in the relevant cohorts. In a long-term perspective the flexible pension system is likely to lead to a more flexible and less standardised labour market for people above age 62. So far all

social protection systems for the economically active population – like unemployment benefits, and disability benefits – continue to apply equally to people above the age of 62. However, it is easy to imagine that there will be pressures to curtail the right to receive social security benefits, for persons who have already begun the take up of old-age pension or who have the possibility to do so. It is also possible to imagine the development of a kind of secondary labour market for people above the age of 62 whose basic income needs are already covered by their old-age pension rights.

There is no doubt that the new flexible system for the take-up of old-age pensions offers wide opportunities for individualised solutions and a more active ageing, but the flexibility and individualisation that follows might also be associated with new individualised risks.

2.5.2 Participation in society

An important precondition for active participation in society is that the individual is secured a decent income, which protects against poverty and keeps the person out of dependency on the family or some form of charity. The comparatively high minimum benefits secured to all pensioners in Norway are arguably the most important contribution by the social security system to granting all elderly the opportunity to participate in society as autonomous individuals. A recent study of the income dynamics in old-age supports the claim that retirement is very rarely associated with an increasing risk of financial hardship (Claus et al. 2011).

2.5.3 Healthy and autonomous living

In Norway it is extremely rare that older people live in an extended family together with their offspring – and certainly such arrangements are not chosen because the elderly are not financially capable of maintaining and independent household.

Most elderly in Norway are home owners, and they only give up independent living arrangements if and when they are unable to cater for themselves in which case they live their last years in extra care housing or nursing homes. As has been described in the section on long-term care, policies in this field have increasingly emphasised the goal of allowing frail elderly to stay as long as possible in the own home. At some point, however, living at home is no longer a satisfactory option, and having sufficient capacity to cover the needs for intensive care nursing homes is a persistent challenge.

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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

[R1] BRUNBORG, HELGE & TEXMOEN, INGER. (2011): Befolkningsframskrivning 2011-2100: Nasjonale resultater. Økonomiske analyser 4/2011. Oslo: Statistics Norway.
"Demographic forecasts 2011-2100: Model and assumptions"

The article gives an updated version of forecasts about developments in key demographic variables over the 21. Century. In the main alternative the Norwegian population is expected to grow very fast as result of high immigration rates particularly in the coming decades. High immigration rates are expected to lead to a slow down of the underlying tendency towards population ageing but even in the high migration scenario the effect is not nearly strong enough to reverse the rise in old age dependency ratios.

[R1; R2] FREDRIKSEN, DENNIS, STØLEN, NILS MARTIN (2011): Utforming av ny alderspensjon i folketrygden. Reports 22/2011. Oslo: Statistics Norway.
http://www.ssb.no/emner/12/90/rapp_201122/rapp_201122.pdf
"The new National Insurance old age pension scheme"
The reports gives an updated version of earlier estimates of the long-term effects of the pension reform in terms of labour force participation and total pension expenditure. Among other things the new calculations take account of the 2009 agreement in the public sector that allowed public employees to maintain opportunities to withdraw from the age of 62 with no actuarial punishments, and to keep unchanged their traditional final salary pension occupational pension schemes. It is documented that, because of this, the total effect from the pension reform on postponed retirement will be lower than earlier predicted and that the total future expenditure will be higher. A new system for taxation of pensioners' incomes implemented from 2011 supports the incentives for increased labour supply among pensioner, but it will at the same time increase the incentives to withdraw pension benefits earlier and to combine pension and work in the last years of the active period, resulting in higher than expected public expenditure over the coming decades.

[R1; R2] FREDRIKSEN, DENNIS, STØLEN, NILS MARTIN (2011): Pensjonsreformen – økte utgifter til alderspensjon motvirkes av sterkere vekst i arbeidsstyrken. Økonomiske analyser 6/2011. Oslo Statistics Norway.
http://www.ssb.no/emner/08/05/10/oa/201106/fredriksen.pdf
"The pension reform – increased expenditure for old age pensions is compensated for by a stronger growth in the labour force".

The article updates earlier estimates of the long-term effects of the pension reform particularly in the light of new prognoses about immigration to Norway. Due to higher immigration the labour force is expected to grow faster than assumed, and this will lead to a reduction in the financial burden over the coming decades compared to previous estimates.

[R2] LIEN, OLE CHRISTIAN (2012). Når bør man ta ut alderspensjon. *Arbeid og Velferd*. No. 1/2012. Oslo: Arbeids- og velferdsdirektoratet.

"When should you start drawing your old age pension?"

