Annual National Report 2009

Pensions, Health and Long-term Care

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1 Executive Summary

Policy developments in pensions, health and long-term care followed existing paths and principles from January 2008 to October 2008, most notably in trying to increase labour supply. Policy developments in the following eight months were influenced by the financial crisis and measures have especially tried to reduce the extent or effects of the financial crisis. Compared to other EU member states the extent of crisis and the policy responses is Overall developments in the three areas can be summarised as:

PENSIONS: No major changes has been made to the public pension from 2008 to April 2009: The Danish pension system consists of a relative modest national old age pension (folkepension), two supplementary funded pension schemes (ATP and arbejdsmarkedspensioner) and various individual saving vehicles. In addition there is a voluntary early exit scheme for insured persons (efterløn).

The retirement age in the national old age pension is currently 65 years of age and 60 years of age in the voluntary early exit scheme. A broad based coalition of political parties decided in 2006 to increase the retirement age in these two schemes with two years gradually starting in 2019.

The only minor change in 2008 was an increase of the personal pension supplement (that is part of the national of old age pension) from DKK 7,800 [1] in 2008 to DKK 10,300 in 2009 (to increase even more as to mitigate the effects of financial crisis for low income old age pensioners).

HEALTH: The general health care system is universal and publicly financed. Traditionally, the hospitals are public. However, one of the main trends is greater choice for patients between public and private hospital treatments and in the role for private hospitals. Sickness absenteeism was the perhaps biggest topic in the first half of 2008. To increase labour supply various measures have been introduced.

In the Spring of 2008 nurses and care workers in hospitals and long-term care institutions demonstrated for better and more equal wages in the public sector.

LONG TERM CARE: Denmark has the most comprehensive public system of free long-term care for elderly. Elderly have got still more choice between the type of long-term care and between providers of long-term care. Recruitment, i.e. lack of labour, is probably the biggest challenge for long-term care.

FINANCIAL CRISIS: The financial crisis and the economic downturn have resulted in increased unemployment and deteriorating economic situation of many households. The severity of the crisis is less than in many other countries due to a better starting point for Denmark with regard to its economic situation and multi-tiered pension system.

The Government has enacted a series of measures since October 2008, not least tax relieves and guarantees to the financial sector. The personal pension supplement has been increased marginally to soften the blow of the financial crisis on old age pensioners.

Rising unemployment have helped secure jobs in the public sector becoming more attractive vis-à-vis the private sector jobs. Larger segments of youth choose such educations as nurses and caring.

[1] EUR 1 is DKK 7.46 (annual average for 2008, source: http://www.nationalbanken.dk visited 27 May 2009 (Danish National Bank).

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

Denmark has been doing well since 1993 and also in the last few years. The economy has developed favourably with low unemployment, budget surpluses and falling budget deficits. The lack of labour in certain sectors was generally seen as the major problem that was exacerbated by adverse demographic developments in the years to come.

Lack of labour is probably also the main concern in the medium to long term, but an expected tripling of unemployment over only two years has revitalised concerns of unemployment and stagnant economic growth. The latest prognosis of the Government thus expects unemployment to go up from about 45,000 persons in 2008 to 145,000 persons in 2010 (FINANSMINISTERIET, 2009). However, the expected unemployment rate of 5% in 2010 is still being a far cry away from the 12.5% in 1992 or that of many other EU countries.

Politically, Denmark got a Liberal-Conservative government in 2001 that is still in power. Anders Fogh Rasmussen of the Liberal Party was prime minister until 5 April 2009, when he left to become Secretary General of NATO. Lars Løkke Rasmussen from the Liberal Party is now the Danish prime minister[2].

The Danish People's Party has proven to be a loyal supporter of the Liberal-Conservative Government. Important reforms – for example Structural Reform in 2006 and Spring Package 2.0 (including a tax reform) - have been decided upon with a small minority consisting of the Government and the Danish People's Party. Sometimes the disintegrative party, Liberal Alliance, has participated in the agreement. More often, however, the major opposition parties, especially the Social Democrats, but also the Social Liberal and the Socialist People's Party have been excluded.

Some reforms and political measures have in recent years been going through tripartite consultation with the social partners before being put into legislation and policies in parliament. This goes for example for recent initiatives to reduce sickness absenteeism, described below.

2.1 Pensions

The Danish pension system consists of a national old age pension (folkepension) in the first pillar, two supplementary pension schemes in the second pillar and a variety of individual saving vehicles in the third pillar.

The Danish national old age pensions in turn 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 63,048 annually or DKK 5.254 monthly (all amounts for 2009). The supplementary amount is DKK 29,640 annually or DKK 2,470 monthly. The supplementary pension benefit is DKK 10,300 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.

[2] From 1993 to 2001 it was a third Rasmussen, Poul Nyrup, of the Social Democrats who led various coalition governments.

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. During the negotiations in the autumn of 2008 the Government and the Danish People's Party agreed to raise the elderly cheque from DKK 7,800 in 2008 to DKK 10,300 in 2009 costing an estimated DKK 480 million.

The same parties agreed in March 2009 to raise the elderly cheque by DKK 2,000 in 2010 as part of the Spring Package 2.0 that seeks to address the financial crisis. Both the Government and the think tank of the labour movement, AE *Arbejderbevægelsens Erhvervsråd*, estimate the costs of this increase to be DKK 1 billion per year.

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 in 2006 there was introduction of a demographic adjustment of the retirement age so that increases in longevity in part translates into longer working life and do not exclusively contribute to longer time in retirement.

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).

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.

Thus, there was a pressure for many years for new supplementary pensions that paid out higher benefits. This resulted in 1990 a big expansion of supplementary pensions that were negotiated as part of collective agreements, i.e. varying across sectors on the labour market.

These supplementary pension schemes are 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.

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 covered 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 pertain into old age.

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 key to gender equalities for pensions. This has been found in repeated studies. Most recently, the ATP showed that gender differences are even growing despite more women entering work (ATP 2008).

For more information on the issue of private pensions and inequality and disincentives to work and save, see analysis of the Welfare Commission (Velfærdskommissionen 2006), the Economic Council (2008) and individual researchers (especially Amilon 2008, Jørgensen 2008).

The main challenge for private pensions in the current volatile financial market is undoubtedly to avoid huge losses.

The impact on work incentives from the increased prevalence of supplementary pensions schemes is not clear. On the one hand getting into and staying longer on the labour market result in higher pensions. On the other hand the existence of pensions may allow some people to leave the labour market earlier. The Economic Wise Men of the Economic Council have highlighted the complex incentive effects of the Danish pension system on saving and work and suggested ways to improve the design of the system in this regard, see below (Det Økonomiske Råd 2008).

Most recently, in the Spring 2008 the economic wise men of the Economic Council argued (1) that legislation should force everybody to make their own supplementary savings thereby covering also the residual without such coverage of about 5% of the population, and (2) that the supplement part of the national old age pension should be abolished as it would de facto be tapered away with other pension income for everybody (see Det Økonomiske Råd 2008). This scheme, they argue, give a better incentive structure to work and to save (see also Birch Sørensen et al 2008). However, this is a politically minefield and the Government have not taken any action in this direction.

As part of the crisis package, Spring Package 2.0 described in more detail below, there is, however, certain policy measures that may affect private pensions. Most notably there has been put a ceiling on the amount of tax privileged contributions that can be made, i.e. DKK 100,000 yearly.

