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Hearing on "Future Financing of Social Security and Pensions"

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"FUTURE FINANCING OF SOCIAL SECURITY AND PENSIONS"

Briefing Note

(IP/A/EMPL/IC/2008-074)

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REFORMING SOCIAL SECURITY PENSION SYSTEMS
SOCIAL POLICY DIVISION, OECD[1]

1. INTRODUCTION

Pension policy is indeed challenging and controversial because it involves long-term decisions in the face of numerous short-term political pressures. It is often said that reforming public pensions is the "third rail" of politics: touch it and you die. Nevertheless, much has been done since the early 1990s to make pension systems fit for the future; often, more than governments are given credit for. Nearly all the 30 OECD countries have made at least some changes to their pension systems in that period. In 16 of them, there have been major reforms that will significantly affect future entitlement of pension benefits and fiscal sustainability of social security pension systems.

This brief starts by examining what fiscal challenges are posed by public pension systems. It also outlines which countries reformed their pensions systems since 1990. Section 2 describes the reform measures themselves. These include, among other things, increases in pension age, changes in the way benefits are calculated and smaller pension increases in retirement than in the past. Section 3 explores the social impact of these reforms on future pension entitlements of today's retirees, showing a clear trend to a lower pension promise for today's workers than for past generations. This means that people will need to save more for their own retirement in private pension schemes (or by other means). But how much – this issue is examined in section 4. The next section, section 5, presents the projected public pension expenditures for EU countries, so as to analyse fiscal impact of pension reforms. Concluding observations for future pension policy are given in section 6.

Table 1 shows data on *actual* public pension spending in OECD countries during 1990, 1995, 2000 and 2003. Back in 1990, pension spending was already above 10% of gross domestic product (GDP) in five EU countries: Austria, France, Germany, Greece and Italy. In all five, spending continued to grow throughout the 1990s and 2000s. Italy moved to the top, with spending of around 14% of GDP in 2003. At the other end of the scale are two other EU countries: Ireland and the United Kingdom – public pension spending is low in these two countries and it changed little over the period 1990-2003. These countries have relatively favourable demographics and they also have relatively small public pensions and rely heavily on private pensions.

[1] This brief is prepared at the request of the European Parliament's Committee on Employment and Social Affairs (EMPL), in preparation of a hearing on the "Future financing of social security and pensions", June 3, 2008. The analyses reported here draws on OECD's substantive research on pensions, reported in 'Pensions at a Glance' (OECD 2007) and in several other pieces of work at the Social Policy Division, Directorate of Employment, Labour and Social Affairs. Results reported here make use of OECD's pension entitlements model, which is maintained in co-operation with the European Commission.

Table 1. Public spending on old-age and survivors' pensions, 1990-2003

	1990	1995	2000	2003	Change 1990-2003
Australia	3.7	4.2	4.5	4.1	0.4
Austria	11.9	12.8	12.8	13.2	1.3
Belgium	9.1	9.4	9.1	9.3	0.2
Canada	4.3	4.8	4.4	4.4	0.1
Czech Republic	6.1	6.5	8.0	8.0	1.8
Denmark	7.4	8.4	7.1	7.2	-0.2
Finland	8.1	6.8	5.9	6.4	-1.7
France	10.9	12.2	12.0	12.3	1.4
Germany	10.2	10.9	11.2	11.7	1.5
Greece	11.1	10.8	12.2	12.4	1.3
Hungary	na	na	8.0	8.7	na
Iceland	3.5	3.8	3.6	4.2	0.6
Ireland	4.2	3.7	3.4	3.7	-0.5
Italy	10.2	11.4	13.7	13.9	3.6
Japan	5.0	6.3	8.0	9.3	4.3
Korea	0.8	1.3	1.5	1.4	0.6
Luxembourg	9.6	10.3	7.8	6.5	-3.1
Mexico	0.6	0.8	0.9	1.2	0.7
Netherlands	7.0	6.1	5.6	5.8	-1.2
New Zealand	7.4	5.7	5.0	4.5	-2.9
Norway	7.6	7.5	6.8	7.4	-0.3
Poland	5.3	9.6	10.9	12.4	7.2
Portugal	5.4	7.9	8.7	10.5	5.1
Slovak Republic	n.a.	6.6	6.6	6.5	6.5
Spain	8.1	9.2	8.8	8.4	0.3
Sweden	9.3	10.7	10.0	10.8	1.5
Switzerland	5.8	6.9	6.9	7.2	1.3
Turkey	3.2	3.7	na	na	na
United Kingdom	5.3	6.0	5.9	6.1	0.8
United States	6.1	6.3	6.0	6.3	0.2
OECD	**6.7**	**7.3**	**7.4**	**7.7**	**1.0**

n.a.: not available.
Source: OECD Social Expenditures database.

Such growing cost of paying for pensions, both in the past few years and projected into the future, was often cited as the main motive for reform. Six of the ten countries with the *highest* public expenditures on pensions as a percentage of national income in 1990 – Austria, France, Germany, Italy, Sweden and Finland – have undertaken major pension reforms since 1990. This brief analyse both the social and fiscal impact of pension reforms: these reforms have cut pension benefits (the social impact) and they will lead to lower pension spending by the government in the future (the fiscal impact).

2. WHAT PENSION REFORMS SINCE 1990?

This paper analyses 16 countries that introduced *major* pension reforms since 1990. The definition of "major" is clearly subjective, but we have chosen those changes that will significantly affect future retirement benefits. Indeed, the analysis focuses on the impact on retirement incomes, but many countries have also changed pension contribution rates or financing mechanisms (building public pension reserves, for example).

Most of these 16 countries' pension reforms were packages comprising numerous different measures, as summarised in Table 2. Some of these changes, such as increases in pension ages, are highly visible and often politically controversial.

Others, such as changes in the way in which earnings are measured when calculating benefits, are more technical and less transparent. Some countries maintained the structure of the pension system, modifying only parameters and some of the rules, while others overhauled the entire system. Table 2 distinguishes between changes to parameters and changes to the paradigm of pension schemes (Table A.1 in the Annex give a more detailed description of pension reforms in OECD countries since 1990).

