Synthesis Report 2011

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Author: Sabine Horstmann, GVG

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1 Executive Summary

There have been rather substantial, dynamic and partly dramatic changes in social protection systems across asisp countries in 2010-2011. The financial, economic and budgetary crisis has not led to a complete re-orientation of social protection policies, but has often strengthened the rationale for reforms. Austerity measures have impacted quite heavily on social protection systems in particular in countries with high public deficits and are in a number of cases understood as the main cause for retrenchment and weakening of the welfare state.

Pensions

Pension policies have been in the focus of social protection related austerity measures, often targeted at increasing the effective retirement age. This included a rise in the statutory retirement age, tightening eligibility conditions for early exit pensions, and linking the pension system to the development of life expectancy.

The asisp Annual National Reports illustrate a wide variety of initiatives to increase the statutory retirement age, including those for old-age pensions, minimum pensions, early exit pensions, and public sector pensions. A number of countries will increase statutory retirement ages, accelerate an already legislated increase or extend the increase further to a higher age. Some countries have equalised the statutory retirement ages for women and men.

The limitation of early exit pathways is expected to contribute substantially to an increase in the effective retirement age. Eligibility conditions have been tightened and incentives to retire before the statutory retirement age have been decreased. While general access to early exit schemes has been made more difficult, access to disability benefits for the elderly has partly been extended. Early exit pensions have earlier often been used by employers as an instrument to manage their workforce in times of high unemployment and excess labour supply. It seems that this is generally no longer a preferred approach and a re-orientation of policies took place in view of expensive early exit schemes and workforce shortages. A stronger involvement of employers in the costs of early exit pensions is expected to increase the responsibility of employers with regard to providing adequate employment opportunities for elderly workers.

Linking the pension system to life expectancy is an automatic stabiliser to adjust pension expenditures in line with demographic changes. In recent years, a number of countries have linked the benefit level to life expectancy and introduced either NDC systems which consider development of life expectancy by a conversion of the notional account into an annuity, taking into account the life expectancy of the retiring cohort or a life expectancy coefficient in the benefit formula, i.e. resulting in benefit reductions. One main finding of the 2011 asisp Annual National Reports is that debates were even more focused on introducing a direct link between the retirement age and life expectancy, and there are a number of countries which have introduced or are discussing periodic surveying of the retirement age in view of the evolution of life expectancy. The political debates described in the asisp reports reflect that many countries hesitate to introduce a strict “automatic” link between life expectancy and retirement age, but rather intend to keep the issue on the political agenda by establishing periodic procedures to review the interrelation.

The financial and economic crisis impacted quite drastically on the design of a number of mandatory funded pension schemes, in particular in the new Member States. Transition costs of the recently introduced private schemes were considered as a heavy financial burden for the state budget. Mandatory funded schemes were suspended, opened for a limited period, or reduced considerably in size. In many countries with complementary private savings, policy

measures in the past year had been focussing on stricter regulation and supervision of private pensions.

Health Care

Reforms and public/political debates in the health care sector have been less pronounced and focused as compared with pension policies. Reform goals include both cost containment and measures to improve the quality of and access to health care services.

The financial, economic and budgetary crisis in conjunction with fiscal consolidation measures is assumed to impact health care. Overall, the issue of financial sustainability of health care systems has attracted considerable attention in the reporting period and there are a number of countries which report that measures to rationalise health care expenditures have been in the focus in health care policies during the past years, including privatisation of health care providers, reimbursement mechanisms, and increased private co-payments.

Health care staff shortage is an issue which is increasingly debated in the asisp countries. In particular, in the new Member States' reports it is outlined that health care staff shortages are caused by emigration of health care professionals. In other countries, austerity measures included a substantial reduction of the health care workforce or salary levels. There are remarkable regional disparities in the distribution of health care personnel and it seems that this phenomenon may increase in the future. Policy responses to cope with future shortages of medical staff are, however, still rare.

There is a large number of countries which report on an increase or a persistently high level of health inequalities. Health inequalities are reported with regard to income and education. Moreover, there are countries which are characterised by substantial regional inequalities in the access to health care. While there is also a general trend to increase official private financing in health care in many other countries, one key measure to reduce inequalities have been compensation payments for low income earners.

Quality assessment obtains increasing attention in health care policy making. Nationwide assessment of health outcome indicators has been introduced in a number of countries.

Long-term care

There is a general awareness that LTC needs are going to increase in the future. Long-term care arrangements are characterised by a low degree of institutionalised structures in particular in new Members States, while South European countries depend to a high degree on informal care by family members or migrant workers. Few Central European countries have established a social insurance scheme to cover long-term care risks. However, in those countries where a public mandatory insurance scheme has been discussed rather recently, these ideas have largely been rejected, assuming that they are too costly. With regard to reforms in the field of long-term care, the general picture in the reporting period is that long-term care policies have been "put aside" on account of the economic and financial crisis.

There are very diverse financing approaches in long-term care across asisp countries. Often, public financing is provided by a fee-for-service or a fee-for-person. In some countries, co-payments for institutional care are dependant on income; sometimes income of first-grade relatives is also taken into account. There are also countries where long-term care benefits are fully means-tested. Others cover the cost of care services, while board and lodging has to be paid by the resident himself/herself. Costs for institutional care vary significantly across regions and there seems to be too little knowledge of the cost structure of home care.

Across asisp countries, an overall priority to provide support for home care as opposed to institutional care can be observed. There are various measures to foster home care, e.g. financial allowances to purchase private support, labour market regulations which allow a

temporary reduction of working hours for relatives, and publicly financed social services to enable a person in need of long-term care to stay as long as possible at home. There is also an ongoing trend to increase responsibilities of regions and municipalities, but this often goes along with substantial regional disparities in service provision. There is awareness of an increasing need of long-term care staff in the future, but little evidence of concrete policy responses.