2.2 Health

The Danish health care service can for practical purposes be divided into two sectors:

Primary health care and the hospital sector (this section draws on the booklet Health care in Denmark by the Ministry of Health, 2008).

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.

2.2.1 Financing

The Danish health care system is based on a principle of free and equal access for all citizens. Thus, the vast majority of health services in Denmark are free of charge for the users.

In 2005 the public expenditure constituted 84% of the total health expenditure and private expenditure constituted 16% of total health expenditure. Private health care expenditure mainly covers out of pocket expenditure for pharmaceuticals and dentistry. 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.

In 2005, Danish health care expenditures as share of GDP constituted 9.4%. This places Denmark above the average and above countries such as Sweden, The Netherlands, Norway, Finland and the United Kingdom.

Health care in the regions is financed by four kinds of subsidies: A block grant from the state (approx. 75%), a state activity-related subsidy (approx. 5%), a local basic contribution (approx. 10%) and a local activity-related contribution (approx. 10%).

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. For 2007, in accordance with the agreement between the Government and Danish Regions concerning the economy of the regions, 50% of the hospital budgets will depend on activity-related contribution.

Under the Health Care Reimbursement Scheme services are provided by self-employed professionals such as general practitioners, specialists, dentists, etc. who are licensed by the state. These services are provided in accordance with collective agreements between the regions and the relevant unions. Collective agreements include prices of individual services which are covered by the Health Care Reimbursement Scheme.

2.2.2 The hospital sector

The hospital sector is in the responsibility of the five regions. The regions must provide free hospital treatment for the residents of the region and emergency treatment for persons in need who are temporarily resident.

The obligation to provide its citizens with hospital treatment is fulfilled in the vast majority of the cases by the individual region's own hospital and to a certain extent by hospitals in other regions. Private hospitals are used to a certain degree, especially specialist hospitals which have an agreement with one or several regions.

The hospitals are responsible for specialised examinations, treatment and care of somatic and mental illnesses which it would not be more expedient to treat in the primary or social sector because of the need for specialist knowledge, equipment or intensive care and monitoring.

The principal framework for how the region provides hospital services is prescribed in a plan setting out the organisation and preparation of the regions' activities in the health sector.

The Ministry of Health and Prevention through the National Board of Health contributes to health care planning in the form of guidance and regulation regarding the basic and specialised treatment and functions within the hospital services and information on how different forms of treatment should be organised, including coordination of the different levels of treatment.

The regions are obliged to make agreements between themselves regarding the use of highly specialised departments with a view to ensuring the inhabitants equal access to necessary specialised treatment. This reflects the fact that the individual region cannot be expected to cover all hospital treatment in its own hospitals.

Furthermore, the regions may, after the authorisation of the National Board of Health, refer patients to highly specialised treatment abroad paid for by the state. The regions also have the possibility of referring patients to approved hospitals abroad and paying for the services themselves.

Apart from treating illnesses, the hospital service gives diagnostic support to the practice sector in the form of laboratory analyses and scanning and X-ray diagnoses etc. Furthermore,

another important element is the hospitals' state of readiness in that an appropriate number of hospitals are generally manned around the clock in order to deal with acute illnesses and accidents.

The hospital service plays an important role regarding the training of staff for the entire health care service and in the field of research; and it is normal in the hospital service that research results are put into clinical practice.

The hospital service is expected to coordinate closely with the primary sector regarding both the admission of patients and the discharge of patients back to the primary health care sector and the social sector (rehabilitation, care). The legislation prescribes formal coordination between the regional councils and the municipalities in the different regions.

2.2.2.1 Freedom of choice

Since 1 January 1993, citizens who are in need of hospital treatment have the possibility, within certain limits, of choosing freely which hospital they wish to be treated in. The citizens may choose among all public hospitals which offer basic treatment and a number of smaller, specialist hospitals owned by associations which have agreements with the regions. If a citizen after a medical evaluation is judged to need treatment on a specialist level, he has a further choice between hospital departments which offer treatment on a highly specialised level.

From 1 July 2002, the citizens may choose among private hospitals or clinics in Denmark or abroad if the waiting time for treatment exceeds two months and the chosen hospital has an agreement with the regions' association regarding the offer for treatment. From 1 October 2007 this waiting time was reduced to one month.

2.2.2.2 Specialisation and the future hospital structure

With the local government reform the National Board of Health has been bestowed with increased leverage regarding the planning of specialist functions. There is an on-going process in which the National Board of Health – in a continuing dialogue with the medical associations and the regions – are formulating new and revised standards regarding the basic treatment and regulation regarding specialist treatment (specialised and highly specialised treatment).

This planning, which also involves the planning of emergency functions, will undoubtedly result in changes in the hospital structure. This development is part of an international and national trend towards more specialised and thus qualitatively improved treatment.

2.2.3 Treatment and subsidies

The general practitioners occupy a central position in the health service. This is due to the fact that general practitioners are the patients' primary contact with the health service. The general practitioner must ensure that the patient is given the right treatment and sent to the right professionals in the health service. The general practitioner is thus the coordinator and the person with professional responsibility for referring patients to hospitals, specialists and other professionals. There are about 4,100 general practitioners, who take part in the collective agreement with the public health care scheme. Each general practitioner has about 1,300 patients.

The public health care scheme pays for all or part of the treatment given by specialists. There are approx. 1,200 practising specialists with agreement under the public health care scheme.

All residents in Denmark are free to choose their own dentist. There are approx. 4,600 authorised dentists. Around 2,500 dentists take part in the collective agreement with the public health care scheme. For those who are 18 years or older, the public health care scheme partly pays for preventive and other dentistry treatment. Reference from a general practitioner is not required. Children under the age of 18 receive free dental care. Furthermore, there are special arrangements, with limited user payment, for those who due to low mobility or mental or physical disability have difficulties using the ordinary public dentistry services.

There are approx. 2,100 physiotherapists. The public health care scheme partly pays for treatment by physiotherapists, but persons who have serious physical disabilities due to illness may receive physiotherapy free of charge. The treatment is only subsidised if it has been prescribed by a general practitioner.

The public health care scheme partly pays for treatment by chiropractors. It is not necessary to be referred by a general practitioner in order to receive a subsidy. There are approx. 300 chiropractors who have an agreement with the public health care scheme.

All citizens in a municipality are entitled to home nursing. When prescribed by a general practitioner, the municipalities must provide home nursing free of charge. Moreover, the municipalities are obliged to provide all necessary appliances free of charge. Home nursing provides treatment and nursing at home for people who are temporarily or chronically ill or dying.

The municipalities offer rehabilitation free of charge for persons who are discharged from hospital when the requirement for rehabilitation is well-founded from a medical point of view.

The public primary health care service also subsidises treatment by a chiropodist to patients suffering from diabetes and patients suffering from severe chronic polyarthritis.

Treatment by psychologist in the primary sector is subsidised for particularly endangered groups of persons.

Children under the age of 16 needing glasses will receive a subsidy. It is not necessary to have a referral from a general practitioner.

When a person dies who had the right to public health care services prior to death, the municipality will pay a funeral grant. The funeral grant is calculated according to the financial circumstances of the diseased person if he/she was aged 18 or above.