The article is a systematic attempt to assess the financial consequences for the individual of starting to withdraw pension rights from the age of 60 while continuing working. It is motivated by the observation of very high take up of pension benefits from early ages since the introduction of flexible retirement from January 1. 2011, which appears to have been encouraged by pension advisors and the media, claiming that such early take-up is profitable for large segments of the eligible population. The author recognises that the new system of taxation for pensions does in itself make it more profitable to start drawing benefits early, but he argues that other factors point in the opposite direction and that the result of a more comprensive analysis would make it advisable for most of the eligible population to postpone the take of pension benefits.

HERMANSEN, ÅSMUND (2011): Pensjonering før fylte 67 år. Tidligpensjonering og bruk av AFP innen KS' tariffområde 2002–2009. Fafo-report 2011:23.
http://www.fafo.no/pub/rapp/20214/20214.pdf
"The take-up of early retirement schemes in the municipal sector 2002-2009"

The report analyses recent early retirement behaviour among employees aged 50-67 in the muncipal sector. The calculations and analyses are based on micro-data obtained from insurance providers. The report describes changes in expected retirement age and retirement outflow rates by age, gender and occupation. It also investigates the use of the various early retirement schemes that are available for employees in the municipal sector. The overall average expected retirement age for a fifty-year-old is estimated to just above 61 years in 2009. Over the period from 2002 to 2009 the effective retirement is found to have risen with 7 months for employees in the municipalities, while there has been a slight decline among employees in the counties.

DAHL, ESPEN HALLAND & LIEN, OLE CHRISTIAN (2011): Pensjonsreformen:
Effekter på sysselsettingen. *Arbeid og Velferd*. No. 1/2012. Oslo: Arbeids- og velferdsdirektoratet.
"The pension reform: Effects on employment".

The authors study register data on pension take-up and labour force participation in the first two quarters of 2011 (post-reform) and compare it with the same indicators in the preceeding years. They find an extraordinary high take up of old age benefits after January 1. particularly among men, but also that the tendency for increasing employment rates over the last years appears to have continued also after the implementation of the new flexible retirement age. Most of those who have taken advantage of the new possibility to start drawing a pension from age 62 continue working and the majority in full time jobs.

[R4] HERNÆS Erik & JIA, Z. (2012): Earnings Distribution and Labour Supply after a Retirement Earnings Test Reform, Memorandum No. 01/2012, Department of Economics, University of Oslo.

Norwegian administrative data are used to evaluate the impact of a doubling of the threshold in the retirement earnings test. We find almost no impact on the extensive margin, but a positive effect on the intensive margin. This positive effect is uneven over the earnings distribution, and concentrated on workers around the threshold, increasing with exposure to the reform and leading to a decrease in earnings inequality. Individuals who remain active until retirement age respond more to the reform. Conditional on prereform earnings, we find little evidence that individual characteristics such as working histories influence the responsiveness to the reform.

[R4] HIPPE, JON M.; MIDTSUNDSTAD, TOVE; SEIP, ÅSMUND ARUP; BOGEN, HANNE & HERNES, GUDMUND (2012): «When I'm Sixty-Four» – seniorpolitiske framtidsbilder. Fafo-report no. 2012:02. Oslo: Fafo. http://www.fafo.no/pub/rapp/20229/20229.pdf
"When I'm Sixty-Four – future scenarios for active ageing"

In this report the authors describe and discusss trends in policies towards the elderly population from pension policy, over employment policy to care policy, and they present four alternative scenarios for the future of ageing and ageing policy in Norway. They suggest the emergence of a fourth age in the lifecours between the fullblown working career and fullblown retirement.

[R5] CLAUS, GUNNAR; KRISTOFFERSEN, SØHOLT ELISABETH; MELBY, INGRID & STRØM, FRØYDIS (2012): Inntektsstatistikk for den eldre befolkningen 1999-2009. En kohortanalyse av inntektsutviklingen for aldersgruppen 60 år og eldre. Reports 4/2012. Oslo: Statistics Norway. http://www.ssb.no/emner/05/01/rapp_201204/rapp_201204.pdf

"Income statistics for the elderly part of the population 1999-2009. A cohort analysis of income developments for the age group 60 year and older."

The report analysis income developments for persons aged 60 and above over the years 1999 through 2009. It shows that the proportion of those with income from work has increased for all age groups from 60 to 75 years of age in the period 1999 to 2009. The proportion 68 to 70 year olds with income from work has respectively increased with approximately 8 percentage points from 1999 to 2009. The report shows further that the elderly have experienced an impressive income increase during decade from 1999 to 2009 – partidularly in real terms but also relative to the general population. Persons and households within the lowest income groups experienced greater income growth through the transition to retirement than those in the higher income brackets.

