Annual National Report 2010

Pensions, Health and Long-term Care

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Table of Contents

1 Executive Summary

The period from April 2009 to May 2010 has been marked by adverse economic developments, but few political initiatives in pensions, health and long-term care. Although the economic developments turned out less dramatic than projected at the beginning of the crisis, it resulted in the first report on an excessive deficit for Denmark on the 12 May 2010. When examining the policy initiatives, it makes sense to distinguish between the period before and after the 25 May 2010, when the Government and the Danish Peoples Party agreed on a recovery plan.

There were few policy initiatives from April 2009 to May 2010 in the three areas of this report:

Pensions. No major changes to basic pensions, but some to supplementary pensions. The SP scheme abolished. The Budget 2010 (agreed 12 November 2009) eases means-test for pension supplement so more persons become eligible and allows holdings on certain saving accounts to be paid out tax free. A special tax (udligningsskat) of 6% will be levied on high pensions starting in 2011.

Health. No major policy changes. The Government launched a Health Plan with iniatives to be implemented, mainly improvements rather than cuts. Some regions were forced to fire staff at the end of the period due to budget constraints. The Budget 2010 sets off extra DKK 700 million to renovate hospitals and advance other such projects.

Long term care. No major changes. Recruitment is easier due to adverse economy. The Budget 2010 allows extra DKK 300 million to enhance quality of elderly care.

The recovery package of May 2010 contains cuts in existing public expenditure of DKK 34 billion and an increase of public expenditures in two areas, health and measures for vulnerable groups. With regard to the three areas of this report the following can be noted:

Pensions. Originally, the Government announced that it would freeze pensions and other cash benefits. However, the recovery plan does not alter the indexation of pensions with wage and price increases.

Health. The health sector will get an extra DKK 5 billion.

Long term care. Originally, the governement announced cuts of DKK 4 billion in the budget of municipalities that would inevitably adversely impact on long term care. However, the recovery plan saves the municipalities from any cuts and allows them to maintain services on current levels.

In sum, both policy changes that are part of the recovery plan and changes before leaves the three pillars of social protection of key interest for this report, i.e. pensions, health and long-term care, more or less intact. At least compared to the reforms underway in other areas, the three policy programmes show a remarkable resilient to retrenchment

2 Current Status, Reforms as well as the Political and Scientific Discourse

The Danish economy has taken a blow in the past 12 months. This is not least the case for public finances. Gone are the days with high employment, low unemployment, budget surpluses and falling budget deficits.

On 12 May 2010, the European Commission presented the first ever excessive deficit report on Denmark (European Commission 2010). The Commission noted that the planned excess of 5.4% of GDP for 2010 is exceptional as it results from a severe economic downturn. Clearly above the 3%, the deficit cannot be considered close to the reference value. The planned deficit is not temporary, as is evidenced by the spring forecast. The Commission therefore concluded that the deficit criterion in the Treaty is not fulfilled.

The report on the excessive deficit was expected in Denmark by the Government, the opposition as well as by the social partners and think tanks.

Indeed the report was used strategically. The day before its publication, May 11, the two major opposition parties, the Social Democrats (Socialdemokraterne) and the socialists (Socialistisk Folkeparti), announced their joint proposal, Fair Solution (Fair løsning), on how to secure a Danish recovery.

Also the Government used the publication of the excessive deficit report to launch their vision of an exit strategy. Their proposal was announced May 12, and launched May 19.

Details on the various exit strategies are presented in section 3. The remainder of this section 2 sketch the organisation, principles, changes, main discussions and studies made on pensions, health and long-term care from April 2009 to May 2010.

2.1 Pensions

In this section, we first describe the organisation of the Danish pension system in the conventional pillar system. Then we describe each of the various schemes in the pension system as well as the changes they may have undergone from April 2009 to May 2010. This includes an analysis of the policy dynamics surrounding pension reforms as well as reference to studies that have been undertaken.

2.1.1 Structure

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

Table 1: The three pillar system applied to the Danish pension system

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

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

The national old age pension

The Danish national old age pensions consist of a basic amount, a supplementary amount and the so-called supplementary pension benefit. The basic amount is the same for everybody, i.e. DKK 65,376 annually or DKK 5,448 monthly (all amounts for 2010). The supplementary amount varies for single persons and others. For single persons the supplementary amount is DKK 67,896 or DKK 5,658 monthly and for others DKK 32,820 annually or DKK 2,735 monthly. The supplementary pension benefit is DKK 10,700 annually, paid out as a 'cheque' once a year.

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

The basic amount and the supplementary amounts are automatically indexed each year according to wage and price developments.

The supplementary pension benefit, popularly called the Elderly Cheque, was introduced in 2003 to meet demands made by the Danish Peoples Party (Dansk Folkeparti) in budget negotiations with the Government. The cheque is highly visible as it is being paid out once a year, rather than spread out over the year as incremental changes of the national old age pension, and is thus of significant political importance for the Danish People's Party.

Since 2003, the supplementary pension benefit/elderly cheque has been raised each year after pressure of the Danish Peoples Party during Budget negotiations that take place in the autumn.

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

All elements of the national old age pension are financed through general taxation on a pay-

as-you-go basis.

The virtue of the Danish national old age pension is that it constitutes a very good minimum pension effectively combating poverty in old age. Especially this is the case because virtually all benefits in kind are free of charge (except institutional care). Most notably this concerns health care and social services for elderly like long-term care schemes as home nursing, for more details see section 2.2 and 2.3.

ATP

However, the national old age pension does not provide good income maintenance for middle and high income earners. The supplementary labour market pension, ATP Arbejdsmarkedets Tillægs Pension, from 1964 does not significantly change this picture. The ATP provides a supplement to the national old age pension which is significant for groups with low to middle earnings but less important for middle to higher income groups expressed by its share of their income in retirement. In nine out of ten municipalities the national old age pension and the ATP are more important sources of income than private pensions (ATP 2009a).

Contributions to the ATP scheme and thus the ATP benefit in retirement depends on the scope of work, but is independent of the size of earnings, see Table 2 below.

Table 2: ATP contributions for most employees in the private sector according to number of monthly working hours, in DKK, 2010.

Hours per month	Employee	Employer	Total
Minimum 117	90	180	270
78-116 hours	60	120	180
39-77 hours	30	60	90
Below 39 hours	0	0	0

Note: These are the ordinary contributions to ATP, also called a-contributions, which are by far the most common. However, there are b, c, d and e contributions typically at a lower level for employees in the public sector depending on their collective agreements and seniority.

To partly compensate for the growth in labour market pensions that do not benefit person not in a job, claimants of temporary social security benefits are also paying mandatory contributions to the ATP scheme with public authorities paying the 'employer part'. Typically, these are larger than the ordinary a-contributions to ATP. For example, claimants of unemployment insurance pay DKK 1.28 per hour they receive compensation with the unemployment insurance funds (a-kasser) pay in an additional sum of twice this amount. In total this brings the montly contribution for a full-time unemployed to about DKK 560 or a little more than the ordinary ATP saving.

SAP

Persons outside the labour market on more permanent schemes also have the possibility of an ATP like scheme, namely the Supplementary Labour Market Pension for Disability Pensioners (Supplerende arbejdsmarkedspension for førtidspensionister - SAP). However, unlike the ATP contributions made for persons on temporary social security, the SAP scheme is voluntary. SAP gives persons on disability pensions the possibility to contribute to a

supplementary labour market pension (that happens to be administered by the ATP institution). The rationale of SAP, introduced in 2003, is to partly compensate for their lack of an ordinary labour market pension. Contributions are voluntary. They amount to DKK 450 per month of which the insured should pay DKK 150 and the municipality of residence will supplement with the remaining DKK 300.

SP

Primarily to take some heat out of the Danish economy the then Social Democratic-Social Liberal government introduced a special pension saving (særlige pensionsopsparing) of 1% of gross earnings. Everyone – employees, self-employed and most claimants of social security benefit – made contributions in the period 1998 to 2003. In 2004, the Liberal-Conservative government annulated the payment of the SP contribution for one year and this was repeated the years after.

In 2008, the Government and the Danish Peoples Party agreed to allow people to withdraw their SP savings to stimulate the economy, for more details see the description of the Spring Package in ANR 2009. Because the far majority took out their SP pension, a parliamentary majority decided January 8, 2010, to close down the scheme altogether. Hence, all insurance holders have been requested to withdraw their holdings or replace them in another pension vehicle at the latest by April 2015. The impact of the SP on financial crisis through stimulating domestic demand has not been performed to the knowledge of the author (besides observations that a lot of the SP payments were used for holidays etc.).

Labour market pensions

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

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

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

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

Administrative costs

The administration costs of pensions are very low. Based on the OECD Global Pension Statistics the ATP finds that the costs of administration are lower in Denmark and the Netherlands than in the other EU countries (ATP 2009b). The ATP scheme is by far the cheapest pension fund administrator in Denmark with cost running at 0.04 percentage of the administered pension wealth compared to 0.2 percentage for pensions in Denmark as a whole. This 0.2 percentage compares to 1.4 percentages in Germany (ATP 2009b).

2.1.2 Inequalities in pensions

The shift towards a pension system with more private pensions that are based on labour market participation obviously favours those with high and stable income over those with smaller and instable incomes. This is in part compensated by the introduction of the pension supplement to the national old age pension and compulsory contributions to the ATP scheme by recipients of social security and social assistance, both described earlier. However, inequalities for those on the labour market still pertain into old age reflecting social divisions of gender, family type, ethnicity, geography etc.

Overall, women in Denmark have more or less the same participation as men, but not in their fertile years due to maternity leave and disproportionate take up of other leave schemes. The labour market is highly gender segregated with more women working in the public sector, especially in health, social and education areas.

Gender equalisation in the labour market is the main reason for gender equalities in pensions. On average women tend to work fewer years and hours at smaller earnings than men with a similar background with regard to education. This results in women paying fewer and smaller contributions to supplementary pensions. In late spring 2010 the Wage Commission that was sat down in October 2008, will publish its analysis and recommendations, of which some are likely to touch up gender inquality issues in pensions.