2.2.4 Medicine

Most medicine is sold by pharmacies which are authorised by the state. It is the Ministry of Health and Prevention which decides the number of pharmacies and where they may be situated. There are approx. 300 pharmacies. Some OTC products (over the counter; medicines which can be bought without a prescription) are sold in shops which have been approved by the Danish Medicines Agency.

According to the Danish Health Care Act a general reimbursement is granted for the costs of medicinal products which have been authorised for reimbursement by the Danish Medicines Agency. In general, reimbursement is granted for medicinal products which have a certain and valuable therapeutic effect when used on a well-defined indication. Furthermore, the price of a given medicinal product must be proportionate to the effect of this product.

All reimbursable medicinal products have an equal status from the point of view of reimbursement. The reimbursement system is based on individual needs, and the reimbursement rate for reimbursable medicinal products depends on a given patient's prior consumption of medicine within a reimbursement period of one year.

The reimbursement will be calculated on the basis of the price of the cheapest medicinal product among the different products with the same effect and the same active ingredients. The pharmacy is obligated to give patients the cheapest product, unless the price difference is negligible. Only if the doctor makes a specific note on the prescription, the pharmacy will give the patient a more expensive medicinal product.

If a patient is chronically ill, the patient may incur very large expenses for medicine. A ceiling is put on the patient's expenses if the patient is granted reimbursement for the chronically ill by the Danish Medicines Agency.

Dying patients who choose to spend the remainder of their life in their own home or in a hospice should not be left in a worse position than patients remaining hospitalised.

2.2.5 Preventive health care and health promotion

Over the last 10-15 years, preventive health and health promotion have been given a higher priority in Denmark. This is due to recognition of the fact that lifestyle related diseases like cancer and cardiovascular diseases are dominating the pathological picture today. Only a limited part of total preventive health care and health promotion lies within the health sector and thus with the central health authorities. Developments in the environment, the working environment, the housing sector, traffic, safety and product safety (and more indirectly in the educational and social sector) are of great importance to the general health status of the population.

Policies and initiatives either supported or put forward by the Government since 2002 have been part of the Government's public health and disease prevention programme "Healthy throughout Life". The programme is based on the targets of the former government's programme and will maintain a clear focus on the risk factors – tobacco, alcohol, accidents, eating habits, and too little physical activity - but will, furthermore, broaden the scope to also include preventive treatment of the major preventable diseases, e.g. asthma, allergies, diabetes, cardiovascular diseases and osteoporosis. One of the aims of the programme is enhanced quality of life, also for the elderly and for people with chronic diseases. The programme stresses the responsibility of the individual, but also underlines that the individual must be able to make well-informed choices. The programme enhances the role of the civil society – the social networks, the workplace, private organisations etc. Lifestyle cannot be changed without regard for the social context in which people live.

With its extensive reorganisation of the public sector and the new health legislation The Government has given the municipalities the primary responsibility for preventive health and health promotion from 2007. The Government, thereby, aims to use the already established and close contact between the municipalities and the citizens as well as the large amount of knowledge about local conditions to make preventive health and health promotion more effective.

As part of the new Government platform 2007 the Danish Government launched two new initiatives to follow up on "Healthy throughout life". Firstly, in January 2008 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. Secondly, the Government will publish a new public health and disease prevention

programme in 2009 including clear aims for the future effort on the background of the committee's recommendations.

The committee delivered its recommendations in April 2009 on how health promotion and disease prevention in Denmark can be improved. 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.

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.

In 2008 the age limit for selling tobacco to persons was lifted to the age of 18.

Since 2007 prevention and health promotion are primarily the responsibility of the municipalities.

A number of preventive health schemes are available to people resident in Denmark free of charge.

Persons aged 65 years and above and from 2007 also persons with some chronic diseases and persons, who have taken early retirement, can be vaccinated against influenza, free of charge. The costs are covered by the regions.

2.2.6 Quality improvement

To create a more transparent and accountable public sector as well as to improve the quality of health care a number of initiatives have been launched. The regions being the primary health care providers have also traditionally been the starting and focal point of quality management initiatives. However, in 2001 it was decided to introduce the Danish Quality Model – an initiative designed to integrate and systematise existing quality initiatives. A central goal is the accreditation of all hospitals according to general standards for optimal patient treatment and flow. Subsequently, the model will be applied to private practitioners, municipal health service, and pharmacies as well.

The Danish Institute for Quality and Accreditation in Healthcare has been established to create Danish standards and indicators and to conduct the accreditation of Danish health care. The basis for the evaluation will in the first place be the following three categories: A general category which covers e.g. medication and information of patients, an organisational category covering e.g. hygiene and quality management, and lastly a category for specified diseases.

Data generated through the Danish Model has to be made available to health professionals and the general public. This transparency will help set high standards in the health care system and provide patients with information they can use when choosing among hospitals. The National Indicator Project, which is integrated into the Danish Model, has already made available data on treatment of selected disorders, e.g. apoplexy, lung cancer and schizophrenia.

The results are available on the integrated web portal for health matters in Denmark https://www.sundhed.dk/ which serves both professionals and the general public. On the web portal citizens can, by using a digital signature, view their own medical record (treatment at hospitals) and the prescription medication they have purchased.

In 2006, the National Board of Health and the former Ministry of the Interior and Health launched the website http://www.sundhedskvalitet.dk/. The aim of the website is to communicate information on quality and service at the different hospitals. The information must be easy to comprehend for the citizens and should also help the citizens when choosing a hospital.

The website has information on both the clinical quality, e.g. information on the number of complications, on the quality experienced by patients expressed through national surveys of patient experiences, and on the organisational quality, which among other things expresses the standard of hygiene and the hospitals' observance of agreements.

On the website patients can compare information on different hospitals. For a number of treatments it is possible to see how the different hospitals are placed in relation to each other and compared to the national average, by choosing information on length of stay in hospitals, number of rehospitalisations, waiting time for treatments, hygiene, etc.

Every second year the Danish Regions and the Ministry of Health and Prevention conduct a survey of the patients' experiences in hospitals. The objective of the survey is to compare patient experiences at hospital level and at medical specialities level. Also, it is the aim to compare patient experiences over time. The survey includes questions on clinical services, patient safety, patient and staff member continuity, co-involvement and communication, information, course of treatment, discharge, inter-sectoral cooperation, physical surroundings, waiting time and free hospital choice. The survey made in 2006 showed that the patients' overall impression of the hospitalisation process is positive. It also showed areas where the patients experience a potential of improvement.

To improve patient safety and health care a national reporting system for adverse events was established in 2004. The reporting system aims to collect, analyse and communicate knowledge of adverse events in order to reduce the number of adverse events in the health care system.

The National Board of Health runs the register for adverse events. After receiving the analysed and anonymised reports from the regions, the National Board of Health looks for common patterns and trends and provides feedback and knowledge to the regions regarding specific risk situations. The information is distributed by the National Board of Health in newsletters, alerts and reports on specific subjects, for example medication errors. Furthermore, the National Board of Health publishes an annual report on overall issues and results. All publications are available on the website http://www.dpsd.dk/.

The number of reports has increased from 5,740 in 2004 to 15,556 in 2006. The increase probably reflects that the reporting system has become known and accepted by the health care professionals, and that a change of safety culture has taken place focussing on the potential of learning from adverse events.

