Annual National Report 2011

Pensions, Health Care and Long-term Care

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Author: Jon Kvist

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1 Executive Summary

In May 2011, the Danish Government launched a reform package that includes reforms in the field of pensions, as well as an agreement with both the Association of Regions (in the field of health) and the Association of Municipalities to freeze local budgets in 2012 but also recommending municipalities to keep the same scope of long-term care.

The pension reform basically pushed forward a change of the retirement age for both voluntary early exit schemes and the national old-age pension that was part of the Welfare Agreement of 2006; but the reform also contained some new elements. Among its main features are:

- Gradual increase of the pensionable age from 2013 onwards for the voluntary early exit scheme and the national old-age pension
- Higher benefit levels and new, stricter income testing in the voluntary early exit scheme that favour low income groups and will most likely deter some persons with medium and higher earnings for using the scheme
- A fast track scheme for persons over 60 years to apply for a new Senior Disability Pension

The agreement on the 2012 budget for the regions keeps a lid on health expenditure in general, but also allocates extra money to, for example, new super hospitals in line with the plans that were part of the Recovery Plan of last year (see asisp ANR 2010).

The Health Profile Project reported from its first survey of 180,000 persons. In combination with register data this is to help politicians and civil servants to design better policies and stimulate collaboration across regions and municipalities.

The 2012 budget for municipalities curbs municipal expenditure in general, but allows and encourages re-allocation of means from administration towards more client-based services, including long-term care.

Denmark has the largest long-term care scheme in the world which is free of charge. The by far biggest share of recipients receives practical care or a combination of practical and personal care for less than two hours per week. More than eight out of ten recipients of care are either satisfied or very satisfied with their received services. Private care provision is on the rise whereas knowledge of flexible home care is limited and diminishing year by year.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

The Danish public finances are doing better than expected a year ago as reflected by a lower public deficit for 2010. Currently, public finances are actually fulfilling the EMU criteria of public debt of under 60% of GDP and public deficits under 3% of GDP, see Table 1.

Table 1: Public debt and public deficit according to the EMU criteria, percentage of GDP, 2007-2010

	2007	2008	2009	2010
Public debt	27.5	34.5	41.8	43.6
Public deficit	4.8	3.2	-2.7	-2.7

Source: Statistics Denmark (2011).

Nevertheless, there is still a sense of crisis and the spring 2011 was full of discussion and negotiations on reforms of which some were related to pensions, health and long-term care. In particular, the Government made a deal with some other political parties on a retirement reform.

The recommendation of the EU of 12 May 2010 (European Commission 2010) to end the deficit on public budgets was used by the Government and the opposition alike to engage in a vivid debate on what was to be the best exit strategy. The first exit strategies, described in the asisp ANR 2010, formed the basis for discussions and later negotiations. At first, pensions, health care and long-term care were more or less unaffected by the austerity measures.

However, this changed as new negotiations opened up after the turn of the year and continued into spring 2011. During May 2011, the Government managed to get a majority of the Parliament behind the various reform elements that, taken alltogether, make up the reform package. Most notably, the reform package includes a retirement reform and, also on health and long-term care – though indirectly through budget agreements with, regions and municipalities respectively. These reform plans are set out in detail in the asisp ANR 2011 at hand.

The main thrust of the new reform plans is to increase effective retirement ages three years earlier than scheduled in the Welfare Agreement of 2006 by changing eligibility rules and making it less financially attractive for medium and higher income groups. As for health the issues are of controlling costs through stricter regulation mechanisms and of spending more on specific areas. In long-term care the pertinent issue is how to maintain current levels of activity in view of budgetary pressure on municipalities in the short term and ageing populations on the medium to long term.

Elections for Parliament will be held after the summer 2011 (the exact date will be selected by Prime Minister Lars Løkke Rasmussen). Depending on the election results and subsequent negotiations on the budget for 2012 a wave of reforms can be expected.

2.2 Pensions

2.2.1 The system's characteristics and reforms

In this section we first describe the characteristics of the Danish pension system and afterwards the reforms that are underway as part of agreements between the Government and other political parties. These agreements, concluded in May 2010, concern withdrawal from the labour market and thus concern not only national old-age pensions but also the voluntary early exit benefit scheme (*efterløn*) which is not officially a pension but which nevertheless is an important exit route out of the labour market for older workers.

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

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

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

Source: Socialministeriet et al. (2002), Finansministeriet et al. (2005) and own adaptations.

The Danish national old-age pensions consist of a basic amount, a supplementary amount, and the supplementary pension benefit. The basic amount is the same for everybody, i.e. DKK 66,624 annually or DKK 5,766 monthly (all amounts for 2011). The supplementary amount varies for single persons and others. For single persons the supplementary amount is DKK

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

69,192 or DKK 5,766 monthly, and for others DKK 33,444 annually or DKK 2,787 monthly. The supplementary pension benefit is DKK 10,900 annually, paid out as a 'cheque' once a year.

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

The basic amount and the supplementary amounts are automatically indexed each year according to wage and price developments. The level of the supplementary pension benefit, popularly called the Elderly Cheque, has from its introduction in 2003 to 2010 been set politically in budget negotiations between the Danish People's Party (*Dansk Folkeparti*) and the Government (for more details, see ANR 2010).

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

The virtue of the Danish national old-age pension is that it constitutes a very good minimum pension, effectively combating poverty in old age. This is the case in particular because virtually all benefits in kind are free of charge (except institutional care).

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

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

Persons outside the labour market on a more permanent basis also have the possibility of an ATP-like scheme, namely the Supplementary Labour Market Pension for Disability Pensioners (*Supplerende arbejdsmarkedspension for førtidspensionister – SAP*). The rationale of SAP is to partly compensate for the lack of an ordinary labour market pension. Unlike the ATP contributions made for persons on temporary social security benefits, the SAP scheme is voluntary. SAP gives persons on disability pensions the possibility to contribute to supplementary labour market pension scheme.

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

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

Since 1990, the contribution rate to these schemes has gradually been raised as part of most of the collective agreements, resulting in contribution rates between 12% and 17% of gross wages.

In other words, there has been a silent revolution of the Danish pension system in the 1990s. As private pensions become more salient, there will be smaller differences between the working and the retired population but greater inequalities among the retired.

Reforms

On 13 May, the Government reached an agreement on retirement, i.e. on a reform of the voluntary early exit benefit and the national old-age pension with the Social Liberals, the New Alliance, and the Danish People's Party. In brief, the agreement brings forward the implementation of the increase of the retirement age that was already agreed upon in the Welfare Agreement of 2006, but it also contained some new elements.

The agreed reform consists of a series of elements:

- Advancement of the gradual increase of the retirement age stipulated in the Welfare Agreement of 2006 so that it starts already in 2014, and not only in 2019.
- When the increase of the retirement age will have been fully phased in, the voluntary early exit benefit scheme will become a three-year benefit scheme.
- The voluntary early exit benefit is increased but also contains a stricter tapering of benefits with income from other pensions and assets.
- Persons can get their paid contributions to the voluntary early exit benefit paid out tax-free if they leave the scheme.
- A new scheme, the Senior Disability Pension, for people with health problems.

According to calculations by the Ministry of Finance, the agreement will:

- increase employment by 65,000 persons in 2020;
- improve public finances by 18 billion DKK in 2020;
- strengthen the sustainability of public finances with almost 10 billion DKK equal to 0.5% of GDP by 2020;
- increase wealth as measured by GDP by 47 billion DKK in 2020.

Table 3 compares the existing rules with the planned changes following the Welfare Agreement of 2006 and the New Plan on Retirement Reform. The Table shows how the new plan concerns in particular the voluntary early exit benefit and not so much the national old-age pension. The new plan does not increase the retirement age for the national old-age pension further, which will remain at 67 years. The new plan increases the retirement age for the voluntary early exit benefit by two more years than the two years already agreed in the Welfare Agreement of 2006. The retirement age for the voluntary early exit benefit thus becomes 64 years instead of 60 years as is now.