Quality standards, in particular in home care, are an issue in many countries, and improving the quality of long-term care services is a key concern. Decentralised long-term care systems have often resulted in substantial disparities with regard to the quality of care. The introduction of nationwide unified assessment instruments appears to be of key importance in providing access to quality care and fostering the efficient use of financial resources.

Linkages between long-term care and poverty are often implicitly addressed through issues such as poverty and the pension debate. This clearly reflects the interlinkages between the pension system, health care, and long-term care. Increased poverty among those in need of long-term care is expected in the future due to reduced public spending, lower pension levels and increased co-financing. A key challenge for social protection policies in Europe will thus be to effectively link pension, health care and long-term care policies.

2 Current Status, Reforms and the Political and Scientific Discourse

2.1 Overarching developments

2011 has been a turbulent year with regard to social protection. Although countries were differently affected by the crisis, the overall picture is that there have been rather substantial, dynamic and partly dramatic changes in the national social protection systems.

The way how austerity measures have been conceived in terms of having influenced social protection varies widely, and the asisp Annual National Reports demonstrate how differently this reflects in national debates. While there are few countries which seem to be only marginally affected by the crisis and which have not experienced a substantial re-orientation in social protection policies, in most countries the crisis, having revealed structural weaknesses and long-term unsustainability, is understood as a catalyst for reform initiatives. There are countries in which the crisis has strengthened the rationale of social protection, but in some cases it is indeed understood as the main cause for retrenchment and a weakening of the welfare state.

Neoliberal approaches with regard to social protection policies have been questioned in the aftermath of the crisis e.g. in Iceland and in Serbia. In Ireland, national debates have focused mainly on cost containment, and although there has not been a strong re-orientation of social protection, austerity measures are considered to be unbalanced and not sufficiently taking account of those in need of support.

Some countries, in particular those with serious public budget deficits, saw quite far-reaching social protection reforms in the past year, which also resulted in severe political turbulences. A number of countries entered into the crisis with an already existing high level of debt, which limited their ability to counteract with stimulus measures (e.g. Italy, Hungary). Cutbacks in social protection expenditures in Hungary met with strong political resistance and resulted in the collapse of the government coalition. Incisive austerity measures in countries under bailout agreements also met with serious opposition among those affected. Portugal is still faced with negative growth rates and has concluded a bailout agreement with the EU/IMF in May 2011 which is considered to have far-reaching social consequences. In Romania, austerity measures exacted by the crisis were mainly targeted at the social protection sector; measures met with strong public resistance and – in view of 2012 elections – are expected to contribute to a change of the government. Greece has been struck by recession for three consecutive years. The asisp expert assesses the bailout loan package and austerity measures as having substantial negative effects on social protection. A similar pessimistic assessment is made for Latvia, which has also been under a bailout agreement and where austerity measures considerably affected social protection systems. Despite a visible economic recovery uncertainty and a lack of medium and long-term strategies with regard to social protection are considered to have undermined trust in the social protection system.

2.2 Pensions

2.2.1 Overarching developments

Demographic ageing and financial sustainability are key concerns across the asisp countries, and pension reforms have been in the centre of social protection initiatives. While the immediate impact of the OMC on social protection policies is considered to be rather limited, a number of countries report, however, that European comparisons with regard to different

parameters of pension systems are increasingly used in national reform debates. Furthermore, the EU Green Paper Consultation on Pensions in autumn 2010 has initiated a broader public debate in a number of Member States, and the EU2020 strategy is expected to result in continuous attention of governments to pension policies.

The overall picture is that pension policies have been in the focus of social protection related austerity measures. Often they aim at securing long-term financial sustainability, but pension cuts or suspended indexations also contributed to short-term financial savings. The main issues discussed in the countries, however, focus on policies to increase the effective retirement age and on a reshaping of mandatory funded pension schemes.

2.2.2 Increasing the effective retirement age

Against the background of demographic ageing an increase of the effective retirement age has been on the agenda in many countries. Some countries focus particularly on raising the effective retirement age. A broad consensus was found e.g. in Finland, where social partners and the government have agreed to raise the effective retirement age by at least three years by 2025. The forthcoming European Year on Active Ageing has also contributed to focus on policies targeted at raising the actual retirement age towards the statutory retirement age. Different measures are being discussed and implemented to increase the effective retirement age.

These include

- an increase of the statutory retirement age
- closing down of early exit pathways
- incentives to stay longer in the labour market

Increasing the statutory retirement age

While the topic of increasing the statutory retirement age has been on the political agenda already for a couple of years, the financial and economic crisis is considered to have accelerated reforms.

Even though an increase in the statutory retirement age will not necessarily be reflected in a corresponding rise in the effective retirement age, it might have a cognitive impact for employees, employers, and the society and influence norms with regard to employment and productivity.

The asisp reports illustrate a wide variety of initiatives to increase the statutory retirement age, and this does not only refer to the retirement age in statutory old-age pension, but also in minimum pensions, various forms of early exit pensions, and public sector pensions.

A number of countries will increase statutory retirement ages (Bulgaria, Ireland, France, Spain, Latvia, Romania); some have accelerated an already legislated increase of the retirement age (United Kingdom, Denmark) or extended the increase further to a higher age (Estonia). In some countries, minimum retirement ages for part time or early retirement have been increased (Finland, Spain, Serbia). There are further countries in which an increase of the retirement age is still being discussed (Lithuania). In Germany, where an increase of the retirement age was legislated already at an earlier stage, a governmental assessment of labour market participation of the elderly affirmed the intention to start with the actual increase in 2012.