Table 2: Main elements of pension reform packages in selected OECD countries

	Changing parameters						Changing paradigm		
	Pension age		Retirement	Calculation		Indexation			Life
	M	F	incentives	measure	revaluing		DC	NDC	Expectancy
Austria	●	●	●	●		●			
Finland			●	●	●	●			●
France			●	●	●				●
Germany	●	●	●						●
Hungary	●	●	●	●		●	●		
Italy	●	●	●			●		●	
Japan	●	●		●					
Korea	●	●							
Mexico							●		
NZ	●	●							
Poland			●	●		●	●	●	
Portugal		●	●	●	●	●			●
Slovakia	●	●		●			●		
Sweden				●			●	●	
Turkey	●	●							
UK	●	●	●						

Source: based on OECD (2007), Table II.1.1. See also Whiteford and Whitehouse (2006) and Zaidi and Grech (2007).

2.1 Changing pension-system parameters

Changes in **pension age** are the most common feature of reform packages. The rationale for these changes is clear: starting in the 1960s, life expectancy started growing rapidly, but many countries cut their retirement ages. The average age at which full-career workers can first draw their pension in OECD countries for men fell from 64.5 years in 1958 to 62.2 years in 1993 and for women from 61.8 to 60.7 years (Turner, 2007).

Recent reforms have reversed the trend to lower pension eligibility age, with ten countries introducing gradual increases in pension age for both men and women. Portugal will increase pension age for women to equal that of men.

When these reforms are complete, most OECD countries will have a standard retirement age of 65 years, although in some of countries the pension age is or will be 67 or more in some other countries (e.g. Denmark, Germany and the United Kingdom). Only France, Hungary and the Czech and Slovak Republic plan to have normal pension ages below 65; in four more countries, only women can retire on a full benefit before reaching 65.

Nonetheless, effective retirement ages – the age at which people actually stop working – are lower on average than the standard pension age in most countries (OECD 2006). A common policy response, adopted by nine countries, has been to encourage older workers to stay longer in their jobs by changing pension **incentives to retire**. Penalties for early retirement have been introduced or increased in many countries, including Austria, Germany and Italy. Similarly, countries such as France and Sweden have increased the number of years of contributions required to receive a full pension. Other countries have introduced or increased the increments or bonuses paid to people retiring after the normal pension age (see Queisser and Whitehouse 2006, for further discussion).

The other changes to pension systems have been more technical and less visible. Two of these relate to **calculation** of the earnings base for pension entitlements. *First*, seven OECD countries have extended the period over which earnings are taken into account instead of just basing the benefit on a limited number of final or best salaries. For example, France is moving from the best 10 years to the best 25 years in the public scheme. Austria, Finland, Poland, Portugal, the Slovak Republic and Sweden are all moving to a lifetime average earnings measure. As a result of these reforms, most OECD countries – 17 out of the 22 with the relevant kinds of scheme – will use a lifetime earnings measure or a close proxy for it. Extending the period over which earnings are measured will tend to cut pension benefits. The average of the best years or final earnings is usually higher than the average over the lifetime because the latter also takes earlier years with lower earnings into account. *Secondly*, many systems revalue past earnings to take account of changes in living standards between the time pension rights accrued and when they are claimed. Several countries have moved to a less generous adjustment. For example, France moved to price revaluation in the public scheme as early as 1985 and in the occupational schemes in 1996. How past earnings are re-valued also has a large effect on retirement benefits.

The final technical reform has been to the way that pensions in payment are adjusted: **indexation** policy. Many OECD countries have moved from adjusting pension benefits to earnings towards full or partial indexation to prices. This preserves the purchasing power of pensions, but it also means that pensioners do not share in the general growth in living standards.

All of these changes can have a strong effect on pension benefits. But their technical nature may mean that some of them attract less political opposition than more visible and easily understood reforms.

2.2 Changing pension-system paradigm

A number of countries opted for wholesale or systemic reforms. The most common policy has been to remove all or part of the public defined-benefit pension system and replace it with **defined-contribution (DC)** provision. In these schemes, the pension depends on contributions and interest earned on them. Amongst the EU countries, Hungary, Poland, the Slovak Republic and Sweden have all introduced mandatory, privately managed individual accounts to replace part of the public pension.

Another change of retirement-income paradigm has been the shift in public pensions from defined-benefit plans to **notional accounts**. These schemes, adopted in Italy, Poland, Latvia and Sweden, are designed to mimic some of the features of DC schemes. Hence, they are often called notional defined-contribution schemes **(NDC)**.

Again the pension depends on contributions but, unlike DC plans, the notional interest rate is set by the government and often linked to national wage or GDP growth. The schemes remain pay-as-you-go financed: no assets are accumulated.

The systemic reforms share one important feature: pensions will in future automatically adjust to changes in life expectancy. When pension capital is accumulated in an individual account it is usually transformed into a regular pension payment – an "annuity" – at retirement. Annuities will be lower the higher life expectancy is at the time of retirement because the pension will be paid for a longer time. Benefits from notional accounts are calculated in a similar way. But such automatic adjustments to **life expectancy** can also be built into systems that have not undergone systemic reforms. Germany, Finland and Portugal have linked benefit levels to life expectancy. France will extend the years of contributions necessary for a full benefit as people live longer.

3. SOCIAL IMPACT OF PENSION REFORMS

The primary motive for pension reforms was to contain the future costs of public pensions in the context of population ageing. There have been various studies of the effect of pension reform on the public finances[2]; and we will cover some of them below (in Section 5). Here, our focus will be on the *social* rather than the *fiscal* impact of pension reforms – on equity and on the distribution of income – an issue that has been rarely studied in a cross-country context. Such microeconomic analysis is designed to complement the macro picture provided by long-term financial projections of pension systems.

Reforms to retirement-income regimes often altered a range of the parameters and rules of pension schemes. This makes it difficult to compare these reform packages between countries based on changes in pension parameters and pension paradigms alone. The analysis that follows uses microsimulation modelling of the replacement rate: pension income relative to earnings when working. The indicator of interest here is the *net* replacement rate, which takes account of taxes and contributions paid on retirement incomes and on earnings. Before turning to the results, we provide a brief description of the methodology used.

3.1 Methodology

The results described as post-reform take the situation of a worker entering the labour market in 2004 and spending the whole of his or her career under the same set of pension parameters and rules: those applying in 2004 along with any legislated changes that will take effect over time. The calculations show the pension entitlements of a worker who enters the system today and retires after a full career, defined as entering the labour market at age 20 and working until the standard pension-eligibility age, which, of course, varies between countries. The results are shown for a single person only. The replacement rates include all mandatory pension schemes for private-sector workers, regardless of whether they are public or private. Resource-tested benefits for which retired people may be eligible are also included.