Women also live longer than men. Hence, in private pension, fully actuarial pensions would therefore result in women either enjoying lower benefit than men or women would have to pay larger contributions than men if there should be no difference on the level of benefits. To counter such practice in the ATP scheme, a parliamentary majority decided in 1998 to adop a unisex principle which determines that men and women are covered by the ATP in the same way independently of their gender. As a result there is a significant redistribution of income from men to women (ATP 2010a).

Pension inequalities also exist between pensioners depending on whether they are single or couples. Both single and cohabiting pensioners earn close to DKK 184,500 annually. However, the composition differs with single having bigger public pensions and the couples bigger private pensions (ATP 2009c). Because living costs are higher for single they have less for consumption.

Pension inequalities also have an ethnicity dimension. Because persons with a minority background, especially persons from non-western countries save less than native Danes, they will receive less in pensions when they retire. At the moment only 1.5% of the pensioners are immigrants from non-western countries equal to 14,000 persons (ATP 2009d). In 2050, an estimated 7% percentage of the pensioners will be immigrants from non-western countries equal to more than 100,000 persons. They will to a large extent be dependant on means-tested benefits like the pension supplement, housing benefits and personal allowances.

More of those permanently parked outside the labour market, i.e. disability pensioners, have taken up the SAP coverage. Hence, the number of insured has increased from 63,000 in 2005 to 95,000 in 2009 (ATP 2010b). Today nearly 40% of the disability pensioners are insured with SAP. Professor of economics and member of the Economic Council, Hans Whitta-Jacobsen, finds this a positive development whereas professor of social policy, Jon Kvist, argue that the scheme should be made mandatory to secure all, especially the weakest of the disability pensioners, become covered (ATP 2010b).

Pension inequalities are also reflected on spatial dimensions. For example the Danish Association of Insurance found that old age pensioners in the West of Jutland on average have DKK 61,000 annually besides the national old age pension. The similar amount for a

pensioner in the North of Sealand is DKK 107,000 (FORSIKRING & PENSION 2010a).

2.1.3 Making people working longer

The retirement age is 65 years of age for the national old age pension. As part of the Welfare Agreement in 2006, this age will be gradually raised by two years, i.e. half a year in 2019, 2020, 2021 and 2022, making it 67 years of age in 2022. Also as part of the Welfare Agreement a demographic adjustment of the retirement age was introduced so that increases in longevity in part translates into longer working life and do not exclusively contribute to longer time in retirement. Thus, from 2025 increases in longevity will result in higher retirement ages aiming at keeping the period in retirement at 19.5 years as it was in 1995 (REGERINGEN et al 2006).

Although not part of the Danish old age pension system, the early exit benefit (efterløn) is one of the most important channels into retirement. A recent study on the effectiveness of the 1999 reform of the early exit benefit (efterlønsreformen af 1999) by Michael Jørgensen (2009) finds that the reform has resulted in fewer people at the age of 40 years being members of the scheme. In turn this will mean fewer people will retire on this particular scheme. At the same time, however, other sources of incomes, e.g. pension wealth, has accumulated and may more than off-set this trend toward later retirement caused by the reform of the early exit scheme.

Another study on effective retirement ages from 1992 to 2008 has been undertaken by the Danish Association of Insurance (FORSIKRING & PENSION 2009). The study is looking at not only retirement through the national old age scheme, but also the disability pension (førtidspension) and the early exit benefit. They find that the average retirement age fell by 2 years from 1992 to 2008 mainly because of earlier entries into the early exit benefit. Also they find an increase in the share of persons with long education taking out early retirement.

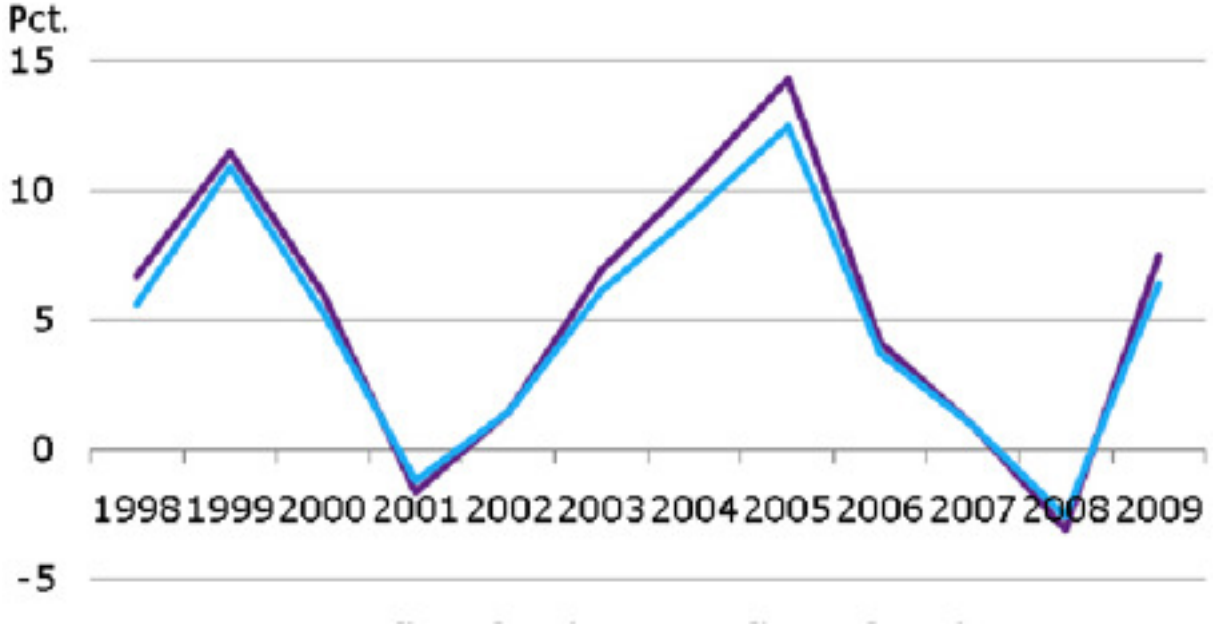
Persons working in the core areas of the Danish welfare system, i.e. health, education and social service, face a greater risk of early retirement than person with the same length of education working in the private sector (FORSIKRING & PENSION 2010d).

Several studies find that an increasing amount of early exit through the disability pension is due to ill mental health. For example, in 2000 less than 30% of disability pensions compared to half of all new awards today (FORSIKRING & PENSION 2010d).

2.1.4 Crisis impact and policy responses

The main challenge for private pensions in the current volatile financial market is undoubtedly to avoid huge losses. However, the Danish Association of Insurance shows that the very bad times of 2008 was already reversen in 2009 that gave a return on investments of DKK 104 billion (FORSIKRING & PENSION 2010b). Figure 2 below shows how returns on investments fluctuate between 1998 and 2009.

Figure 1: Pension returns, percentages, 1998-2009



Source: FORSIKRING & PENSION (2010b).

The Budget 2010 agreement between the Government and the Danish Peoples Party on 12 November 2009, resulted in an increase of the meanstest to the pension supplement allowing some 13,000 more pensioners to receive the benefit.

April 15, 2010, the Government and the Danish Peoples Party agreed on a special tax on big pensions. Persons will from 2011 and five years ahead be levied a 6% tax on pensions exceeding DKK 362,800 annually. The Danish Insurers Association estimates that 30,000 persons will be affected, more among persons with middle and long educations (FORSIKRING & PENSION 2010c).

As part of the 2009 crisis package, Spring Package 2.0, described in the previous national report on Denmark (ANR 2009), there were, however, certain policy measures that affect private pensions. Most notably was the ceiling on the amount of tax priviledged contributions that can be made, i.e. DKK 100,000 yearly. As a result there was an increase of persons making contributions to private pensions in 2009 when there was no ceiling (FORSIKRING & PENSION 2010).

Part of the Spring Package was also to open the SP scheme for early withdrawal of pensions in order to stimulate domestic demand. No comprehensive study has investigated the impact.

As discussed in depth in section 3 on exit strategies the Government originally planned in May 2010 to not index social security benefits, including pensions, for two years to bring down budget deficits. However, the opposition and the traditional supportive party for the Government, ie. Danish People's Party, did not want to let pensioners experience relative worse pensions. Hence, there was not made any changes to the level of pensions in this or other ways.

2.1.5 Statistics

There are regular statistics on the national old age pension provided by Statistics Denmark. However, regular statistics on private pensions, which are of increasing importance for still

larger parts of the population, has been absent. Instead there has been ad hoc studies, but they have not been able to provide good pictures of patterns and trends.

Therefore it is comforting that there will soon come new statistics on private pensions deriving from tax registers. Thus, it is now possible to make better assessments of the developments of private pensions. To illustrate please find below two figures on the development over the last ten years that are based on information from the tax registers and made available by the Danish Association of Insures. Figure 2 shows contributions and Figure 3 the number of insurance holder for second pillar pensions, i.e. labour market pensions, and third pillar pensions, i.e. individual schemes.