[H] Health

[H2, H4, H5] NORWEGIAN DIRECTORATE OF HEALTH (2011) Innsatsstyrt finansiering 2012. Oslo.
http://helsedirektoratet.no/publikasjoner/regelverk-innsatsstyrt-finansiering-2012/Sider/default.aspx
"Activity based system of financing 2012"

The document describes in detail the new regulations for health care financing that have taken effect from January 1. 2012 as a consequence of the Coordination Reform.

[H2, H5] NORWEGIAN DIRECTORATE OF HEALTH (2012). Samhandlingsstatistikk 2010. Oslo.
http://helsedirektoratet.no/publikasjoner/samhandlingsstatistikk-2010/Sider/default.aspx
"Statistics on coordinated health services 2010"

The report presents statitics on and prognoses for the future development in primary and secondary health care services in Norway in view of the Coordination Reform that has taken effect from January 1. 2012. It describes developments and variation accross municipalities in a range of output indicators and costs per capita.

[H1, H5] MEDIN, E.; ANTHUN, K.S.; HÄKKINEN, U.; KITTELSEN, S.A.C.; LINNA, M.; MAGNUSSEN, J.; OLSEN, K. & REHNBERG, C.; (2011): Cost efficiency of university hospitals in the Nordic countries: a cross-country analysis. *European Journal of Health Economics* , 12(6), 509-519.

The paper estimates cost efficiency scores for hospitals in each of the Nordic countries. The results demonstrate significant differences in university hospital cost efficiency when variables for teaching and research are entered into the analysis, both between and within the Nordic countries. The most important explanatory variables are geographical location of the hospital and the share of discharges with a high case weight. However, a substantial amount of the variation in cost efficiency at the university hospital level remains unexplained.

[H3] BAMBRA, CLARE (2011) Social inequalities in health: The Nordic welfare state in comparative context, in Jon Kvist, Johan Fritzell, Bjorn Hvinden, Olli Kangas (eds.) *Changing social equality. The Nordic welfare model in the 21st century.* Bristol: Policy Press.

The article reviews existing comparative research on overall health performance and health inequalities in the Nordic countries. It discusses the the paradoxical finding that the Nordic countries continue to exhibit comparatively high levels of *relative* health inequality while the average performance on various health indicators is among the best in the world. The significance of the finding of large health inequality (and hence of the paradox) is modified with reference to the fact that the Nordic countries appear to do comparatively well in terms of protecting particularly vulnerable groups, like childring and the elderly, from health risks.

[H3] ELSTAD, JON IVAR (2011) Hva er det med Arendal og Ålesund - og Oslo? Om dødelighetsforskjeller mellom norske byområder. Notat no. 1/11. Oslo: NOVA.

"What is it with Arendal and Ålesund – and with Oslo? On differences in lifeexpectancy between urban areas in Norway "

The report studies differences in mortality accross Norwegian urban areas. Large differences in average mortality rates persist after controlling for a wide range of compositional factors like the level of education and income of the inhabitants. The results show that remaining higher average mortality in certain urban areas including the area of Oslo are to a large extent driven by a particularly high mortality among low educated segments in these areas. The author suggests that the causal mechanism seems to be related to greater inequality in socioeconomic variables and in social status in areas that are characterised by higher mortality and lower lifeexpectancy.

[H3] ELSTAD, JON IVAR, TORSTENSRUD, R., LYNGSTAD, T.H. & KRAVDAL, Ø. (2012) Trends in educational inequalities in mortality, seven types of cancers, Norway 1971–2002. *The European Journal of Public Health*, 1-6. Oxford University Press.

This study examines educational inequalities in Norway 1971–2002 for mortality in lung and larynx, colorectal, stomach, melanoma, prostate, breast and cervix uteri cancer based on data covering all Norwegian inhabitants registered some time during 1971–2002 while aged 45–74.

The results show that educational inequalities in lung and related cancer mortality widened considerably from the 1970s to the 1990s for both sexes, while the educational gradient for the other cancer types remaiend stable or showed a slight decline. As lung cancer mortality constitutes a large proportion of all cancer deaths, this increase may result in larger disparities for overall cancer mortality.

[H3, L] MOE, Joakim O. & HAGEN, TERJE .P. (2011) Trends and variation in mild disability and functional limitations among older adults in Norway, 1986-2008. European Journal of Ageing 8(1): 49-61.