There are other changes to the voluntary early exit benefit. The new plan shortens the benefit period for the voluntary early exit by two years, strengthens income-testing with other pension assets and periodical payments, and increases the benefit levels. The yearly contribution of 5,362 DKK and the requirement of a 30-years contribution record remain unchanged. Tax free premiums for people retiring later than the retirement age in the voluntary exit benefit remain unchanged. As before the tax-free premium people receive increments by 11,930 DKK for each three months they retire later than the retirement age in

the voluntary early exit scheme. However, now they have to work longer, i.e. until the new retirement age of 64 years, instead of the former 62 years, as set in the Welfare Agreement of 2006, see Table 3 below.

Table 3: Main elements of the national old-age pension and the voluntary early retirement benefit according to existing rules, rules of the Welfare Agreement and the New plan for Retirement Reform of 13 May 2011 (2011 figures and rules as if fully implemented)

	2011	**Welfare Agreement of 2006**	**New Retirement Reform of 13 May 2011**
1. Contribution			
Yearly contribution	5,362 DKK	5,362 DKK	5,362 DKK
Contribution period	30 years	30 years	30 years
2. Retirement age (before indexation)			
Voluntary early exit benefit	60 years	62 years	64
National old-age pension	65 years	67 years	67
Life time indexation	No	Yes	Yes
3. Benefit period for voluntary early exit benefit			
Maximum	5 years	5 years	3 years
4. Income-testing			
Start 1st or 2nd year			
Value of pension wealth	Y es	Yes	Yes
- basic allowance	13,800 DKK	13,800 DKK	0 DKK
- tapering percentage	60%	60%	80%
Periodical payments	50% without basic allowance	50% without basic allowance	64% without basic allowance
Start 3rd year or later			
Value of pension wealth	No	No	Yes
- basic allowance	-	-	0 DKK
- tapering percentage	-	-	80%
Periodical payments	55% without basic allowance	55% without basic allowance	64% without basic allowance

5. Yearly voluntary early retirement benefit			
Start 1st or 2nd year (before tapering)	181,220 DKK	181,220 DKK	199,160 DKK
Start 1st or 2nd year (after tapering in case of pension wealth of 966,00 DKK)	160,520 DKK	160,520 DKK	160,520 DKK
Start 3rd year or later (before tapering)	199,160 DKK	199,160 DKK	199,160 DKK
6. Tax-free premium			
Premium per quarter	11,950 DKK	11,950 DKK	11,950 DKK
Saving period	3 years	3 years	3 years
Maximum total premium	143,400 DKK	143,400 DKK	143,400 DKK
Payment	At age of retirement for national old-age pension	At age of retirement for national old-age pension	At age of retirement for national old-age pension

Compared to the EU goals of adequate, sustainable and modern pensions the reform offers higher benefits and more sustainability in that the scheme is now more favourable towards low income groups due to higher benefits and more income testing than earlier, albeit these groups are also suffering most from the increase of the retirement ages due to often unfavourable working conditions.

Advancing the Welfare Agreement affects the possibility of receiving the national old-age pension for persons aged between 50.5 years and 56 years by the end of 2010, see Table A1 in the Annex. If the rules of the Welfare Agreement of 2006 had continued, these cohorts would have received more years on pension and voluntary early exit benefit than cohorts before and after them. With the new plan the retirement age increases between half a year and two years, most for younger ones in this group and less for elderly.

The life time indexation of both the national old-age pension and the voluntary early exit benefit that were part of the Welfare Agreement of 2006 is kept in place in the new plan. Increased longevity means more years on the labour market. The Parliament decides every five years on whether retirement ages should be increased in view of expected longer life expectancy, the first time in 2015. Such decisions on increases are going to take place three years earlier than planned in the Welfare Agreement of 2006. An increase in the age for the national old-age pension is only possible from 2030. The first time the age for the voluntary early exit benefit can be increased due to life time indexation is in 2027, i.e. a warning of 12 years before the time of decision in 2015.

With the current demographic projections, the eligible age for voluntary early exit benefit will be increased by one year in 2027. Similarly, the age for the national old-age pension will be increased by one year in 2030, see Table A2 in the Annex.

However, as part of the reform of retirement the Government, the Danish People's Party and the Social Liberals also agreed to introduce a new scheme, the Senior Disability Pension as of

1 January 2014. This new Senior Disability Pension (*seniorførtidspension*) may offer an alternative early exit possibility for the above groups with no regard to their contribution records and with a fast administrative procedure of a maximum of six months from application to reward or rejection.

The purpose of the scheme is to enable quicker access to disability pension for persons on the labour market and who reach the retirement age within the next five years. The scheme contains a simpler procedure for the award of disability pensions targeting persons who are attached somehow to the labour market, i.e. in ordinary employment or on sickness benefits or the like. The award is based on existing information, i.e. without test of work capacity etc. Benefit levels are the same as for the ordinary disability pension.

Moreover, the pension reform also offers some new or improved incentives for people to work longer such as an increase of the tax allowance and tax free portions, along with the abolishment of fixed pension ages. The tax allowance that allows retired persons above the age of 65 to earn DKK 30,000 exempt from taxation is increased to 60,000 DKK. The current possibility of earning up to 12 tax free portions to a total value of DKK 143,400 is kept also in the new three-year voluntary early exit benefit scheme. Accordingly, every time a person works 481 hours when on voluntary early retirement benefit, the person is entitled to a tax free portion of DKK 11,950. Also, the pension reform will expand the possibilities for elderly to work more and longer, e.g. the public sector collective agreement schemes that operate a fixed pension age of 65 or 70 years beyond which one cannot work will have these fixed pension ages removed. Finally, the reform contains plans for a campaign to inform elderly about their possibilities to continue working whilst partially retired or during regular retirement.

2.2.2 Debates and political discourse

In Denmark, exit from the labour market mainly takes place through disability pensions (*førtidspensioner*), the voluntary early exit benefit (*efterløn*) or through old-age pensions. Because of the early exit schemes – disability pensions and the voluntary early retirement scheme – the effective retirement age is lower than the stipulated 65 years of age in the national old-age pension.

In particular, the voluntary early exit benefits are subject to reforms, see previous section. The latest reform dates back to the Welfare Agreement in 2006 when both the voluntary early retirement scheme and the national old-age pension were reformed (for more information see asisp ANR 2009).

Reforms of the voluntary early retirement scheme have been a political taboo since the then Danish Prime Minister, Mr Poul Nyrup Rasmussen (Social Democrats), before the 1998 election had promised to preserve the voluntary early retirement scheme as it was. After the election he agreed with other political parties on changes to the scheme that made it more difficult to earn entitlements. This had led to a lack of credibility and at the next election Poul Nyrup Rasmussen lost. Hence, most politicians have been as reluctant to reform the voluntary early retirement scheme as economists and other experts have talked about the need for reform. It was a surprise, therefore, when the current Prime Minister, Mr Lars Løkke Rasmussen, declared in his new year's speech that the Government wanted to reform or even abolish the voluntary early retirement scheme.

From January until mid May 2011, divergent views were being put forward in the debate on the reform of the voluntary early retirement scheme. The Government, in particular the Conservatives, initially wanted to abolish the scheme (see also REGERINGEN, 2011a). The

two social liberal parties (*Radikale Venstre* and *Liberal Alliance*) support abolishment. However, these four parties are not sufficient to get a majority of the votes in Parliament.

The Government's traditional supporter, the Danish People's Party (*Dansk Folkeparti*), did not want to abolish the scheme and instead promoted a model of 40 years of work to become eligible for the benefit. The 40-year model was also supported by the Christian Democrats *(Kristendemokraterne).*

The opposition parties, mainly the Social Democrats and the Socialist People's Party, did not want to abolish the voluntary early retirement scheme. Instead, they have advocated an increase of working time by 12 minutes per day and a faster and more comprehensive activation of social assistance claimaints.

On Friday, 13 May 2011, the Government and the Social Liberals and the Danish People's Party agreed on a reform of retirement from the labour market. The Danish People's Party thereby backed down from their 40-years model and asked for a series of concessions that were not related to the three fields of pensions, health care and long-term care of this report (e.g. the re-instalment of border controls). For details on the Friday 13 package, as the opposition likes to call it, or the New Plan, as the Government prefers to call it, please consult section 2.1. above.

In fact, the reform of retirement is part of the reform package that the Government launched on 14 April 2011. The Reform Package 2020 (*Reformpakken 2020*) consists of proposals regarding:

- retirement, including reforms of the voluntary early retirement pay,
- student loan reform, and a
- reform of the disability pensions and flex jobs.

