Annual National Report 2011

Pensions, Health Care and Long-term Care

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1 Executive Summary

Norway has only been very mildly affected by the international economic downturn in the wake of the financial crisis, and therefore the policy making climate has not been changed in any significant way as a result of the crisis. The policy initiatives and discourses in the fields of pensions, health care and elderly care are characterised by continuity and they largely evolve around the long-term challenges of ageing and maintaining economic competitiveness in a globalising world.

The most important and significant of the current reform efforts concern the pension system. From January 1. 2011 important aspects of the pending pension reform have started to take effect. A completely flexible age of retirement has been introduced from the age of 62 to age 75, based on the condition of actuarial neutrality. Individuals who choose to retire early will pay for it themselves by accepting lower annual benefits, and vice-versa for individuals who choose to postpone retirement. With this new flexible and neutral system the take-up of old age benefits is no longer conditioned on a full or partial withdrawal from the labour market. The take-up of pension benefits and work can be freely combined. At the same time a system for automatic longevity adjustment of retirement benefits is put in place. Cohorts that are born after 1944 will have their benefits reduced in proportion to any future increases in life-expectancy compared to the life-expectancy of the 1944 cohort. A final very important cornerstone of the pension reform is the introduction of a new system of the accrual of pension rights that is proportional to lifetime earnings, but with a high minimum threshold. This new benefit system will be implemented more gradually and only for younger cohorts.

The main idea of the pension reform is to safeguard economic sustainability by both putting a break of future expenditure and by stimulating more labour supply. There is reason to doubt, however, whether the latter effect will be as strong as originally expected. In the last phases of the reform process it has been decided to raise the level of minimum pensions, and this means that pension contributions for many (low wage earners) will appear to be a simple tax, rather than a form of forced saving. A clear setback for the reform efforts has been the failure to adapt the occupational pension schemes for public sector employees in line the main principles of the national pension reform. It is possible, however, that this structural weakness can be mended in negotiations with the public sector unions in the years to come.

Changes in the health care and elderly care sectors are less dramatic although they are clearly affected by the prospect of ageing to much the same extent as the pension system. Both these types of services are largely publicly provided in Norway, and this poses an enormous challenge for the welfare state to keep up with the continuously increasing demand while maintaining control and economic efficiency. Norway has not embarked on a route towards outright privatisation, but New Public Management ideas and the creation of quasi-markets have been widely used. Coordination between the state and the municipalities is one of the big challenges involved and here the Government has launched a reform that is intended to clarify the division of labour between state financed secondary health care and municipal primary health care and elderly care. It remains to seen whether this reform will be successful and whether it will create new problems of its own.

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

2.1 Overarching developments

Maintaining fiscal discipline is an important concern in Norway but this simply does not require anything like the acute austerity measures that we are currently seeing in other European countries. Norwegian fiscal policy has over the last decade been guided by a self-imposed rule. The rule implies a political commitment to balance the state budget without counting in current petroleum revenues and only adding the 4 per cent real return on the financial assets held in the State Petroleum Fund. The rule has been formulated with a degree of flexibility to allow a somewhat higher deficit spending in economic recessions. The fiscal stimulation packages that were introduced by the Government in the beginning of 2009 even overstretched this inbuilt flexibility in a conscious attempt to combat the adverse effects of the international economic downturn. However, the Government has all the way signalled a firm commitment to seek a rapid return to the goal of only spending the equivalent of a 4 per cent real return. In 2009 and early 2010 it was generally believed that a return to the fiscal policy rule would require non-trivial discrete initiatives to curb public expenditure growth, but due to favourable developments in tax revenues in 2010 and 2011, it seems as if the immediate need for such measures has largely disappeared. Without any significant cut backs in public expenditure or increases in tax rates, the overspending (defined in terms of the self-imposed fiscal policy rule) has declined from about NOK 40 billion in 2009 to a modest NOK 7 billion both in 2010 and 2011, corresponding to about 0,2 per cent of GDP. According to the most recent forecast for 2012 and 2013 economic activity is expected to continue increasing, and this will by itself help bring the state budget back on track in terms of the fiscal policy rule – already in 2012.

In Norway one simply cannot talk of dramatic fiscal austerity measures an associated paradigmatic rethinking of social policy (pension policy and health policy) in the wake of the financial crisis. This does not mean to say, however, that a continued adherence to the fiscal policy rule will not be difficult and require tough priority decisions in the years to come. The point is that, the fiscal policy challenges facing Norway are primarily related to the demographics of ageing.

Over the last years the most pressing issue on the wider social policy agenda has been the growth in benefit recipience among people in working age – almost entirely concentrated on disability benefits, sickness benefits and other medicalised social security benefits. The situation is paradoxical because the high rates of benefit recipience go together with – in a comparative perspective - very high labour force participation and employment rates. The fact that a significant minority of the population are not participating in the labour market due to ill health is increasingly being framed as a type of social exclusion and used as an argument in favour of improving the incentives to work for people with frail health. So far most policy initiatives in the field have been concentrated on strengthening the gate-keeping mechanisms in relation to sickness benefits and disability benefits, while suggestions to cut benefit levels have not received broad support.

Another new issue on the political agenda is discussions about a potential need for adjusting the social security system to mass immigration - both from EU countries (particularly the new Member States in Eastern Europe) and from countries outside the EU. A new turn in the debate is a tendency among important actors – including the Norwegian Employers'

Association - to view immigration to Norway (even labour migration from the new member states) as a potential threat to the long-term sustainability of the Norwegian welfare system. A commission that was appointed by the Government two years ago with a mandate to evaluate consequences of migration on the Norwegian welfare system, released its report in April 2011 (NOU 2011:7). It paints a rather pessimistic picture of the economic impact of immigration on the Norwegian welfare state and the commission in the end launches a number of measures to strengthen labour market activation – including general cut backs in the benefit levels offered to families with children in both the disability system and in social assistance.

2.2 Pensions

2.2.1 The system's characteristics and reforms

From January 1st of 2011 the main features of a major, structural reform of the Norwegian pension system have started to take effect. However, for a long transition period the pre-reform and the reformed systems will coexist. I will therefore start by briefly describing the main features of the pre-reform system, before I move on to a presentation of the content of the reformed system that is now starting to take effect.

The pre-reform system

The pre-reform old-age pension system dates back to a major reform in 1967. It combines a universal flat-rate benefit paid to all elderly with a second tier of earnings-related benefits. The earnings-related second tier is a defined benefit scheme that originally promised to replace 45 % of earnings between a lower threshold fixed at the level equivalent to the flat-rate basic pension (the so-called Base Amount) and an upper ceiling well above the average full time wage.[1] To qualify for full earnings-related benefits you need a 40 year contribution record and benefits are calculated on the basis of the twenty best years of an individual's earnings career. In 1969 a third benefit component was introduced – the Special Supplement. The supplement is tested against benefits from the earnings-related part of the system with a 100% taper, and it functions as a sort of guaranteed minimum increment to the universal basic pension for individuals with low earnings-related pension rights. During the 1970s and 1980s the benefit level was gradually raised, and the supplement has come to constitute a significant part of the rather generous minimum protection provided by the national pension system (Pedersen 1999). Today the Special Supplement is equal in size to the universal Basic Pension for a single pensioner.

Figure 1 illustrates the benefit structure and the compound profile of the existing old-age pension system for a stylised worker with stable earnings over a 40 year contribution period. The figure assumes that the parameters as of 2010 have been in operation for the entire contribution period.

When interpreting the figure one should bear in mind that it is based on gross benefits and gross earnings and that the replacement rates offered are higher in terms of after tax figures. In Norway old age pensions are taxable income but a number of factors contribute to the fact that retirees tend to pay lower taxes than wage earners: the general progressivity of the tax system, a special flat tax allowance for all old age and disability pensioners[2], and finally a special rule securing that those old age pensioners whose incomes do not exceed the minimum pension level will not pay any income tax at all.