Some of the new Member States and Candidate Countries as well as Greece have equalised statutory retirement ages for women and men, and Italy has adopted a faster phasing-in of the equalisation of retirement ages for women employed in the public sector.

The following table gives an overview of changes introduced in the reporting period:

Country	Changes introduced in 2010-2011
Bulgaria	✓ Increase of the retirement age for regular pension from 2021 onwards to 65 (men) and 63 (women) ✓ Increase of the retirement age for minimum pension from 2021 onwards to 67 (both women and men)
Croatia	✓ Gradual equalisation of the retirement age for men and women: Increase for women to 65 (60 for early retirement) by 2030
Denmark	✓ Earlier start of the increase in the retirement age to 67 by 2022 ✓ Increase of the retirement age for the voluntary early exit benefit from 62 to 64
Estonia	✓ Increase of the retirement age to 65 by 2026
Finland	✓ Age limit for part time pension has been increased from 58 to 60 ✓ Minimum age for unemployment path to retirement has been increased from 57 to 58
France	✓ Increase in the minimum statutory retirement age from 60 to 62 by 2018 ✓ Increase of the minimum age to get a full pension without a penalty from 65 to 67 by 2023
Greece	✓ Equalised retirement age to 65 for women and men ✓ Increase of the minimum age for retirement after 40 years of work to 60
Italy	✓ Faster increase of the statutory retirement age for women in the public sector to 65 by 2012
Ireland	✓ Increase of the qualifying age for state pensions from 65 to 68 by 2028 ✓ Increase of public sector retirement age in line with state pension age
Latvia	✓ Increase of the statutory retirement age from 62 to 65 until 2021
Romania	✓ Increase of the retirement age to 65 (men) and 63 (women)
Serbia	✓ Increase of the minimum retirement age from 53 to 58 until 2023 ✓ Increase of the minimum retirement age for privileged pensions from 53 to 55
Spain	✓ Increase of the statutory retirement age from 65 to 67 until 2027 ✓ Increase of the minimum and early retirement age from 61 to 63
United Kingdom	✓ Increase of the state pension age to 66 by 2020, further increase to 68 by 2046 envisaged ✓ Increase of the public sector retirement age from 60 to 65

Reshaping early exit pathways

The limitation of early exit pathways is expected to contribute substantially to an increase in the effective retirement age. In Greece, eligibility conditions for disability pensions will be tightened; this is expected to decrease the share of disability pensioners from 14.5% to 8-9%. In Austria, the entry age for an important early exit pension was raised, and eligibility conditions tightened with the aim to reduce take-up rates of this scheme in the future. In the Netherlands, financial incentives were cut as contributions to certain early exit schemes are no longer tax deductible. In Norway, eligibility conditions for disability pensions will be tightened since nearly 40% of all new pensioners are disability pensioners. A number of pension systems in the new Member States and candidate countries are still characterised by a wide range of early exit pathways including so-called privileged pensions granted to specific professions. These exit pathways will be gradually closed or made financially less attractive by (partly actuarially fair) deductions in case of retirement, or by other measures. In Bulgaria, Latvia, and Croatia, financial deductions in case of early retirement were increased.

Denmark has increased the retirement age for the voluntary early exit benefit and increased income testing in combination with a higher benefit level, thus introducing stronger targeting mechanisms in the voluntary early exit scheme. At the same time, a new benefit, the senior disability pension, will be introduced. Likewise, in Austria, while general eligibility conditions for invalidity pensions have been tightened, access has been eased for unskilled workers who traditionally had very limited access to invalidity pensions.

Country	Changes introduced in 2010-2011
Austria	✓ Tightened conditions regarding the "Hacklerregelung" (early retirement subject to very long insurance periods), increase of the entry age, restriction of substitutional insurance periods, prices for post-purchasing of contributory periods increased ✓ Tightened eligibility criteria for invalidity pensions, but better access to these pensions for low-skilled workers
Belgium	✓ Increased co-financing by employers of the so-termed bridging pensions; interim unemployment benefit for workers before retirement age
Croatia	✓ Increase of financial deductions in case of early retirement
Denmark	✓ Increase of the retirement age for the voluntary early exit benefit (from 60 to 64), strengthened income testing with other pensions, increase of the benefit level ✓ Introduction of a senior disability pension
Finland	✓ Unemployment pension abolished in 2010
Greece	✓ Tightened conditions for disability pensions ✓ Revision of professions entitled to privileged pensions
Latvia	✓ Gradual abolishment of privileged pensions
The Netherlands	✓ Contributions to voluntary early retirement schemes and pre-funded flexible schemes are no longer deductible from taxable income
Norway	✓ Tightened eligibility conditions for disability pensions
Romania	✓ Abolition of privileged pension ✓ Financial deductions in case of early retirement

Formerly, early exit pensions have often been used by employers as an instrument to manage their workforce in times of high unemployment and excess labour supply. It seems that this is generally no longer a preferred approach and a re-orientation of policies took place in view of expensive early exit schemes and workforce shortages. A stronger involvement of employers in the costs of early exit pensions is expected to increase the responsibility of employers with regard to providing adequate employment opportunities for elderly workers. In Belgium, for example, increased co-financing by employers of "bridging" pensions, provided in case of unemployment before retirement age, is expected to result in a reduced take up of this early exit pathway.

Promoting longer working lives

While the need to extend working lives has been apparent for many years in view of the financial sustainability of pension systems, upcoming scarcity of skilled workforce now also makes employers aware of the need to take action. The overall picture is that across the asisp countries a majority of policy measures to promote longer working lives focus on the abolishment of disincentives to work. Such negative incentives include a default retirement age, regulations with regard to employment after the statutory retirement age, and how employment income is taxed or deducted from pension income and whether it is considered in the future calculation of pensions.