Health care services are only indirectly touched upon as part of the attempts to get a better governance of the public sector. Also, the Government announces that its reform package will enable an annual increase of 4 billion DKK for the areas of health, education and research (Regeringen, 2011b).

As the above testifies, there has been a vivid discussion of increasing retirement ages among political parties, the social partners, think tanks, commissions, researchers, NGOs, and the general public. It seems safe to say that the debate of how to reform withdrawal from the labour market has never before been subject of such intense discussion. Positions range from the abolishment of certain schemes, most notably the voluntary early exit benefit scheme, to keeping the status quo in pensions and finding solutions in other fields instead, most prominently the bid of extending daily working hours by 12 minutes as described earlier.

However, there has not been much debate related to a guaranteed minimum income in pension age or on the role of private and funded schemes. Already, the national old-age pension together with extensive free or heavily subsidised service benefits for elderly provides a pretty good insurance against poverty and destitution in old age. Already, the private element of the Danish system is very elaborate with almost universal supplementary pension schemes according to collective agreements.

There is little doubt that the financial and economic crisis has been used to fertilise the ground for reforms that were already in the making due to ageing populations.

2.2.3 Impact of EU social policies on the national level

The impact of EU social policies on the national level is negligible in the field of pensions, health care and long-term care. For example the Green Paper on Pensions launched 7 July 2010 (European Commission, 2010b) did not ignite any debate in Denmark. There were only 11 articles written between 7 July 2010 and 15 June 2011 that mention the EU Green Paper and pensions (search on national mediadatabase, Infomedia, 15 June 2011), including one article referring to the 2005 Green Paper on Pensions. Not even the interest organisations for elderly made a hearable response. The Commission itself described that "the consultation was extremely successful, receiving almost 1,700 responses from across the EU including around 350 from Member State governments, national parliaments, business and trade union organisations, civil society, and representatives of the pension industry." However, 1,008 of these responses came from a UK campaign on portability of pensions. Only seven responses came from Denmark.

In comparison, the European year of poverty in 2010 was fuelling intense debates throughout the year at levels of NGO and the general public as well as among political parties. However, there have been no debates on pensions, health care or long-term care due to EU strategies on these issues.

This is not to say that there has been no impact or discussion of the impact of the EU on the national level with relevance for pensions, health care and long-term care. However, these debates have not been ignited through EU social policies, but other EU policies and situations; for more please see section 2.2.5 on pension matters and section 2.3.5 on health matters.

2.2.4 Impact assessment

The Danish pension system is a genuine multi-pillar system, see section 2.2.1 above. Hence, the different pension schemes serve different purposes with some mainly tax-financed pay-as-you-go schemes reducing inequalities and securing a de facto guaranteed minimum income in old age and other mainly contribution-financed funded schemes rewarding participation in the labour market. For a recent overview on how the multi-pillar system impacts on inequalities across gender, income, education, skills, ethnicity, geographical location please see the asisp ANR 2010. Since that report, there has not been much research or studies on the national old-age pension. Instead, the voluntary early exit benefit has taken centre stage.

In other words, there is general consensus that the old-age pension system is economically sustainable as such. However, when including related schemes like the voluntary early exit scheme and the disability pension, there are issues related to labour supply and the financial sustainability of the Danish welfare model. The social partners, think tanks, council, and researchers have taken up this discussion, see next section.

As described earlier, the reform of the voluntary early exit benefit scheme is the single biggest reform initiative on labour supply and social expenditures that thus will make the largest contribution to obtain sounder public finances by 2020.

2.2.5 Critical assessment of reforms, discussions and research carried out

Of course, the reform of 13 May has been subject of discussion. As described earlier the Government and the coalition partners claim that the reform will get 65,000 persons work and strengthen public finances by 0.5% of GDP by 2010. The Association of Unemployment Insurance Funds (*A-Kassernes Samvirke*) stated that the reform will result only in an additional 55,000 persons working. The dispute is about the assumptions laid down with regard to how large the share among future cohorts who will stay insured and make use of

their right to the early exit benefit will be. Next to the changes in regulations set out earlier, there are a number of counteracting factors to be taken into account. The tax reform of 2009 (see asisp ANR 2010) is gradually reducing the tax advantage on insurance contributions from 32% to 25%, making it less attractive to pay into a voluntary early exit scheme. This should result in fewer people retiring early in the future. Similarly, the option for insured people to take out the contributions they have made so far tax-free is likely to result in many persons leaving the insurance scheme altogether, whereas on the other hand there is the general development towards more stressful work and the increase of the general retirement age, both factors pushing towards a larger share of a cohort going on the voluntary early exit benefit scheme.

The national inclusion target – which has been set down for the first time in the Danish National Reform Programme 2011 – is to lift 22,000 persons out of households with low work intensity. This goal has been set following more than a year of debates and discussions.

There are no separate targets related to the risk of poverty or severe material deprivation in total or for persons above a certain age (e.g. +65 years of age), or gender. There are also not yet figures relating particularly to the situation of elderly persons that would allow to assess the progress towards inclusion of the elderly.

The focus on households with low work intensity is not random, but can be seen as an expression of how the Danish Government find the at-risk-of-poverty measures to be of little avail in the Danish context. To illustrate this, the draft NRP noted that there were 200,000 persons in the total population that figure in more than one of the three subgroups of social inclusion, i.e. the risk of poverty, material deprivation, and households with very low employment. The report was sceptical about this figure and called for a closer examination. As noted in earlier asisp reports, especially the at-risk-of-poverty rate is not informative about poverty or social exclusion in the Danish context where there are universal and free health care and long-term care services and various other tax-benefits favouring elderly. Therefore, the Government summoned up a working group to develop 'relevant national poverty indicators' to be finished some (unspecified) time in 2011. The result, most likely, was to focus on persons in households with low work intensity.

The exclusive focus on households with low work intensity is debatable. The Government rightly states that the lack of work is the root of many problems of inclusion. The NRP states that "a fall in employment may impede the present and future welfare of families and increase their risk of becoming victims of intergenerational transmission of poverty. Lack of employment also contributes to increase the structural challenges of the welfare state. A firm affiliation to the labour market is the best safeguard against poverty and social exclusion, both for the individual and for society as a whole," (NRP, p. 31). There is a broad consensus in Denmark that having a job is the best insurance against social exclusion.

However, that said, the opposition and some interest organisations would emphasise that there are also groups of persons who have real difficulties in making ends meet and who are not likely to be able to be integrated into the labour market, at least not without considerable help.

Most notably, the choice of focussing on households with low work intensity shifts the focus away from the elderly. Elderly in households with low work intensity are seen as retired and thus voluntarily in this situation. However, there are retired persons with risk of social inclusion problems also when defined in economic terms. To illustrate, the NRP does not mention or comment on the perhaps biggest problem of poverty and social inclusion among elderly. This problem relates to a group called 'fraction pensioners'. The term 'fraction pensioners' relates to how the national old-age pension is calculated. The size of the national

old-age pension is determined by the years of residence. People earn 1/40 of a full national old-age pension for each year they have lived in Denmark between 15 and 65 years of age. To illustrate, a person who has lived in Denmark for 20 years prior to retirement (at 65 years) is entitled to half of the national old-age pension. Obviously, this is not enough to lift the person above the risk of poverty as defined by 60% of the medium income after social transfers and taxes. 'Fraction pensioners' are often of a foreign descent and various social assistance and housing benefits are often allocated to enable these persons to lead a normal life.

Not all households with low work intensity can be said to be at risk of social exclusion. Of the total of 347,100 persons in households with low work intensity, 4,500 are on maternity benefits, and 82,000 are students (NRP 2011). By far, the majority of persons on maternity leave and students are likely to be lifted out of low work intensity under their own steam. Some 51,300 children are living in households with low work intensity (but obviously cannot be targeted for work). What is more, there are 46,600 persons who receive no benefits. In other words, there are 84,000 on disability pensions, 62,400 persons on social assistance, unemployment benefits and unemployment allowance, and 15,500 on rehabilitation, flexi-jobs, sheltered employment and wage subsidies. In sum, the target group for policy measures to lift the number of 22,000 persons out of households with low work intensity consists of 161,500 persons.

As the national indicator chosen on social inclusion is not relevant for elderly, we have to go beyond the National Reform Programme in search for evidence. Based on information from Eurostat on various indicators, see Table 4 below, we may be able to assess the situation of elderly.