Figure 2: Contributions to individual pension and labour market pensions, millions of DKK, 1998-2009

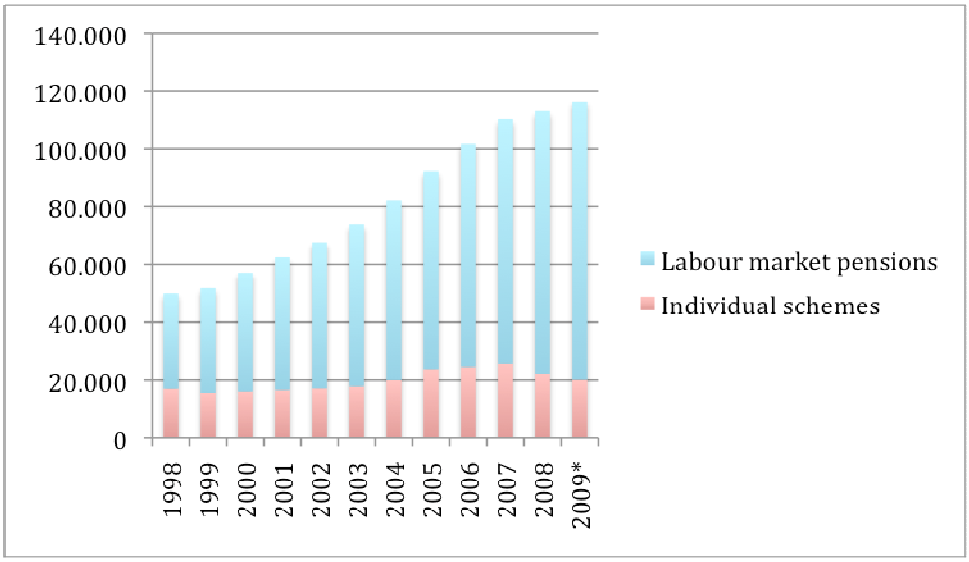
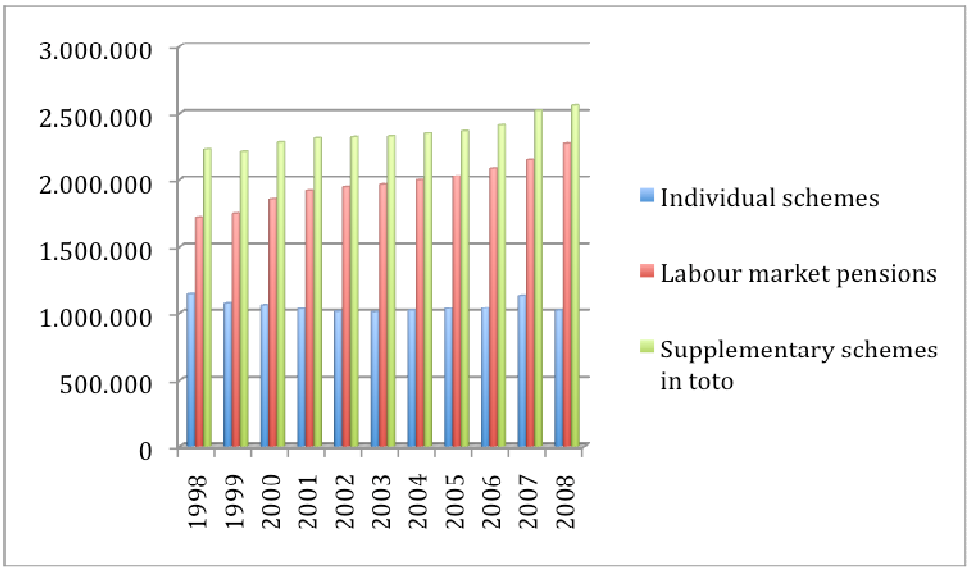


Figure 3: Contributions to one or more individual schemes, labour market pensions and supplementary pensions, 1998-2008



The Figures show that tax deductible contributions to supplementary schemes grew by DKK 3.4 billion compared to 2008 to a total of DKK 116.3 billion, see Figure 2. Contributions to labour market pensions grew by DKK 6.5 billion and to individual schemes fell by

DKK 4 billion. Nearly all contributions to labour market contributions are set by collective agreements whereas they are voluntary in individual schemes. In light of wage development and financial crisis straining some household budgets, the diverse development is not surprising.

However, still the information on private pensions cannot be assessed through Statistics Denmark nor does it yet contain information on the distribution of private pensions, their contributions and payments, according to socio-economic groups etc. Hence, it will most likely take another year or two before really interesting studies can be made on the adequacy of pensions for various population groups.

2.2 Health

The Danish health care system is based on a principle of free and equal access for all citizens. In the last ANR 2009 we described the Danish health services as they were organised just after the Structural Reform of 2007. In this report we go in more details with some of the developments in the period from April 2009 to May 2010 where the Danish health care system has been subject of much public debate and development that has put the principle of free and equal access put to a test. The debate has evolved around the placement of new hospitals, the quality of treatment, the budget deficits and firing of health personel. Two policy programmes has been announced, the Health Package in October 2009 and an action plan for psychiatry in November 2009. Budget 2009 and the Recovery Plan 2010, see section 3, both contain extra money for the health sector. Some consultancy and departmental reports have been published.

In this section, we first sketch the structure of the Danish health care sector.

2.2.1 Structure

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

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

When contracting an illness, the citizen normally first comes into contact with primary health care.

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

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

the general practitioner.

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

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

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

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

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

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

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

2.2.2 Expenditures

The total consumption of health benefits in Denmark amounted to DKK 146 billion in 2008, see Table 3. About 85% was public consumption. Regions make up the lions share not least because of the hospitals. Other regional expenses are health insurance whch cover expenses to general practitioners, specialists. Finally, regions pay out subsidies to medicine.

For municipalities it is nursing homes and elderly care that makes up the main part of their health expenditures. Notice, however, that not all expenses to elderly care is included, for example, home nursing (hjemmehjælp) that is part of the social expenditures.

Private sector health expenses are primarily expenses to doctors, dentists and medicine.

Table3: Health expenditures according to sector and main category, fixed prices in billion DKK and percentages, 1999 and 2008

		1999	2008	Share in 2008	Annual real growth
		- billion DKK (2008 prices) -		--- percentage ---	
Regions	Total	69.0	95.5	65.3	3.7
Of which:	Hospitals	53.5	71.7	49.0	3.3
	Health insurance	9.3	13.3	9.1	4.1
	Medicine	5.1	8.0	5.5	5.1
Municipalities	Total	27.8	28.9	19.8	0.4
Of which:	Nursing homes and elderly care	20.4	20.5	14.0	0.1
	Ambulant treatment	6.2	7.5	5.1	2.1
Public consumption	Total	96.8	124.5	85.1	2.8
Private consumption of health benefits	Total	17.5	21.8	14.9	2.5
Of which:	Medicine	4.5	6.2	4.2	3.6
	Glasses, hearing aid etc.	2.6	3.5	2.4	3.4
	Doctors, dentists	8.3	8.7	6.0	0.5
Consumption of health benefits	Total	114.3	146.2	100.0	2.8

Source: Ministeriet for Sundhed og Forebyggelse (2009).

Notes: The expenditures does not include social security benefits like sickness benefits nor all social services like home nursing.

After many years of stable development of expenditures, they have grown markedly over the last ten years. As can be seen in Table above, there is an annual growth rate of 2.8% in from 1998 to 2008. This is particular caused by an annual increase of 3.7% in regions (compared to a modest growth of 0.4% in the municipalities).

Both in the public and private sector subsidies to medicine has grown markedly.

To better control expenditures research has gone into studying the determinants of

expenditure growth. Studies typically distinguish between demographic determinants and non-demographic determinants. Demographic determinants include changing age composition of the population, increased longevity and changing patterns of illness. Non-demographic patterns include increased demand due to increased income and wealth, more and better possibilities for treatment, productivity development in the health sector compared to other sectors.

One of the important issues with increasing longevity is whether the extra years turn out to be inexpensive or not for the public exchequer. Economists in the Secretariat of the Economic Council have investigated the importance of age versus proximity to death (terminal costs). They find that it is primarily proximity to deat has a significant impact on the health costs of the individual (ARNBJERG & BJØRNER 2009; see also HANSEN & FRANK 2009). The results are then combined with a long term population forecast to predict the impact on publich health expenditures of demographic change, i.e. cohort effects and effects of improved life expectancy (ARNBJERG & BJØRNER 2009). When life expectancy increases, the terminal costs are postponed and the increases in health expenditures that follow from longer life expectancy are not as large as the increase in the number of elderly persons would suggest. This is referred to as "healthy ageing". Based on the empirical estimates healthy ageing is expected to reduce the impact of increased life expectancy on real health expenditures by 50% compared to a situation without healthy ageing (ARNBJERG & BJØRNER 2009).

The Economic Council finds in a major study that health expenditures will increase faster than the economy for two reasons. First ageing populations will result in an increasing amount of elderly with close distance to death. Second wealth increases is likely to result in extra demands for services. Thus, both demographic and non-demographic factors puts pressure on health expenditures (DET ØKONOMISKE RÅD 2009).

2.2.3 Financing

To ensure free and equal access for all citizens to the Danish health care system the vast majority of health services in Denmark are free of charge for the users.

For financing of the majority of the regional and local health care expenditure, the state imposes a health care contribution tax. The health care contribution is 8% on taxable income.

Health care in the regions is financed by four kinds of subsidies: A block grant from the state (approx. 77%), a state activity-related subsidy (approx. 3%), a local basic contribution (approx. 8%) and a local activity-related contribution (approx. 12%), see Table 4 below.

Table 4: The financing of regions according to financer and relation to performance

Subsidy from	No connection to activity	Connection to activities	Total
State	Block grants (approx. 77%)	Activity funds (approx. 3%)	80%
Municipalities	Basic amount according to number of citizens (approx. 8%)	Activity based on citizens consumption (approx. 12%)	20%
Total	85%	15%	100%

Source: Ministeriet for Sundhed og Forebyggelse (2009), Effektiv styring på sundhedsområdet.

The state block is distributed by a number of objective criteria that reflect expenditure needs (e.g. demography and social structure of each region).

The state activity-related subsidy to regions may constitute up to 5% of the health care expenditure of the regions and aims to encourage the regions to increase the activity level at the hospitals.

A novelty is that the municipalities following the local government reform contribute to financing health care. When considering the new local health care tasks (preventive treatment, care and rehabilitation), the municipalities have acquired a more important role within health care. The purpose of the local contributions is to encourage the municipalities to initiate efficient preventive measures for their citizens with regard to health issues.