In the UK, the default retirement age will be abolished. In Belgium, income earned after the statutory retirement age is from 2011 onwards also taken into account in the calculation of the pension, which was not the case before. Many countries have rather strict regulations with regard to the taxation of additional income to pensions. Increasing the income ceilings is considered to be an incentive for the elderly to stay longer in the labour market, or to work whilst being retired (Denmark).

Country	Changes introduced in 2010-2011
Belgium	✓ Income earned by persons older than 65 (statutory retirement age) will be taken into account in the calculation of a pension ✓ "Transitory premium" offers temporary compensation for employees above 50 who change positions within the same company
Denmark	✓ Abolishment of the fixed pension age in the public sector ✓ Increased tax exemptions for income when retired ✓ Information campaign on options to work in retirement
The Netherlands	✓ Tax reductions and exemption from social security contributions after the age of 65 increase net income
Spain	✓ Increased accrual rate for working years after the statutory retirement age
United Kingdom	✓ Default retirement age abolished in October 2011

Other measures are targeted incentives for employees and employers. In Spain, accrual rates for years worked after the statutory retirement age have been increased so that working after the retirement age will overproportionally increase the pension. Such regulations were implemented in Finland and France already earlier. There are temporary subsidies to encourage workers over the age of 50 to change job positions into one that is more adequate

for elderly workers (Belgium). In Denmark, an information campaign will inform pensioners on options to work while drawing a pension, thus making the legal framework and financial consequences in old age more transparent for the employee.

However, a general observation is that there is still rather little political awareness of the need to extend working lives in the new Member States (Poland, Bulgaria, Czech Republic).

2.2.3 Linking the pension system to life expectancy

Linking the pension system to life expectancy is an automatic stabiliser to adjust pension expenditures in line with demographic changes. There are various ways to do this, either by adjusting benefits or eligibility criteria, in particular the retirement age in line with the development of life expectancy.

Formerly, most of the countries have linked the benefit level to life expectancy, e.g. NDC systems introduced in Sweden, Italy, Poland and Latvia which consider development of life expectancy by a conversion of the notional account into an annuity taking into account the life expectancy of the retiring cohort. One main finding of the 2011 asisp Annual National Reports is that debates in the asisp countries were even more focused on introducing a direct link between the retirement age and life expectancy, and there are countries which have introduced a periodic surveying of the retirement age observing the evolution of life expectancy.

In Italy, starting from 2015, the Ministry of Labour and Social Protection will raise the retirement age in order to neutralise changes in life expectancy over the past three years in addition to the earlier introduced notional accounts. Until 2050, a cumulative increase of the retirement age by approximately 3.5 years is expected. An automatic adjustment of the retirement age to life expectancy is also envisaged in Greece from 2021 onwards. In Denmark, as of 2015, the Parliament will decide every five years whether the statutory retirement age needs to be increased due to increased life expectancy. In the Netherlands, current debates indicate that the retirement age will be linked to the development of life expectancy every five years. In the UK, government intends to link the retirement age to life expectancy as well. In Malta, the introduction of a retirement age longevity indexation mechanism has been proposed by the Pension Working Group, which would rise the retirement age every time there is an increase in the longevity index. The question whether and how to relate an increase of the retirement age formally to life expectancy has been widely discussed in Estonia, but no agreement has been reached so far. Nevertheless, it has been agreed that a decision be taken on these issues until 2019. The political debates described in the asisp reports reflect that many countries hesitate to introduce a strict "automatic" link between life expectancy and retirement age, but rather intend to keep the issue on the political agenda by establishing regular procedures to review the interrelation. The final decision, however, is supposed to be a political one and reflects national preferences with regard to intergenerational distribution.

There are also other options to link the pension system to life expectancy. In contrast to countries with a NDC system as mentioned above, in Finland, a life expectancy coefficient has been included in the earnings-related benefit formula, which reduces earnings-related pensions in line with the increase in longevity. This is going along with a flexible retirement age with higher accrual rates between 63 and 68 years of age, so that pension reductions can be compensated by extended working lives. Similarly, Portugal introduced a sustainability factor in 2008 in order to reduce the (earnings-related) pension amount in accordance with the development of life expectancy. In 2011, this sustainability factor resulted in a pension reduction by 3%. An indirect link of demographic changes to the pension amounts is made in Germany via the pension indexation formula. This includes a so-termed sustainability factor

which reflects the relation of pensioners to employed persons. The larger the share of pensioners, the smaller the indexation of pension benefits.

Country	Changes introduced in 2010-2011
Denmark	✓ Starting in 2015, the Parliament will decide every five years whether the statutory retirement age needs to be increased in view of longer life expectancy
Greece	✓ As from 2021, the statutory retirement age will be revised according to changes in longevity
Italy	✓ Starting in 2015, retirement age will be adapted every three years to the evolution of life expectancy over the proceeding three years ✓ NDC formula includes a conversion coefficient which takes into account mortality rates and life expectancy
Norway	✓ Pension benefit will be calculated with longevity adjustment ✓ Retirement age is flexible between 62 and 75

The distributional impact of a NDC system compared to a longevity adjustment in the benefit formula depends on the concrete design of the overall pension system. NDC systems are in many cases complemented by a sort of minimum or guarantee pension. In the Norwegian case, as of 2011, the retirement age has become flexible between the age of 62 and 75, and a NDC system similar to the one in Sweden and Italy will be phased in. However, the formal proportionality of the NDC system is strongly modified by a guarantee pension and an upper income level and results in a benefit profile which does not differ substantially from the previous system. In general, it seems that a link between life expectancy and the benefit level might be more rational in combination with a flexible retirement age on actuarially fair terms, as this indicates a choice and direct interrelation between retirement age and benefit level. Given the diversification of pension schemes and the increasing role of occupational and private pensions across Europe, it would be important, however, to ensure coordination between the different schemes with regard to the retirement age.