Table 4: Development of selected indicators related to social risk for elderly, Denmark, 2005-2009.

		2005	2006	2007	2008	2009
At-risk-of-poverty rate, 65+ years, income below 60% of the median income, percentage of population	Total	17.6	17.4	17.7	18.1	19.4
	Female	18.4	18.6	18.6	18.9	20.3
	Male	16.5	15.9	16.5	17.0	18.3
Severe material deprivation, 65+ years, percentage of population	Total	0.2	1.1	0.8	0.9	0.9
Aggregate replacement ratio[1)]	Total	0.35	0.37	0.39	0.41	0.42
Average life expectancy at age 65, years	Female	19.1	19.2	19.2	19.5	19.5
	Male	16.1	16.2	16.5	16.6	16.8

Source: Eurostat, www.eurostat.eu, retrieved 10 April 2011. Notes: [1)] Ratio of the median individual gross pensions of 65-74 age category relative to median individual gross earnings of 50-59 age category, excluding other social benefits.

Table 4 shows that the share of elderly at risk of poverty has increased in recent years. As explained earlier, the risk-of-poverty measure is controversial in Denmark when it is defined as income below 60% of the median income. At 19.4% in 2009, the risk-of-poverty rate in Denmark is indeed higher than for the EU27 at 17.8%. Danish men with a rate of 18.3% are at a greater risk of poverty than in the EU27 with a rate of 14.9%. Danish women with a rate of 20.3% are at nearly the same risk of poverty as that in the EU27 with a rate of 20.1%.

The Table also shows an increase of persons at risk of poverty in Denmark. The share of the elderly population at risk has risen from 17.6% in 2005 to 19.4% in 2009, an increase of 1.8 percentage points. For women the share has increased from 18.4% in 2005 to 20.3% in 2009 and for men in the same period from 16.5% to 18.3%.

The Danish trend runs counter to that of the EU27, where the risk for elderly decreased from 18.9% in 2005 to 17.8% in 2009. For both men and women in the EU27 the risk of poverty decreased by one percentage point from 2005 to 2009, i.e. for men from 15.9% to 14.9% and for women from 21.1% to 20.1%.

How can gender inequalities and developments be explained? Since there have been no cuts in national pensions, this cannot explain the increase of the at-risk-of-poverty rate in Denmark. Instead, the increase may in part reflect that wages increased faster than social benefits in the second half of the 2000s. The higher rate for women than for men is most likely a reflection of former work records importance for occupational pensions.

Severe material deprivation has also increased. The share of elderly reporting severe material deprivation increased from 0.2% in 2005 to 0.9% in 2009. This increase also runs counter to the decrease in the EU27. However, the levels of material deprivation are still much lower in Denmark than in most other EU countries. Only Luxembourg with a share of 0.2% of the elderly reporting severe material deprivation, the Netherlands with 0.4%, and Sweden with 0.5%, have lower rates than Denmark. The EU27 rate went down from 10% in 2005 to 6.7% in 2009.

Seen together, the information on the risk of poverty and on severe material deprivation shows that the Danish pension system manages to provide minimum income benefits that keep elderly out of absolute poverty but not of relative poverty when the 60% of median income line is used. This line is just above the national old-age pension.

The generosity of aggregate pensions has increased. The ratio of median gross pensions to median gross earnings rose from 0.35 in 2005 to 0.42 in 2009. Most likely, this rise reflects a number of factors both for pensions and labour market developments. For pensions the most important factors are probably the maturation of pensions and that women are getting longer previous work records with higher earnings. The both of these factors contribute to larger occupational pensions.

Nevertheless, the ratio of 0.42 is still somewhat below the EU27 ratio of 0.51. However, the below average level of generosity of pensions should be seen in the light of universal and free benefits for elderly. The generosity measure does not take into account that the range of non-monetary benefits is very extensive in Denmark encompassing free elderly care and free health care. Pensions in Denmark are in other words not going to pay for care as may be the case in most other countries. The consumption possibilities of elderly are thus higher than the ratio of gross benefits to median gross earnings indicate.

The Table shows that the average life expectancy for persons aged 65 increased from 2005 to 2009 by 0.4 years for women and 0.7 years for men. In 2009, the average life expectancy for persons aged 65 was 19.5 years for women and 16.8 years for men. The gender gap decreased from 3 years in 2005 and was 2.7 years in 2009. Both men and women in Denmark have a lower life expectancy than the EU27 total. In 2008, for example, the life expectancy at the age of 65 was 20.7 years for the EU27, compared to 19.5 years in Denmark and for men the respective figures were 17.2 and 16.5.

2.3 Health Care

2.3.1 The system's characteristics and reforms

In this section we first describe the Danish health care system and then the most recent reforms. The Danish health care service can be divided into two sectors: Primary health care and the hospital sector.

The primary health care sector deals with general health problems and its services are available to all. This sector can be divided into two parts: One which chiefly deals with treatment and care: general practitioners, practising dentists, physiotherapists etc. (the practice sector) and district nursing. The other part is predominantly preventive with preventive health schemes, health care and child dental care. In case of illness, the citizen normally first comes into contact with primary health care. The hospital sector deals with medical conditions which require more specialised treatment, equipment and intensive care.

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

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

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

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

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

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

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

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

Reforms

The Government and the Association of Regions came to an agreement on the economy of regions for 2012 on 2 June 2011. This agreement comes in continuation of the Health Package 2009 described in the asisp ANR 2010.

According to the new agreement regions will be given DKK 1.5 billion in 2012 to increase the number of surgeries and treatments in hospitals and to cover other expenditures, including medicine and the general practitioners (Regeringen & Danske Regioner, 2011).

The continuation of the Health Package can be seen by the focus on new super hospitals and the stricter activity-based means of allocating funds to regions and hospitals (see asisp ANR 2010).

When the Structural Reform in 2007 changed the organisation of municipalities and regions in Denmark the former 278 municipalities and 13 counties were merged into 98 municipalities and 5 regions. The reform also led to municipalities getting many more health tasks than previously (see asisp ANR 2009). The Health Profiles project, see below, is supposed to inform the decision making at the local level and, for example, help municipalities to collaborate in planning health policies. What risk factors deter our health? What is the scope of risk factors among various socio-economic groups and in different municipalities? How does health, well-being and illness relate to education and civil status? What should be kept in mind when planning health interventions?

2.3.2 Debates and political discourse

Due to ageing populations and the economic crisis there are regular debates on how to overcome these challenges. The ageing of the population means that there is a larger group of patients and a greater competition over labour like nurses and doctors to staff the health care system. The economic crisis entailed a debate on how to use best public means in general, including health care services.

The national debates have also concerned privatisation and retrenchment. Privatisation is seen by the Government as a way of increasing user satisfaction as patients get to choose what and where they want their services and as a way of increasing cost effectiveness by getting more competition between providers. Privatisation according to the opposition parties, i.e. the Social Democrats and the Social People's Party, is leading to more inequalities in the take up of social health services and constitutes a retrenchment by the state.

As described in the asisp ANR 2010 the Ministry of Health paid too much for treatment of patients in the private sector. Also, the hospitals had to dismiss staff, mainly nurses, in the

second half of 2010 in order not to exceed their budget targets. This also resulted in some debates.

2.3.3 Impact of EU social policies on the national level

There has not been much impact of EU social policies on national health policies. However, there has been some debate on the issue of EU mobility of patients and national health systems.

2.3.4 Impact assessment

The goal set out in the National Action Plan for prevention that formed part of the Health Package 2009 (see asisp ANR 2009) was to increase the average life expectancy by 3 years in the next ten years. As part of its EU2020 strategy the Government has furthermore set the target of Denmark becoming one of the ten countries where people live the longest in 2020. The Structural Reform of 2007 gave a stronger role in health policies to the municipalities that became larger through mergers of smaller municipalities. To investigate the potential for improvements and use resources in the best way possible to promote public health a project on health profiles was launched in 2009. This project is to inform policy making at the national, regional and municipal level. The idea is to repeat the study every four years, but it will already be repeated in 2013 to help inform municipalities in the work with health issues. Hence, future studies will be undertaken so that they can be reported just as the new local politicians enter office and are to decide on health policies and strategies.