Local financing consists partly of a basic contribution and partly of an activity-related contribution. Together they constitute approx. 20% of total financing of health care in the regions.

The basic contribution is determined by the regions. The maximum limit is fixed by statute (DKK 1,500 per inhabitant at the price and wage level of 2003). The municipalities (min. 2/3 of the municipalities in the region) are able to veto a region's proposal to increase the contribution in excess of the price and wage development. The local basic contribution is initially fixed at DKK 1,000 per inhabitant.

The activity-related contribution depends on how much the citizens use the regional health services. It will primarily reflect the number of hospitalisations and out-patient treatments at hospitals as well as the number of services from general practitioners. In this way the municipalities that succeed in reducing the need for hospitalisation, etc. through efficient measures within preventive treatment and care will be rewarded.

As a part of the activity-related contribution to the regions, the regions have to redistribute the contributions to the hospitals.

2.2.4 Recent policy responses

In October 2009, the Government announced its Health Package 2009 which sets out eight set of initiatives of improving the health care services (REGERINGEN 2009). The aim is to increase longevity with 3 years by:

1. A new map of Denmark with modern hospital
2. Focus on results
3. Municipalities should focus on better nursing
4. An action plan for psychiatry
5. Life threatening cancer and cardiac diseases – package process and new cancer plan
6. Extended free choice of hospitals and fair competition puts patient in center
7. Action plan for prevention
8. New patient ombudsmand

The new map of Denmark with modern hospitals has obviously been subject to much public debate about the localisation of the planned four new hospitals. The Government has set aside DKK 25 billion which together with DKK 15 billon of the regions amount to an investment of DKK 40 billion.

The state activity subsidies to regions have, in the eyes of the Government, been a success.

Therefore, the Government will change the conditions of getting these activity funds to that the number of treated patients get a greater weight. The aim is to get shorter and more effective treatment of patients and fewer contacts and in-bed stays at hospitals. Also the state want to establish better performance target and cut red tape (REGERINGEN 2009).

To prevent unnecessary in-bed hospital stays, the municipalites must focus on better nursing. Especially among the chronically ill and elderly medical patients municipalities has good possibilities for improving their health. As noted earlier, municipalities co-finance around 20% of the regional health expenses based on a basic amount and an activity-related amount. The Government will change the municipal co-financing so more weight is planced on the activity-related contribution as to encourage municipalities to prevent unnecessary hospitalisation (REGERINGEN 2009). Also the Government wants to encourage municipalitites to take on a greater responsibility in the treatment of elderly in the municipal elderly care so as to avoid these person becoming hospitalised (REGERINGEN 2009). The latter was in accordance with the proposals of a working group (MINISTERIET FOR SUNDHED OG FOREBYGGELSE 20009).

The action plan for psychiatry aims to reduce the scope and severity of mental illness, improve accessibility to psychiatric treatment, and to contribute to more effective diagnostics, treatment and rehabilitation of high quality. Two projects of DKK 1.6 billion are planned just as DKK 250 million is set aside for better housing and increasing the capacity in legal psychiatry (mentally ill criminals who in the moment often are mixing with mentally ill non-criminals) (REGERINGEN 2009).

The governmane will launch a new cancer plan (Kræftplan III) in 2010. The aim will be to continue efforts to cure cancer, to identify cancer as early as possible and to strengthen rehabilitative efforts so that persons with cancer can return to their lives when treatment is over (REGERINGEN 2009). Also the introduction of so-called packages for cardiac illness that started in September 2009 will continue to be gradually implemented in all regions (REGERINGEN 2009).

The extended choice to hospitals and fair competition is still high on the government agenda. To inspire negotiations between the Association of Danish Regions and private hospitals the Government will make a categologue on costs in the most effective hospitals to be used as reference rates. The Government also encourages the regions to make increased use of tenders on strategic health services. The potential is seen as large in areas like planned surgery of hips and knees (REGERINGEN 2009).

The Government launches an action plan on prevention. Six basic principles guides the plan: (1) personal responsibility, (2) clear economic incentives, (3) social responsibility, (4) municipal responsibility, (5) corporate responsibility, and (6) economic responsibility (REGERINGEN 2009). Based on these six basic principles the Government has formulated 30 initiatives, including warning pictures on cigarette packages, increased duties on alcohol, ice, sugar and sodas, and launch a national action plan for kids having at least seven hours of physical activity (REGERINGEN 2009).

Finally, the Government will reorganise the appeal system. The aim is to get a more transparent system that can faster process complaints and contribute to learning (REGERINGEN 2009).

However, there were other initiatives than the Health Package 2009. Over the last 10-15 years, preventive health and health promotion have been given a higher priority in Denmark.

As part of the newplatform 2007 for the Government the launched new initiatives to follow up on the former campaign “Healthy throughout life” (see ANR 2009). Most prominently the Government appointed a committee consisting of experts in the field of health promotion and

disease prevention programme, health economics and representatives from both the public and private sector.

The committee delivered its recommendations in April 2009 on how health promotion and disease prevention in Denmark can be improved (FOREBYGGELSESKOMMISSIONEN 20009). The Committee made 51 proposals some containing new regulation, offers on prevention, and increase of knowledge and instruments. The regulation contained a number of proposals that proved very controversial. For example, the committee suggested doubling the tax on tobacco and prohibiting smoking indoor, except in people's own homes. Furthermore the committee proposed to double the duty on food containing sugar and to extend the material scope of application to include products with a high content of sugar that is not a part of the daily nutrition. Especially these two proposals met with a lot of resistance by the relevant industries and the Government seemed unlikely to proceed with these elements and instead focused on the softer measures of campaigns etc.

2.2.5 Inequalities in health

There are marked inequalities in both health policies and health outcomes.

Inequalities in health policies can be found both for usage of public and private delivery of health services. For example, the Economic Council has studied how the probability of using the extended free choice depends on personal and other characteristics. Most generally, the probably decrease with age, especially persons above 75 years of age do not make use of the extended choice probably because they feel more secure in a public hospital and because they have more complex diagnoses that can only be treated in the public hospitals (DET ØKONOMISKE RÅD 2009).

Also the Economic Council find that the probability of making use of the extended free choice between hospitals increase for persons in employment, of Danish origins, with an education, and high income (DET ØKONOMISKE RÅD 2009). This may in part be explained by the fact that these groups face higher costs in terms of lost income caused by waiting times for treatment in the public hospitals.

Households with single persons and persons without children are also less likely to choose treatment in a private hospital. This may be due to a better follow up in the public hospitals where people making use of the extended choice are more dependent on relatives helping them out in various ways (DET ØKONOMISKE RÅD 2009).

More generally lack of information and abilitites to process complex information may help explain inequalities in the take up of health policies. There are no gender differences, but the take up increase with education indicating that persons with longer education are better at finding out what possibilities they have and to take action on it (DET ØKONOMISKE RÅD 2009).

The use of the health care services by the socially vulnerably has been the focus of a recent study (DAVIDSEN et al 2010). Social vulnerable are defined as homeless, alcohol and drug addicts, mentally ill and other socially vulnerable. The study investigates the frequency and type of contact to the primary health sector, main general practitioners, and for the usage of the hospital sector what caused the contact and thus what illness socially vulnerable persons suffer from. Socially vulnerably have a marked higher use of the health care than the general Danish population. This goes for all types of contacts, genreral practitioners, emergency aid, hospitals etc, and both for men and women. How much larger the consumption of health care is varies across types of illness. However, the socially vulnerably are having a higher use on all illness and contacts, also when controlling for education and other socio-economic factors.

Perhaps not surprisingly inequalities are prevant in private health insurance and the general rise in private health insurance thus question the main principle of health care in Denmark of easy and equal access to health services. There are various types of private health insurance. The most general one is "danmark" which is a non-profit firm owned by its members. Today there are about 2 million member of "danmark" and it pays out subsidies for medicine expenses and for user payments for specialist treatment.

However, the most notable development has been in the more have been in another type of private health insurance that is run by private for-profit companies. These provide insurance that allows policyholders to skip the que for public treatment and go directly to a private specialist for treatment. Private health insurance has increased from a neglible level of 50,000 policies in 2000 to over 1 million policies in 2009 (DET ØKONOMISKE RÅD 2009). This massive expansion can be explained by favourable taxation. One of the first acts of the Liberal-Conservative government coming into office in 2001 was to change the tax legislation in 2002 so that health insurance could be treated as a tax free fringe benefit. Before it was only alcohol treatment that was eligible. Private health insurance is mainly signed by employers for their employees without the insurance being taxed as income for the insured employee. The condition for becoming tax free is that the employer offer the scheme to all employees in the company and that treatment much somehow be justified on medical grounds. It is primarily persons employed in the private sector which are covered by a health insurance. Few persons working in the public sector and nobody outside the labour market are covered by a tax subsidised health insurance (DET ØKONOMISKE RÅD 2009).

Many studies have documented the unequal distribution of health inequalities. Every second year the Institute of Public Health publish a large volume. The period in question did not witness a publication though, so please consult ANR 2009 for a description of findings in the latest study. Some of the researchers of this institute have, however, made an interesting study on mental health (CHRISTENSEN et al 2010). This is an explorative study that try out indicators of mental health to better designb preventive and health promoting measures for this group.

The Economic Council of the Labour Movement has run a couple of analysis on the skew distribution of health inequalities. One study found that early exit claimants had a higher mortality than others in the same age group (AE 2010a). Another study found large health inequalities between different occupational sectors (AE (2009). The most recent study found shorter average life expectancy for members of the trade union for unskilled (AE 2010b).