In 2006 an evaluation of the system showed that generally the reporting system worked well at local, regional, and central level. However, the evaluation also showed that not all adverse events are reported, and different reasons were mentioned. Some professionals are unsure of the definition of an adverse event and others pointed at the lack of time and resources. The evaluation showed a wide support of the expansion of the reporting system to cover adverse events occurring in the primary health care sector, including the pharmacies, and to facilitate patient reporting to the system. As a result of the evaluation an expansion to the primary

health care sector and to patients and their relatives is planned to take place during 2009. After this expansion the reporting system of adverse events will cover all sectors of the health care system.

In an international perspective, health status in Denmark can generally be characterised as good. Surveys show that the population continues to consider their own health as being good. The Danish life expectancy is rising again after a period of stagnation in the '80s. Since the mid-90s the Danish life expectancy has been improving although still being behind the EU average mainly because the health status of women which is lagging behind. Thus, mortality, especially among the 35- to 64-year old women, has been higher in Denmark. Middle-aged women in Denmark have a 40 to 50% higher mortality rate in comparison with the other EU countries. Especially the development in the incidence of cancer amongst women (breast cancer and lung cancer) gives cause for concern. However, cardiovascular diseases and alcohol-related diseases in women have also contributed to accentuating this development. The development of the mortality rate amongst Danish men is parallel with that of men in other EU countries.

Though it is the most common cause of death in many EU countries, mortality as a consequence of cancer has decreased over the last decade. Like in many other EU countries there has been a significant fall in the mortality rate due to cardio-vascular diseases in Denmark over the last 20 years. Mortality due to cardiovascular diseases decreased by 36% from 1994 to 2005 when 202 out of 100,000 inhabitants died from cardiovascular diseases in compared to an EU average of 273. Mortality caused by diseases in the respiratory system decreased by 15% from 1994 to 2005 when 61 persons out of 100,000 died compared to an EU average of 48.

Research into morbidity shows that nearly 40% of the adult population had at least one prolonged illness (defined as six months or more) in 2005 compared to 32% in 1987.

The most common of the prolonged illnesses are muscular and skeletal diseases, cardiovascular diseases, diseases of the respiratory organs, neural diseases and sensory diseases.

Looking at illness on the shorter term, the most common complaints and symptoms during a 14-day period were pains or aches in the neck or the shoulders; pains in the limbs, hips or joints; pains or aches in the back or the small of the back; tiredness; headaches; sleeping problems; and colds, head colds or coughing in 2005.

The level of activity at Danish hospitals shows that there has been a change in the pattern of illnesses over the past years. More and more people develop cancer; 8.1% of all discharges at the somatic hospitals were cancer related in 2007. Three common cancers are: cancer in stomach and intestines (18.1% of all cancer discharges); breast cancer (10.3% of all cancer discharges); cancer in lung and bronchi (9.5% of all cancer discharges). Disregarding births, the second most dominant illness treated at hospitals are musculoskeletal diseases. Other dominant diagnoses are ischemic heart diseases and chronic diseases of the respiratory passages.

The sustainability of the health care system is discussed heavily, although perhaps not so much in economic terms as in terms of too little qualified staff. Many analyses have shown that the ageing population involves a double challenge for health and long term care. Fewer people will have to care for more persons. For example, professor of health economics, Kjeld Møller finds that the Danish health care system by 2015-2020 will be missing 5,000-6,000 nurses, 5,000 social – and health assistants, 2,000 doctors and 2,000 other staff (Møller-Pedersen 2008).This equals 12-15% of currently employed staff in the health sector. Taking

account of the increased demand for more health care, Møller-Pedersen (2008) finds that the health care sector will lack of 20% of its staff in 2020.

2.2.7 Sickness benefit and labour supply

Sickness benefits (sygedagpenge) is the main benefit to employees, including persons in flexjobs (subsidised jobs), self-employed, and insured unemployed who are temporarily incapable of working due to sickness. The employer pays the sick-listed person the benefit, or normal wage, during the first 21 days. The municipality pays out the benefit after 21 days or reimburse the employer. Chronically ill receive benefits from the municipality from day one. Thus, employers do not have any costs to sickness benefits to chronically ill employees. Small and medium sized companies can insure themselves so that they are entitled to reimbursement after the second day of sickness. A similar scheme exists for self-employed.

The maximum sickness benefit period is 12 months. Having exhausted the maximum period the sick-listed will be assessed to determine whether they are eligible to a flexjob or a disability pension (førtidspension). However, in order to prevent such persons from loosing their means of subsistence the Government, the Danish People's Party and the Liberal Alliance agreed 1 April 2009 to make it possible to extend the maximum sickness benefit period with up to 26 weeks (effective as of 6 Juli 2009).

Reducing sickness absenteeism is one of the most important ways of increasing labour supply in Denmark, as, for example, witnessed by the white paper "To reduce sickness absenteeism" from June 2008 (REGERINGEN, <<Sygefravær - en fælles udfordring>>).

The attempt to reduce sickness absenteeism has resulted in a series of policy changes and other initiatives as well as research. Recent changes of the sickness benefit legislation were evaluated in 2008. In 2005 the sickness benefit act changes included (1) obliging municipalities to collect information on the sick-listed using a questionnaire, (2) visitation of sick-listed into three categories (i.e. smooth cases, risk cases and long term cases), (3) case-worker has follow-up talk with the sick-listed within 8 weeks in all cases, (4) more intense follow up in risk cases (i.e. more frequent and demand on personal show up), (5) new medical declaration, (6) increased emphasis on longer working lives, (7) better coordination between municipalities, doctors and companies, (8) increased use of other actors in relation to the follow up on sick-listed. The analysis show that the municipalities have held more follow-up talks and that these have more focus on getting back to work (Høgelund et al 2008).

The social partners and the Danish Government entered a tripartite agreement on sickness absenteeism 29 September 2008. They agreed on 39 proposals for initiatives under four headings: Prevention of sickness absenteeism (9 proposals), early intervention (13 proposals), activation during sickness (12 proposals), and better coordination between health and employment policies (5 proposals).

As part of the Budget negotiations for 2009 the parties behind the Job Plan 2008, i.e. the Government, the Danish Peoples Party, the Social Liberals and the Liberal Alliance approved this tripartite agreement on the 5 November 2008 and allocated DKK 170 million to 39 initiatives. In total the agreement and initiatives are expected to raise labour supply by 4,000 persons.

The rationale for the agreement on sickness absenteeism was obviously to increase labour supply because of labour shortages that are to become worse with ageing populations. However, the financial crisis has reversed fortunes on the labour market. Although still at low levels, increasing unemployment may adversely hit potentially sick more than more healthy persons and thereby reduce the potential of the initiatives to reduce sickness absenteeism.

2.3 Long-term 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 municipalities. The local government reform that came into force 2007 established 98 local authorities (previously 273) giving larger units to design long-term care.

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.

2.3.3 Quality of care

The quality of care, especially for elderly, is a political hot potato. Elderly care is heart blood for both the Social Democrats and the Danish People's Party. The Government has launched a so-called Quality Reform of the public sector. The reform is comprised of some 180 initiatives, many of those concerned with elderly care described in the National Strategy Report 2008 for Denmark.

The opposition, most notably the Social Democrats, Social Liberals and Socialist People's Party, argue that better quality also entails wage increases of care workers. Indeed quality of elderly care and how to recruit qualified care workers in the future was a prominent issue during the election debates in 2007. This led long-term care staff to believe that such words of praise for care workers could be cashed in. However, the Liberal-Conservative was not willing to meet the demands of the trade unions. Massive strikes among long term care staff (and health care staff) followed in the Spring 2008, but did not lead to higher wages. This was a major disappointment for the care workers.