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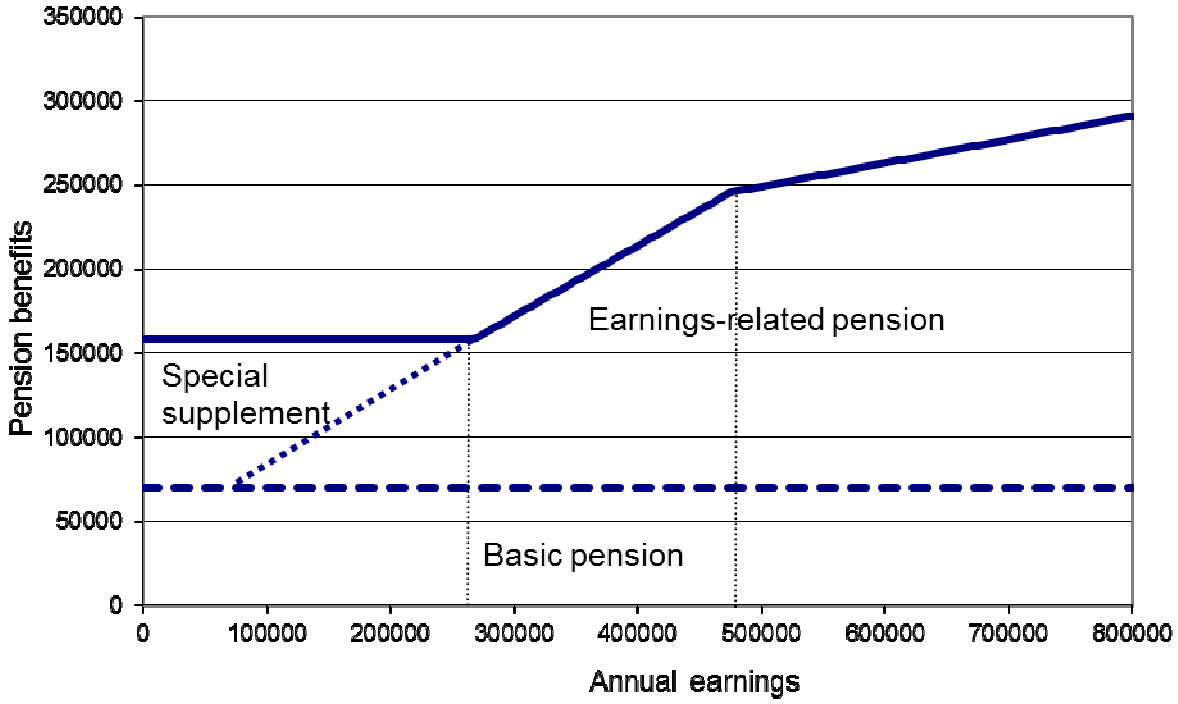
1 As part of a parametric retrenchment reform in 1992, the replacement rate was reduced to 42 % of previous earnings and the ceiling was reduced.

2 From 2011 this has been converted into a tax credit see Prop. 1 LS (2010-2011) "Skatter og avgifter" and Pedersen 2011).

One of the most important features of this system is the generosity of minimum protection offered to old age pensioners, and this characteristic has in fact been reinforced over the last decade through a series of improvements in the Basic Pension and the Special Supplement. The minimum pension is currently (from May 2011) fixed at just above NOK 158,400. Since receivers of this minimum benefit will generally not pay taxes, the effective minimum benefit is quite high and equivalent to about 45 % of the net (after tax) value of an average full time wage (Christensen et al. 2009).

While the accrual of earnings-related benefits formally starts at a yearly income of NOK 79,200, the 100% taper of the Special Supplement implies that wage earners need a much higher level of yearly earnings in order to escape the taper interval. In 2011 you need an average earnings level of about NOK 270,000 combined with a 40 year contribution record to break out of the taper interval and receive an old-age benefit that exceeds the universally guaranteed minimum. At an annual income of NOK 475,000 (= 6 Base Amounts) there is another threshold. For earnings above this level, pension accrual is reduced from 42% to (42/3=) 12%. In 2011 this threshold is almost identical to the official estimate of an average full-time wage in the Norwegian labour market. Pension accrual stops entirely at an earnings level of NOK 950,000 (=12 Base Amounts), which is equivalent to about twice the average full time wage.

Figure 1: The benefit profile of the existing old-age pension system 2010. Single pensioner with a stable 40 year contribution record. NOK 2011



Source: Author's own compilation

At average (full-time) wage levels (about 475,000 NOK), gross replacement rates for a single pensioner is just above 50%. For wage earners with lower pre-retirement earnings (due to lower wage levels or part-time work) replacement rates will be significantly higher, and replacement rates decrease very rapidly for yearly earnings exceeding the threshold at six

times the Base Amount. In terms of after tax values, replacement rates are somewhat higher and close to 66 % at average earnings levels.

All three benefit components (Basic Pension, Earnings-related Benefit and the Special Supplement) are measured and indexed in terms of the Basic Amount. The principle guiding the indexing of the Base Amount – and hence of benefits - has always been to follow general developments in the incomes of the non-retired population but, for many years the practical implementation of this rules meant that the indexation of pension benefits lagged somewhat behind the development in wages. Over the last decade, however, the indexation has been roughly in line with the development of average wages.

The pre-reform system is based on pay-as-you-go financing and the system has since the early 1970s been entirely integrated in the general state budget. Current public expenditures on old-age pensions in Norway is surprisingly low when measured against the total size of the economy, and about on par with notorious low-spenders like UK and the US. In 2007, for instance, public expenditure on old-age pensions amounted to no more than 4.7% of GDP in Norway compared to an OECD-average of 7.0% (OECD 2011). Four factors contribute to the comparatively low expenditure levels: the high GDP that currently is further inflated by oil revenues, the comparatively high formal retirement age, the incomplete maturation of the National Insurance scheme, and the relative modesty of replacement rates offered by the existing scheme to average and high income earners (while the level of minimum protection and replacement rates for low income earners are high).

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

The expected consequences for the tax load on future tax-payers was less dramatic, however. Thanks to booming oil revenues, Norway has since the mid-1990s run huge surpluses on the state budget that have been transferred to the so-called “State Petroleum Fund” and invested in international capital markets. Since 2001 the build of this fund has been regulated by a self-imposed fiscal policy rule linked to the balance of the general state budget. The rule basically says that all state revenues from the petroleum sector will be set aside in the fund, while only an amount corresponding to a 4 % real return on the financial assets is allowed to be consumed annually.

In 2009 the accumulated assets in this fund surpassed the value of GDP, and in the Spring of 2011 the total value is about 3,100 billion NOK.[3] The continued build-up of this fund over the coming decades is expected to help smooth out the financial burden associated with population ageing. Although no formal link exists between the fund and the National Insurance system, it can be seen to provide a partial pre-funding of future pension liabilities. To signal that a primary function of the fund is to help shoulder future pension liabilities it has recently been renamed “The State Pension Fund”.

[3] http://www.nbim.no/no/Investeringer/markedsverdi/, April 30, 2011.

Due to the projected vast increases in the returns on this fund over the coming decades, the financing of the existing pension system by the year 2050 has been estimated to "only" require an increase in the overall tax load of about 5 percentage points.

Occupational pension schemes

All employees in the public sector (state and municipalities) have since the early 1960s been covered by generous occupational pension schemes offering a gross replacement rate of 67% of the final salary after a minimum of 30 years of active service. Yearly earnings up to 12 times the Base Amount are taken into account with no reduction in the pension accrual rate at 8 or 6 times the Base Amount like in the National Insurance system. Particularly for wage earners with earnings above the average full time wage (6 times the Base Amount), participation in these schemes significantly improves the income position after retirement.