The comparisons are based on a single set of economic assumptions. Although the level of pensions will be affected by economic growth, wage growth and inflation – and these will vary between countries – a single set of assumptions ensures that the calculations for the different pension regimes reflect differences in pension systems and policies alone.[3]

The baseline assumptions are:

Real average earnings growth	2% per year
Individual earnings	in line with economy-wide average
Price inflation	2.5% per year
Real return on DC schemes, net of administrative charges	3.5% per year
Discount rate	2%
Mortality rates[4]	Country-specific for 2040

2. For example, Economic Policy Committee (European Union, 2005, 2006), Salomaki (2006) and Dang *et al.* (2001).
3. See OECD (2005, 2007) and Queisser and Whitehouse (2007) for analysis of the sensitivity of the results to these assumptions.
4.These are used in the calculation of pensions that are linked to life expectancy. DC benefits are assumed to be paid in the form of a price-indexed life annuity at an actuarially fair price. Similarly, the notional annuity rate in notional accounts schemes is generally calculated from mortality data using national assumptions.

The pre-reform scenario is built on the following question: what would the parameters and rules of the pension system have been in 2004 had the pension reform not taken place? This stylised approach is designed to isolate the effects of the reform programme from other changes of the past decade. The aim is not to calculate pensions for people retiring in 2004.

3.2 Average earners

Figure 1 gives net replacement rates for a full-career spent under the rules before and after reforms. The results for average earners are shown in the right-hand panels. Before reform, the average net replacement rate of the countries under study was 84%. In Portugal, the net replacement rate exceeded 100% in Portugal and it was close to 100% in Austria. At the other end of the spectrum, Japan and the United Kingdom had relatively low pensions before embarking on the recent rounds of reforms: 47% and 41% respectively.

Turning to the reforms, the average replacement rate after the changes are in place will be just under 70%, compared with 84% before reform. Amongst the European countries that experienced largest (relative) cuts for average earners were Portugal and Germany, where long-term benefits will be just 40% and 27%, respectively, of those under the previous system. In contrast, reforms increased the net replacement rate for average earners in Hungary and left it unchanged in the United Kingdom.

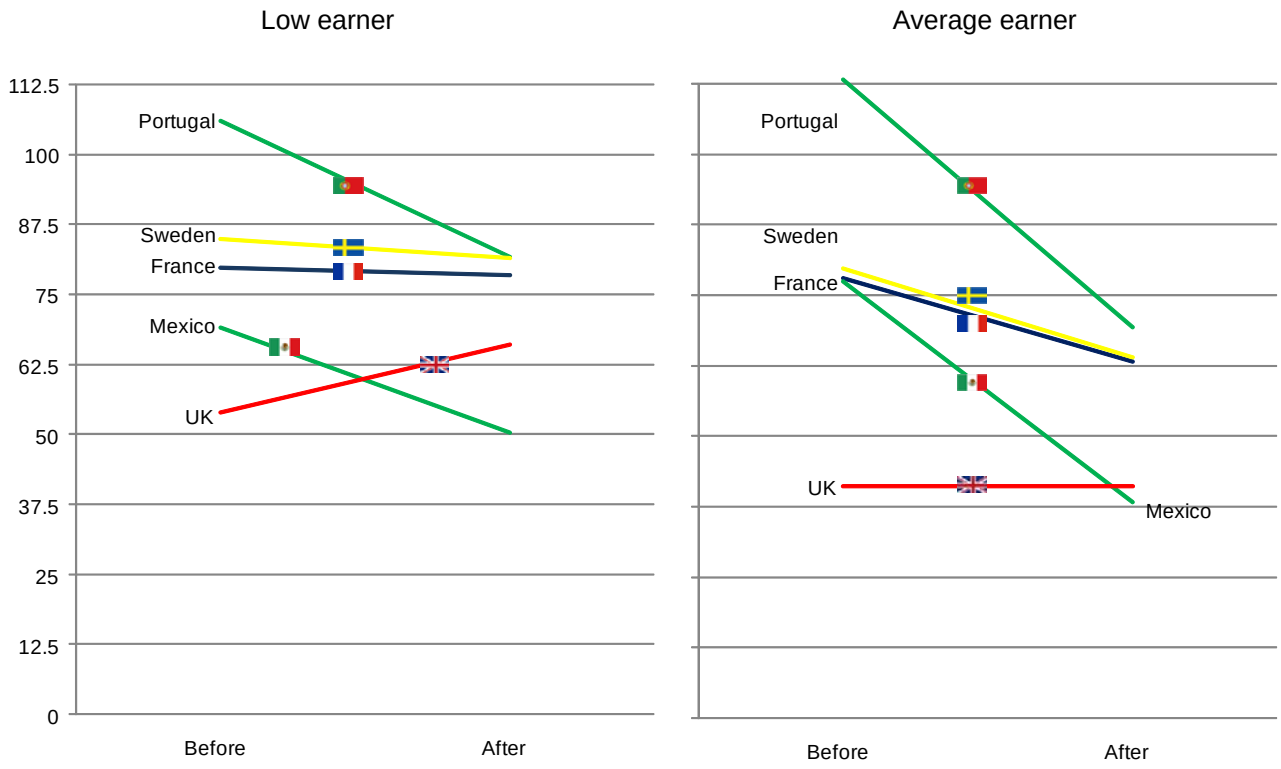
3.3 Low earners

The left-hand panels show how low earners were affected by the reforms, where low earnings are defined as half of average (mean) economy-wide pay. Before reform, the average net replacement rate for these workers was 87%, slightly higher than the pre-reform figure for average earners because of the redistributive features of some countries' pension systems. After reform, the average net replacement rate for low earners is projected to fall to 77%.