This is a study of changes in the prevalence of mild disability and functional limitations among persons aged 67 or older. It is based on repeated cross-sectional surveys conducted in 1987, 1991, 1995, 2002, 2005, and 2008. The results show that both functional limitations free and disability-free life expectancy appeared to have increased more than total life expectancy at age 67 during this period. The analysis suggests downward trends in the prevalence of mild disability and functional limitations among older Norwegians between 1987 and 2008 and a compression of lifetime in such health states. The reduced numbers of older people with disability and functional limitations may have restrained the demand for health and care services caused by the increase in the number of older adults.

[H4] ASKILDSEN, JAN ERIK; HOLMÅS, TOR HELGE; KAARBØE, ODDVAR MARTIN (2011): Monitoring prioritisation in the public health care sector by use of medical guidelines: the case of Norway. *Health Economics*, 20(8): 958-970

The paper presents a new way to monitor priority settings in public health-care systems. The method involves comparing actual waiting times for different medical description with official medical guidelines. In this way medical guidelines are used as a tool for monitoring prioritisation in the health sector. The results from an application to data from the Norwegian Patient Register indicate that patients suffering from the most severe conditions are receiving too low priority in the Norwegian health-care sector relative to patients of lower priority.

[L] Long-term care

[L, H4] GAUTUN, HEIDI (2012): Planlagt og faktisk bemanning i sykehjem og hjemmesykepleien. Fafo-report 2012:5. Oslo: Fafo.
http://www.fafo.no/pub/rapp/20232/index.html,
"Planned and actual use of manpower in municipal eldercare"

The report investigates the factors leading to a chronic mismatch between the planned and actual use of manpower in municipal eldercare services – nursing homes and home based care. According the findings a key problem arises from difficulties experienced by the municipalities in finding qualified replacements for employees in sickness absense. It is argued that the major coordination reform of public health and caring services could add to the problems municipalities experience in recruiting sufficient qualified personel.

[L] GODAGER, G.; HAGEN, T.P. & IVERSEN, T. (2011) Omfang og sammensetning av omsorgstjenester i tre nordiske land. HERO Working Paper 2011/02: Oslo: Institutt for helse og samfunn, Universitetet i Oslo.

http://www.med.uio.no/helsam/forskning/nettverk/hero/publikasjoner/skriftserie/2011/hero-2011-02.html. "Scope and content of caring services in three Nordic countries"

The report is written on behalf of the Norwegian Ministry of Health and Long-term Care and it offers a comprehensive comparison of trends in caring services in Norway, Sweden and Denmark. It shows that Denmark has furthest of the three countries in the direction of deinstitutionalising elder care. Norway has the highest coverage rate with institutional care for elderly above the age of 80. Sweden has gone furthest of the three countries in curbing public expenditure on both institution based and home-based care. The authors find stronger intercountry differences between municipalities in Norway compared to the two other countries.

[L] OTNES, BERIT (2012): Utviklingslinjer i pleie- og omsorgstjenestene. In Daatland, S.O. and Veenstra, Marijke (eds.) Bærekraftig omsorg? Familien, velferdsstaten og aldringen av befolkningen. NOVA report 2/2012. Oslo: NOVA.

"Developments and trends in elder care services"

The article describes both long-term development paths and more recent trends in Norwegian eldercare services. It describes the basic dilemma of raising enough resources to meet the ever increasing demand for eldercare in a rapidly ageing population.

[L] VABØ, MIA (2011): Home care in Norway. Shaped by competing drivers of change. In Rostgaard, T. (ed.): *LIVINDHOME. Living independently at home. Reforms in home care in 9 European countries*. Copenhagen: SFI – The Danish National Centre for Social Research

http://www.sfi.dk/Files/Filer/SFI/LIVINDHOME/LIVINDHOME.pdf

The chapter describes and discusses the historical evolution of home based care in Norway from its roots in civil society to a comprehensive publicly financed system that is being increasingly governed by New Public Management ideas.

[L] NOU 2011:11 Innovation i omsorg. Oslo: Norges Offentlige Utredninger.

http://www.regjeringen.no/nb/dep/hod/dok/nouer/2011/nou-2011-11.html?id=646812
"Innovation in care"

This is a report from a commission appointed by the Government to investigate the possibilities for technological, institutional and social innovations in the delivery of care services. It is argued that there exists a large unexplored potential for innovation in this sector that need to be mobilised in order to meet the rapid growth in need to be expected over the coming decades. One of the key concepts in the report is active ageing built on ideals like the right to self-determination, independence and influence over ones own life also for sick and disabled elderly. The commission strongly recommends that Norway participates actively in the European Year for Active Ageing.