2.3.4 Sustainability

With the ageing population the expenditure on long-term care is expected to rise from currently about 1.1% of GDP to 2.2% of GDP in 2050 compared to an expected EU average of 1.5% of GDP.

2.3.5 Statistics

In 2007, persons in residential care received help 19.5 hours per week in average. 17.5 hours were personal care and 2 hours were practical help (Danmarks Statistik 2008). Persons living in their own home, including elderly housing, receive on average 3.7 hours help per week, of which 2.9 hours are personal care and 0.8 hours are practical help.

The amount of care increase with the age of the care receiver; fewer younger elderly receive less care than older elderly. More than half of persons (52%) above 80 years of age receive home help, i.e. 116,000 persons above 80+ years (Danmarks Statistik 2008a).

In total 207,000 persons receive long-term home help, including 41,000 living in residential care (Danmarks Statistik 2008a).

However, the extent of home help received varies tremendously. 106,000 persons – or 51% of all recipients – receive less than 2 hours per week. 26,000 persons receive more than 20 hours of help per week (Danmarks Statistik 2008a).

There are 75,000 persons living in residential care and housing for elderly (Danmarks Statistik 2008b). 70,000 of these persons are above the age of 60 years.

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 (Danmarks Statistik 2008b).

Long-term care is a major area of employment in Denmark. 103,000 full time persons work with care for the elderly in the municipalities (Danmarks Statistik 2009). 86% are care workers, 10% work with cleaning and cooking and 4% are managers and administrative staff.

2.3.6 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.

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 2009.

2.3.7 Studies

Free choice has been one of the main priorities of the current Government since it got into office in 2001. Already in 2002, the Government together with the Social Democrats passed an act that gave more free choice in elderly care.

In a couple of studies and publications professor Jørn Henrik Petersen has expound the problems of the extent to which free market principles like free choice can be sensibly be applied in the area of elderly care (Petersen 2008a, 2008b). Basically, he argues that care cannot be compared to other goods, that persons in need of care cannot exercise choice like in other markets and that the market of care is not perfect in terms of information, number of providers etc.

Another critical study by professor Asbjørn Sonne Nørgaard and colleagues focused on the trend towards more auditing in long-term care (Nørgaard et al 2008). When scandals of care failure hit the front page, the policy response is often to increase the monitoring, documentation or to introduce new procedures. Auditing is in other words an insurance type mechanism for politicians at the national and local level to safeguard them against becoming 'responsible' in cases of care neglect. However, Nørgaard and associates show in a qualitative study of three larger municipalities with different approaches to auditing and managing of care workers, that the popularity of the auditing trend is divided. Politicians and care managers tend to like the auditing where all the documentation makes glossy reports and show signs of action. Care workers, on the other hand, complain that time on documentation goes away from actual care work and that auditing takes away motivation for caring. Care workers prefer monitoring with feed-back on how their work may become better. Finally, the elderly themselves also express dissatisfaction with the increased time spent on standard procedures and documentation.

The quality of elderly care has been analysed. Two researchers, Rostgaard and Thorgaard (2008), has made a survey among 683 elderly, 185 visiting case officers and 557 care workers about their understanding of what sort of quality is good for whom. All groups agree that quality in elder care is first and foremost about how elderly meet care personnel that should be kind and show respect. The elderly give a higher priority to cleaning than care workers. Visiting case officer differ on several points from both the elderly and the care workers. Thorgaard and Hougaard (2008) have made a small scale evaluation of the development of new methods among care workers to increase the quality of their work.

The trade association of non-life and life insurance and multi-employer pension funds in Denmark, Danish Insurance Association (Forsikring og Pension), argue that there is a large private insurance market for long-term care. The Danish Insurance Association commissioned a consultancy firm to write up a report on the past and possible future role of private health insurance (COPENHAGEN ECONOMICS, *Sundhedsforsikringer - En løsning på fremtidens velfærd?*). In the report the authors argue that there is market for private health insurance especially in relation to long term care and that this may not only provide more choice for the elderly but also relieve the public sector for some pressure.

3 Impact of the Financial and Economic Crisis on Social Protection

The financial crisis hit the building sector already affected in the Spring of 2008, but it was not until the Autumn of 2008 that the crisis seriously spilled over into other sectors and the political debate.

Like other countries the Government in Denmark has since October 2008 made a variety of crisis packages or measures to reduce the scope of the financial crisis or its effects. Like in most other countries there is not a national consensus on what to do when and to what extent. The Danish Government have with the help of the Danish Peoples Party introduced tax relieves for about DKK 10 billion in 2009, agreed on an expansive budget for 2009, have passed two crisis packages specifically for the banks (i.e. Bank Package I and Bank Package 2.0), public investments in infrastructure and Spring Package 2.0.

Especially Spring Package 2.0 is of interest to social protection as it involves certain measures directly related to social protection policies:

- the personal pension supplement was raised by DKK 2,000 to improve the financial situation of low income old age people
- a tax reform entailing lower marginal tax rates and a broader base, including
- ceiling on tax privileged contributions to private pensions of DKK 100,000 to increase the tax base

The opposition in Parliament, including the Social Democrats (Socialdemokraterne), the Social Liberals (Radikale Venstre) and the Socialists (Socialistisk Folkeparti) has criticised these measures for being either too late, too small or plainly wrong.

Also trade unions have heavily criticised the Government for not doing enough and for doing the wrong things. For example, the president of the trade union 3F (Fagligt Fælles Forbund), Poul Erik Skov Christensen, noted that Spring Package 2.0 would create five time as many jobs if the Government replaced their tax relieves with renovations of schools, nursing homes and other institutions. The vice president of the Danish Federation of Trade Unions (LO), Lizette Risgaard, added that the Spring Package 'is inadequate compared to the rises in unemployment we are currently witnessing'.

To ensure stability for policyholders and the market for mortgage bonds the Ministry of Economic and Business Affairs and The Danish Insurance Association entered into an agreement 31 October 2008 (Aftale mellem Økonomi- og Erhvervsministeriet og Forsikring & Pension om finansiel stabilitet på pensionsområdet). The agreement includes temporary adjustment of the discount rate for calculation of technical provisions and stronger demands on consolidation. Pension and insurance companies are also allowed to temporarily recognise the Danish mortgage rate in the discount rate applied when calculating technical provisions. The agreement aims to prevent policyholders and house owners to suffer unnecessary losses due to the financial crisis.

As part of the Spring 2.0 Package, that is to address the financial crisis, the Government and the Danish Peoples Party agreed to put a ceiling of DKK 100,000 annually on the amount of tax privileged contributions that can be made to private individual saving accounts (ratepensionsordninger) that are part of the third pillar in the Danish pension system. The purpose is to raise more taxes to finance tax relieves in other areas. The value of the measure

is estimated at DKK 1.1 billion annually by both the Government and the think tank of the labour movement, AE Arbejderbevægelsens Erhvervsråd (AE 2008, Fordelingseffekter af aftale om forårspakke 2.0, 6 March).

Also as part of the Spring 2.0 Package Danes were allowed to take out the Special Pension (Særlige Pension, SP) prematurely from June 2009. An estimated 1.6 million Danes – more than half the Danes between 25 and 65 years of age - is expected to withdraw DKK 25 billion from June to December 2009 (ATP, 2009).