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

In 2001 a new comprehensive legislation on private sector occupational pensions was put in place, allowing for the first time favourable tax treatment to be extended to defined contribution schemes (either of an insurance type or the pure savings type). The explicit purpose of the new legislation was to stimulate a further diffusion of private occupational pensions, based on the assumption that defined contribution schemes are cheaper and less risky for employers and (therefore) more attractive to employers. In the following years coverage with occupational pensions only expanded slowly but many employers have reacted to the new legislation by replacing and existing defined benefit schemes with new defined contribution schemes.

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

Retirement age and early retirement schemes

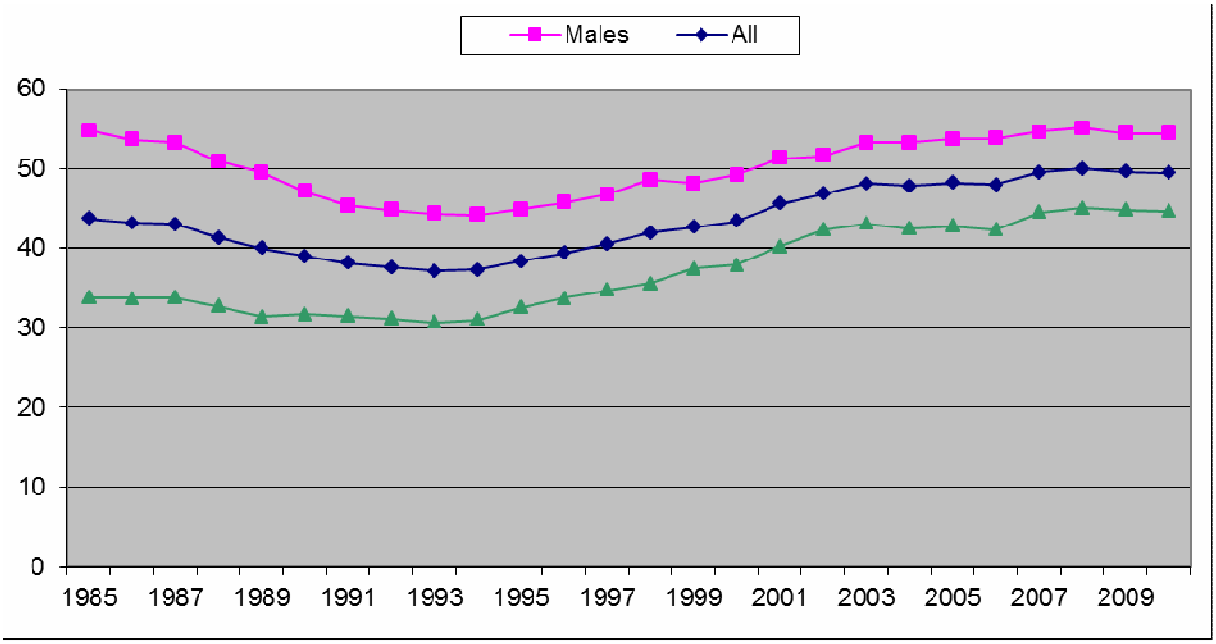
The normal age of retirement in the National Insurance scheme has since 1973 been fixed at the age of 67. In 1988 in the middle of a serious economic downturn, a round of tripartite wage negotiation between the Norwegian Confederation of Trade Unions (LO), its employer counterpart (NHO) and the Government resulted in the establishment of a voluntary early retirement for employees covered by the LO-NHO wage agreement. The so-called AFP scheme initially allowed the covered employees to withdraw at age 65 with benefits calculated as an ordinary old-age benefit in the National Insurance scheme. During the 1990s the AFP-scheme was expanded to cover broader segments of the (organised) workforce. Also the earliest age of retirement was lowered in several steps to reach the age of 62 in 1998.

Although the different variations of the AFP-schemes were established through negotiations between the social partners rather than through legislation, the state participates in the financing with some 40% of the total costs, while the rest is financed through premiums levied collectively on the participating employers and some co-financing from individual employers when their employees take up the benefit. Part of the state sponsorship consists of granting favourable tax rules and allowing individuals who take up AFP-benefits to accrue pension rights in the National Insurance system as if they had continued working. In other words, there are no actuarial penalties for taking up AFP-benefits between age 62 and 67.

It has been estimated that about 60% of the workforce was covered by one of the AFP-schemes. This figure includes younger workers, many of whom are likely to become covered at a later point in their employment career. Among the older cohorts who are about to enter the relevant age span, it has been estimated that coverage was close to 80% (Midtsundstad 2004, see also Christensen et al. 2009).

On this background it is somewhat surprising that labour force participation among elderly cohorts in Norway has not shown a consistent decline since the AFP-scheme was first introduced in 1988. As can be seen in Figure 2, since the mid1990s there has even been a slight increase in overall participation rates among the population 55+. A tight labour market and low unemployment rates for most of the period are likely to be the major explanation for this. One should note however that the labour force rates portrayed in Figure 2 include also very short part-time work, and the development in full-time equivalents is likely to have been somewhat weaker.

Figure 2: Labour force participation among the population aged 55-74



Source: Statistics Norway, http://statbank.ssb.no/statistikkbanken/ *, May 12. 2011.*

For the first time in many years the participation rates for these age groups showed a small drop in 2009 – most likely as the result of a slightly less tight labour market due to the financial crisis - but they appear to have stabilised again in 2010.

The reformed system

The Norwegian pension reform is strongly inspired by the innovative Swedish (and Italian) pension reforms from the previous decade. It can be described as consisting of 5 main elements:

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

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

The new system for the accrual of pension rights

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

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

pension rights will be automatically indexed with the development in average wages. This approach guarantees direct proportionality between life-time earnings (below the yearly earnings ceiling) and accumulated pension rights.

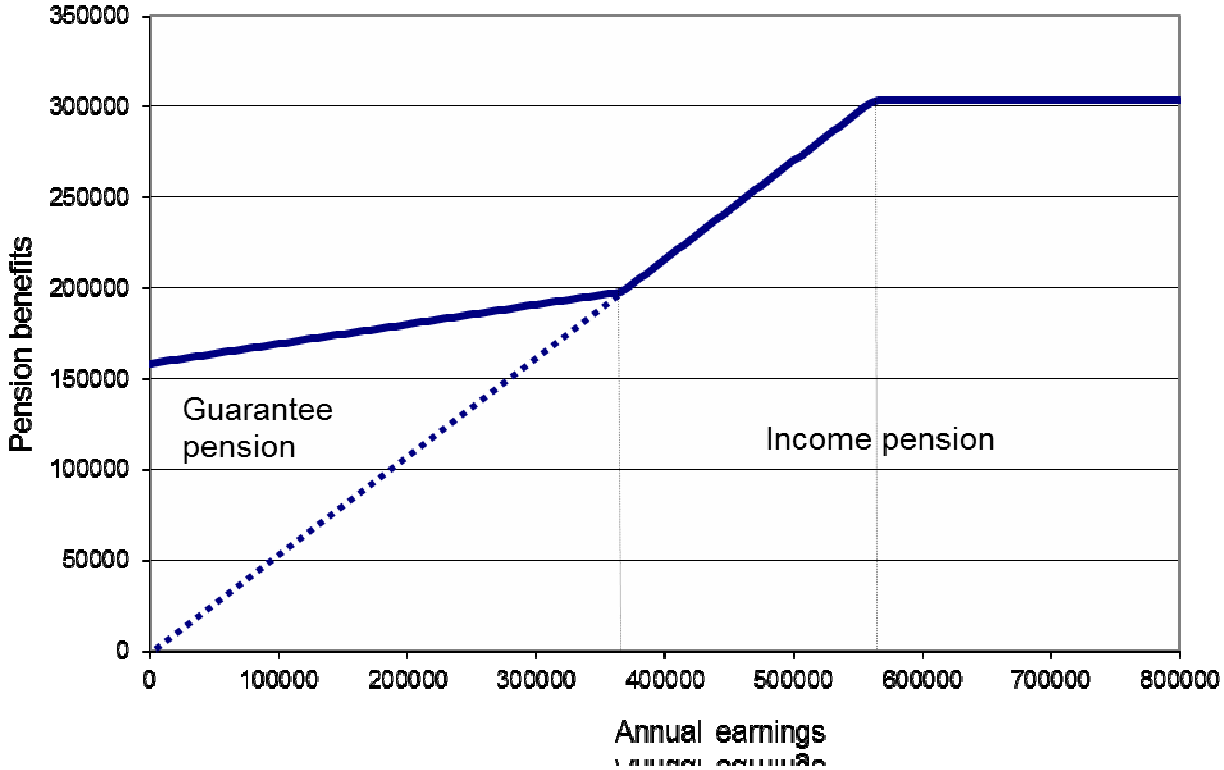
Individuals who do not participate in gainful employment for particular (politically sanctioned) reasons are also secured the accrual of pension rights. Parents with small children (under the age of six) are guaranteed a minimum pension accrual equivalent to an earnings level of 4.5 Base Amounts (NOK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