2.2.4 Development of complementary private savings

The financial and economic crisis impacted quite radically on the design of a number of mandatory funded pension schemes, in particular in the new Member States. Transition costs of the recently introduced private schemes were considered as a heavy financial burden for the state budget.

In Hungary, the mixed system of a pay-as-you-go scheme and a mandatory funded scheme was suspended by the end of 2010. Less radical approaches are reported from other new Member States. In Slovakia, the funded system was opened twice during the crisis and, since January 2008, people born after 1986 very recently were allowed a six month period to decide whether to join the funded system or remain solely in the public pay-as-you-go system. Recently, the government announced to switch to a mandatory system again. In Poland, the contribution rate to the funded scheme was reduced substantially from 7.3% to 2.3%. In Latvia, the contribution rate to the mandatory second pillar was reduced and will be increased in the future only to 6%, as opposed to 10%, as was foreseen previously. In Lithuania, the contribution rate to the funded pillar was equally reduced (from 5.5% to 2%). Despite earlier intentions the contribution rate has remained at its reduced level in 2011, and the introduction

of the funded pillar is questioned from various sides. In Estonia, in the period 2009-2010 a default option for contribution payment to the funded pillar was opened. About 60% of total participants suspended their contributions. Contributions have been gradually re-introduced in 2011. Futhermore, stricter investment rules for conservative investment funds were introduced. In general, in many countries with complementary private savings, policy measures in the past year had been focussing on stricter regulation and supervision of private pensions in order to re-establish confidence after the financial and economic crisis.

Another important development with regard to complementary private savings has been the issue of auto-enrolment. This is going to be introduced in the UK as from October 2012, with an employee contribution of 4% of the salary; an employer contribution of 2%, and the state contributing another 2%. There have also been debates on auto-enrollment on a small scale in France, where 50% of the bonuses in profit share schemes will automatically be transferred to a private scheme unless the employee decides otherwise. In Ireland, the auto-enrolment approach, which had been proposed as a way to bring forward the Irish pension system, has met with mixed response; particularly employers argued that the new system represented an additional administrative burden. The introduction of funded elements was also put to question in view of a modest performance of pension funds, and it was argued that the envisaged contribution rate would not be sufficient to provide adequate pensions.

2.2.5 Adequacy of pension benefits and poverty in old-age

Adequacy of pensions and the potential impact of current pension reforms on the future pension income situation have been addressed in a number of asisp reports, but the debates about poverty in old age have not obtained comparatively high attention as those debates on financial sustainability. In the UK, political debates focused on poverty alleviation. Currently, nearly one half of all pensioners is eligible for a means-tested pension benefit (*pension credit*), and ways forward to establish a state pension level above the pension credit minimum guarantee are discussed.

One important development to mention is the introduction of a guarantee pension in Finland in 2011, which tops the minimum pension. Around 10% of pensioners will benefit from this newly introduced guarantee pension. In France, the minimum pension will be increased by 25% in 2012.

Other debates, interestingly, could rather be seen in those countries where poverty among pensioners is currently not widespread. In France and Italy, the expected future impact of pension reforms on the adequacy of pensions is rather discussed on an academic level, while in Germany concerns about the future adequacy of pensions has also gained public attention. In most new Member States, public debates about the adequacy of pension benefits did not meet with broader public attention.

2.3 Health

2.3.1 Overarching developments

Reforms and public/political debates in the health care sector have been less pronounced and focused as compared with pension policies. Reform goals include both cost containment and measures to improve the quality of and access to health care services.

It appears that little direct reference is made in political and public debates to EU level health policies in most asisp countries, although general OMC objectives to ensure equal access and quality care is a concern in many countries. A number of countries address the importance of good health and active ageing in the context of the National Reform Programmes. EU support in health care development (health infrastructure, medical equipment supply) is also provided through Structural Funds (Bulgaria). Issues of cross-border health care provision and mobility of patients in the context of EU social security coordination rules are debated in some countries, too (Cyprus, Denmark, Germany, Luxembourg, Poland). There are also examples of how national public health policies are reflecting EU strategies (Croatia, Estonia). In countries with high fiscal deficits, budget constraints are considered as the main drivers of health care reform (Greece); in other countries, budget constraints are used to explain and justify cost containment measures including those in the health care sector (France).

The financial and economic and budget crisis along with fiscal consolidation measures is considered to impact health care. There is a number of cases where a direct impact of the economic and financial crisis has been reported (Greece, Latvia, the Netherlands, Portugal, Romania).

2.3.2 Financial sustainability

The issue of financial sustainability of health care systems has attracted considerable attention in the reporting period, in particular in those countries with high public deficits. The Euro Plus Pact highlights that "… in order to secure the full implementation of the Stability and Growth Pact, the highest attention will be paid to sustainability of pensions, health care and social benefits." There is a number of countries which report that measures to rationalise health care expenditures have been in the focus in health care policies during the past years (Austria, Germany, Greece, Italy, the Netherlands, Portugal, Ireland).

On the other hand, rising demand has also led to an increase in health care spending in some countries, resulting in the need to increase revenues. In Germany, Luxembourg and Liechtenstein contribution rates for health insurance were increased. In Slovakia, the assessment base for health insurance contributions was extended. Other countries such as Greece or Ireland have considerably reduced health care spending in the context of austerity measures.