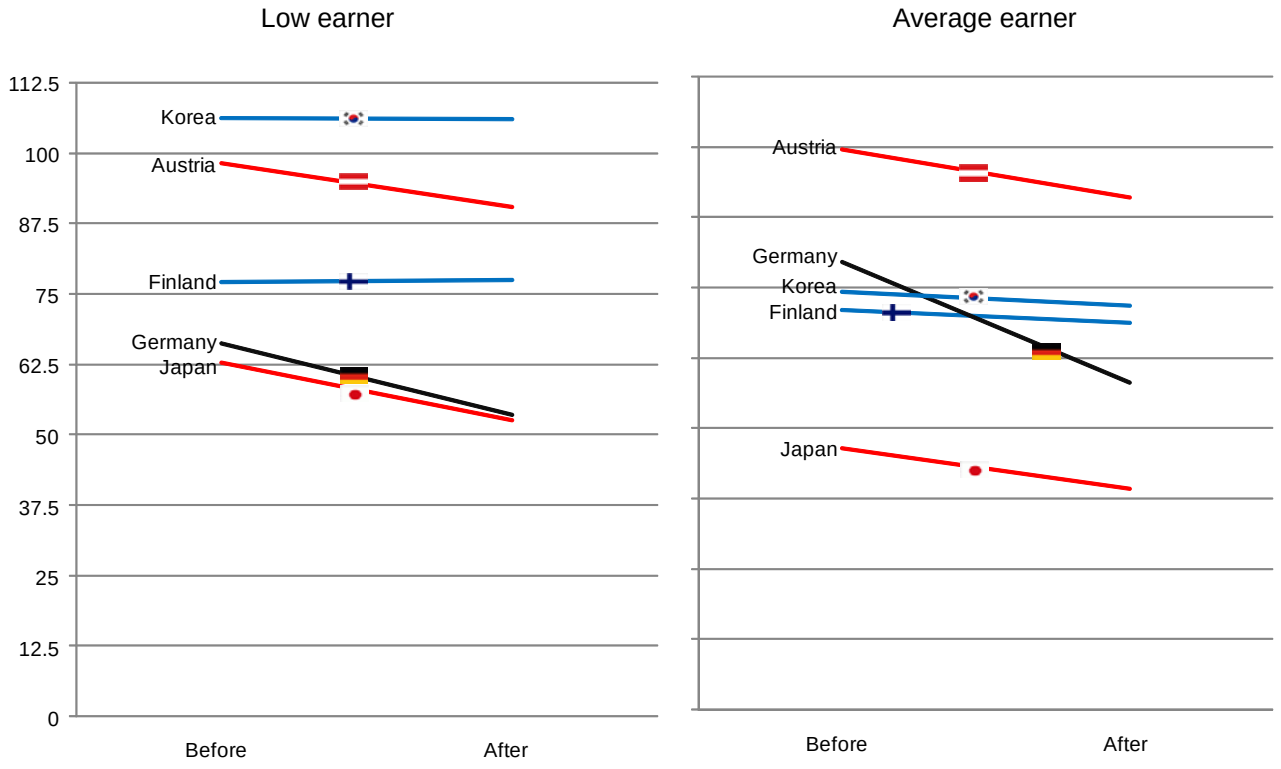
The largest cuts in benefits for low earners – of one fifth or more – are found in Germany, Poland and Portugal. In contrast, net replacement rates were increased by changes in Hungary and the United Kingdom. There was no change in benefit levels in Finland.

Figure 1. Impact of pension reforms on net replacement rates by earnings level

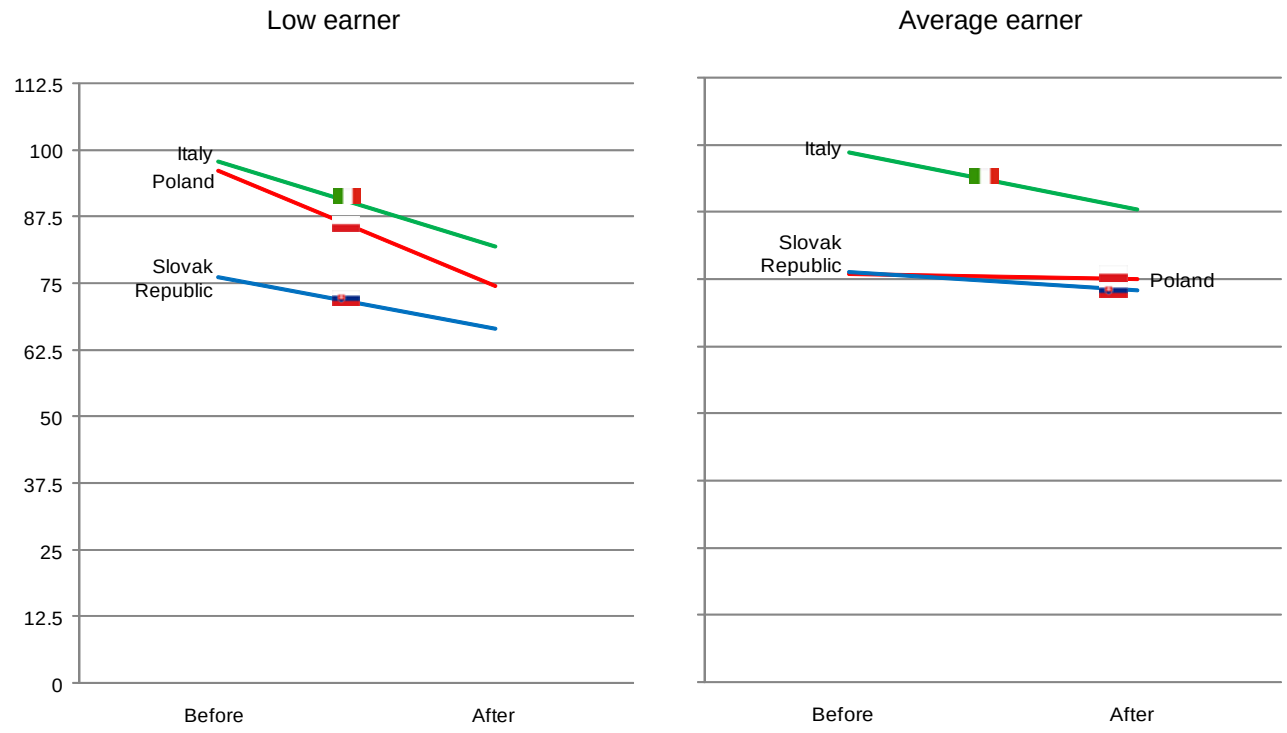
2a. Reforms that protected low earners



2b. Across-the-board cuts in benefits



2c. Reforms that strengthened the link between contributions and earnings



Source: OECD (2007)

3.4 Changing patterns of pensions with earnings

The impact of pension reforms on people at different levels of earnings varies between countries. Figure 1 divides them into three categories. At the top (Figure 1a) are reforms that protected low earners. In France and Sweden, for example, pensions for average earners will fall by around 20%. However, low earners should expect only a slightly smaller pension than previously. In Portugal, the reductions in benefits were much smaller for low earners. While benefits of average earners remained unchanged in the United Kingdom, low earners can expect a higher net replacement rate because of the new pension credit and second state pension. All of these reforms shown in the top row of Figure 1 increased the targeting of the pension system on people who had low incomes when working. It is therefore expected that in this group of countries women, who more often experience employment disruptions and experiences of low wage employment, be more protected. This can be expected in the reforms undertaken in the United Kingdom, France and Sweden.