Minimum protection will be provided by a Guarantee Pension that replaces both the Basic Pension and Special Supplement in the pre-reform system. The level of the Guarantee Pension has been fixed at the same level as the existing minimum pension, and it will be indexed with the same wage index as accrued pension rights in the Income Pension system. The Guarantee Pension will be tapered against Income Pensions by 80%. This ensures that people with rights to Income Pensions are always allowed to keep at least part of their advantage vis-a-vis individuals with no earned pension rights what-so-ever.

The compound profile of the new system is shown in Figure 4 in the stylised case of a (single) worker with 40 years of stable earnings/contributions to the system. It shows that the formal proportionality of the Income Pension system is strongly modified in the long tapering interval of the Guarantee Pension that in this case stretches to a yearly earnings level of NOK 367,000 – which is more than ¾ of an average full time wage.

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

Figure 3: The benefit profile of the reformed old-age pension system. Single pensioner with a stable 40 year contribution record. NOK 2011



Source: Author's own compilation

The compound benefit profile of the new system does not deviate dramatically from old system. Both are rather strongly progressive, offering very high replacement rates in the bottom parts of the earnings scale and declining replacement rates in the intervals well above average wages. The high level of minimum protection is a dominant common characteristic of both the existing and the reformed system.

The progressivity of the benefit profile has been reinforced by a revision of pensioner taxation that was passed by Parliament in connection with the 2011 budget (Prop. 1 LS (2010-2011) Skatter og avgifter). The main purpose of the new legislation is to make sure that pensioners who receive the minimum benefit only, will continue to be complete exempt from income taxation. While the general tax rules of old age pensioners will be normalised (by removing a general tax-allowance to all old age pensioners), poorer pensioners will be given a tax credit that is tapered off against pension income (but not earnings) in excess of the minimum pension level. The taper is relatively mild (17%) which means that the credit will benefit a significant share of the pensioner population.

Flexible retirement between 62 and 75 on actuarially neutral terms

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

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

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

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

Longevity adjustment and indexation of benefits

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

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

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

Financial structure

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

2.2.2 Debates and political discourse

Two sets of issues related to the implementation of the pension reform have remained highly controversial and neither was fully settled when the reform took effect from January 1, 2011. The first is concerned with the way the old age pension reform is implemented for disability pensioners, and the second with the adaptation of public sector occupational pension schemes.

The treatment of disability pensioners

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

A commission appointed by the Government to deal with these issues published its report already in 2007 (NOU 2007:4). However, the Government has several times postponed its follow up on the commission's proposal and therefore a solution was not ready when the reform started to take effect. Finally the Government has in May 2011 presented its proposal for new legislation that is supposed to take effect from January 2015 (Prop. 130 L (2010–2011): Ny uføretrygd og alderspensjon til uføre). In this topic there appears to be at least as much tension within the Government (between the Socialist Left Party (SV) and the Labour Party) than between the Government and the non-socialist opposition.

In line with the proposal from the commission the Government has decided to tighten the conditions for the accrual of pension rights for disability pensioners compared to the present system. Today disability pensioners are transferred to the old-age pension system at the normal retirement age of 67, and they earn pension rights based on their pre-disability earnings level up until that age. This rule is viewed as problematic when from 2011 the non-disabled can start taking up old-age pensions at 62 with a heavy actuarial penalty. On this background the Government now proposes a compromise saying that disability pensioners should be allowed to continue drawing disability benefits until they reach 67 (just like today), but that their accrual of earnings-related old age benefits is stopped at age 62.

An even more controversial issue connected with this is the question whether the general longevity adjustment should be applied with equal force to people entering retirement from the disability system. These individuals do not have the opportunity to compensate for the longevity adjust by working longer, and has been seen as a powerful argument for giving the disabled some sort of protection. On the other hand, if the disabled should be fully shielded

from the effects of longevity adjustment, a significant part of the overall retrenchment effect will be lost and both negative legitimacy and incentive effects are foreseen if it appears that coming into old age via the disability system is particularly attractive. The Government's suggestion for a compromise on this very difficult issue has been to implement mechanism for a partial shielding of disability pensioners who will retirement in the coming years (putting a limit to the adjustment effect of 0.25 percentage points per year). This mechanism will later be evaluated in light of developments in the retirement behaviour of the non-disabled. If it turns out that most people choose to adapt to the longevity adjustment by working longer, the disabled will be shielded to a higher degree, while they will not be shielded if most people do not work longer and simply accept lower annual benefits as a result of longevity adjustment.

The proposals from the Government on these issues not been met with strong critique from the opposition parties and they are likely to be carried through Parliament in good time before the next general election in 2013.

The adaptation of occupational pension schemes

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

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

In the public sector the situation is even more complex and unstable. In addition to upholding the existing AFP-scheme the public sector unions also managed in 2009 to shield older cohorts of public employees from the effects of another crucial aspect of the National Insurance reform, the longevity adjustment, and to uphold a system where the total pension benefits of public employees is determined by their final salary and a full pension is earned after 30 years – see Prop. 107 L (2009-2010) for a description of the concrete legislation. This means that crucial aspects of the general pension reform – life-time accrual of pension rights, a flexible and actuarially neutral retirement age – do not apply to the about 1/3 of the workforce employed in the public sector. However, some of the unions that took part in the negotiations in 2009 have signalled that they are willing to revise this settlement and bring the pension system for public sector employees more in line the principles of the general pension reform.

Little impact of the financial crisis

The financial crisis has been extremely mild in Norway and it has had very little effect on the pension policy discourse. The fall in stock market values and the low interest rates in wake of the credit crunch in 2008, did give heavy losses for the State pension fund and it was felt in

the occupational pension sector. However, the State pension has more than regained the losses and occupational pension schemes – both of the defined benefit and the defined contribution type – have not been seriously disrupted by the crisis.

The tendencies for a slightly less tight labour market in 2009 did show up in a higher demand for early retirement both from individual workers and employers, but as we are in 2011 back to a situation of full employment the labour market situation for older workers is likely remain relatively positive.