The rationale of the current Government strategy of fence-sitting is probably twofold. First, the Government wants to see what the effects will be of the measures described above as well as get a better understand of how deep and long the crisis will get. Second, the Government do not want to completely empty their toolbox of interventions as that would make the small country vulnerably to speculations against the Danish currency, the Kroner.

3.1 Economy

The public budget gave a surplus of 3.6% of GDP in 2008. According to the most recent Government Report by the Ministry of Finance, public finances run a budget deficit of 1.3% in 2009 and 3.3% in 2010 (FINANSMINISTERIET, 2009). Higher unemployment will increase expenditures to social security and the economic downturn will decrease revenues from personal income taxes, VAT and duties. Also the political measures made in the Spring of 2009, described above, result in more expenditures just as the tax reform agreed on in the Spring of 2009 will result in fewer revenues during the first few years.

GDP is expected to fall by 2.5% in 2009 and increase with 1% in 2010. Unemployment will rise to 3.5% in 2009 and 5% in 2010. However, the Ministry of Finance acknowledge the uncertainty of their prognosis. If the financial crisis prolongs or gets deeper an alternative scenario with GDP falling in both 2009 and 2010 predicts unemployment reaching 6% in 2010 and public deficit 5% of GDP (FINANSMINISTERIET, 2009).

Public debt is estimated rise from 11.25% of GDP in 2008 to 16% of GDP in 2009. Corrected for loans in connection with the financial crisis the public debt would increase from 11% in 2008 to 12.2% in 2009 (FINANSMINISTERIET, 2009).

Increasing public deficits and public debt constitute a u-turn in public finances. Over the last ten years of more Denmark has managed to use public surpluses to reduce public debt. The economic downturn and the various crisis packages and the underfinanced tax reform changed this practice.

There is no sector specific analysis of the impact of the financial crisis on pensions, health care or long-term care. However, a few general observations can be made.

3.2 Pensions

The impact of the financial crisis and the severe economic downturn have a mixed impact on the Danish pension system.

The national old age pension will due to small wage increases and low inflation at the moment be indexed only marginally in the next few years. Thus, old age pensioners will maintain their relative position in society but also share the general reduction in the increase of wealth that Danes have become accustomed to. However, the Danish Peoples Party has over the last six months managed to increase the pension supplement from DKK 7,800 in 2008 over DKK 10,300 in 2009 to around DKK 12,300 in 2010 thereby softening the blow from the financial crisis on low income old age pensioners.

However, the financial crisis will affect the majority of coming pensioners as Danish supplementary pensions in the second pillar are sensitive to not only the labour market record of the individual (i.e. contributions made) but also the market performance of the pension fund manager (i.e. return on contributions).

Most vulnerable to the financial crisis and the economic downturn are the savings made in the third pillar. Here the general pooling of risks is the smallest and the investment perspective the shortest. Especially persons having made savings to become retired in these years have often suffered immense losses.

3.3 Health

To the extent that actors, like employers, are rational they will keep the most productive employees and get rid of the least productive in times of lay-off. To prevent such rational behaviour one can have policies like employment protection legislation or economic subsidies. In Denmark, there is little employment protection legislation for individuals and only negative economic subsidies inherent in the relatively long employer financed period of the first three weeks of the sickness benefit period. Thus, the economic downturn may indeed result in the persons with the longest records of sickness being the ones that will disproportionately become fired.

At the same time, the health care sector may benefit from the current crisis on some dimensions. Most acutely, the crisis may help get more people to apply for jobs as nurses and doctors, see the general argument elaborated below in the section on long-term care.

Being disabled does not automatically exclude you from the labour market in Denmark, but is dependant on both micro-level factors about firms and individual as well as macro-economic and demographic factors. Indeed the positive economic developments from 1993 until the financial crisis in October 2008 witnessed a surge of persons with handicaps getting into work. With an economic downturn one may fear that this trend will reverse. However, due to the ageing population there is likely to be a potential labour shortage on the medium to long term and thus employers may remember the feasibility of employing persons with handicap even in economic bad times.

3.4 Long-term care

The financial crisis leads to more unemployment and more uncertainty about job security. Stereotypically, the Danish public sector is often perceived as offering secure, but less well

paid jobs. Similarly, the private sector is perceived as offering less secure, but better paid jobs than the public sector. Uncertainty about the future may lead more young people to apply for jobs in the public sector than would have been the case without the uncertainty caused by the financial sector.

Paradoxically, the financial crisis may help the public sector, including long-term care, to recruit more people. And recruitment of people is probably the biggest challenge facing long-term care due to the retirement of very many social and health assistants in the medium term.

However, long-term care is not immune to the financial crisis. When municipalities lack revenue due to higher unemployment they will have to take a stricter view on their expenses and long-term case is such a major budget item that it is likely also to be cut.

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.

[R] ARBEJDERBEVÆGELSENS ERHVERVSRÅD, <<Fordelingseffekter af forårspakke 2.0>>, 27 February, 2009, Copenhagen.
"Distributional effects of Spring Package 2.0"

The think tank of the labour movement analyse the distributional effects of the Spring Package. The analysis is based on a well-established micro-simulation model also used by the Government (Lovmodellen) that covers a sample of 10% of the population.

[R] ARBEJDERBEVÆGELSENS ERHVERVSRÅD, <<Regeringens forårspakke 2.0: Store forskelle i gevinster>>, 6 March, 2009, Copenhagen.
"Spring Package 2.0: Big differences in who gains"

The think tank of the labour movement analyse the distributional effects of the Spring Package.

[R] ARBEJDERBEVÆGELSENS ERHVERVSRÅD, <<Regeringens forårspakke 2.0 giver mest til mænd>>, 7 March, 2009, Copenhagen.
"Spring Package 2.0 gives more to men"

The think tank of the labour movement analyse the gender distributional effects of the Spring Package.

[R, R2, R5] AMILON, Anna <<Danskernes forventninger til pension>>, 2008, Copenhagen: SFI – The Danish National Centre for Social Research.
"Danes' expectations to pensions".

Based on a survey with 9,500 persons covering eight cohorts between 1920 and 1955, economist, Anna Amilon, investigates whether current pensioners are satisfied with their economic situation and whether current working active have realistic expectations to their future pensions. Although 70% of the working active are satisfied with the information they receive about their pension, the researcher nevertheless finds that the information is not sufficient or intelligible as there are great discrepancies between people's expectations and calculated consumption possibilities as pensioners. Because knowledge increase with educational level and since the study suffered from a bias with more middle and high income groups answering than low income groups we can expect that the problem of financial literacy is even greater than found in the report of Amilon.

[R, R2] DET ØKONOMISKE RÅD <<Dansk Økonomi, forår 2008>>, Copenhagen: The Economic Council, 2008. Danish language report downloadable from http://www.dors.dk/sw1596.asp.
"Danish Economy, Spring 2008"

The Economic Council has a special chapter on pensions in the Spring report. The Council analyse the development of private pensions and its impact on adequacy as well as incentives to work and save.