4 List of Important Institutions

Arbeidsdepartementet - Ministry of Labour
Postal address: Postboks 8019 Dep., 0030 Oslo
Visiting address: Einar Gerhardsens plass 3, Oslo
Phone: +47 22 24 90 90
Webpage: http://www.regjeringen.no/en/dep/aid.html?id=165

The Ministry is responsible for labour market policy, working environment and safet, pension policy, and welfare and social policy.

Fafo - Institute for Labour and Social Research
Contact person: Jon Hippe
Postal address: Fafo, Pb 2947 Tøyen, 0608 Oslo
Visiting address: Borggata 2b
Webpage: http://www.fafo.no/indexenglish.htm

Fafo was founded by the Norwegian Confederation of Trade Unions (LO) in 1982. Fafo develops and disseminates knowledge about changes in living and working conditions, societal participation, democracy and development in a range of social and economic settings. Our ambition is to contribute to processes of social and economic development based on rigorous ethical and scientific standards. Fafo is organised in two institutes: the Fafo institute for Labour and Social Research and the Fafo Institute for Applied International Studies. Anchored in a tradition of empirical research, Fafo have developed special expertise in the collection and analysis of quantitative data which we combine with qualitative research approaches.

Folkehelseinstituttet - The Norwegian Institute of Public Health

Contact person: Geir Stene-Larsen, Director-General
Address: P.O.Box 4404 Nydalen, N-0403 Oslo
Webpage: http://www.fhi.no/eway/?pid=238

The Norwegian Institute of Public Health is a national centre of excellence in the areas of epidemiology, mental health, control of infectious diseases, environmental medicine, forensic toxicology and drug abuse. Our vision: A healthier society. Our motto: Knowledge for better public health.

Helseøkonomisk forskningsprogram (HERO) ved Universitetet i Oslo - Health Economics Research Programme at the University of Oslo - HERO
Contact person: Tor Iversen
Postal address: Postboks 1130 Blindern, 0318 OSLO Norge
Webpage: http://www.hero.uio.no/

HERO is a research programme concentrating on research in health economics at the University of Oslo. HERO has its foundation in economics, but emphasises the need for crossdisciplinary cooperation to ensure the relevance of research to the needs of the health care sector. The programme's staff members include researchers in social sciences, mainly economics, and

researchers from the medical profession. The programme has three research units:, The Institute of Health Management and Health Economics, The Frisch Centre, and The Department of Economics at the University of Oslo. HERO's research activity is financed by the Research Council of Norway, but the programme does also cooperate with others whose projects are not financed by the Council.

Helse- og Omsorgsdepartementet - Ministry of Health and Care Services

Postal address:	PO Box 8011 Dep., 0030 Oslo
Visiting address:	Einar Gerhardsens plass 3 (S-blokken), Oslo
Phone:	+47 22 24 90 90
Webpage:	http://www.regjeringen.no/en/dep/hod.html?id=421

The Ministry of Health and Care Services bears the main responsibility for the provision of adequate and appropriate health and care services for everyone in Norway, irrespective of geographical location and financial circumstances, and the promotion of public health. The Ministry has the overall responsibility for government policy on health and care services in Norway.

NOVA - Norsk institutt for forskning om oppvekst, velferd og aldring – Norwegian Social Research

Contact person:	Britt Slagsvold
Postal address:	PO box 3223 Elisenberg, 0208 Oslo
Visiting address	Munthesgt. 29
Webpage:	http://www.nova.no

NOVA is a research institute under the auspices of the Norwegian Ministry of Education and Research. The aim of the institute is to develop knowledge and understanding of social conditions and processes of change. Research focus on issues of life-course events, level of living conditions and aspects of life-quality as well as on programmes and services provided by the welfare system. Nova is carrying out research on social problems, public services and transfer schemes; carrying out and developing research on the family, children and young people and the conditions under which they grow up; carrying out and developing research, pilot and development programmes with particular emphasis on vulnerable groups and child welfare services and carrying out and developing gerontological research and related research, including gerontology as an interdisciplinary science.

Senter for Seniorpolitikk (SSP) - Centre for Senior Policy (CSP)

Contact person:	Kari Østerud, Director
Address:	St Olavs plass 3 0165 Oslo, Norway
Webpage:	http://www.seniorpolitikk.no/informasjon/english

The purpose of the Centre is to make individuals, companies and politicians aware of the benefits of being adaptable in the workplace as an increasing proportion of the workforce is aging. By promoting research, through awareness campaigns and by forging links with the Workers´Union, the Employers´ Association and politicians, the Centre encourages a broad range of activities that aim to reverse the growing trend towards early retirement.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(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