2.2.3 Impact of EU social policies on the national level

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

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

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

2.2.4 Impact assessment

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

Concerning the retirement age Norway has over the last decades had comparatively high effective retirement ages. Since the mid1990s there have even been tendencies for an increase in labour force participation of people age 60+ and in effective retirement ages but this tendency turned to a slight decrease in 2009 and 2010 (Haga and Lien 2011). From January 2011 the two phenomena – withdrawal from the labour market and the drawing of a pension – will in principle be separated with the new flexible system of retirement. The political interest is concentrated on the first: will individuals age 60+ increase their labour supply and postpone the age of actually withdrawing from the labour market in response to the new flexible system that gives strong incentives to continue working? It is of course far too early to tell. If people choose to postpone retirement it will give a welcome boost total labour supply and for the state coffers it will have a positive effect due to higher tax payments. Attempts to estimate a structural model the retirement behaviour of Norwegian workers based on historical data have indicated the introduction of actuarial premiums will have a very substantial positive effect on the labour supply of workers age 62+ (see Hernæs and Iskhakov 2009). However one should note that these estimations do not take into account the fact the new flexible system does not apply among public sector employees who make up between a 1/4 and a 1/3 of the entire

workforce. Also it has been pointed out that for those groups that were not covered by the old AFP-scheme, the reform has in fact opened up a new possibility to withdraw from the labour market and take up a pension from age 62, and it is a general finding in research on retirement behaviour that some individuals will retire at the earliest possible date – despite any incentives to stay on (Lien 2009).

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

In the revised state budget published in early May 2011 the Government updated its projection about the rate of take of early old age retirement benefits in view of the inflow of claims in the late 2010 and early 2011. The new projection indicate a much higher take up of old age benefits among people aged 62-66 than originally expected by the Government (Meld. St. 2 (2010 – 2011) Revidert nasjonalbudsjett). Actually the new projection operates with a doubling of the take-up from 11 to 22 thousand in 2011. As already mentioned, this does not necessary imply that more people withdraw from the labour market. Here the state of the labour market is likely to play a crucial role, and since Norway is back to a situation of virtually full employment there is little reason to expect a strong negative development in the labour supply of older workers. Most likely the increased take-up of old age pensions is simply an indication that the decisions to take-up benefits and to retire from the labour market have been detached from each other.

2.2.5 Critical assessment of reforms, discussions and research carried out

The pension reform is just about to be implemented. The content of the reform has undergone significant changes and amendments since the first outline was sketched by a Government commission in 2004. The overall distributive profile of the reform has been modified by decisions made in the recent years to significantly improve the level of minimum protection. When we have information on the income distribution for 2010, which is the year when the new high level of minimum benefits was reached, it is to be expected that the "in risk of poverty" rate among old age pensioners will reach a very low level – possibly below 5 per cent. Since the level of minimum benefits will in the future be indexed with wages – but adjusted to increases in longevity – relative poverty rates among the elderly are likely to remain very low and only slowly increase in the long run as a result of longevity adjustments.

The strong emphasis given to distributive concerns in the last phase of the reform process means that the overall system will not provide as powerful incentives to participate in gainful employment throughout the life-course as was the original intention. Failure to implement the main principles of the reform for employees in the public sector represents a very serious setback that weakens the reform both in terms of its expected economic effects and in terms of its legitimacy. The raises the issue whether and to what degree the goal of economic sustainability has been reached after all.

The Government has announced that it will commission a large research based evaluation of all aspects of the reform, and this evaluation will hopefully show what impact the reform has had on economic and political outcomes.

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

2.3 Health Care

2.3.1 The system's characteristics and reforms

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

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

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

About ten years ago two important reforms of the Norwegian health services were implemented. The first introduced a new principle on the provision of primary health care, while second changed the organisation of specialised care.

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

Under the present system patients are obliged to stick to one general practitioner at a time, and they are only allowed to change two times per year. In addition patients are offered the right

to have a second opinion by another doctor, in the case that a conflict arises with their current practitioner. The introduction of this system was originally rather controversial and met with scepticism from part of the medical profession. One of the objectives of the reform was to achieve a more effective regulation of the access to expensive specialised services, and another was to secure more continuity in the patient-doctor relationship, which was believed to be particularly useful for people suffering from chronic diseases. The reform was subject to a thorough research based evaluation over the period 2001-2005, and the main conclusions of the evaluation were positive.

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

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

Despite the emphasis of public financing user charges do play a role in some parts of the public health service. Both in primary health care and in specialised care and out-patient treatment patients are charged modest user fees. Patients also have to pay for pharmaceutical products but when prescribed by a doctor to treat a chronic illness they are strongly subsidised by the state. Individual expenditures on user charges and pharmaceutical products are further limited by a scheme that secures reimbursement of expenditures in excess of a specified ceiling. When it comes to treatment in-patient treatment in hospital, there is no user charges in the Norwegian system.

2.3.2 Debates and political discourse

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

The "coordination reform"

Currently the Government is in the process of legislating and implementing a new health care reform. The process started in June 2009 when the government launched a White paper on a comprehensive reform agenda for both health services and elder care services in Norway. The

White paper was titled: 'The coordination reform' and the main thrust of the document was to improve integration and coordination between primary and secondary health care (hospital care and out-patient specialist treatment) and between health care and elderly care (St.meld. nr. 47 (2008-2009)).

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

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

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

The agenda is far from radical. It mainly contains proposals to fine tune the division of labour between municipalities and the state and between primary health services and specialised services. The main idea is to strengthen the role of the municipalities in the overall system. Arguably this approach faces the obstacle that many Norwegian municipalities are extremely small and therefore it is questionable whether they are capable of filling a more important role as providers and gatekeepers in overall health care system.

Among the more radical and also politically controversial ideas is to let the municipalities take part in the co-financing of hospital and specialist treatment. This in essence involves the introduction of economic incentives as a means to control the gate-keeping behaviour of the municipalities and the general practitioners. At the same time it is suggested to play down the role of activity based financing of the hospitals in order to avoid some of the perverse behavioural adjustments that have been observed under the present system.

Another aspect of the reform is to integrate the general practitioners more in the Municipalities' health plan and put a lower limit on the number of patients they are allowed to treat.

After extensive rounds of consultations with stake holders and parliamentary debates the Government presented its proposal for a concrete legislative follow-up in April 2011 (Prop. 91 L (2010-2011)).

The proposal is loyal to the original reform agenda. It contains a long list of measures to clarify the division of labour between the municipalities and the health enterprises and the responsibilities they have vis-à-vis different groups of patients. For instance it is suggested that the municipalities should be given full responsibility for patients that are ready to be discharged from hospital treatment.

One important aspect of the reform is an attempt to make the legal responsibility for providing services more neutral in terms of the professions that are involved in the provision. This particular aspect of the reform has been met with resistance from doctors' and nurses' associations.

Also a modified version of the radical and controversial idea to introduce co-financing of secondary health care services by the municipalities is being pursued in the Government's

proposal. The Government now suggests that the co-financing arrangement shall be restricted to include medical treatment of hospital patients only and not include any types of surgical treatment. This restriction is meant to help limit the risks and financial obligations of municipalities. The rate of co-financing has not been specified in the proposal. It is suggested that the law should give the Government the authority to decide the specific rate as it sees fit. It appears from the debates that a rate of 10 per cent is seen as the most likely target. This municipal co-financing will form part of the activity based financing of the regional health services which at present amounts about 50 per cent of the total revenue. It is suggested that the total share of activity based financing should be reduced to a level around 40 per cent and replaced with bigger block grants to the regional health authorities.

It remains to be seen whether all details of the reform proposal will be approved by Parliament. So far the debate seems to indicate that they will although the opposition has raised objections against giving a bigger responsibility to municipalities without a radical reform to increase the size of the many small municipalities. The Government is not very likely to concede that given the preferences of one of the junior partners (*Centerpartiet*).

As mentioned, private health insurance and private health care plays a very modest role in Norway. The former centre-right government (Bonnevik II) introduced a system of favourable tax rules for private companies that pay directly for treatment of their employees or purchase health insurances. This led to a rapid expansion of the coverage with supplementary health insurance coverage among private sector employees, but this development was stalled when the present red-green government in 2006 removed these tax concessions (Aarbu 2010).