The bottom row of Figure 1 shows countries with reforms that worked in the opposite way to those in the top row. In Poland and the Slovak Republic, average earners face only modest benefit reductions. Low earners, in contrast, will have pensions 22% and 12% lower, respectively, than under the pre-reform systems. In Italy, the reduction in benefits for low earners is larger than for people on average pay. The countries in Figure 1c explicitly wanted to strengthen the link between pensions in retirement and earnings when working. The underlying belief was that this was fairer than a redistributive pension system and that it would reduce distortions in the labour market. Women can be expected to be losers in these kinds of pension reforms as they are more likely to experience disruptions in their work career and thus miss out contributions towards their pension accumulation process.

In the middle of Figure 1 are five reforms – including Austria, Finland and Germany – that cut benefits "across-the-board". In these EU countries, the proportional reduction in benefits is broadly similar for low and average earners.

4. The growing role of private pensions

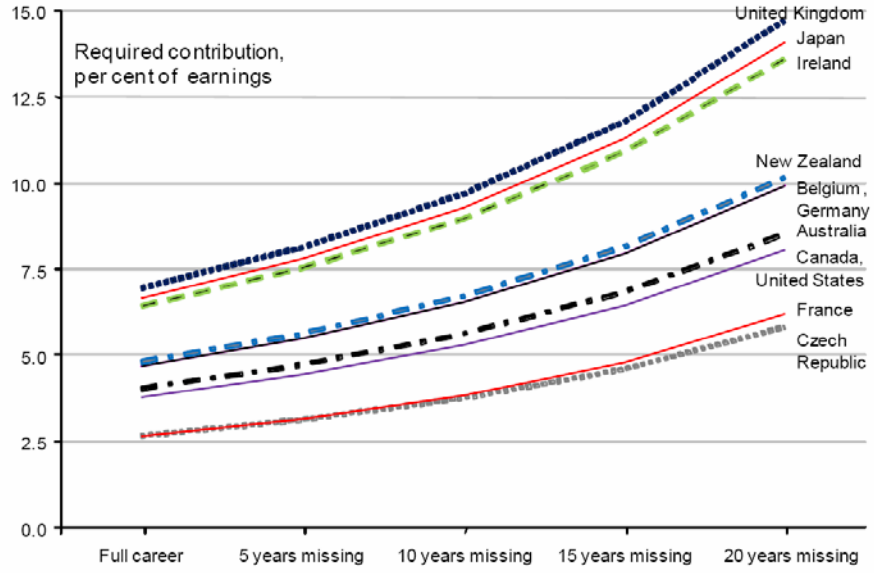
Recent pension reforms mean – directly or indirectly – that private pension savings will have to play a greater role in providing adequate incomes in old age in the future. Many countries that cut public pensions explicitly stated that they expected private provision to offset the impact on future retirement incomes. Four EU countries – Hungary, Poland, the Slovak Republic and Sweden – introduced mandatory private pensions as a *substitute* for part of public pension provision. In Denmark, the Netherlands and Sweden, there are already existing private pension schemes that can be described as "quasi-mandatory", because industrial-relations agreements ensure coverage of 80% or more of the workforce. The United Kingdom and Ireland have long had broad coverage of voluntary private pensions because of the low level of public pensions, especially for middle and high earners. Belgium and Germany also have a relatively high coverage of workers in private pensions.

Taking account of all relevant factors – gross replacement rates offered by the mandatory pension schemes, differences in pension age and life expectancy – it is possible to calculate the percentage of earnings that individuals would need to contribute to achieve an overall – mandatory plus voluntary – replacement rate equal to the OECD average. The OECD average gross replacement rate (59%) is obviously an arbitrary target but it is useful to use it as a benchmark for all OECD countries – the average figure includes those with mainly mandatory retirement provision.

The results are illustrated in Figure 2. We start at the left-hand side of the chart with the situation of workers who contribute to the private pension for a full career. The United Kingdom has the largest replacement-rate gap and the highest required contribution rate for private pensions. The required contribution rate is much smaller (just 2.6%) in France and the Czech Republic, principally because the gross replacement rate for an average earner from mandatory pension schemes is rather close to the OECD average. These results also show that the contributions required during a disruptive employment career would be much larger. [5]

Figure 2: Contributions required to fill the pension gap

Contribution rate needed to reach OECD average replacement rate
for average earners by years of contributions



5. FISCAL IMPACT OF PENSION REFORMS[6]

Table 3 reports on the gross public pension expenditures, which include 'old-age and early retirement' pensions (including minimum and earnings-related pensions; also disability and widow's pensions paid out to persons over the standard retirement age) and 'other' pensions (disability, survivors', partial pensions without any lower age limit, including minimum and earnings-related pensions).

In 2004, public pension spending in EU Member States stood at just above 10% of GDP, with a large variation across countries (from 4.7% of GDP in Ireland to 14.2% of GDP in Italy). The low levels in Ireland and the United Kingdom stem mainly from the fact that public pension schemes play a relatively small role in the total provision of pensions. Public pension spending is also below the EU average in a number of new Member States such as Cyprus and Malta as well as Estonia, Latvia, Lithuania, and Slovakia. For the Eastern European countries, the low spending can partly be attributed to the fact that the current pension payments are relatively flat-rate as most of pensioners acquired their pension rights in the former communist regimes which had relatively smaller wage differences, and in some cases to the fact that the levels of pensions have been based only on the whole length of service.

In contrast, high GDP percentages of public spending in countries, such as France, Austria, Poland and Italy, reflect the fact that the pension provision mainly relies on public pension schemes and that the main scheme is an earnings-related one.