[R, R2] FORSIKRING OG PENSION, <<Konkurrencen om pensioner 2009>>, Forsikring og Pension Analyserapporter 2008, 7 April 2008.
"Competition about pensions 2009"

This report is made by the trade association of non-life and life insurance and multi-employer pension funds in Denmark, Danish Insurance Association, DIA (Forsikring og Pension). The DIA report can be seen as a reply to the report of the Konkurrencestyrelsen from 4 February 2009 which found that there was limited competition in the pension sector. In contrast, the DIA report finds strong competition in the area of life and pension insurance. Administrative costs have fallen and the range of consumer choices has increased over the last five years. The report acknowledges that most customers have not got individual rights to change pension funds because the market is dominated by compulsory schemes. However, this is not seen as hampering competition. DIA argues that the collective pressure stemming from the possibility of whole sectors in collective agreements shifting pension fund administrators makes such companies compete both on quality and price. Limited financial literacy inhibits customers from making full use of the tools made available by DIA, among others. Finally, surveys of customers show that particularly young persons show little interest in their pension savings.

[R, R2] JØRGENSEN, Michael <<Danskernes indbetalinger til pension - Hvordan påvirker tilknytningen til arbejdsmarkedet de fremtidige pensioner?>> Copenhagen: SFI – The Danish National Centre for Social Research, 2008.
"Danes' payments to pension - How does labour market participation influence future pensions?"

Economist Michael Jørgensen first shows how much Danes have paid into pensions - private voluntary individual pensions and private compulsory supplementary pensions agreed in collective agreements. Then he analyse the role of being part of the labour market on the old age pensions that are likely to be paid out in the future.

[R, R2] KONKURRENCESTYRELSEN, <<Konkurrenceredegørelsen 2008>>, 4 February 2009. "Yearly Report on Competition 2008, with a chapter on competition on pension"

This report is made by the independent public authority, Konkurrencestyrelsen (Danish Competition Authority), which is responsible for monitoring competition. One chapter examined the private pension market and found that it suffered from problems primarily because customers, i.e. insured, have few, if any possibilities to freely choose their pension fund manager. This is because the bulk of pension schemes are compulsory schemes that are negotiated as part of collective agreements. Thus, it is not individuals, but rather trade unions, that on behalf of their members decide which fund administers the savings.

[R, L] PETERSEN, Jørn Henrik <<Velfærd for ældre – holdning og handling>>, Odense: Syddansk Universitetsforlag, 2008b. 'Welfare for the elderly - values and policies'

In this volume, Professor Jørn Henrik Petersen situates an evaluation of home help for the elderly in Denmark in a more general analysis of the historical development of social policies for the elderly, including pensions, institutional care and home help.

[R, R1] TOWERS PERRIN, <<Financial literacy and transparency initiatives and tools in life and pensions>>, Forsikring og Pension Analyserapport 2008:6, 4 November 2008.

This report is commissioned by the trade association of non-life and life insurance and multi-employer pension funds in Denmark, Danish Insurance Association, DIA

(Forsikring og Pension). On the background of a greater emphasis on private pensions and life insurance this report examines how different countries handle demands for greater financial literacy and access to suitable information with a view to identify possible lessons for the Danish situation. The authors behind the report, Tower Perrins and DIA, argue that there is a general trend towards initiatives and tools to empower consumers for improved decision making and indicate a number of best practices. The report suggests ten factors of particular importance: clearly defined strategy, coordination and ownership of stakeholders, efficient allocation of resources, importance of education, importance of political support, importance of engaging consumer, increasing the awareness of tools, simplicity and consistency of message, appropriate level of resources, and, measuring of effectiveness.

[R, H, L] VELFÆRDSKOMMISSIONEN <<Fremtidens velfærd – vores valg>>, Copenhagen: The Welfare Commission, 2006.
"The Welfare of the Future – Our choices"

The summary report of the Welfare Commission including main analytical findings and policy recommendations. Most analysis were based on an economic model called DREAM.

[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

[H1, H3, H4, H5] BESKÆFTIGELSESMINISTERIET, <<Analyse af sygefraværet>>, April 2008, Copenhagen: Ministry of Employment.
"Analysis of sickness absenteeism"

This report by the Ministry of Employment finds that the sickness absenteeism in Denmark equals about 150,000 persons or nearly 5% of the labour force in 2006. Depending on the sector each person is sick between 8 and 13 working days on average. The costs are great for the individual and for society the costs amount to DKK 37 billion in paid wages and sickness benefits. More people get sickness benefits than earlier and for longer periods. Migrants from non-western countries have higher rates of sickness absenteeism. Sick-listed persons are increasingly returning to work on special conditions, especially reduced hours and adapted work tasks. Some 17,000 persons used this scheme in 2007, and the usage varies across municipalities. More unemployed are sick-listed than previously. The increase in sickness absenteeism can be explained by a combination of factors, including economic factors where the upturn, until the financial crisis, gave less healthy persons a place in the labour market or a job offer. Sickness benefits have also been opened to persons in flexjobs (subsidised jobs on special conditions) and for longer periods. Also the implementation of the government reform from 2005, described above, may have caused less time for case workers to follow up on sick-listed etc.

[H1, H3, H4] COPENHAGEN ECONOMICS, <<Sundhedsforsikringer - En løsning på fremtidens velfærd?>>, Forsikring og Pension Analyserapport 2008:4, 22 October 2008.
"Private health insurance - A solution for the future of welfare?"

This consultancy report is commissioned by the trade association of non-life and life insurance and multi-employer pension funds in Denmark, Danish Insurance Association (Forsikring og Pension). The report contains an analysis of the role private health insurance has played since their emergence in 2002 and the role health insurance may play in the years to come. The authors behind the report argues that long-term care provide the largest potential for private health insurance in the future.

[H3] DAVIDSEN M, JUEL Kirsten, & Mette KJØLLER <<Sygdomsudviklingen i Danmark fremskrevet til 2020 – arbejdsnotat>>, Statens Institut for Folkesundhed, Syddansk Universitet, 2007.
"The development of sickness in Denmark in 2020"

This working paper by two researchers makes a prognosis of the development of health in Denmark until 2020. For example, the number of hospital admissions is estimated to rise by approx. 230,000 to just fewer than 1.4 million admissions in 2020, and the number of outpatient contacts is expected to almost double from 2005 to 2020 to approx. five million in 2020.

[H2] HØGELUND Jan, BOLL Joakim, SKOU Mette & JENSEN Søren, <<Effekter af ændringerne i sygedagpengeloven>>, 22 April, 2008, Copenhagen: SFI.
"Effects of changes in the sickness benefit act"

The authors of the report evaluate the effects of changes made to the Act on sickness benefit enacted in the reform of 2005 described above. Based on two comparable data collections in 2002 and 2006 totalling telephone interviews with 1,700 persons that have been sick-listed for more than 8 weeks combined with information on each of the cases based on information from the municipalities and their practice as well as register information on the sick-listed persons. The 2005 changes included (1) obliging municipalities to collect information on the sick-listed using a questionnaire, (2) visitation of sick-listed into three categories (i.e. smooth cases, risk cases and long term cases), (3) case-worker has follow-up talk with the sick-listed within 8 weeks in all cases, (4) more intense follow up in risk cases (i.e. more frequent and demand on personal show up), (5) new medical declaration, (6) increased emphasis on retainment on the labour market, (7) better coordination between municipalities, doctors and companies, (8) increased use of other actors in relation to the follow up on sick-listed. The analysis show that the municipalities have held more follow-up talks and that these have more focus on getting back to work. However, due to data limitations the report cannot establish employment effects of the measures taken.