2.3.3 Impact of EU social policies on the national level

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

2.3.4 Impact assessment

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

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

Projection about future demand and expenditures

The financial burden related to an expected increase in public health care expenditure has been a cause for concern in a number of official policy documents. Most recently these issues

are thoroughly discussed in a Government white paper on the long-term prospects for the Norwegian economy (St. meld, nr. 9 (2008-2009)).

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

Health outcomes

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

One somewhat disturbing fact is, however, that social (relative) inequalities in health outcomes appear to be higher in Norway and the other Scandinavian countries than they are in Central and Southern European countries – see for instance Mackenbach (2006). There is, in other words, a comparatively strong social gradient in health outcomes in Norway. Part of the explanation might be a very strong social gradient in smoking and other health-related behaviours, and it has been suggested that the information campaigns that have helped to reduce smoking and other harmful behaviours among the middle classes have not yet succeeded in changing the behaviour of lower status segments of the population.

2.3.5 Critical assessment of reforms, discussions and research carried out

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

Government in general, and the Government is constantly under pressure to interfere in these types of conflicts.

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

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Up until the 1980s Norway was somewhat of a laggard in the development of services for the elderly compared to the other Scandinavian countries. This is no longer the case. The number of man years devoted to long-term care services increased from 11,000 in 1960 to 117,000 in 2006. Today Norway has a strongly developed system for providing both home-help, nursing and institutionalised elder care. In 2006 Norway spent 1.7% of GDP on services to the elderly - compared to 4.9% on cash benefits (old-age pensions), see NOSOSCO (2008, Appendix 5). Like ordinary health care, long-term care is provided as a universal right to all residents that is inscribed in the law. Long-term care is the responsibility of municipalities, and the right to receive care is stated in the Municipal health services act.

Traditionally, voluntary organisations have played a significant role in owning and running nursing homes for the elderly. However, while there still are quite a few privately owned nursing homes in Norway, most have been fully integrated in the public system and completely dependent upon public financing. While the municipalities provide most the financing of elderly care given within and outside institutions, income related user charges are levied on the recipients of the services – particularly on the inhabitants in long-term care institutions. In 2007 user charges covered 7.5% of the total costs devoted by the municipalities to long-term care (St. meld. nr. 9 (2008-2009), p. 89). The growth in the provision of long-term care for the elderly has been associated with reforms in the mode of provision. Two important reform tendencies can be identified since the 1980s.

While the counties used to have responsibility for nursing homes, the responsibility was transferred to the municipalities in 1988. The municipalities finance these services out of their tax revenue and general grants from the state. Previously a major part of the state's financial support for a range of municipal services was given in the form of earmarked reimbursements, but over the last decades a clear priority has been to increase municipal autonomy by giving general grants instead. To compensate for the loss of a direct influence through earmarked financing the state has instead put emphasis on steering through legal obligations and contractual agreements with the confederation of municipalities.

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

Table 1: People aged 67+ who live in institutions or service housing and people aged 67+ who receive home help (practical assistance). 2008. Absolute numbers and %.

	Number of individuals in thousands	% of population 67+
Living in institutions or service housing	68	9.7
Receiving home help	76	10.8

Source: NOSOSCO 2010

2.4.2 Debates and political discourse

Public expenditure and the consumption of man-years on long-term care have grown very rapidly over the last decades. From 1988 to 2005 the input of manpower grew by almost 60%. Attempts to decompose the sources of this increase in the input of manpower have shown that only a smaller part – about 20% - is attributable to an increase in the size of the relevant age groups. The rest – almost 40% – growth comes from increasing take-up and increasing quality of the services provided.

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

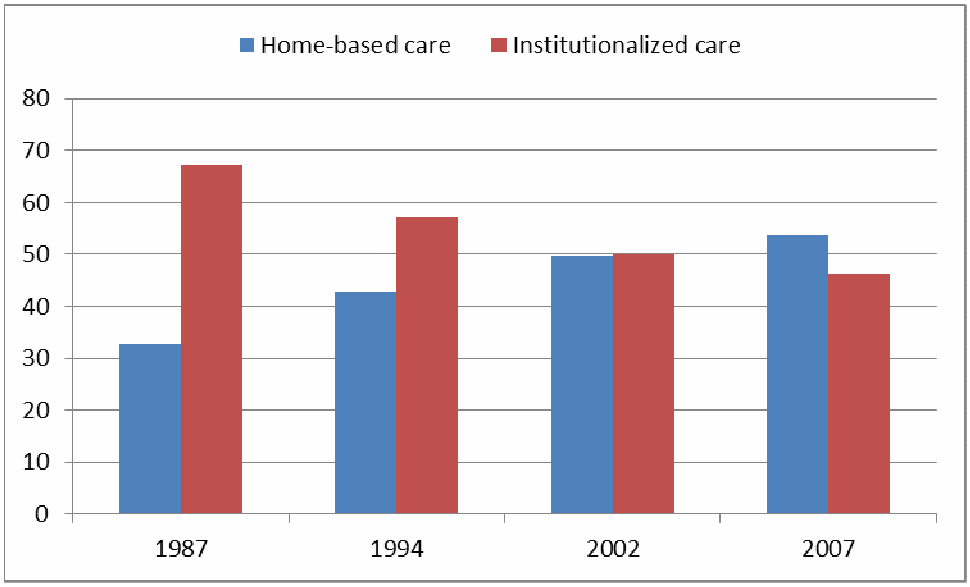
The attempt to build a larger private care sector in Norway suffered a severe setback in early 2011 when it was revealed that one of the big commercial actors (the multinational company Adecco) had consciously violated the Norwegian law on labour protection in its running of nursing homes in Oslo. The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

Also publicly run nursing homes are continuously being criticised for offering an inadequate number of places and for not living up to official standards – in terms of time spent with the elderly, the quality of nutrition, medical attention etc. The present government has promised to strengthen the long-term care sector very significantly to overcome both the quantitative

problem of an insufficient number of places in nursing homes and problems of poor quality in the delivery of both institution-based and home-based services. However the existing governance structure where the municipalities have responsibility for providing these services - financed out of non-earmarked block grants - makes it difficult for the central political authorities to ensure that national targets of in terms of resource spent and service output are actually met. There are continuous debates whether the municipalities are actually delivering on the promised increase in the provision of long-term care.

As shown in figure 4 there has since the late 1980s been a shift in the balance between man-hours provided through institution-based services (nursing homes) and home-based services. This has been the result of a deliberate policy to shift the emphasis more in the direction of home-based care for frail elderly. However, it seems clear that the potential for substituting nursing homes with home based care has been exhausted, and that the decline in the number of man-hours devoted to nursing homes must be reversed if the supply of services should meet the strong increase in demand that is driven by ageing.

Figure 4: Number of man-years in institutions and home based care in selected years between 1987-2007



Source: Vabø 2011a.

2.4.3 Impact of EU social policies on the national level

There is no impact of EU policies in this field on Norwegian policy debates and developments, except again the indirect effects of competition law etc..