Table 3: Gross public pension expenditure as a share of GDP between 2004 and 2050

Country	2004	2010	2015	2020	2025	2030	2040	2050	2004-2030	2030-2050
BE	10.4	10.4	11.0	12.1	13.4	14.7	15.7	15.5	4.3	0.8
CZ	8.5	8.2	8.2	8.4	8.9	9.6	12.2	14.0	1.1	4.5
DK	9.5	10.1	10.8	11.3	12.0	12.8	13.5	12.8	3.3	0.0
DE	11.4	10.5	10.5	11.0	11.6	12.3	12.8	13.1	0.9	0.8
EE	6.7	6.8	6.0	5.4	5.1	4.7	4.4	4.2	-1.9	-0.5
ES	8.6	8.9	8.8	9.3	10.4	11.8	15.2	15.7	3.3	3.9
FR	12.8	12.9	13.2	13.7	14.0	14.3	15.0	14.8	1.5	0.5
IE	4.7	5.2	5.9	6.5	7.2	7.9	9.3	11.1	3.1	3.2
IT	14.2	14.0	13.8	14.0	14.4	15.0	15.9	14.7	0.8	-0.4
CY	6.9	8.0	8.8	9.9	10.8	12.2	15.0	19.8	5.3	7.6
LV	6.8	4.9	4.6	4.9	5.3	5.6	5.9	5.6	-1.2	-0.1
LT	6.7	6.6	6.6	7.0	7.6	7.9	8.2	8.6	1.2	0.7
LU	10.0	9.8	10.9	11.9	13.7	15.0	17.0	17.4	5.0	2.4
HU	10.4	11.1	11.6	12.5	13.0	13.5	16.0	17.1	3.1	3.7
MT	7.4	8.8	9.8	10.2	10.0	9.1	7.9	7.0	1.7	-2.1
NL	7.7	7.6	8.3	9.0	9.7	10.7	11.7	11.2	2.9	0.6
AT	13.4	12.8	12.7	12.8	13.5	14.0	13.4	12.2	0.6	-1.7
PL	13.9	11.3	9.8	9.7	9.5	9.2	8.6	8.0	-4.7	-1.2
PT	11.1	11.9	12.6	14.1	15.0	16.0	18.8	20.8	4.9	4.8

[5] Further analysis and a detailed illustration of Figure 5 are set out in OECD (2007), pp. 83-85.
[6] Analyses in this section are derived from European Union, Economic Policy Committee (2006).

SI	11.0	11.1	11.6	12.3	13.3	14.4	16.8	18.3	3.4	3.9
SK	7.2	6.7	6.6	7.0	7.3	7.7	8.2	9.0	0.5	1.3
FI	10.7	11.2	12.0	12.9	13.5	14.0	13.8	13.7	3.3	-0.3
SE	10.6	10.1	10.3	10.4	10.7	11.1	11.6	11.2	0.4	0.2
UK	6.6	6.6	6.7	6.9	7.3	7.9	8.4	8.6	1.3	0.7
EU15	10.6	10.4	10.5	10.8	11.4	12.1	12.9	12.9	1.5	0.8
EU10	10.9	9.8	9.2	9.5	9.7	9.8	10.6	11.1	-1.0	1.3
EU12	11.5	11.3	11.4	11.8	12.5	13.2	14.2	14.1	1.6	0.9
EU25	10.6	10.3	10.4	10.7	11.3	11.9	12.8	12.8	1.3	0.8

Source: European Union, Economic Policy Committee (2006), pp. 71

Over the next 50 years, public spending on pensions is expected to decline in Estonia, Latvia and Poland. These decreases, as well as small increases in Lithuania and Slovakia, stem partly from the pension reforms enacted during the last decade: these countries switched part of the public old-age pensions into privately funded schemes. Austria is one of the only EU15 countries which experienced a decline in public pension spending, and this is to be attributed to the parametric pension reforms enacted since 2000 (increasing legal retirement age, linking pension benefits more closely to contributions, making actuarial deductions for early pensions and switching from a wage to a price indexation).

Public spending on pensions in Italy and Sweden will remain relatively unchanged, and this is not surprising since their post-reform public pension schemes are defined-contribution and thus the spending on pensions is driven primarily by the accumulation of contributions.

Over the same period (2004-2050), the largest rise in pension expenditure in the EU15 is faced by Portugal (an increase of 9.7 p.p. of GDP), Luxembourg (7.4 p.p.) and Spain (7.1 p.p.) There have been no significant pension reforms in Luxembourg and Spain since 1990, despite the fact these two countries belonged to the group of countries with the highest pension spending as early as in 1990. Relatively larger increases are also projected for Belgium and Ireland, 5.1 and 6.4 percentage points, respectively. The increase is Ireland is from a small base, 4.7% of GDP in 2004, and it will largely be due to the maturing the pension system.

Amongst the 10 new Member States, there will be a projected increase of 5.6 p.p. for the Czech Republic, 6.7 p.p. in Hungary, 7.3 p.p. of GDP in Slovenia and 12.9 p.p. in Cyprus, during the period 2004-2050. These countries face the biggest challenge amongst the whole of EU countries and they require bringing about some form of pension reforms to move away from their predominantly pay-as-you-go public pension schemes. One recent change in the Slovenian pension system, by which pension benefits will be fully indexed to the net wage growth as of 2006, is an important factor in the projected increase in public pension spending. Likewise, in Hungary, recent measures to include improvement in widow's pension level and a gradual introduction of 13th month pension are partly the reasons behind the projected increases in public pension expenditures.

Notably, when one compares the projections of pension spending made in 2001 by the Economic Policy Committee and the European Commission with those made in 2006, one finds that reforms made in just five years have managed to cut back more than a third of the projected impact of ageing on public expenditure. This is particularly the case for Germany, France, Austria and Finland. This downward revision was achieved despite that the new projections are based on assumptions of a sharper acceleration in ageing.

6. CONCLUSIONS: PENSION CHALLENGES

Despite the many, sometimes radical, pension reforms in many countries there is no reason for complacency: the pension-reform agenda is far from finished.

6.1 Fiscal and financial challenges still dominant in many countries

Some countries still need to make major reform efforts. For example, four of the countries with the highest pension spending in 1990 saw little or no change in their pension systems over the same period. This group comprises Greece, Luxembourg, Belgium and Spain; pension expenditure in 1990 in these countries averaged 9.5% of GDP, compared with 6.7% for the OECD as a whole. In all except Luxembourg, spending continued to increase between 1990 and 2003, whereas in all spending is also projected to increase during the period between 2004 and 2050. In contrast, reforms in Austria, France, Germany and Sweden, for example, are projected to slow or even reverse the growth in public pension spending.