Studies by the Prevention Committee also found large social inequalities in health outcomes. For example, death causes like cancer and cardiovascular diseases are unevenly distributed in the population decreased with the level of education (FOREBYGGELSESKOMMISSIONEN 2009). Many of the important diseases such as cancer, cardiovascular diseases, allergies and musculoskeletal disease may have their reason in lifestyle factors. A large consumption of tobacco and alcohol, very little or no exercise and a deficient diet are the most important lifestyle factors behind the development of these illnesses. The increase of alcohol consumption doubled between 1961 and mid 1980s, which was more than in the other OECD countries (FOREBYGGELSESKOMMISSIONEN 2009). In 2004 the yearly consumption was more than 11 liters per capita which was only exceeded by five other countries (UK, Ireland, France, Czech Republic and Hungary).

2.3 Long-term care

Long-term care is a political sensitive programme in Denmark. As part of Budget 2010 agreement between the Government and the Danish People's Party an extra DKK 300 million was allocated to increase the quality of elderly care.

2.3.1 Structure

Denmark has one of the most comprehensive systems of free long-term care.
The goal of long-term care is to increase the quality of daily life for persons in need of such care and to increase their possibilities to take care of themselves.

The Danish system of long-term care is organised locally in the 98 municipalities.

Long-term care may be provided by way of residing in institutional care facilities, or special housing typically with nurses attached, or home help.

Typically, the municipality offers its own home help and long-term care. But it is also possible for the elderly person to choose between different providers.

2.3.2 Accessibility of care

All citizens in need of intensive care are entitled to long-term care. Target groups are frail elderly and persons with physical or psychological handicaps.
Long-term care is free of charge, although there may be user charges on food and various other services. Persons living in elderly care institutions pay rent, but also get their national old age pension and housing allowances, if eligible.

Every so often, it is discussed if services for the elderly like long-term care should be subject to increased user fees, contracted out or cut, but so far little political action has happened. One reason to explain this may be that the Danish People's Party has long-term care as one of its core priorities.

2.3.3 Statistics

In total 1,820,000 persons receive home help in their own homes (STATISTICS DENMARK 2010). The extent of home help received varies tremendously. 115,000 persons – or 63% of all recipients – receive less than 2 hours per week. 6,000 persons, or 3%, receive more than 20 hours of help per week (STATISTICS DENMARK 2010a). On average, the older the person, the more home help. 60% of persons above 85 years of age received home help compared to 24% aged 75-84 years and 6% of those between 65 and 74 years. Half of the recipients of home help, 90,181, only received practical help. 73,759 received both personal and practival help whilst 18,325 persons only received personal care.

There are 75,700 persons living in residential care and housing for elderly in 2009, an increase of 600 persons from 2008 (STATISTICS DENMARK 2009). The older you are, the more likely you will be living in one of these places. More than four out of ten persons aged 90+ lived in residential care or housing for elderly compared to, say, one of eight persons aged between 80 and 85 years. The figure was only 0.7% of persons aged 60 to 65 years.

85% of all residential care and housing for elderly has been build or restaured since 1987 (STATISTICS DENMARK 2009)

Long-term care is a major area of employment in Denmark, especially for women. 104,600

full time persons work with care for the elderly in the municipalities in 2009 (STATISTICS DENMARK 2010a). This is an increase of 1,500 persons compared to 2008, primarily due to staff working on average half an hour more per week (STATISTICS DENMARK 2010b). In total 129,700 persons work with long-term care.

87% are care workers, 9% work with cleaning and cooking and 4% are managers and administrative staff. Women amount to 92.5% of persons working in long-term care.

In 2008 an estimated 2,100 persons were working in private firms delivering long-term care (STATISTICS DENMARK 2010b).

2.3.4 Inequalities in long-term care

Little is known about the inequalities in long-term care receipt. Two competing thesis are frequently debated. One thesis state that it is the rich on resources who also manage more often to get allocated home help and for more hours than less privileged persons. Another thesis state that home help is allocated strictly on the basis of need and thus that there is a strong case of redistribution, although perhaps not necessarily in economic terms.

Which thesis is correct may matter a lot for the future of welfare. For example, the Welfare Commission set down in 2003 to 2006 to investigate the Danish welfare system and to come up with suggestions for reforms based a lot of their analysis on the first thesis. They argued, like the economists they were, that with increasing wealth persons tend to ask for more immaterial goods, including personal services. Thus, increasing wealth among elderly would result in greater demand for long-term care services. In a situation with an ageing population this would put immense pressure on public finances, according to the Welfare Commission (VELFÆRDSKOMMISSIONEN 2006).

In fact, however, we know very little about this issue even though it takes up a significant part of the economy and may be of increasing importance. The Economic Council estimates that the anticipated wealth effects will be more than off-set by healthy ageing (DET ØKONOMISKE RÅD 2009).

Fortunately, Statistics Denmark is currently working on a new set of statistics on homecare that is based among other things on the Danish central personal register number, i.e. each person living in Denmark is given a unique personal identification number that is used for almost all contact with all sorts of authorities, including tax, health and social authorities. With the new statistics on homecare it will be possible to identify the socioeconomic position and the health situation of persons receiving home help and much more. Exactly, when the new statistics will be airborne was not know ultimo May 2010.

As part of the government de-bureaucratisation project in the autumn of 2009 a consultancy examined the possibilities of simplifying rules for visitation to elderly care services (see REGERINGEN 2009; DELOITTE 2009).

3 Impact of the Financial and Economic Crisis

The financial and economic crisis has hit Denmark hard, but initially not too many changes in social protection. However, with the recent recovery package agreed between the Government and the Danish People's Party on 25 May social protecion is also adversely influenced. However, the cuts do not affect the three areas of concern for this report, i.e. pensions, health, and long term care. In this section, we first sketch the impact of the crisis and then the various exit strategies discussed and decided on. We show how the excessive deficit report of May 12 has been used strategically to justify the need for reforms, as anticipated by the AE back in February (AE 2010c).

3.1 Impact

According to the most recent economic survey of the Ministry of Finance (Finansministeriet 2010), Denmark is free of the crisis by now.

Denmark led an expansive finance policy in 2009 and 2010. However, the opposition and the Economic Council argued that the finance policy should be more expansive. The Economic Council repeatedly argued that the Government should lead an even more explansive finance policy of about 1 percentage point of the GDP (e.g. SØRENSEN et al 2009a, 2009b; ASMUNDSEN et al 2010).

According to the latest OECD projections launched at a press conference 26 May 2010 Denmark's economic performance will remain relatively dismal being second last of the current 31 OECD countries until 2025.

3.2 Exit strategies

There are marked differences in the policy responses or exit strategies suggested by, respectively, the Government and the Opposition as well as those suggested by the social partners and dominant think tanks.

The Social Democrats and the Socialists announced their Fair Solution that entails initiatives on five dimensions, i.e. (1) More jobs here and now by advancing the planned public investements with DKK 5 billion in 2010 and DKK 10 billion in 2011, (2) investments in jobs, (3) tripartite agreement on economic sustainability, (4) more and faster education, and (5) new welfare (SOCIALDEMOKRATERNE & SOCIALISTISK FOLKEPARTI 2010). Of most direct relevance to social protection are the suggested tripartite agreements and the new welfare proposals.

The most discussed proposal in the suggested tripartite agreement is to increase the working week by one hour paid for. 12 minutes extra per day is by the Opposition portrayed as an alternative to cuts in welfare services like long-term care and popular social security cash benefits like unemployment and sickness benefits, the early exit benefit and the national old age pension. Other elements of the suggested tripartite agreement is to give positive economic incentives to elderly to keep working longer, to increase life-long learning efforts, to increase active social policy, stop social dumping and strengthen flexicurity.

The other dimension, new welfare, contain, a.o., proposals of improving the economic situation of the municipalities by DKK 12 billion, introduce longer economic agreements

between central and local government, and to create the best public health service system in the world through DKK 15 billion investments in hospitals and prevention. Among other things, this includes a targeted measure against cancer and other life threatening diseases, patient rights to a diagnosis after maximum one month, improvement of conditions for long-term psychiatric patients and a general, marked improvement of psychiatry.

Not surprisingly, the plan of the opposition, Fair Solution, was met by harsh critisism from the Government and by support from, especially, the trade unions. The Government accused Fair Solution for not being fully funded and thus unable to meet the requirements of the EU for a healthy economy (e.g. RØMER 2010). However, calculations of the Economic Council of the Labour Movement found that Fair Solution brought the public down from DKK 95 billion in 2010 to DKK 43 billion in 2013, which is below 3% of GDP (AE 2010). These calculations are based on the same model, ADAM, that the Ministry of Finance use. The Danish Confederation of Trade Unions, LO, supported the Fair Solution. LO president, Harald Børsting, welcomed the plan and was ready to enter tripartite negotiations (LO 2010a).

One week later, the 19 May, the Government launched its plan for a recovery (GOVERNMENT 2010a). The plan identified two key challenges following the financial crisis. One challenge was to pay for the costs and the other to secure new growth after the crisis. The Government pleaded for first to pay for the costs to avoid detrimental increases in interest rates and hence the main emphasis is on reducing public expenditures. The aim is to reduce expenditures by DKK 24 billion over three years which would live up to the EU recommendation of improving the structural accounty with at least 1.5% of GDP by 2013. That being said, the Government still wanted to increase health expenditures by DKK 5 billion. In short, municipalities and regions were to reduce expenditures by DKK 4 billion and central government by DKK 6 billion.

One of the main elements of the government plan was to reduce social expenditures by not indexing social security benefits, including public pensions, for two years. Not surprisingly the government proposal of cuts in both benefits in kind and cash met fierce resistance. For example, the president of the Confederation of Trade Unions Harald Børsting argued that claimants of disability and old age pensions were now to pay for the tax reliefs of the rich, and expressed worries that the plan would suppres an emerging growth in the economy (LO 2010b).

Not only the usual suspects like the opposition, trade unions and federations for regions and municipalities opposed the plan, but also the traditional supporter of government plans, i.e. the Danish People's Party. The Danish People's Party vetoed the planned cuts in municipalities the same day that the Government launched its plan.

One week of negotiations between the Danish Peoples Party and the Government followed. The opposition was not invited to the negotiations.