To a certain extent, new regulations concerning the public-private mix in health care provision are expected to secure future health care financing. In the Netherlands, private financing of hospital care is encouraged, and in Poland, likewise, public hospitals are transformed into legal entities which allow further privatisation. In Slovakia, state hospitals are planned to be transformed into joint stock companies. Other cost containment measures include new regulations with regard to pharmaceuticals, favouring generic products (Belgium), or changes in reimbursement mechanisms in order to encourage more efficient health care spending (e.g. remuneration mechanisms for pharmacists/pharmaceuticals or hospital services). In France, changes introduced in 2010 mainly increased private financing of health care services through higher co-payments. In Germany, the employers' contribution

rate has been frozen so that all further increases of the contribution rate must be born by the individual insured.

2.3.3 Sustainability of health care systems with regard to human resources

Health care staff shortage is an issue which is increasingly debated in asisp countries. Shortages are partly explained by ageing populations implying shortages in the workforce, but also by an increasing demand for health care due to a changing age structure. In particular, in the new Member States' reports it is outlined that health care staff shortages are caused by emigration of health care professionals (Bulgaria, Estonia, Hungary, Latvia, Lithuania, Romania). The main reason for emigration flows is the low salary level. Hospital doctors' protests in the Czech Republic for increased salaries spilled over to Slovakia. Futhermore, in Italy, Latvia, and the Czech Republic the age structure of physicans is mentioned as a specific concern, as a large part of them are in pre-retirement age.

In Ireland, austerity measures included a substantial reduction in the health care workforce. In Spain, budget cuts in the context of austerity measures have also affected salaries of physicians.

There are remarkable regional disparities in the distribution of health care personnel (Belgium, France, Germany, Portugal) and it seems that this phenomenon may increase in the future. In Belgium, regional disparities in the density of doctors have considerably increased over the past years.

The profile of shortages identified varies according to countries (e.g. high density of doctors in Austria, but shortage of other medical staff, in particular with regard to preventive care; shortage of general practitioners in Portugal and Finland). However, there is still little information available on the quantitative dimension of shortages in the future and to what extent this is caused by an ageing society and general decrease of the workforce, or increased needs due to an increasing share of the elderly. In Spain, the development of a nationwide system for human resources planning has been initiated to identify shortages of medical staff and introduce a national registry of health professionals, including data on remuneration, career status, and professional category.

Country	Changes introduced in 2010-2011
Romania	✓ Incentives for physicians to work in remote rural areas
Finland	✓ Shifting of specific tasks from physicians to nurses
Germany	✓ Incentives for physicians to work in rural areas

In Macedonia, low wages for medical professionals are reported as a reason for shortage of personnel in public health care provision. In some countries, a lack of re-training and vocational education of medical staff has been identified as a challenge for the future sustainability of human resources in the health care system.

Policy responses to cope with future shortages of medical staff are, however, still rare. In Finland, a rearrangement of tasks to be provided by physicians and nurses has contributed to mitigate the shortages of physicians. In Romania, incentives for doctors who are willing to settle in remote rural areas have been introduced. Special incentives for those who commit

themselves to working in rural areas have also been debated in Germany, including higher remuneration or preferential access to health care education.

2.3.4 Quality and performance indicators (or lack of them)

Quality assessment obtains increasing attention in health care policy making. In the Netherlands, quality of care measured by health outcomes and patient satisfaction has become a highly debated issue. Quality indicators to collect objective and standardised information have been developed over the past decade. While, in general, quality is perceived as high, there are also clear indications that quality can be improved in certain areas. One key objective of quality and performance indicators in the Netherlands is to ensure transparency among patients, insurers and health care providers on comparative health outcomes in order to increase quality and enable patients to make informed choices. However, the report states that the emphasis on quality measurement and performance-related payments has also been criticised as it involves high administrative costs and general limits of quality measurement given the complexity of health care.

In Denmark, a nationwide assessment of the health status of the population including comparisons on regional and community level is expected to contribute to higher transparency in health outcomes. Outcome indicators refer inter alia to self-reported health, physical and mental health, stress, and long-term illness. These comparative data are expected to enable health care policy makers and clients to assess and compare quality and performance of health care services.

In Spain, a national system of health care outcome indicators will be introduced. In Slovenia, a National Strategy on Quality and Safety in Health Care has been published which includes rules with regard to accreditation and quality assessment. In Luxembourg, improved medical documentation aims to enable health authorities to measure the quality of medical treatments by comparing the health status before and after treatment. Furthermore, a unit for medical evidence was established at the Ministry of Social Security which will assess effectiveness, quality and efficiency of selected diagnostic and therapeutic interventions.

Country	Good practice in quality assessment
Denmark	✓ Comprehensive nationwide data collection on various dimensions of health care outcomes are used to assess quality in a comparative perspective
Luxembourg	✓ Improved medical documentation is being established in order to measure quality of services
The Netherlands	✓ Quality and performance indicators have been developed to improve quality of health care services
Slovenia	✓ A National Strategy on Quality and Safety in Health Care has put the issue on the political agenda
Spain	✓ A national system of health care outcome indicators will be developed

2.3.5 Health inequalities, access to health care, poverty and health

There is a large number of countries which report on an increase or a persistently high level of health inequalities. This is often linked to differences in the quality of care provision by public and private providers, and better access of higher income groups to occupational or

private services (Germany, Finland, France, Italy, Portugal, United Kingdom). Health inequalities are also reported with regard to education (Netherlands, Malta). Moreover, there are countries which are characterised by substantial regional inequalities in the access to health care. Waiting lists in different regions have been addressed e.g. in Italy by political agreements. In Serbia, limited access to health care for Roma children, asylum seekers, refugees, and IDPs is observed.

There are also countries in which concerns are articulated that health inequalities will increase in the wake of recent changes in the health care system (Greece, Poland, United Kingdom, Latvia).

Waiting lists are also a serious indicator for limited access to health care (Malta, Slovenia, Sweden). In Slovenia, transparency and public monitoring of waiting lists as well as referral of patients to health care providers with shorter waiting times are expected to reduce waiting lists.