[H2, H3] KJØLLER, Mette, Kirsten JUEL & Finn KAMPER-JØRGENSEN (eds.) <<Folkesundhedsrapporten 2007>>, Copenhagen: National Institute of Public Health, 2008. Danish language report available from http://www.si-folkesundhed.dk/Udgivelser/B%C3%B8ger%20og%20rapporter/2008/2897%20Folkesundhedsrapporten%202007.aspx.
"The Public Health Report 2007"

The National Institute of Public Health regularly publish a major report on the state of public health in Denmark. This is the most recent published in 2008. The Public Health Report contains a lot of information on inequalities in health and a little information on inequalities in health care treatment.

[H4, H5] KRISTENSEN, Troels, Kim Rose OLSEN, Kjeld Møller PEDERSEN <<Hospitalers omkostninger, struktur og effektivitet. En undersøgelse af stordrifts- og samdriftsfordele i det danske sygehusvæsen>>, Health Economics Paper 2008:11, 2008.

Danish language paper downloadable from
http://www.sdu.dk/Om_SDU/Institutter_centre/c_ist_sundoek/Forskning/Forskningspublikationer/Publications/Publications_2008.aspx.
"Hospitals' costs, structure and effectiveness. An examination of economies of scale and of collaboration between hospitals in Denmark"

This group of health economists have analysed the costs and benefits of running hospitals in Denmark depending on their size and type of collaboration with other hospitals.

[H, L] MADSEN, Marie Henriette <<Hurtig og effektiv behandling på sygehuse – har det konsekvenser for kommunerne? Litteraturgennemgang af afledte konsekvenser for kommunerne>>, Copenhagen: Danish Institute for Health Services Research, 2008.
"Quick and efficient hospital treatment - consequences for municipalities"

The author reviews the literature on the effects of hospital treatments of patients on the municipalities. In Denmark regional authorities, regions, are responsible for running hospitals and local authorities, municipalities, for social care and some health services.

[H, H1, H4, H5] PEDERSEN, Kjeld Møller <<Manglen på arbejdskraft i sundhedsvæsenet og hvordan man kan tiltrække og fastholde kvalificeret arbejdskraft>>, Health Economics Paper 2008: 2, 2008.
"The lack of labour in the health care system and how to attract and retain qualified labour"

Professor of health economics, Kjeld Møller, use recent material on the Danish health care system to analyse one of the most pertinent problems that is to be exacerbated by adverse demographic developments, i.e. the lack of qualified labour to staff the Danish health care system. By 2015-2020 there will be missing 5,000-6,000 nurses, 5,000 social – and health assistants, 2,000 doctors and 2,000 other staff. This equals 12-15% of currently employed staff in the health sector. Taking account of the increased demand for more health care, Møller Pedersen finds that the health care sector will lack of 20% of its staff in 2020.

[H2, H5] REGERINGEN, <<Sygefravær - en fælles udfordring. Regeringens handlingsplan for at nedbringe sygefraværet>>, June 2008.
"Sickness absenteeism - a common challenge. Government white paper/action plan"

[R, H, L] VELFÆRDSKOMMISSIONEN <<Fremtidens velfærd – vores valg>>, Copenhagen: The Welfare Commission, 2006.
"The Welfare of the Future – Our choices"

Summary report of the Welfare Commission including main analytical findings and policy recommendations. Most analysis were based on an economic model called DREAM.

[L] Long-term Care

[L] DANMARKS STATISTIK, <<20 timers hjælp om ugen til plejehjemsbeboere>>, Nyt fra Danmarks Statistik, nr. 194, 8 May 2008a.
"20 hours of help for persons in residential care"

Statistics Denmark publishes regular information about health and social issues. This publication is on the amount of help, including not the least amount of received personal care according to the age and housing situation of the care receiver.

[L] DANMARKS STATISTIK, <<70.000 ældre bor i pleje- og ældreboliger>>, Nyt fra Danmarks Statistik, nr. 526, 10 December 2008b.
"70,000 elderly live in residential care and housing for the elderly"

A yearly publication of the Statistics Denmark. This publication provides information about the number of elderly person in residential care and housing for elderly according to their age and type of accommodation.

[L] DANMARKS STATISTIK, <<103.000 arbejder i ældreomsorgen>>, Nyt fra Danmarks Statistik, nr. 64, 18 February 2009. '103,000 persons work with elderly care'
This is another publication of Statistics Denmark giving the latest available data on the number and composition of persons working with elderly care.

[H, L] MADSEN, Marie Henriette <<Hurtig og effektiv behandling på sygehuse – har det konsekvenser for kommunerne? Litteraturgennemgang af afledte konsekvenser for kommunerne>>, Copenhagen: Danish Institute for Health Services Research, 2008.
"Quick and efficient hospital treatment - consequences for municipalities"

The author reviews the literature on the effects of hospital treatments of patients on the municipalities. In Denmark regional authorities, regions, are responsible for running hospitals and local authorities, municipalities, for social care and some health services.

[L] NØRGAARD, Asbjørn, Maud ROSENDAHL & Didde Cramer JENSEN <<Plejehjemstilsyn: Politik på pressens præmisser>>, Odense: Syddansk Universitetsforlag, 2008.
"Audits of institutional care for the elderly - Policy on the premises of the press"

Professor of political science, Asbjørn Nørgaard, and colleagues examine the cause and consequences of the trend towards more and stronger auditing in institutional care for the elderly.

[L] PETERSEN, Jørn Henrik <<Hjemmehjælpens historie. Idéer, holdninger, handlinger>>, Odense: Syddansk Universitetsforlag, 2008a.
"History of Home Help - Ideas, attitudes, actions"

This book by professor of economics and social policy, Jørn Henrik Petersen, gives the history of home help for the elderly in Denmark from its origins to the present. The author traces the ideas and values as expressed by key actors in Parliament and elsewhere and pinpoints all major developments.

[L] ROSTGAARD, Tine & Camilla THORGAARD, <<God kvalitet i ældreplejen - Sådan vægter ældre, plejepersonale og visitatorer>>, Copenhagen: SFI – The Danish National Centre for Social Research, 2008.
"Good quality in elderly care"

The two researchers made a survey among 683 elderly, 185 visiting case officers and 557 care workers about their understanding of what sort of quality is good for whom.

[L] THORGAARD, Camilla & Iben B. HOUGAARD <<Metoder til kvalitet i ældreplejen - Evaluering af et metodeudviklingsprojekt>>, Copenhagen: SFI – The Danish National Centre for Social Research, 2008. Danish language report downloadable from http://www.sfi.dk/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fSFI%2fPdf%2fRapporter%2f2008%2f0805_Metoder_aeldrepleje.pdf.
"Methods for quality in elderly care - evaluation of a method development project"

The authors evaluate a small scale project that was aimed at developing better quality in elderly care.

[R, H, L] VELFÆRDSKOMMISSIONEN <<Fremtidens velfærd – vores valg>>, Copenhagen: The Welfare Commission, 2006.
"The Welfare of the Future – Our choices"

The summary report of the Welfare Commission including main analytical findings and policy recommendations. Most analysis were based on an economic model called DREAM.

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.

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

AKF-Anvendt Kommunal Forskning - AKF-Applied Municipal Research
Address: Nyropsgade 37, DK-1602 Copenhagen K
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.

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.

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

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.

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.

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

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.

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.

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.

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/employment_social/progress/index_en.html