May 25 the Government and Danish Peoples Party reached an agreement on "recovery of the Danish economy" (GOVERNMENT 2010b). Main elements of the agreements include:

- Consolidation with DKK 24 billion in 2013 (cuts equal DKK 34 billion and new expenses equal DKK 10 billion)
- The announced cuts in municipalities in 2012 and 2013 of DKK 4 billion are cancelled
- The announced freeze on indexing cash benefits is cancelled
- Health expenditures are increased with DKK 5 billion in 2011
- Additional DKK 5 billion are reserved to education and weak and vulnerable groups
- Automatic regulation of levels for taxes etc are suspended 2011-2013

- Planned increase of level for marginal taxation postponed for three years to 2014
- Halving unemployment benefit period from 4 to 2 years
- Ceiling on total child family allowances of DKK 30,000 yearly per family
- Ceiling on tax deductible membership fees of trade unions to DKK 3,000 yearly

The trade unions oppose the plan. In particular, the halving of the maximum unemployment benefit period is unpopular. The Confederation of Trade Union see it as a 'declaration of war' (LO 2010c). Its president, Harald Børsting, says that the measure will force the trade unions to demand greater job security, thus hurting the private sector (ASTRUP et al 2010). Also the trade unions for unskilled, 3F, and for skilled, FOA, argue against the plan (ASTRUP et al 2010).

The Social Democrats are also among the critiques arguing that is is not least families with children and unemployed that have to pay. The Social Democrat's political spokesperson, Henrik Sass Larsen, calls it 'an absolutely unsympathetic plan´and the chairperson, Helle Thorning-Schmidt finds the plan 'so unjust that she lacks words' (Hjortdal 2010).

In the 12' O'Clock Radio News the chairperson of the Danish Peoples Party, Pia Kjærsgaard, explained the u-turn of her party on unemployment benefits. Hitherto these had been saved for cuts. Kjærsgaard claimed that cuts had to be made in order to save the national old age pension (and study grant) from cuts.

The Association of Municipalitites (KL) was happy to see that they were no longer to undertake major cuts, but can maintain services, including long-term care, on the current levels. The Vice Chair of KL, Erik Fabrin states that 'KL is happy to see that not only the saving track, but also the reform track' is being used by the Government in its exit strategy (ASTRUP 2010).

In sum, the recovery plan navigates around the three pillars of social protection of key interest for this report, i.e. pensions, health and long-term care. The Government had originally planned a freeze on pensions for two years and a cut on municipal expenditures of DKK 4 billion that was bound to adversely impact on long-term care. Due to the influence of the Danish People's Party none of this will be part of the exit plan. Pensions will stay as they are indexed with wage and prices and services will stay are they are. Health will experience an increase of DKK 5 billion, an increase that the Government and broader opposition seemed to agree upon.

References

AE ARBEJDERBEVÆGELSENS ERHVERVSRÅD (2009). Store branchemæssige forskelle i befolkningens sundhed, April 5, Copenhagen: Economic Council of the Labour Movement. www.aeraadet.dk.

AE ARBEJDERBEVÆGELSENS ERHVERVSRÅD (2010a). Større dødelighed blandt efterlønsmodtagere, March 8, Copenhagen: Economic Council of the Labour Movement. www.aeraadet.dk.

AE ARBEJDERBEVÆGELSENS ERHVERVSRÅD (2010b). Kortere middellevetid blandt medlemmer af 3F, March 18 Copenhagen: Economic Council of the Labour Movement. www.aeraadet.dk.

AE ARBEJDERBEVÆGELSENS ERHVERVSRÅD (2010c). Regeringen misbruger EU-henstilling som undskyldning for hestekur i 2011, February 17, Copenhagen: Economic Council of the Labour Movement. www.aeraadet.dk

AMUNDSEN, Eirik S., Claus Thustrup KREINER, Michael ROSHOLM, & Hans Jørgen WHITTA-JACOBSEN (2010). Vedtag reformer nu og undgå uheldig stramning, Børsen, 21 January, retrieved from www.borsen.dk

ASTRUP, SØREN, NIELS HOLST, LENE JACOBSEN (2010). LO: Halvering af dagpenge er en krigserklæring, Politiken, 25 May, www.politiken.dk.

ASTRUP, SØREN (2010). Kommuner undgår frygtet sparekniv, Politiken, 25 May, www.politiken.dk.

ATP (2009a). Offentlige pensioner og ATP vigtigst for pensionister i ni ud af ti kommuner, faktum: om pension og samfund, nr. 71, August, www.atp.dk.

ATP (2009b). Danske pensionselskaber blandt de billigste, faktum: om pension og samfund, nr. 70, June, www.atp.dk.

ATP (2009c). Enlige pensionister tjener det same som gifte – man har mindre til sig selv, faktum: om pension og samfund, nr. 72, September, www.atp.dk.

ATP (2009d). Udsigter til 700 procent flere ikke-vestlige pensionister, faktum: om pension og samfund, nr. 73, October, www.atp.dk.

ATP (2010a). Fem milliarder pensionskroner optjent af mænd går til kvinder, faktum: om pension og samfund, nr. 80, May, www.atp.dk.

ATP (2010b). Flere og flere førtidspensionister sparer aktivt op til alderdommen, faktum: om pension og samfund, nr. 79, April, www.atp.dk.

CHRISTENSEN, Anne Illemann, Michael DAVIDSEN, Mette KJØLLER & Knud JUEL, (2010). Mental sundhed blandt voksne danskere, Copenhagen: Statens Institut for Folkesundhed og Sundhedsstyrelsen.

EUROPEAN COMMISSION (2010). Denmark –Report prepared in accordance with Article 126(3) of the Treaty, SEC(2010) 585, Brussels, 12 May 2010.

FINANSMINISTERIET et al. (2005). National strategirapport om det danske pensionssystem, July, Copenhagen: Finansministeriet, Økonomi- og Erhvervsministeriet, Beskæftigelsesministeriet, Socialministeriet.

FORSIKRING & PENSION (2009). Tilbagetrækningsalderen 1992-2008. Analyserapport 2009:3, Copenhagen: Danish Association of Insurers, www.forsikringogpension.dk.

FORSIKRING & PENSION (2010a). Pensioner giver igen overskud, 12 May, retrieved from www.forsikringogpension.dk.

FORSIKRING & PENSION (2010b). Vestjyder får de laveste pensioner, 19 May, retrieved from www.forsikringogpension.dk.

FORSIKRING & PENSION (2010c). Hvem rammes af udligningsskatten, 11 May, retrieved from www.forsikringogpension.dk.

FORSIKRING & PENSION (2010d). Velfærdstropper har stor risiko for førtidspension, 25 May, retrieved from www.forsikringogpension.dk.

GOVERNMENT (2010a). GenopretningsPakken: Danmark ud af krisen - regningen betalt, 19 May, Copenhagen: Ministry of Finance, www.fm.dk.

GOVERNMENT (2010). Aftale om genopretning af dansk økonomi, 25 May, Copenhagen: Ministry of Finance, www.fm.dk.

GOVERNMENT (2010). Aftale mellem regeringen og Dansk Folkeparti om genopretning af dansk økonomi, 25 May, Copenhagen: Ministry of Finance, www.fm.dk.

HANSEN, Marianne Frank & Lars Haagen PEDERSEN, Sundhedsudgifter og finanspolitisk holdbarhed, Working Paper 2010:2, www.dors.dk.

HJORTDAL, MARIE (2010). S: En aldeles usympatisk plan, Politiken, 25 May, www.politiken.dk.

JUEL, Knud, Michael DAVIDSEN, Pia Vivian PEDERSEN & Tina CURTIS, (2010). Socialt udsattes brug af sundhedsvæsenet. Copenhagen: Statens Institut for Folkesundhed og Rådet for Socialt Udsatte.

JØRGENSEN, Michael (2009). En effektmåling af efterlønsreformen af 1999. August 21, Copenhagen: SFI – The Danish National Institute of Social Research.

KJØLLER, Mette, Michael DAVIDSEN & Knud JUEL (2010). Ældrebefolkningens sundhedstilstand I Danmark – analyser baseret på Sundheds- og sygelighedsundersøgelsen 2005 og udvalgte register, Copenhagen: Institut for Folkesundhed & Sundhedsstyrelsen.

LO (2010a). LO: Klar til at arbejde for fremtiden, 12 May, Copenhagen, www.lo.dk.

LO (2010b). Regeringen gambler med opsvinget – de fattigste betaler prisen, 19 May, Copenhagen, www.lo.dk.

LO (2010c). Krigserklæring mod arbejdsløse, 25 May, Copenhagen, www.lo.dk.

MINISTERIET FOR SUNDHED OG FOREBYGGELSE (2009). Effektiv styring på sundhedsområdet. Copenhagen: Ministry for Health and Prevention, July 19, www.sum.dk.

MINISTERIET FOR SUNDHED OG FOREBYGGELSE (2009). En analyzer af ældre patienter forløb – på tværs af kommuner og regioner. Copenhagen: Ministry for Health and Prevention, October, www.sum.dk.

MINISTERIET FOR SUNDHED OG FOREBYGGELSE (2010). Det danske sundhedsvæsen i nationalt perspektiv. Copenhagen: Ministry for Health and Prevention, www.sum.dk.

MINISTRY FOR HEALTH AND PREVENTION (2010). International benchmarking af den danske hospitalssektor, February 11, Copenhagen: Ministeriet for Sundhed og Forebyggelse, www.sum.dk.

REGERINGEN, SOCIALDEMOKRATERNE, DANSK FOLKEPARTI OG DET RADIKALE VENSTRE (2006). Aftale om fremtidens velstand og velfærd og investeringer i fremtiden. Copenhagen: Ministry of Finance, www.fm.dk.

REGERINGEN (2009). Sundhedspakke 2009 – Godt på vej mod et sundere Danmark – 8 store skridt der gør et godt sundhedssystem endnu bedre. Copenhagen: Ministry of Health and Prevention, www.sum.dk.