In some of the new Member States, informal payments constitute a serious problem in the access to care for those with low incomes (Lithuania, Romania, Slovakia). While there is also a general trend to increase official private financing in health care in many other countries, one key measure to reduce inequalities has been a compensation payment for low income earners. In Austria, people receiving social welfare benefits are included in the general health insurance scheme. In the Netherlands, people on low income can apply for a state allowance to cover part of the health insurance premium. Many countries have implemented exemptions for low income earners with regard to co-payments. In Germany, health insurance funds receive compensation payments for low income insurees through financial equalisation.

Finland is a rather rare example linking health issues to poverty alleviation in the National Reform Programme and emphasising the importance of public health services for low income households.

Country	Changes introduced in 2010 - 2011
Austria	✓ Persons receiving social assistance are included in the general health insurance scheme
Germany	✓ Introduction of a new compensation mechanism for health insurance funds for insurees with low income
The Netherlands	✓ State allowance for persons with low income to cover part of the health insurance premium
Portugal	✓ Re-organisation of primary care by establishing community care centres has improved coverage
Slovenia	✓ National monitoring of waiting lists, referrals, and increased transparency are expected to shorten waiting lists

2.4 Long-term care

2.4.1 Overarching developments

There is a general awareness that LTC needs are going to increase in the future, but little fact-based evidence with regard to timing and the extent of increasing needs. It is also rarely

debated whether different forms of disabilities in old age might require a different form of support, e.g. people with dementia or people with physical disabilities. Still, there seems to be a large future potential of preventive action to avoid or delay the dependency on care. While many countries report on compensatory measures, prevention (e.g. the reduction of falls) in the context of long-term care seems to gain limited attention in accordant policies so far.

There is a low degree of institutionalised structures for long-term care in particular in new Members States. South European countries are characterised rather by a high degree of informal care by family members or migrant workers, few Central European countries have established a social insurance scheme to cover long-term care risks (Germany, the Netherlands, Luxembourg). However, in those countries where a public mandatory insurance scheme has been discussed rather recently, these ideas have largely been rejected, assuming that they are too costly (France, Poland).[1]

The degree to which family members are considered to be responsible for taking care of the elderly differ from one country to another. Highly institutionalised structures e.g. in the Netherlands and in Scandinavian countries go along with a rather limited role of family members in long-term care; but responsibilities for family members seem to be much higher in new Member States or Candidate Countries (Poland, Romania, Turkey). In the light of an ageing population and increasing female labour market participation, the increasing demand for care became more visible and gained momentum in public discussions in countries which have formerly relied on informal family care (e.g. Italy).

As in the field of health care, European long-term care policies are hardly reflected in national political and public debates. This can be partly explained by the fact that long-term care policies are often fragmented with regard to political responsibilities between central, regional and community level, and between health and social services, so that a unified and strategic approach to develop long-term care policies is often missing. However, the Lithuanian report states that the long-term care as a comprehensive policy area has only been introduced by the OMC. Furthermore, a general trend to introduce competition between different service providers is linked to overall EU policy goals and the directive on social services of general interests. EU structural funds are used in a number of countries to upgrade long-term care infrastructure or to develop pilot services. In Estonia, for example, ESF-funded initiatives include integrated guidance services presenting persons with care obligations opportunities to take part in employment.

With regard to reforms in the field of long-term care, the general picture in the reporting period is, however, that long-term care policies have been "put aside" on account of the economic and financial crisis.

2.4.2 Financing long-term care

There are very diverse financing approaches in long-term care across the asisp countries. Often, public financing is provided by a fee-for-service or a fee-for-person. In some countries, co-payments for institutional care are dependant on income, sometimes income of first-grade relatives is also taken into account. There are also countries where long-term care benefits are fully means-tested. Others cover the cost of care services, while board and lodging has to be paid by the resident himself/herself.

There are countries where the costs for institutional care vary significantly across regions (Germany, Luxembourg). It is also emphasised that there is too little knowledge of the cost structure of home care and that it is unclear whether fees and tariffs are adequate to cover real

[1] In Slovenia, a proposal to introduce a long-term care insurance under preparation since 2005 is still under discussion.

costs. Given the general trend of shifting long-term care services from institutional to home care services, a more transparent financing approach for home care services seems to be an important challenge.

Given the strain on public budgets, there is a common understanding that long-term care will need to be financed by both public and private sources. Thus, in fact, EU economic policy coordination is framing long-term care policy debates. In those countries where long-term care is financed to a large extent from public budgets, an increasing share of private co-financing is either expected or in fact targeted. Co-payments are based on income, age, assets, or the living situation. Most nursing homes are co-financed to a large extent by private sources. In Ireland, under the Home Nursing Support Scheme residents of nursing homes contribute 80% of their income plus an amount of up to 5% of assets for every three years. A similar percentage of the income is to be paid by residents in Lithuania and Malta. There are other countries, e.g. France and the Netherlands, where the way how assets are taken into account in the determination of co-payments are debated.

EU Structural Funds have been used in some countries, in particular in the new Member States and candidate countries, to upgrade long-term care infrastructure and develop and pilot new services. The use of operational programmes to finance long-term care services seems to be of importance e.g. in Bulgaria, Croatia, Estonia, Latvia. In particular, developing pilot services is supposed to provide potential for mutual learning and identifying structural solutions.

The introduction of private long-term care insurance as one instrument to cover long-term care costs is discussed in a number of countries. In most cases, this is considered as a supplementary voluntary insurance and the introduction of a compulsory private long-term care insurance, e.g. debated in France and Germany, has lost momentum. In Finland, there is concern that policies to promote private long-term care insurances will replace benefits which otherwise would be provided by public providers. It is also debated how existing regional disparities will impact on the need to conclude private insurance contracts.