2.4.4 Impact assessment

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

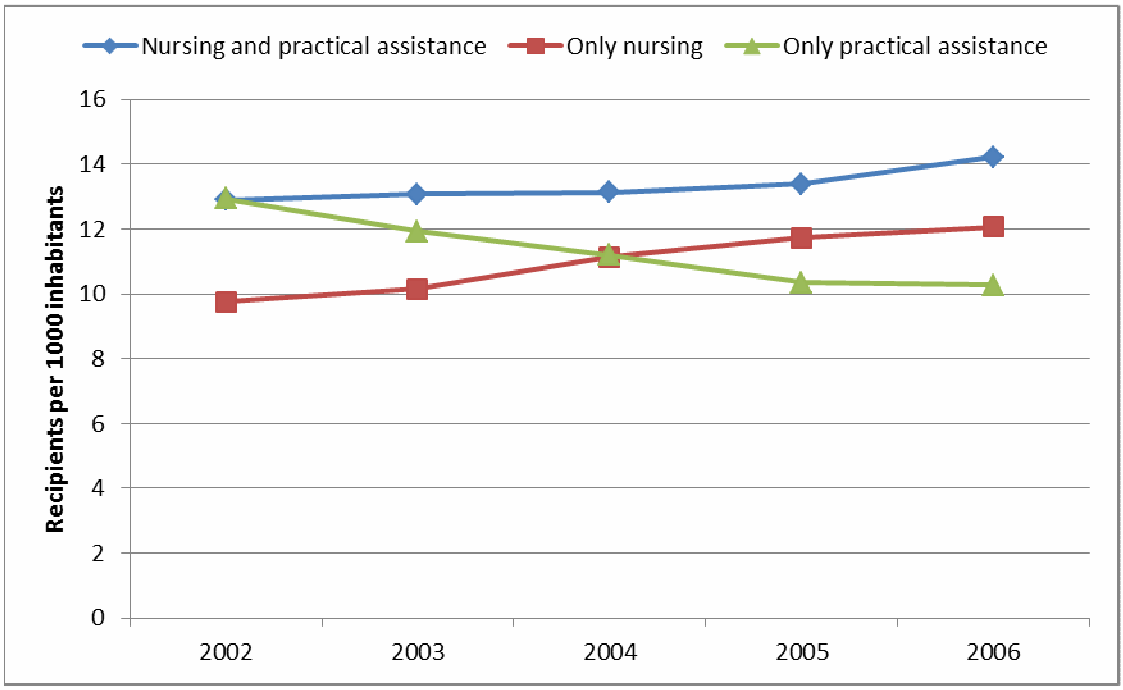
Table 2: The number of elderly people living in nursing homes, per 1000 inhabitants in the respective age brackets. 2002-2006.

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

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

Over the same years there has been an increase in the recipiency rate of home based services – particularly of services that involve nursing – as can be seen from figure 5.

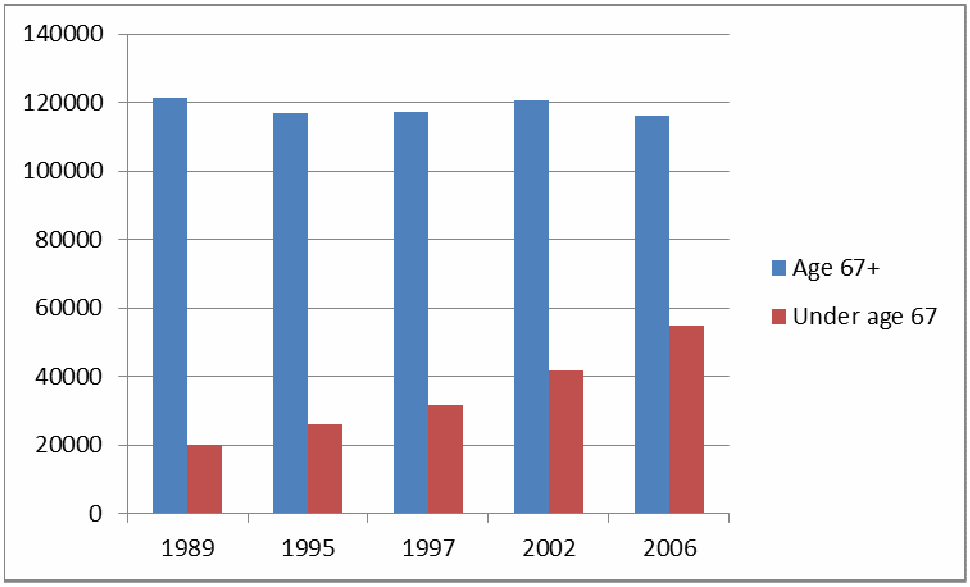
Figure 5: The number of recipients of home based care serviced per 1000 inhabitants.



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

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

Figure 6: Home based care, number users aged 67+ and under age 67.



Source: Vabø 2011a

2.4.5 Critical assessment of reforms, discussions and research carried out

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

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

In view of the very strong demographic changes that will take place over the coming decades, the financing of elder care is a matter of concern together with health care and old-age pensions. Arguably, however the biggest challenge in connection with the future of care services in Norway is related to problems to recruit sufficient manpower. Salaries in the relevant occupations have traditionally been relatively low, and it is an open question whether it will be possible to recruit sufficient manpower to meet the growing demand in a rapidly ageing society. Immigrants from non-western countries provide a growing share of the manpower that produces these services, and it has been speculated whether import of trained personnel and increased immigration more generally can be the only way to solve the projected shortages of manpower in this sector. This argument, however, goes against the increased scepticism towards immigration from the political authorities and social partners that was mentioned in section 2.1 on overarching developments.

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3 Abstracts of Relevant Publications on Social Protection

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

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

[L] Long-term care

[R] Pensions

[R3] DAHL, E.H. (2011), Fleksibel alderspensjon: Hvem benyttet seg av muligheten til tidlig uttak? *Arbeid og velferd*. Issue no. 2/11: 66-74.

"*Flexible retirement age: Who used the opportunity to early take-up?"*

The article looks at the first available evidence about the behavioural responses to the new system of flexible retirement from age 62 that was introduced from January 1st 2011. It turns out that almost 12 per cent of the eligible population between 62 and 67 have chosen to take up old age benefits from January 1. Most of these were men and this can only partly be explained by the fact that a large share of women in these cohorts are not eligible because their accumulated pension rights are too small to meet the minimum level required to be allowed to take out old age pension benefits with an actuarially calculated penalty. However rate of take-up among those eligible is still about two times higher among males than among females. Take-up further appears to be high among people with long employment careers and relatively low earnings. Physically demanding industries like building and construction and manufacturing industries are the primary bases for recruitment.

[R3] HAGA, O. & LIEN, O.C. (2011). Nedgang i forventa pensjoneringsalder og yrkesaktivitet. *Arbeid og velferd*. Issue no. 2/11: 55-64.

"Reduction in the expected age of pension take-up and labour force participation".

The article reviews the latest trends in the average expected age of pension take-up and in labour force participation with a particular focus on the elderly. It turns out that there in 2009 and 2010 has been a non-trivial decline in the expected age of pension take-up after many years with a modest but steady increase. The labour force participation of people aged 60+ also decreased slightly in 2009 – most likely as a result of the financial crisis – while this indicator has remained stable in 2010.

[R2] HIPPE, JON M. & LILLEVOLD, PÅL (2010) Den gylne middelvei. Nye tjenestepensjoner mellom ytelses- og innskuddsordninger og virkningen av disse. Fafo-report 2010:36. Oslo: Fafo.

"Finding the middle ground. New occupational pensions between defined benefit and defined contribution."

The report discusses how new occupational pension schemes can be structured in a way achieve a compromise between characteristics of the pure defined benefit model and the pure defined contribution model. A number hybrid models are described and analysed in terms oft their implications for distribution of risks between employers and employees and the expected level of benefits provided.

[R1; R3; R5] PEDERSEN, A.W. (2010), Pensjonsreformen – status og konsekvenser for insentivene til arbeid. ISF Rapport (2010:015) Oslo: Institute for Social Research.

"The Norwegian pension reform – status and consequences for the incentives to work".

This report that was commissioned by the Norwegian Employers' Association takes stock of the pension reform process with a particular view of the goal to provide stronger incentives to work – both throughout the economically active life-phase and in the years around the normal retirement age. It is argued that the original aspirations on behalf of the reform that it would lead to a significantly higher labour supply were overly optimistic. It is pointed out first of all that the original estimations provided by Statistics Norway rested on an unrealistic image of the incentive structure that is produced by the reformed system. Secondly some of the premises of the estimations have changed due to political decisions taken in the implementation phase, e.g. the failure to incorporate public sector employees and the strengthening of the level of minimum protection that weakens work incentives in the lower part of the earnings distribution.