REGERINGEN (2009). Mere tid til velfærd: Regeringens plan for mindre bureaukrati i kommuner og regioner. October, Copenhagen: Government.

REGERINGEN (2009). Styrket indsats for sindslidende. November, Copenhagen: Government, www.sum.dk.

RØMER, MICHAEL (2010). Beregning: S-SF plan opfylder EU's krav, Ekstra Bladet, 12 May, www.eb.dk.

SOCIALDEMOKRATERNE & SOCIALISTISK FOLKEPARTI (2010). En fair løsning – sammen ud af krisen, Copenhagen, www.fairlosning.dk.

SOCIALMINISTERIET et al. (2002). National strategirapport om det danske pensionssystem, 2002. Copenhagen: Socialministeriet, Finansministeriet, Økonomi- og Erhvervsministeriet og Beskæftigelsesministeriet.

SØRENSEN, Peter Birch, Michael ROSHOLM, Hans Jørgen WHITTA-JACOBSEN & Eirik Schrøder AMUNDSEN (2009)a. Indfør øremærket sundhedsbidrag, Berlingske Tidende, 10 November, retrieved from www.berlingske.dk

SØRENSEN, Peter Birch, Michael ROSHOLM, Hans Jørgen WHITTA-JACOBSEN & Eirik Schrøder AMUNDSEN (2009b). Finansloven er kun et lille skridt I den rigtige retning, Information, 3 December, retrieved from www.information.dk

STATISTICS DENMARK (2009). 14.900 af de allerældste bor i pleje- og ældreboliger, Nyt fra Danmarks Statistik, nr. 523, November 26, Copenhagen, www.dst.dk.

STATISTICS DENMARK (2010a). 182.000 får hjemmehjælp i eget hjem, Nyt fra Danmarks Statistik, nr. 187, April 29, Copenhagen, www.dst.dk.

STATISTICS DENMARK (2010b). 104.600 arbejder i ældreomsorgen, Nyt fra Danmarks Statistik, nr. 64, February 16, Copenhagen, www.dst.dk.

4 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

[R1; R2; R3; R4] ARBEJDSMARKEDSKOMMISSIONEN (2009). Velfærd kræver arbejde kort fortalt. Copenhagen: The Labour Market Commission.
"Welfare demands Work – in short"

In December 2007 the Government set down a Labour Market Commission to increase revenue with DKK 14 billion annually. The Commmission launched its proposals in August 2009. The main proposals relating to retirement were either to gradually abolish the early exit scheme (efterløn) or to increase the retirement age in the national old age pension and the early exit scheme from 2011 onwards rather than from 2019.

[R2; H3] AE ARBEJDERBEVÆGELSENS ERHVERVSRÅD (2009). Øget polarisering i Danmark: Fordeling & Levevilkår 2009. Copenhagen: The Economic Council of the Labour Market Union.
"Increased polarisation in Denmark: Distribution and living conditions 2009"

This report by the Economic Council of the labour market union investigates on monetary incomes and social mobility, but one of the themes is on working conditions and health. Generally, persons with long education and higher earnings have less physical demanding jobs and better working environments than persons with medium and, especially, short education and lower earnings. There are also analyses of how health inequlities affect public finances because health impacts on the number of years in work. If all educational groups had the same risk of early exit from the labour market and death as the highly educated group it would increase the labour supply with 106,000 persons.

[R2; R5] FORSIKRING & PENSION, Forsikringens samfundsmæssige betydning, 15 October 2009, retrieved from: www.forsikringogpension.dk.
"Insurance and society"

This report by the Danish Insurance Association draws on a vartiety of data. The main claim of the report is that insurance has a major positive impact on the economy and society in a broad sense; increased wealth dure to risk sharing that increase investments of both companies and households; increased protection and freedom; increase

security, increased welfare, increased wealth; and, better behaviour with regard to the environment etc.

[R3] FORSIKRING & PENSION, Velfærdstropper har stor risiko for førtidspension, Fronter, 25 May 2010, retrieved from: www.forsikringogpension.dk.
"Welfare staff in high risk of early retirement"

In a small study the Danish Insurance Associateion finds, that core workers in welfare services – health, education and social services – are in greater risk of early retirement than workers in the private sector. The early retirement is to disability pensions (førtidspension). The risk of getting early retired is between two and three times higher for persons in the public sector than for groups with the same education employed in the private sector. Also an increasing amount of disability pensions is awarded on the bassis of psychiatric illness. In 2000 less than 30% of disability pensions were awarded because of mental ill health. In 2008 it was half of all new awards. Data is based on figures from the Den Sociale Ankestyrelse.

[R3[FORSIKRING & PENSION, Tilbagetrækningsalderen 1992-2008, 9 June 2009, Analyserapport 2009:3, retrieved from: www.forsikringogpension.dk.
"Retirement ages 1992-2008"

This report by the Danish Insurance Association examines the effective retirement age from 1992 to 2008. It shows that the average effective retirement age has fallen despite political wishes of people stayng longer in the labour market. The study is based on register data from DREAM (a recognised model of the Mininstry of Employment) and population statistics from Statistics Denmark. The report investigates exit to four schemes, i.e. transitional scheme (overgangsydelse, now abolished), early exit benefit (efterløn), disability pension (førtidspension) and national old age pension (folkepension). Among the main findings are: the average retirement age has fallen with 2 years from 1992 to 2008; the fall can in large part be explained by more ad earlier entries into the early exit benefit (especially for women); increase of persons with long education on early exit benefit; the average life expectancy is increased by two years in the same period leading to an average of four more years in retirement; these developments took place in economic favourable times.

[R3; R5] JØRGENSEN, Michael (2009). En effektmåling af efterlønsreformen af 1999. August 21, Copenhagen: SFI – The Danish National Institute of Social Research.
"An effect evaluation of the reform of the early exit benefit in 1999"

Michael Jørgensen (2009) studies the effectiveness of the 1999 reform of the early exit benefit (efterlønsreformen af 1999). The study show that the reform has resulted in fewer people at the age of 40 years being members of the scheme. In turn this will mean fewer people will retire on this particular scheme. At the same time, however, pension wealth has accumulated and may more than off-set this trend toward later retirement. The reform has increased the probability of retiring on the early exit benefit for those who face a small loss and decreased the probability for those who face a greater economic loss.

[H] Health

[H1] ARNBJERG, Søren & Thomas Bue BJØRNER, Estimation af sundhedsudgifternes afhængighed af alder og afstand til død, Working Paper 2010:1, retrieved from:www.dors.dk
"Estimation of health expenditures dependency of age and proximity to death"

Two scholars from the Economic Council studies the individual effects of age and proximity to death (terminal costs of dying) based on micro data from 2000 to 2007

covering a random sample of 10% of the Danish population. Health expenditures include treatment in hospitals, subsidies to prescribed medicine and health care by general practitioners and specialists. The results show that proximity to deat has a significant impact on the health costs of the individual. The results are then combined with a long term population forecast to predict the impact on publich health expenditures of demographic change, i.e. cohort effects and effects of improved life expectancy. When life expectancy increases, the terminal costs are postponed and the increases in health expenditures that follow from longer life expectancy are not as large as the increase in the number of elderly persons would suggest. This is referred to as "healthy ageing". Based on the empirical estimates healthy ageing is expected to reduce the impact of increased life expectancy on real health expenditures by 50% compared to a situation without healthy ageing.

[H1] HANSEN, Marianne Frank & Lars Haagen PEDERSEN, Sundhedsudgifter og finanspolitisk holdbarhed, Working Paper 2010:2, retrieved from: www.dors.dk
"Health expenditures and economic sustainability"

Two scholars from the Economic Council study the development of health care expenditure. Average growth in health care expenditures relative to GDP in Denmark has been among the lowest in the OECD area since 1970, but growth rates are rapidly increasing. This paper separates the expenditure growth into demographic and non-demographic factors. As an innovation compared to previous analyses we include the effects of so-called healthy ageing into the demographic effects. Annual demographic and non-demographic real growth in publicly financed health expenditures is estimated to be 0.4% and 2.0% respectively for the period 1993-2008. For the period 1999- 2008 figures are 0.2% and 2.8%. The average annual real non-demographic expenditure growth rate exceeds the growth rate in real productivity per working hour by 1.5- 2.3% in the period 1999-2008. The effects of growth in health care expenditures on fiscal sustainability are assessed and the results are: Fiscal sustainability is robust with respect to growth in health care expenditures due to future increases in life expectancy. This is a consequence of healthy ageing and the indexation of the statutory retirement age to life expectancy that follows from the 2006-welfare reform. Fiscal sustainability remains very sensitive to non-demgraphic factors: An increase in non-demographic expenditure growth of 0.3% in excess of the productivity growth increases the fiscal sustainability problem by 2.1% of GDP. Doubling the expenditure growth relative to productivity growth to 0.6% increases the fiscal sustainability problem by 4.8% of GDP. Therefore current growth in non-demographic health care expenditures cannot be maintained for a longer period without challenging the public financing of health care expenditures in Denmark.

[H1; H2; H3; H4; H5] DET ØKONOMISKE RÅD, Dansk Økonomi efterår 2009, retrieved from: www.dors.dk
"The Danish Economy Autumn 2009"

This biannual report of the Economic Council consists of two parts. The first part is always an assessment of the Danish economy. The second part takes up a specifik theme. In the Autumn 2009 report the theme was health expenditures and financing. With regard to the economy, the Council notes that the financial crisis had an earlier and more severe impact in Denmark than in many other countries, in part explained by the Danish economy being close to its capacity in 2007 and 2008, thereby laying the ground for modest growth rates even before the crisis hit. The Council recommends a more expansive finance policy in the form of advancement of planned public investments so as to prevent a permanent increase of the expenditures. The Council also recommends structural reforms that include not least reforms of tax policies and labour market policies. Among other things, the Council recommends increased use of user fees

and the introduction of a health contribution that reflects public health expenditures to help prioritise public expenditures.