2.3.5 Critical assessment of reforms, discussions and research carried out

The Health Project study is reported upon in one national report and five regional reports. The national report gives a picture of the health status across regions, and the regional reports give the picture of the health status across municipalities within a specific region. Finally, the study results in a national database that is publicly available at www.sundhedsprofil2010.dk. The politicians at the regional and local level will thus be presented with a new report when they enter office just as their civil servants can access the database at any point in time to make their own studies and benchmarks to identify areas of collaboration or strategic initiatives. The National Board of Health is obliged to inform regions about their health status and this is done through the Health Project. But the details of how politicians are informed about the health status of their community are left to the regional and local authorities to decide and there are some variations across regions.

In 2010, the first study of population health was conducted as part of the Health Profile project. In total 180,000 persons responded to a survey on their health, well-being and illness (*sundhedsstyrelsen 2011*). The scope of the survey is the biggest ever in Denmark and might be one of the largest health policy studies ever.

The 2010 study finds that 85% of Danes report that they have a good health, but also that there are social inequalities in health outcomes (*sundhedsstyrelsen* 2011). The indicators on outcomes relate to self-reported health, physical and mental health, stress, long-term illness, pain, smoking, alcohol, diets, physical activities, obesity, and social relations.

To illustrate this, obesity can serve as an example. On the basis of height and weight the Body Mass Index (BMI) is calculated. The WHO definition of weight groups according to BMI helps identify underweight (BMI<18.5), normal weight (18.5<BMI<25.00), moderate overweight (25.0<BMI<30) and severe overweight (BMI>30). For each weight group one can

establish the distribution according to gender, age, education, labour market situation, civil status, ethnicity, and regions.

2.4 Long-term care

2.4.1 The system's characteristics and reforms

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

In the early 1990s, the strategy on long-term care for the elderly was to change from primarily institutional care to more home care. The slogan was 'as long as possible in your own home'. This helps explain why the extent of Danish home care today is probably the largest in the world and why there are less elderly people in institutional care than in other Nordic countries and, especially, why there are so many in receipt of home care, see Table 7.

Table 7: Persons above 65 years of age living in an institution and in receipt of care or living in their own home and in receipt of care; percentage share of total population above 65 years, 2008.

	Denmark	Finland	Norway	Sweden
Institutional care	4.9	5.4	9.7	6.4
Home care	17.6	6.3	10.8	9.2
Total	22.5	11.7	20.5	15.6

Source: Nososko (2010). Notes: Institutional care encompasses residents in nursing homes, sheltered housing as well as other forms of service institutions. Home care covers persons who receive care in their own homes. Danish figures are for 2009.

Most home help is practical help and by far the largest amount is provided for two hours or less per week. Table 8 shows how the majority of recipients of long-term home help receive only practical help (49.0%) or both personal and practical help (10.3%). Only 10.3% receive only personal care.

Table 8: Number of claimants of long-term home help according to amount and type of home help received, 2010

Amount (weekly)	Total	Only personal care	Only practical help	Both personal care and practical help
Total	176,917	18,301	86,702	71,914
Below 2 hours	111,370	8,567	85,370	17,434
2 - 3.9 hours	21,454	3,654	1,120	16,680
4 - 7.9 hours	20,551	2,630	183	17,738
8 - 11.9 hours	9,778	1,217	19	8,542
12 - 19.9 hours	7,917	1,069	7	6,841
+20 hours	5,847	1,163	4	4,680

Source: Statistics Denmark (2011) (statistikbanken).

Table 8 also shows that the majority of recipients receive less than two hours of home help per week. The amount of home help hours per week is as follows: 63% of recipients receive less than two hours, 12.1% between two and four hours, 11.6% between four and eight hours, 5.5% between eight and 12 hours, 4.5% between 12 and 20 hours, and 3.3% more than 20 hours of home help.

Most persons above retirement age do not receive home care. Table 9 shows that only 2% of men and 4.3% of women receive home care. 65% of home care recipients are women, but men receive in average more home care than women. Where women on average receive 3.5 hours in home care per week men similarly receive 4.1 hours (Statistics Denmark 2011).

Table 9: Share of persons not in receipt of home care according to gender and age, 2010, percentage share of population group

	Men	Women
Age total	98.0	95.7
0-64 years	99.4	99.3
65-66 years	97.3	96.3
67-69 years	96.5	94.9
70-74 years	94.5	90.8
75-79 years	88.4	79.3
80-84 years	77.4	60.2
85-89 years	60.2	37.0
+90 years	31.7	8.2

Source: Statistics Denmark (2011), Nyt fra Danmarks Statistik, nr. 177.

Typically, the municipality offers its own home help and long-term care. But it is also possible for the elderly person to choose between different providers. The role of private providers has been increasing gradually year by year. In 2010, 31% received private home care, compared to 29% the year before. 42% of persons receiving only practical help opted for a private provider in 2010 (Statistics Denmark 2011, Nyt nr. 177). The municipality set standards that private providers must fulfil in order to be authorised to provide personal and/or practical care in the given municipality. The elderly person can choose between personal and practical help and is entitled to obtain flexible care, which means that the recipient of care has the right to change benefits (§94 of the Law on Services) and can always ask his/her home helper for tasks different from the ones allocated. Typically, however, the right will only be exercised when the person has no (longer) a need for a certain task to be carried out. There are a few restrictions to change benefits though: The help has to be provided in the same time framework, it needs to be help which a caregiver can reasonably be expected to provide, and there is no substitution between personal and practical care. The caregiver can reject the request for flexible home help if he/she thinks this is professionally irresponsible.

Users, politicians, companies etc. can find information on what types of home care are delivered by which companies in municipalities. The information is made available through a website called Free Choice, managed by the service authority.[2] Information also includes prices for benefits that municipalities are paying providers and what the typical benefit costs in a given municipality. There are statistics on providers which are also used for benchmarking exercises.

The municipality determines the need for long-term care and allocates it accordingly (both type and scope). Normally, this assessment will be done by a social worker responsible for elderly care. The elderly is also entitled to a contact person in the municipality. Typically, this will be the person the elderly or his/her relative will contact if the need for care changes.

[2] See www.fritvalgsdatabasen.dk.

The demand for long-term care is due to increase with the double ageing challenge, i.e. an ageing population in general but also a larger share of elderly becoming very old. In general, the ageing of the population means more people in need of long-term care, but more importantly also fewer hands and fewer tax revenues to finance staff and long-term care, respectively. The fact that people get ever older probably means that there will be more persons getting into the target group for long-term care.

All citizens in need of intensive care are entitled to long-term care. Target groups are frail elderly and persons with physical or psychological disabilities.

Long-term care is free of charge, although there may be user charges on food and various other services. Persons living in elderly care institutions pay rent, food, hair dresser and laundry services. They do not pay for care and cleaning. Permanent long-term care is free and temporary long-term care is subject to a income-tested fee. Persons living in institutions get their national old-age pension and, if eligible, housing allowances. Long-term care is mainly financed by general taxation with the rent and various user fees amounting to a mere 4% of total expenditures.

Although there have so far been no major studies using new data sources at Statistics Denmark one can consult this agency's regular two-page briefs. Four examples drawn from these briefs are:

- Short waiting time for nursing homes exist in most municipalities. In 91 out of 97 municipalities the waiting period to a nursing home is less than two months (Statistics Denmark 2011, Nyt nr. 227).
- Private home help is most used in Copenhagen. 46% of recipients of permanent home help in Copenhagen had received private home help in 2010 (Statistics Denmark 2011, Nyt nr. 117). This is more than twice as much as the 22% in the Mid Jutland region.
- Every second person above 90 years lives in a nursing home or sheltered housing for elderly. In total, 77,800 persons are living in nursing homes and sheltered housing (Statistics Denmark 2011, Nyt nr. 526). The share of persons living in institutional care rises with age. 6% of persons aged 75-59 years are living in a nursing home or sheltered housing compared to 13% of those aged 80-84 years, 23% of those aged 85-89, and 42% of those above 90 years of age.
- There are 192,600 persons employed in the field of care and nursing – equalling 154,300 persons working full time (Statistics Denmark 2011, Nyt nr. 46). Out of the latter, 133,300 perform direct care, nursing and pedagogical activities, with the remainder being engaged in cleaning, kitchen, management and administration.