6.2 Pace of pension reforms implementation is sometimes painfully slow

The transition to the new rules is sometimes very slow, meaning that the positive impact of the reform is long deferred. Amongst the EU countries, this is the case in Austria and Italy. The Italian reform only affected workers who had been in the system for 18 years or less, so the new system will only be fully in place once labour market entrants of 1995 have retired (*i.e.*, from 2017 onwards). In Austria, benefit cuts cannot exceed 10%. In Germany, in contrast, pension reforms have often had an immediate effect, because changes in the pension-point value affect all existing pension entitlements, including pensions in payment.

6.3 Working lives must be extended in the time of longevity gains

Early retirement and its costs are still a problem in many countries. The standard retirement age has been increased to 65 in most OECD countries and, in some cases, even beyond. However, many routes for early exit from the labour market are still open. The average effective retirement age for men was below 60 in eight OECD countries – including Belgium, France, Hungary and Italy – over the period 1999-2004.

6.4 Will voluntary pension savings be enough?

Many pension systems will have to rely increasingly on voluntary private pensions to provide incomes in old age. This raises numerous concerns. Will enough people save for retirement? Will people save enough of their earnings to ensure a decent retirement income? Will people save for long enough? These seemingly simple questions are important in determining the sustainability of social security pension systems but they do not have easy answers. Many more governments need to show greater commitments towards extending coverage of private pension schemes. It is not just that more people need to save for their retirement, but also that the same people save for longer periods of their careers.

6.5 Adequacy of incomes in old age should not become issues in the future

The defeat of old-age poverty is one of the triumphs of social policy in the second half of the last century. Being old in an earlier era typically meant being poor. Now, according to the OECD income-distribution data, poverty rates for older people are lower than for the population as a whole in all but seven OECD countries.[7]

7. See Förster and Mira d'Ercole (2005).

Our analyses above show that countries that have introduced a closer link between pensions and earnings – such as Italy, Poland and the Slovak Republic – have cut pensions for low earners the most. This increases the risk of being poor retirement for people with low incomes, who also tend to have incomplete contribution records.

Pension reforms have, most likely, achieved fiscal and financial sustainability. However, there are some significant challenges that remain with respect to social sustainability of these systems. First, a stronger safety-net, perhaps including a minimum pension, will be needed to avoid resurgence in old-age poverty. Secondly, a way of encouraging people to contribute to private pensions is needed that avoids excessive fiscal costs and reduction living standards in retirement.

Table A.1: Reforms to national retirement income systems since 1990 in OECD countries

Country	Pension eligibility age	Adjusted retirement incentives	Change of years in benefit formula or qualifying conditions	Link to life expectancy and/or financial sustainability	Defined contribution scheme	Other
Australia	Pension age for women rising from 60 to 65. Increase from 55 to 60 in age to access private pensions.	New lump-sum bonus for deferring public pension.		Through annuity calculation in DC scheme.	Mandatory DC scheme introduced in addition to public pension.	Lower withdrawal rate for income test in the public pension.
Austria	Early retirement age increased by 1.5 years. Pension corridor between 62 and 65. Pension ages for women aligned with those of men.	Benefit reduction for early retirement introduced and set to increase. Tighter access to early retirement.	Best 15 years to 40 years.	Introduction of sustainability factor under discussion.		Reduction in accrual rate. Less generous indexation for higher pensions.
Belgium	Pension age for women aligned with that for men.	Pension bonus for workers above age 62 Different accounting for work and credit periods Fiscal incentive to take-up private pensions only at standard pension age	Contribution condition for early retirement at 60 tightened.			
Canada						Pre-funding of earnings-related plan.
Czech Republic	Phased increase in normal pension age to 63.	Changes in increments and reductions for early/late retirement				
Denmark	Phased increase in normal pension age from 65 to 67.			Normal pension age linked to life expectancy.		
Finland		Increased accrual rate for people working age 63-67.	10 last years to lifetime average.	Life-expectancy multiplier (from 2010).		Basic part of national pension income-tested. Higher valorisation of past earnings and lower indexation of pensions in payment.
France		Changes in adjustment to benefits for early/late retirement in public and occupational pensions.	Minimum contribution period increased. Earnings measure in public scheme from best 10 to best 25 years.	Minimum contribution period to increase further with changes in life expectancy.		Targeted minimum income of 85% of minimum wage. Valorisation now effectively to prices in both plans.

Country	Pension eligibility age	Adjusted retirement incentives	Change of years in benefit formula or qualifying conditions	Link to life expectancy and/or financial sustainability	Defined contribution scheme	Other
Germany		Reduction in benefits for retirement before 65.		Valorisation and indexation cut back as system dependency ratio worsens.	Voluntary DC pensions with tax privileges.	Phased abolition of favourable tax treatment of pension income.
Greece	Pension age rising from 58 to 65.					
Hungary	Gradual increase in pension age from 55 for women and 60 for men to 62 for both.	Accrual rates linear rather than higher for earlier years.	Pension calculation based on gross rather than net earnings.	Through annuity calculation in DC scheme.	DC scheme: mandatory for new entrants, voluntary for existing workers.	Minimum pension to be abolished. Less generous Indexation of pensions in payment. Pensions subject to income tax.
Iceland	No significant changes since 1990					
Ireland					Incentives for voluntary retirement savings.	Pre-funding of public pensions. Increase in basic pension.
Italy	Normal pension age for men increased from 60 to 65 and for women from 55 to 60. Early pension age for men with 35 years' coverage increases from 60 to 62.	Adjustment to early-retirement benefits through notional annuity calculation.	Qualification years for long-service pension increased from 37 to 40 years.	Through notional annuity calculation.		From DB to notional accounts. Less generous indexation of higher pensions.
Japan	Pension age increasing from 60 to 65.		Pensionable earnings extended to include bonuses.	Benefits adjusted to reflect expected change in dependency ratio.		Accrual rate reduced.
Korea	Pension age rising from 60 to 65.					
Luxembourg	No significant changes since 1990					
Mexico					Mandatory private DC scheme replaces public, DB plan.	
Netherlands		Planned abolition of early retirement programme.	Shift from final to average lifetime salary in many occupational plans.			
New Zealand	Pension age increased from 60 to 65.				Voluntary DC pensions with auto-enrolment and incentives.	Pre-funding of public pension.
Norway					Mandatory employer DC contributions.	Pre-funding of public pensions.