[H1; H3; H4; H5] MINISTERIET FOR SUNDHED OG FOREBYGGELSE (2010). Det danske sundhedsvæsen i nationalt perspektiv. Copenhagen: Ministry of Health and Prevention.
"The Danish health system in a national perspective"

This report describes the situation and development in a series of indicators of relevance for better understanding the health system. The indicators concern (1) expenditures and financing, (2) the labour market for health staff, (3) activities, (4) capacity and organisation, (5) free choice and private hospitals, (6) waiting times, (7) productivity, (8) quality, and (9) life style, illness and mortality. Many of the indicators are available for both the national level and the regional level, and a few on a municipal level. Expenditures have increased by 2.7% annually from 1998 to 2008. In the same period health staff has increased by 18.4%. Whilst 38.1% of the population received somatic treatment in 2002 it was 39.8%, or 150,000 more persons, in 2008. The number of persons undergoing operation increased by 2.9% annually from 2001 to 2008. Patient satisfaction is generally high, e.g. at 90% in 2006. The introduction of a contact person for persons undergoing long-term treatment in 2004 now covers 85% of the relevant population. Quality as measured by mortality at hospitals has gone up as hospital standardised mortality ratios has gone down with 4% from 2006 to 2008. Finally, more persons are enganged in healthy life styles like not smoking and getting fit. Longevity has increased from 2001 to 2008 with 1.5 years for women and 1.7 years for men resulting in life expectancies of almost 81 years for women and 76 years for men.

[H2] KJØLLER, Mette, Michael DAVIDSEN & Knud JUEL (2010). Ældrebefolkningens sundhedstilstand i Danmark – analyser baseret på Sundheds- og sygelighedsundersøgelsen 2005 og udvalgte registre, Copenhagen: Institut for Folkesundhed & Sundhedsstyrelsen.
"The health of elderly in Denmark – Analysis based on the Health and Sickness study from 2005 and selected registers"

The study is based on register data combined with a survey from 2005. The study finds that the youngest group of elderly between 65 and 74 years of age live more healthy, is less sick, and have a better life quality than the age group 75-84 years, and that women are generally better off than men. By comparing results from 2005 with 1987 the study finds that there are marked improvements. Elderly's functional capacities have increased as has life quality. There has also been an improvement of healthy living with fewer persons smoking, more being physical active and slightly improved dietary habits. Also the elderly are better at using preventitive health checks and their social networks have improved. On the negative side we find an increase in illness which creates bad life quality and puts pressure on the health sector, both the hospital sector and primary health care. Increased illness is accompanied by increases in medical consumption. Also there is an increase in the share of obese elderly and the share of elderly drinking more alcohol than recommended.

[H3; H5] CHRISTENSEN, Anne Illemann, Michael DAVIDSEN, Mette KJØLLER & Knud JUEL, (2010). Mental sundhed blandt voksne danskere, Copenhagen: Statens Institut for Folkesundhed & Sundhedsstyrelsen.
"Mental health among adult Danes"

The purpose of the report is to develop indicators that can describe the mental health of the population. The indicators are to be used in profiling health in municipalities,

regions and at the national level so as to identify target groups with bad mental health so as to better design preventive and health promoting measures and to monitor the target group. In doing so, this report represents the first comprehensive view on the mental health situation of the adult population in Denmark. The report is based on a survey from 2005 which is a cross-section. Thus, the study suffers from not including dynamic effects which would necessitate a panel study.

[H3; H5] JUEL, Knud, Michael DAVIDSEN, Pia Vivian PEDERSEN & Tina CURTIS, (2010). Socialt udsattes brug af sundhedsvæsenet. Copenhagen: Statens Institut for Folkesundhed og Rådet for Socialt Udsatte.

"The use of health services by socially vulnerable persons"

Based on register data and interviews with 1,041 socially persons and 20,640 persons in a survey the researchers investigates the use of health services by persons who are socially vulnerable. Social vulnerable are defined as homeless, alcohol and drug addicts, mentally ill and other socially vulnerable. The study investigates the frequency and type of contact to th primary health sector, main general practitioners, and for the usage of the hospital sector what caused the contact and thus what illness socially vulnerable persons suffer from. Socially vulnerably have a marked higher use of the health care than the general Danish population. This goes for all types of contacts, genreral practitioners, emergency aid, hospitals etc, and both for men and women. How much larger the consumption of health care is varies across types of illness. However, the socially vulnerably are having a higher use on all illness and contacts, also when controlling for education and other socio-economic factors.

[L] Long-term care

[L] DELOITTE (2009). Undersøgelse af forenklingsmuligheder for visitation på ældreområdet. October, Copenhagen: Deloitte.

"Examination of possibilities for simplifying visitation to elderly care services"

This short consultancy report describes rules and insights from previous studies. Based on a case study in a few municipalities, the study examines barriers and opportunities for simplifying visitation procedures.

5 List of Important Institutions

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

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

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

ATP-Arbejdsmarkedets Tillægspension - ATP-Labour Market Supplementary Pension
Address: Nørre Voldgade 29, DK-1017 Copenhagen K
ATP administers not only the ATP scheme but also a series of other labour market schemes, including the Special Pension (Særlig Pensionsopsparing, SP), the holiday money (FerieKonto) and the Labour Market Occupational Disease Fund (AES).

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

Center for Velfærdsstatsforskning - CWS - Centre for Welfare State Research, Department of Political Science, University of Southern Denmark
Address: Campusvej 55, DK-5230 Odense M
Phone: + 45 65 50 00 00
Webpage: http://www.sdu.dk/Om_SDU/Institutter_centre/C_Velfaerd.aspx

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

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

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

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

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

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

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

Det Økonomiske Råd – The Economic Council
Address: Amaliegade 44, DK-1256 Copenhagen K
Phone: +45 33 44 58 00
Website: www.dors.dk
The Economic Council is chaired by three leading macro economists, the so-called 'economic wise men' of which one is the 'economic over wise man'. The board consists of representatives from the social partners. However, it is the Secretariat of the Economic

Council which writes the biannual reports. These reports consist of two parts. The first part is always a survey of the economy and the second part is on a special theme.Both parts are accompanied by policy recommendations.

Etisk Råd - The Danish Council of Ethics

Address: Ravnsborggade 2-4, DK-2200 Copenhagen N
Phone: + 45 35 37 58 33
Website: www.etiskraad.dk

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

Finansministeriet - Ministry of Finance

Address: Christiansborg Slotsplads 1, DK-1281 Copenhagen K
Phone: + 45 33 92 40 88
Website: www.fm.dk

The Ministry of Finance is as elsewhere an important player and publish the national reform programme among other publications.

Forsikring og Pension - Danish Insurance Association

Address: Amaliegade 10, DK-1256 Copenhagen K
Phone: + 45 33 43 55 00
Website: www.forsikringogpension.dk

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

Frivillighedsrådet - Council for Volunteers and Volunteering in the Social Field

Address: Nytorv 19, 3. sal, DK-1450 Copenhagen K
Phone: + 45 33 93 52 93
Website: www.frivilligraadet.dk

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

Funktionærernes og Tjenestemændenes Fællesråd, FTF -FTF - Confederation of Professionals in Denmark

Address: Niels Hemmingsensgade 12, Postboks 1169, DK-1010 Copenhagen K
Phone: + 45 33 36 45 00
Website: www.ftf.dk

FTF is the trade union confederation for 450,000 public and private employees, making it the second biggest of Denmark's three main trade union confederations. Three out of four members work in the public sector. FTF has approximately 90 affiliated organisations. The five largest calculated by number of members are: The Danish Union of Teachers (Danmarks Lærerforening), The Danish Nurses Organisation (Dansk Sygeplejeråd), The Danish National Federation of Early Childhood Teachers and Youth Educators (BUPL), The Financial Services Union (Finansforbundet), and the Danish Association of Social Workers (Dansk Socialrådgiverforening).

HK Danmark - HK Denmark

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

Trade union of office workers

Institute for Quality and Accreditation in Health Care

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

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

Institut for Folkesundhed - The National Institute of Public Health

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

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

Kommunernes Landsforening - Local Government Denmark

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

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

Konkurrencestyrelsen - The Danish Competition Authority

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

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

Landsorganisationen i Danmark, LO - Danish Trade Union Confederation

Address: Islands Brygge 32 D, Postbox 340, DK-2300 Copenhagen S
Phone: + 45 35 24 60 00
Website: www.lo.dk

Danish trade union confederation.

Lægemiddelstyrelsen - The Danish Medicines Agency

Address: Axel Heides Gade 1, DK-2300 Copenhagen S
Phone: + 45 44 88 95 95
Website: www.dkma.dk

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

Ministeriet for sundhed og forebyggelse -Ministry of Health and Prevention

Address: Slotsholmsgade 10-12, K-1216 Copenhagen K
Phone: + 45 72 26 90 00
Website: www.sum.dk

Patientforsikringen - The Patient Insurance Association

Address: Nytorv 5, DK-1450 Copenhagen K
Phone: + 45 33 12 43 43
Website: www.patientforsikringen.dk

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

Patientklagenævnet - The Patients' Complaints Board

Address: Frederiksborggade 15, DK-1360 Copenhagen K
Phone: + 45 33 38 95 00
Website: www.pkn.dk

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

Patientskadeankenævnet - The Patients' Injury Appeals Board

Address: Vimmelskaftet 43, DK-1161 Copenhagen K
Phone: + 45 33 69 00 44
Website: www.patientskadeankenaevnet.dk

The Patients' Injury Appeals Board functions as a board of appeal for decisions made by professionals.

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

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

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

Statens Seruminstitut - State Serum Institute

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

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

Sundhedsstyrelsen - The National Board of Health

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

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

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

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

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

Velfærdsministeriet - Ministry of Welfare

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

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

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

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

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

3F, Faglige Fælles Forbund - 3F

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

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

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

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