2.4.2 Debates and political discourse

Every so often, it is discussed if services for the elderly like long-term care should be subject to increased user fees, contracted out or cut; but so far little political action has been taken.

One reason to explain the lack of political action so far may be that the Danish People's Party has long-term care as one of its core priorities. Also, the Social Democrats have long-term care as one of their priorities. With veto players on both the political left and the political right it is not likely that long-term care will undergo major reforms on the initiative of the central government.

However, as the economies of municipalities become tighter and tighter year by year long-term care will also be targeted for cuts. Long-term care simply takes up such a large share of

local public budgets that it cannot avoid being reformed when local public budgets are to be cut.

At present, the Social Democrats and the Government are trying to find instruments that can better monitor the economy of municipalities than is the case now. This touches upon the tradition of decentralisation to local governments (municipalities) when it comes to how much and what type of social services should be delivered. Obviously, local governments want to keep as much autonomy as possible.

Because local government expenditure makes up a large share of public expenditure the Government and the Social Democrats are likely to strike a deal as both fractions want to make sure that the EMU criteria on public deficits are met.

On 4 June 2011, the Government agreed on a budget for 2012 with the Association of Municipalities (KL). Normally, the negotiations would be accompanied by intense public debates and complaints from the municipalities that they were not getting a good deal. This year was different. The framework for the agreement was given by the Recovery Plan of 2010 between the Government and the Danish People's Party (see asisp ANR 2010 for details). According to the Recovery Plan of 2010 the expenditures to so-called citizen-centered services are to remain unchanged until 2013.

The budget agreement for 2012 allows changes within the same overall framework, i.e. expenditure cannot go up, but can be re-allocated (Regeringen & KL, 2011). In particular, support in the form of subsidies from the central government can be given to initiatives that aim to reduce costs which can, in turn, be used to expand citizen-centered services. For example, support is given to digitalisation which aims not only at improving services, but also at spare labour to be allocated to social, health and educational services.

In the second half of 2011, ten municipalities have received permission to pilot schemes outside the normal framework. The use of such pilot schemes in so-called 'free municipalities' is common practice in Denmark when looking for new ways of designing public services. Pilot schemes span a broad range of topics ranging from digitalisation to more voluntary social work. The Fredericia municipality will launch initiatives under the slogan 'as long as possible in your own life'. Even prior to the launch of pilot schemes, Fredericia was active under this slogan. Care workers taught elder persons to take part more in their own lives in areas such as cleaning and shopping, leading to greater satisfaction among elderly and care workers, as well as to some savings on public budgets. Small wonder, many municipalities have sought inspiration in Fredericia.

2.4.3 Impact of EU social policies on the national level

It is difficult to see the impact of EU social policies at the national level. But, as mentioned above, there are other channels of influence where the by far biggest (for long-term care) are the constraints on public finances stipulated by the EMU criteria on public debts and public deficits.

2.4.4 Impact assessment

Long-term care is particularly challenged by demographic and economic developments. Demographic changes imply that the share of the population in need of care increased and the share of the population that can be recruited as carers gets smaller. Demographic change also implies a situation where a larger part of both the general population and the elderly are ethnic minorities.

The economic and financial crisis has put the municipalities who are responsible for the delivery of long-term care for the elderly under economic pressure.

Over the past years there have been campaigns aimed at attracting ethnic minority groups to undertake elderly care. A recent study by Tine Rostgaard and colleagues examines the issue of ethnicity and elderly care (Rostgaard et al, 2011). Nowadays, one in ten persons working in elderly care is of another ethnic background than Danish and they expect to continue working with elderly care. All employed in elderly care express that working with people is one of the essential reasons for working in elderly care. Workers with an ethnic non-western background are also attracted by the short, practice-oriented education to become a social worker, the possibility to make a carrier, and the wage and job status are also of larger importance than for workers from an ethnic western background. Workers with an ethnic western background emphasise working conditions and that the preconditions, especially time, allow them to provide a decent care for elderly.

Management expectations of a better care for the elderly through more diversity and inclusion of workers from a cultural background where elderly are perhaps more respected than in Denmark is not reflected among the workers in elderly care nor in the result of the study (ROSTGAARD et al, 2011). Language and racism on the part of the recipients (i.e. elderly) are among the challenges for new workers in the care sector. Workers with a non-western background put less emphasis on the importance of communication just as they work less towards help-to-selfhelp which is one of the principles in Danish elderly care. In short, more diversity in elderly care work gives management new challenges. The study is based on qualitative interviews and a survey among social workers and management in 10 municipalities.

2.4.5 Critical assessment of reforms, discussions and research carried out

What indicators are used to assess quantity and quality of long-term care services? In general, the statistical information on long-term care improves year by year. Regular statistics are provided by Statistics Denmark.

The Government and the Association of Municipalities agreed in 2005 to make a more coherent documentation of various municipal services, including services for elderly. The documentation is established and published by Statistics Denmark. The area of elderly is an important municipal service area.

The documentation consists both of survey data and administrative and register data.

The user survey is a national sample of telephone interviews with recipients of home help. The survey asks about user satisfaction on three aspects, i.e. the quality of home help, the stability of home help, and the number of different home help care workers. Also the user survey asks about awareness of the free choice of home help deliveries and of the flexible home help scheme.

Table 10 shows very high and stable levels of overall satisfaction with home care regardless of the housing situation of the recipient. More than eight out of ten recipients of home care are satisfied or very satisfied with the care received. Persons resident in their own home in 2008 express both the lowest level of satisfaction with 83% for practical help and the highest level for personal help with 95%, but generally differences are marginal.

Table 10: User satisfaction with the quality of home care according to housing situation and type of care, percentage share, 2009.

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

Source: Statistics Denmark (2011).

The perhaps most disputed areas of home care concern the stability of home care. Is home care delivered on time? Does the quality or type of care differ? Are recipients of home care satisfied with the number of carers delivering the service? Table 11 shows indicators on these issues.

Table 11: User satisfaction with the stability of home care according to housing situation, type of care, and aspect of care, 2009, percentage share of recipient.

	Own home				Nursing home or service home			
	Practical		Personal care		Practical care		Personal care	
	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory	Satis-factory	Very satis-factory
Delivered on time	48	36	54	31	56	31	51	24
Uniformity of services	50	25	56	27	59	16	62	22
Number of helpers	42	25	46	23	55	14	56	20

Source: Statistics Denmark (2011).

Table 11 shows that user satisfaction is high both in personal and practical care, be it for persons living in their own home or persons living in nursing or service homes. Between 75% and 87% are either satisfied or very satisfied with the care being delivered on the time agreed. The share of satisfied recipients are slightly lower among persons living in nursing and service homes than among persons living in their own home.

The majority of recipients also find that services are uniform, between 75% and 84%. At least they express that they are either satisfied or very satisfied with the uniformity of services.

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

As described earlier, free choice of types of services and providers has been high on the agenda of the current government that came into office in 2002. People living in their own homes and who are eligible for home care can chose between municipal and private providers of practical care, personal care and both personal and practical care. Also people living in their own homes that are eligible for home care can under certain conditions chose between different benefits and services within practical care, personal care, and between both personal and practical care. However, part of the discussion on long-term care has been on whether people know about their free choices and whether they can indeed process such information. Table 12 shows the share of recipients of home care in their own homes that have knowledge of free choice of providers and of flexible home care.

Table 12: Share of recipients of home help in their own home who has knowledge of free choice of providers and flexible home care, 2007-2009, percentage share.

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

Source: Statistics Denmark (2011).

Two out of three recipients of home care in their own home know that they have the right to choose between the municipal provider of care and a private provider of care. This share has been stable across the three years observed. Much fewer persons know about their possibility of choosing between benefits and services, the flexible home care. Also, the share of those knowing about flexible home care is quickly diminishing. In 2007, 42% of home care recipients knew about flexible home care compared to 32% in 2009, see Table 12. Although not reported here, the awareness of the freedom to chose a provider of home care and flexible home care becomes smaller with age.

The administrative and register data is on the use of hospitals, home help, nursing homes and sheltered housing, preventive home visits, and rehabilitation and user time:

- Use of hospitals. Dismissals and bed days, length of stays and re-admission.
- Home help. Recipients, hours of home help, weekly averages, share receiving private provided care.
- Nursing homes and sheltered housing. Number of places and homes, number of persons living in institutionalised care, average waiting hours.
- Preventive home visits. Number of preventive home visits and number of persons receiving these visits.
- Rehabilitation and user time. Number of persons receiving rehabilitative training.