[R2] VELAND, GEIR 2010. Tjenestepensjoner i endring. Utviklingen i det private tjenestepensjonsmarkedet i Norge og et lite blikk til utlandet. Fafo-notat 2010:22. Oslo: Fafo.

"Occupational pension schemes undergoing change. Developments in the market for private sector occupational pension schemes in Norway – with a short glance to the international context".

The report gives an overview over recent developments in the market for occupational pension schemes in the context of the on-going reform of the National Insurance system. It is shown how defined contribution schemes have become dominant in the private sector when measured in terms of the number of employees covered, but also that DC schemes continue to play a minor role when measured in term of accumulated assets.

[H] Health

[H1; H4] BIØRN, E., HAGEN, T. P., IVERSEN, T., MAGNUSSEN, J. (2010) How different are hospitals' responses to a financial reform? The impact on efficiency of activity-based financing. *Health Care Management Science* 13, 1-16.

For policy-makers the heterogeneity of hospital response to reforms is of crucial concern. Even though a reform may entail a positive effect on average efficiency, policy-makers will consider the reform as less attractive if the variation in hospital efficiency increases. The reason is that increased variance of efficiency across hospitals is likely to increase the impact of geography on access to hospital services. This paper examines the heterogeneity with respect to the impact of a financial reform - Activity Based Financing (ABF) - on hospital efficiency in Norway. From a theoretical model the authors find an ambiguous effect of hospital heterogeneity on the effect of ABF on efficiency. The data set is from a contiguous 10-year panel of 47 hospitals covering both pre-ABF years and years after its imposition. Substantial heterogeneity in the responses, as measured by both estimated and predicted

coefficients, is found. We did not find any significant correlation between pre-ABF measures of efficiency and the effect of ABF on efficiency. We did however find a strongly significant correlation between the effect of ABF and post-ABF efficiency. Thus, the analysis confirms the impression that, whereas pre-ABF efficiency did not play any role in how hospitals responded to ABF, those responding generally ended up as better-performing hospitals. Hence, for the type of reform studied the authors conclude that policy-makers do not need to worry about the impact of location on patients' access to hospital services.

[H3] ELSTAD, J.I. (2011) Does the socioeconomic context explain both mortality and income inequality? Prospective register-based study of Norwegian regions. International Journal for Equity in Health, 10:7

Wilkinson's theory that higher income inequality undermines social cohesion and contributes to more social pathology and higher death rates is controversial. Previous studies on the topic in the Nordic countries have given conflicting results. This article utilises multilevel Poisson regression to analyse register data on the Norwegian population aged 30-64, with mortality follow-up 1994-2003. The considerable mortality differences between the 35 analysed regions cannot be accounted for by individual-level variables. After adjustment for the effects of large cities, composition of industries, and average educational and income levels in the regions, higher income inequality was independently associated with higher mortality levels. The results are strikingly in accordance with the predictions from Wilkinson's theory.

[H4] LAFHIRI, K. (2011) Municipality level accessibility to specialised health care in Norway. Working Paper 2011:7 Department of Health Management and Health Economics, University of Oslo

In the Norwegian health care system equal distribution and access to care regardless of social status, gender, ethnicity and area of living has been raised as an important issue. This paper studies the extent to which the principle of “equal access” to specialised health care is maintained in the specialist health care delivery system of Norway. Access to specialised health care in this study is measured as a distance weighted form of the ratio “per head specialised health care” for each municipality and includes rich information on the capacity of specialist health care and the distance from residence to the hospital and private specialist care. The authors find inequality of access to specialist health care. The capital Oslo has the best access to specialist health care and the residents of the northern- and easternmost county of Norway (Finnmark county) has the worst access.

[H1] LINNA, M. ET AL. (2010) Measuring cost efficiency in the Nordic Hospitals - a cross-sectional comparison of public hospitals in 2002. Health Care Manag Sci, 2010 DOI: 10.1007/s10729-010-9134-7.

The study compares the performance of hospital care in four Nordic countries: Norway, Finland, Sweden and Denmark. Using national discharge registries and cost data from hospitals, cost efficiency in the production of somatic hospital care was calculated for public hospitals. Results suggest that there were marked differences in the average hospital efficiency between Nordic countries. In 2002, average efficiency was markedly higher in Finland compared to Norway and Sweden. This study found differences in cost efficiency that cannot be explained by input prices or differences in coding practices.

[L] Long-term care

[L] INGEBRECHTSEN, REIDUN (2011) Omsorg for eldre innvandrere. Samlede prosjekterfaringer. NOVA Rapport 15/10. Oslo: NOVA.
"Care for elderly immigrants. Experience from projects in the field".

The report reviews and evaluates the experience that has come out of a number development and research project focussing on the challenges associated with the adaption of Norwegian eldercare services to the needs of immigrants. One of conditions for successful adaption that is pointed out in the report is the development of language skills and cultural competences of the care workers.

[L] SUNDSTRÖM, G ET AL. (2011) Diversification of old-age care services for older people: Trade-offs between coverage, diversification and targeting in European countries. Journal of Care Services Management, 5(1):35-42

This article looks at the totality of services that are offered to the elderly in a selection of European countries both from public and private sources (the family). The conventional picture that public services are much more developed in the Nordic countries while family care is substituting for public care in Southern and Eastern European countries. However, it is also shown that family care continues to be very important in the Nordic countries as a supplement to public provision. It is further emphasised that what matters is not only the "big services" in field – institutional care and home based care – but also a range of "smaller services" like the distribution of food, transport services etc.

[L] VABØ, MIA (2011) Changing governance, changing needs interpretations: implications for universalism. *International Journal of Sociology and Social Policy*, vol 31(3/4):197-208

Using Norwegian home care services as case, the paper seeks to explore how established interpretations of needs have been challenged by shifting modes of governance. The study draws on policy documents, interviews and observation from three different case studies undertaken at different points in time representing different eras of governance. The study examines the role of professionals taking part in needs assessment. The results indicate that routines for needs assessment in home care are contingent on shifting logics of governance. A shift in policy of needs testing may be described as a shift from a personal situated approach encouraging "creative justice" towards a detached and impartial approach better equipped to ensure "proportional justice". The latter approach has become more dominant as heightened attention has been paid to citizens' rights. It is, however, questionable to what extent it will improve the preconditions for treating citizens with equal concern and respect.

4 List of Important Institutions

Arbeidsdepartementet - Ministry of Labour

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

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

Fafo - Institute for Labour and Social Research

Contact person:	Jon Hippe
Postal address:	Fafo, Pb 2947 Tøyen, 0608 Oslo
Visiting address:	Borggata 2b
Webpage:	http://www.fafo.no/indexenglish.htm

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

Helseøkonomisk forskningsprogram (HERO) ved Universitetet i Oslo - Health Economics Research Programme at the University of Oslo - HERO

Contact person:	Tor Iversen
Postal address:	Postboks 1130 Blindern, 0318 OSLO Norge
Webpage:	http://www.hero.uio.no/

HERO is a research programme concentrating on research in health economics at the University of Oslo. HERO has its foundation in economics, but emphasises the need for crossdisciplinary cooperation to ensure the relevance of research to the needs of the health care sector. The programme's staff members include researchers in social sciences, mainly economics, and researchers from the medical profession. The programme has three research units: The Institute of Health Management and Health Economics, The Frisch Centre, and The Department of Economics at the University of Oslo. HERO's research activity is financed by the Research Council of Norway, but the programme does also cooperate with others whose projects are not financed by the Council.

Helse- og Omsorgsdepartementet - Ministry of Health and Care Services

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

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

Ministry has the overall responsibility for government policy on health and care services in Norway.

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

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

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

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