2.4.3 Service provision and human resources

Across asisp countries, an overall priority to provide support for home care as opposed to institutional care can be observed. There are various measures to foster home care, e.g. financial allowances to purchase private support, labour market regulations which allow temporary reduction of employment for relatives and publicly financed social services to enable a person in need of long-term care to stay as long as possible at home.

There is also an ongoing trend to increase responsibilities of regions and municipalities, but this often goes along with substantial regional disparities in service provision, e.g. in Italy or Sweden. A lack of coordination between social services and health services is assessed in a number of countries. In Portugal, a national network for integrated continuous care has addressed the lack of coordination between health care and social services and is considered as an achievement and innovative governance structure for long-term care provision.

There is a broad awareness of an increasing need of long-term care staff in the future. Some countries provide unconditional cash allowances for long-term care which are considered to contribute to an extension of the “grey” care market. There are countries which rely to a large extent on informal care by migrant workers (Austria, Italy) or hope to address the future need of care personnel by attracting care personnel from abroad. Other countries address the increasing need of long-term care staff by strategies to increase the attractiveness of employment in long-term care and reforming national education and training systems for long-term care staff (e.g. Germany, the Netherlands). In the Netherlands, the budget includes

a considerable increase to build up the workforce in long-term care (despite general cutbacks in health care spending).

The need for increased support for informal family caretakers (care burden) has been acknowledged. In some countries, options for a limited period of unpaid leave from employment have been legislated (Finland), or proposals for fostering an earlier exit from the labour market for caregivers are discussed (Italy).

2.4.4 Quality issues

Quality standards, in particular in home care, are an issue in many countries, and improving quality of long-term care services is a key concern. In many countries, decentralised long-term care systems have resulted in substantial disparities with regard to the quality of care. The introduction of nationwide unified assessment instruments appears to be of key importance in providing access to quality care and fostering the efficient use of financial resources. In some countries, national assessments of quality highlight that the long-term care system is random with respect to cost and quality, and high costs do not necessarily guarantee satisfactory quality.

Quality assessment is developing in a number of countries and is expected to contribute to an improved transparency and comparison of service providers, better service planning and quality improvements.

In Germany, regular and standardised transparency reports for nursing homes rating their quality in various dimensions facilitate comparisons across nursing homes and are considered a useful tool for patients and their relatives to choose a service provider.

In Finland, quality assessment appears rather advanced. Public reports assessing the quality of institutional and home care contributed to a broad public debate on the lack of quality in long-term care. Indicators to assess quality in institutional care include the intervals and nutritional values of meals provided, psychiatric medications, education and care intensity of personnel, and the number of beds per room. With regard to home care, indicators were the duration of home visits and tasks performed by home care workers; in particular the dominance of support for basic care over support in promoting functional and cognitive abilities was found inadequate. Measurement of abilities of the elderlys living in institutional long-term care since the beginning of the 2000s contributes to an assessment of the development of quality between care units over time.

Country	Good practice in quality assessment
Germany	✓ Nationwide transparency reports of nursing homes ensure regular assessment of quality in various dimensions and facilitate the selection of a nursing home for the caretaker and their family
Finland	✓ Quality assessment of both institutional and home care has been carried out since 2000 and contributed to a public discussion of quality issues in long-term care
Ireland	✓ National quality standards are used for a regular inspection of nursing homes
Iceland	✓ A nationwide regular quality assessment in nursing homes focus on health and social status of the caretaker

Quality assurance in institutional long-term care is an important issue also in Ireland, where national quality standards for residential care have been determined and nursing homes are

regularly inspected. Likewise, in Iceland quality assessment is a government priority. A Resident Assessment Instrument (RAI) evaluation has been introduced in nursing homes, which focuses on the health and social status of the caretaker and aims to improve the quality of care and service planning. In Luxembourg, a system to regularly monitor the quality of long-term care services and improve performance is under development.

Still, in many reports it is stated that there is a lack of indicators to assess quality as well as of coherent approaches to quality control. In particular, in countries with decentralised provision of long-term care in combination with a high level of informal care (e.g. Italy), standardisation of quality indicators and quality assessment seems to be rather difficult.

2.4.5 Linkage between long-term care and poverty

Linkages between long-term care and poverty are often implicitly addressed through issues such as poverty and the pension debate. This clearly reflects the interlinkages between the pension system, health care, and long-term care. Low poverty rates among pensioners are also explained by a system of generous long-term care benefits (Luxembourg) or a comprehensive and publicly provided health care system. A very visible impact of austerity programmes on long-term care arrangements has been observed in Latvia, where public long-term care benefits are only provided to persons with low income. While the overall number and salaries of social workers have been reduced, the number of beneficiaries in need has been growing.

In turn, a more visible link between long-term care and poverty is expected in the future. In the United Kingdom, reduced public spending is expected to contribute to limit access to long-term care for people with low income. Current pensioners in Slovakia do not have an above-the-average poverty risk, but it is expected that social protection reforms ahead will result in lower pension levels which will be going along with a growing demand for long-term care and an increased need for public support. In the Czech report it is stated that the relationship between long-term care and poverty is becoming more pronounced and that the current trend to increase co-financing of long-term care is expected to limit access to long-term care services for the poor. The Irish report states that while policies in general are targeted on providing equal access to institutional care, there are certain groups which have to finance additional rehabilitation services by private sources which might increase the risk of becoming poor. In conclusion, the increasing demand for long-term care in the future in combination with the need to limit public spending and increase private financing might increase the poverty risk of the elderly. A key challenge for social protection policies in Europe will thus be to effectively link pension, health care and long-term care policies.

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