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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] Disability

[L] Long-term care

[R] Pensions

[R1; R2] HØGELUND, Jan & Lars Brink THOMSEN, 2010, Efterløn og nedslidning, Brief, Copenhagen: SFI, retrieved from: http://www.sfi.dk

"Voluntary early retirement pay and adverse health effects from working "

This study analyses the extent of health problems caused by the labour market. Based on a survey from 2006 the study examines if respondents have health problems caused by their past or current work place. The study investigates whether there are differences among different population groups. In particular the study examines whether there are differences between persons in work, on voluntary early retirement pay, on disability pensions and other non-employed groups without voluntary early retirement pay or disability pension. The findings inform the debate on whether restrictions on the voluntary early exit benefit scheme will simply result in more persons being allocated disability pensions due to ill health. Respondents have reported their monthly income, general health situation and employment status. These information have been coupled to register data on age, education, and payment of benefits.

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

"Local integration of disability pensioners"

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

a helping hand to get started with socially inclusive activities. The study is based on 1,753 survey interviews and seven qualitative interviews.

[H] Health

[H3, H4] SUNDHEDSSTYRELSEN, Den nationale sundshedsprofil 2010 – Hvordan har du det?, March 2010, Copenhagen, retrieved from: http://www.sum.dk

"The national health profile 2010"

In 2010, the largest study of population health was conducted as part of the Health Profile project. 180,000 persons responded to a survey on their health, well-being and illness (Sundhedsstyrelsen, 2011). The idea is to repeat the study every four years, but it will already be repeated in 2013 to help inform municipalities in the work with health issues. The study has also resulted in a national database that is publicly available at www.sundhedsprofil2010.dk. The indicators relate to self-reported health, physical and mental health, stress, long-term illness, pain, smoking, alcohol, diets, physical activities, obesity, and social relations.

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

"Disability and employment"

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

[L] Long-term care

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

"Ethnicity and care"

Over the past years there have been campaigns aimed at attracting ethnic minority groups to undertake elderly care. Nowadays, one in ten persons working in elderly care is of another ethnic background than Danish and they expect to continue working with elderly care. All employed in elderly care express that working with people is one of the essential reasons for working in elderly care. Workers with an ethnic non-western background are also attracted by the short, practice-oriented education to become a social worker, the possibility to make a carrier, and the wage and job status are also of larger importance than for workers from an ethnic western background. Workers with an ethnic western background emphasise working

conditions and that the preconditions, especially time, allow them to provide a decent care for elderly. Management expectations of a better elderly care through more diversity and inclusion of workers from a cultural background where elderly are perhaps more respected than in Denmark is not reflected among the workers in elderly care nor in the result of the study. Language and racism on the part of the recipients (i.e. elderly) are among the challenges for new workers in the care sector. Workers with a non-western background put less emphasis on the importance of communication just as they work less towards help-to-selfhelp which is one of the principles in Danish elderly care. In short, more diversity in elderly care work gives management new challenges. The study is based on qualitative interviews and a survey among social workers and management in 10 municipalities.

4 List of Important Institutions

AE Arbejderbevægelsens Erhvervsraad - Economic Council of the Labour Movement

Address: Reventlowsgade 141, DK-1651 Copenhagen K
Contact: + 45 33 55 77 10
Webpage: www.aeraadet.dk

Think thank associated with the labour movement.

Akademikernes Centralorganisation, AC - The Danish Confederation of Professional Associations, AC

Address: Nørre Voldgade 29, DK-1017 Copenhagen K
Contact: + 45 33 69 40 40
Webpage: www.ac.dk

AC is an umbrella organisation for its trade union member organisations. These organisations offer service to professional and managerial staff graduated from universities and other higher educational institutions.

ATP-Arbejdsmarkedets Tillægspension - ATP-Labour Market Supplementary Pension

Address: Nørre Voldgade 29, DK-1017 Copenhagen K

ATP administers not only the ATP scheme but also a series of other labour market schemes, including the Special Pension (Særlig Pensionsopsparing, SP), the holiday money (FerieKonto) and the Labour Market Occupational Disease Fund (AES).

AKF-Anvendt Kommunal Forskning - AKF-Applied Municipal Research

Address: Nyropsgade 37, DK-1602 Copenhagen K
Contact: + 45 4222 3400
Webpage: www.akf.dk

AKF is an applied research institute that undertakes studies focusing on the large role played by local and regional authorities in Denmark.

Beskæftigelsesministeriet – The Ministry of Employment

Address: Ved Stranden 8, 1061 København K, Denmark
Contact: +45 7220 5000
Webpage: http://www.bm.dk

The Ministry of Employment has the overall responsibility for measures in relation to all groups of unemployed persons, i.e. both unemployed persons on social assistance as well as unemployed persons receiving unemployment benefits. In addition, the Ministry of Employment is responsible for the framework and rules as regards employment and working conditions, safety and health at work and industrial injuries, financial support and allowances to all persons with full or partial working capacity as well as placement activities, services in relation to enterprises and active employment measures.

Center for Velfærdsstatsforskning - CWS - Centre for Welfare State Research, Department of Political Science, University of Southern Denmark

Address: Campusvej 55, DK-5230 Odense M
Contact: + 45 65 50 00 00
Webpage: http://www.sdu.dk/Om_SDU/Institutter_centre/C_Velfaerd.aspx

Small research centre placed at the University of Southern Denmark that focus on the Danish welfare state from a comparative and historical perspective.

CEPOS - CEPOS, Liberal think tank

Address: Landgreven 33. sal, DK-1301 Copenhagen K
Contact: + 45 33 45 60 30
Webpage: www.cepos.dk

The most vocal liberal think thank is CEPOS.

Danmarks Statistik - Statistics Denmark- Sejrøgade 11 Address: DK-2100 Copenhagen Ø

Contact: + 45 39 17 39 17
Webpage: www.dst.dk

Statistics Denmark publishes statistical information on the Danish society.

Danske Handicaporganisationer, DH - Danish Handicap Organisations, DH

Address: Kløverprisvej 10 B, DK-2650 Hvidovre
Contact: + 45 36 75 17 77
Website: www.handicap.dk

The umbrella organisation for interest organisations for persons with disabilities.

Danske Regioner - Danish Regions

Address: Dampfærgevej 22, DK-2100 Copenhagen Ø
Contact: + 45 35 29 81 00
Website: www.regioner.dk

Danish Regions is the national association of the five regions in Denmark.

Den Centrale Videnskabsetiske kommitte - The National Committee on Biomedical Research Ethics

Address: Slotsholmsgade 12, DK-1216 Copenhagen K
Contact: + 45 72 26 93 70
Website: www.cvk.sum.dk

The committee acts as an appeals committee in connection with findings in the regional committees, issues guidelines, considers submission of recommendations to the Minister for Health and Prevention regarding specific new fields of research etc.

Det Økonomiske Råd – The Economic Council
Website: www.dors.dk

The Economic Council is chaired by three leading macro economists, the so-called 'economic wise men'. The board consists of representatives from the social partners. However, it is the Secretariat of the Economic Council which writes the biannual reports. These reports consist of two parts. The first part is always a survey of the economy and the second part is on a special theme. Both parts are accompanied by policy recommendations.

Etisk Råd - The Danish Council of Ethics
Address: Ravnsborggade 2-4, DK-2200 Copenhagen N
Contact: + 45 35 37 58 33
Website: www.etiskraad.dk

The Council gives advice to the Parliament and public authorities on the ethical issues related to genetic engineering and biotechnology and it also initiates debates in the public.

Finansministeriet - Ministry of Finance
Address: Christiansborg Slotsplads 1, DK-1281 Copenhagen K
Contact: + 45 33 92 40 88
Website: www.fm.dk

The Ministry of Finance is as elsewhere an important player and publishes the National Reform Programme, next to other publications.

Forsikring og Pension - Danish Insurance Association
Address: Amaliegade 10, DK-1256 Copenhagen K
Contact: + 45 33 43 55 00
Website: www.forsikringogpension.dk

The Danish Insurance Association, DIA, is the trade association of non-life and life insurance and multi-employer pension funds in Denmark.

Frivillighedsrådet - Council for Volunteers and Volunteering in the Social Field
Address: Nytorv 19, 3. sal, DK-1450 Copenhagen K
Contact: + 45 33 93 52 93
Website: www.frivilligraadet.dk

The Council for Volunteers and Volunteering is a NGO active in the social field arranging debates, campaigns and meetings.

Funktionærernes og Tjenestemændenes Fællesråd, FTF -FTF - Confederation of Professionals in Denmark
Address: Niels Hemmingsensgade 12, Postboks 1169, DK-1010 Copenhagen K
Contact: + 45 33 36 45 00
Website: www.ftf.dk

FTF is the trade union confederation for 450,000 public and private employees, making it the second biggest of Denmark's three main trade union confederations. Three out of four

members work in the public sector. FTF has approximately 90 affiliated organisations. The five largest calculated by number of members are: The Danish Union of Teachers (Danmarks Lærerforening), The Danish Nurses Organisation (Dansk Sygeplejeråd), The Danish National Federation of Early Childhood Teachers and Youth Educators (BUPL), The Financial Services Union (Finansforbundet), and the Danish Association of Social Workers (Dansk Socialrådgiverforening).

HK Danmark - HK Denmark

Address: Weidekampsgade 8, Postboks 470, DK-0900 Copenhagen K
Contact: + 45 33 30 44 15
Website: www.hk.dk

Trade union of office workers.

Institute for Quality and Accreditation in Health Care

Address: Olof Palmes Allé 13, 1. th., DK-8200 Aarhus N
Contact: + 45 87 45 00 50
Website: www.kvalitetsinstitut.dk

The Institute is an independent institution which administers and develops the Danish health care quality assessment model.

Institut for Folkesundhed - The National Institute of Public Health

Address: University of Southern Denmark, Øster Farimagsgade 5 A, 1399 Copenhagen K
Contact: + 45 39 20 77 77
Website: www.si-folkesundhed.dk

The primary purpose of NIPH is research into health and morbidity of the Danish population and the functioning of the health care system. NIPH also carries out reviews and consultancy for public authorities and is involved in postgraduate education. The institute also regularly publishes The Public Health Report.

Kommunernes Landsforening - Local Government Denmark

Address: Weidekampsgade 10, P.O. Box 3370, DK-2300 Copenhagen S
Contact: +45 33 70 33 70
Website: www.kl.dk

Local Government Denmark is the national association of municipalities in Denmark.

Konkurrencestyrelsen - The Danish Competition Authority

Address: Nyropsgade 30, DK-1780 Copenhagen V
Contact: + 45 72 26 80 00
Web site: www.ks.dk

The Danish Competition Authority monitors the state of affairs with regard to competition.

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

Danish trade union confederation.

Lægemiddelstyrelsen - The Danish Medicines Agency
Address: Axel Heides Gade 1, DK-2300 Copenhagen S
Contact: + 45 44 88 95 95
Website: www.dkma.dk

The Danish Medicines Agency administers legislation relating to medicines, pharmacists, and medical devices.

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

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

The Patients' Complaints Board deals with complaints against health care professionals.

Patientforsikringen - The Patient Insurance Association
Address: Nytorv 5, DK-1450 Copenhagen K
Contact: + 45 33 12 43 43
Website: www.patientforsikringen.dk

The Patient Insurance Association makes decisions regarding compensation claims from patients injured in connection with treatment etc. in the health service or injured by a drug.

Patientskadeankenævnet - The Patients' Injury Appeals Board
Address: Vimmelskaftet 43, DK-1161 Copenhagen K
Contact: + 45 33 69 00 44
Website: www.patientskadeankenaevnet.dk

The Patients' Injury Appeals Board functions as a board of appeal for patients who wish to complain about the professional treatment in the Danish health service.

SFI-Det nationale center for forskning i velfærd - SFI-The Danish National Centre for Social Research

Address: Herluf Trolles Gade 11, DK-1052 Copenhagen K
Contact: + 45 33 48 08 00
Website: www.sfi.dk

SFI is an applied research institute that undertakes a large number of commissioned studies especially for the Ministry of Welfare and the Ministry of Employment.

Statens Seruminstitut - State Serum Institute

Address: Artillerivej 5, DK-2300 Copenhagen S
Contact: + 45 32 68 32 68
Website: www.ssi.dk

The State Serum Institute is a public enterprise, which prevents and controls infectious diseases, biological threats and congenital disorders. The institute produces vaccines and blood products.

Sundhedsstyrelsen - The National Board of Health

Address: Islands Brygge 67, P.O. Box 1881, DK-2300 Copenhagen S
Contact: Tel: + 45 72 22 74 00
Website: www.sst.dk

The National Board of Health assists the Ministry of Health and Prevention and other authorities with professional consultancy on health issues. In addition, the National Board of Health performs a number of administrative tasks, including supervision and inspection.

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

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

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

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

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

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

Velfærdsministeriet - Ministry of Welfare

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

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

3F, Faglige Fælles Forbund - 3F

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

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

Annex

Table A1: Retirement ages for the national old-age pension and the voluntary early exit benefit according to the Welfare Agreement 2006 and the planned reform.

Persons born in	Age at the end of 2010	Voluntary early exit benefit	National old-age pension	Voluntary early exit benefit	National old-age pension	Number of years on voluntary early exit benefit
1953:1	57	60	65	60	65	5
1953:2	57	60	65	60	65	5
1954:1	56	60	65	60.5	65.5	5
1954:2	56	60	65	61	66	5
1955:1	55	60	65	61.5	67	5
1955:2	55	60	65	62	67	5
1956:1	54	60	65	62.5	67	4.5
1956:2	54	60	65	63	67	4
1957:1	53	60	65	63	67	4
1957:2	53	60	65	63	67	4
1958:1	52	60	65	63	67	4
1958:2	52	60	65	63	67	3.5
1959:1	51	60.5	65.5	63.5	67	3
1959:2	51	61	66	64	67	3
1960:1	50	61.5	66.5	64	67	3
1960:2	50	62	67	64	67	3
1961:1	49	62	67	64	67	3
1961:2	49	62	67	64	67	3
1962:1	48	62	67	64	67	3
1962:2	48	62	67	64	67	3
1963:1	47	63	68	65	68	3
1963:2	47	63	68	65	68	3
1964:1	46	63	68	65	68	3
1964:2	46	63	68	65	68	3
1965:1	45	63	68	65	68	3
1965:2	45	63	68	65	68	3
1966:1	44	63	68	65	68	3
1966:2	44	63	68	65	68	3
1967:1	43	64	69	66	69	3
1967:2	43	64	69	66	69	3
1968:1	42	64	69	66	69	3
1968:2	42	64	69	66	69	3
1969:1	41	64	69	66	69	3
1969:2	41	64	69	66	69	3
1970:1	40	64	69	66	69	3
1970:2	40	64	69	66	69	3
Later		Indexed	Indexed	Indexed	Indexed	3

Table A2: The phasing in of new retirement ages for the voluntary early exit benefit and the national old-age pension according to the Welfare Agreement of 2006 and the New Plan

	Welfare agreement of 2006		New plan	
Year	Voluntary early exit benefit	National old-age pension	Voluntary early exit benefit	National old-age pension
2011	60	65	60	65
2012	60	65	60	65
2013	60	65	60	65
2014	60	65	60.5	65
2015	60	65	61	65
2016	60	65	61.5	65
2017	60	65	62	65
2018	60	65	62.5	65
2019	60.5	65	63	65.5
2020	61	65	63	66
2021	61.5	65	63	66.5
2022	62	65	63.5	67
2023	62	65	64	67
2024	62	65.5	64	67
2025	63	66	64	67
2026	63	66.5	64	67
2027	63	67	65	67
2028	63	67	65	67
2029	63	67	65	67
2030	64	68	65	68
2031	64	68	65	68
2032	64	68	66	68
2033	64	68	66	68
2034	64	68	66	68
2035	65	69	66	69
2036	65	69	66	69
2037	65	69	67	69
2038	65	69	67	69
2039	65	69	67	69
2040	65.5	70	67	70
2041	65.5	70	67	70
2042	65.5	70	67.5	70
2043	65.5	70	67.5	70
2044	65.5	70	67.5	70
2045	66	70.5	67.5	70.5
Later	Indexed	Indexed	Indexed	Indexed

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