Country	Pension eligibility age	Adjusted retirement incentives	Change of years in benefit formula or qualifying conditions	Link to life expectancy and/or financial sustainability	Defined contribution scheme	Other
Poland	Withdrawal of early retirement for certain groups of workers.		From best consecutive 10 in final 20 years to lifetime average.	Through notional annuity calculation in public scheme and annuity calculation in DC.	DC scheme mandatory for new entrants and workers under 30.	Abolition of basic pension. From DB to notional accounts.
Portugal	Pensionable age for women aligned with that for men at 65.	Introduction of increments for late retirement and reductions for early retirement.	From best 10 out of last 15 years to lifetime average earnings	Life-expectancy adjustment to benefits.		Less generous indexation of higher pensions.
Slovak Republic	Increase in pension ages to 62 for men and women.		From best 5 in final 10 years to lifetime average earnings.	Through annuity calculation in DC scheme.	DC scheme mandatory for new entrants and voluntary for existing workers.	From DB to points system.
Spain		Introduction of small increment for late retirement.				
Sweden			Best 15 years to lifetime average (public, earnings-related scheme).	Through calculation of notional annuity and annuity in DC schemes. Additional sustainability adjustment in notional accounts.	DC scheme mandatory for nearly all workers. Occupational plans switch from DB to DC.	From DB to notional accounts. Abolition of income-tax concessions for pensioners.
Switzerland	Pension age for women increased from 62 to 64.					Reduction in required interest rate and annuity rate in mandatory occupational plans.
Turkey	Pension age to increase to 65.					Reduced accrual rate.
United Kingdom	Women's pension age and eligibility for guarantee credit rising from 60 to 65	Increment for deferring pension claim increased. Lump-sum option added.			Employers required to provide access to DC ("stakeholder") pension.	Increase in basic pension. Extension of means-tested supplements. Increased progressivity of earnings-related pension.
United States	Increase in full pension age from 65 to 67.	Changes in adjustment for early/late retirement.				

Source: Whiteford and Whitehouse (2006); national authorities.

PARLAMENTO EUROPEO EVROPSKÝ PARLAMENT EUROPA-PARLAMENTET
EUROPÄISCHES PARLAMENT EUROOPA PARLAMENT ΕΥΡΩΠΑΪΚΟ ΚΟΙΝΟΒΟΥΛΙΟ EUROPEAN PARLIAMENT
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PARLAMENT EUROPEJSKI PARLAMENTO EUROPEU EURÓPSKY PARLAMENT
EVROPSKI PARLAMENT EUROOPAN PARLAMENTTI EUROPAPARLAMENTET

DG INTERNAL POLICIES OF THE UNION

- Directorate A -

ECONOMIC AND SCIENTIFIC POLICY

POLICY DEPARTMENT

"HEALTH CARE FINANCING IN THE CONTEXT OF SOCIAL SECURITY"

Executive Summary

in English

(IP/A/EMPL/ST/2006-208)

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EXECUTIVE SUMMARY

Introduction

Health systems in the European Union perform a vital social security function. They mitigate both health and financial risks and make a major contribution to social and economic welfare. In light of various cost pressures, the Council of the European Union has articulated the challenge facing the member states as the need to secure the financial sustainability of their health systems without undermining the values these share: universal coverage, solidarity in financing, equity of access and the provision of high quality health care (Council of the European Union 2006).

Our aim in this report is to contribute to addressing this challenge by examining how strengthening the design of health care financing can help to secure health system sustainability. The report begins by clarifying the nature of the sustainability problem (Section 1). It then explores the adequacy of current financing arrangements and recent financing reforms in respect of their ability to secure sustainability (Sections 2 and 3). Finally, it offers some practical suggestions as to the best way forward.

The problem of sustainability

The problem of sustainability presents itself as an accounting problem, where health system revenue is insufficient to meet health system obligations. Two notions are often confused: economic sustainability and fiscal sustainability.

Economic sustainability

Economic sustainability refers to growth in health spending as a proportion of gross domestic product (GDP). Spending on health is economically sustainable up to the point at which the social cost of health spending exceeds the value produced by that spending. If health spending sufficiently threatens other valued areas of economic activity, health spending may come to be seen as economically unsustainable.

Growth in health spending is more likely to threaten other areas of economic activity in an economy that is stagnant or shrinking than it is in an economy that is growing. The general consensus, however, is that for the foreseeable future GDP will grow in the European Union at a rate high enough for health spending and other areas of the economy to grow (Economic Policy Committee 2001; Economic Policy Committee and European Commission 2006).

Fiscal sustainability

Concern regarding the fiscal sustainability of a health system relates specifically to public expenditure on health care. A health system may be economically sustainable and yet fiscally unsustainable if public revenue is insufficient to meet public expenditure.

There are three broad approaches to addressing the problem of fiscal sustainability: increase public revenue to the point at which health system obligations can be met; lessen those obligations to the point at which they can be met from existing (or projected) revenue; and improve the capacity of the health system to convert resources into value.

Efforts to increase public revenue face technical obstacles such as institutional capacity, concerns regarding the threat such efforts may present to labour markets, and political obstacles such as the unwillingness of part of the population to continue to subsidise equal access to health care for others. Lessening health system obligations through coverage reduction (de-listing benefits, expanding cost sharing, excluding population groups) may help to secure fiscal sustainability, but will undermine the four values listed by the Council of the European Union.

Furthermore, encouraging private financing of health care may exacerbate problems of economic sustainability due to the lower value for money that private markets are able to achieve vis-à-vis public systems.

Improving the ability of health systems to generate value can focus on the reform of service delivery or on the reform of financing systems (although the two are related). Reform over the past two decades has focused on the former. In this report we focus on the latter route to securing sustainability. We argue that improving value through health financing system design should be at the forefront of efforts to secure health system sustainability. But we also note that the problem of fiscal sustainability is a political problem, one that pertains to what has been called the 'political economy of sharing' (Reinhardt et al. 2004). Effort to secure population commitment to the four values must accompany any attempt at technical reform to enhance value.

Health care financing in the European Union

Health financing policy encompasses a range of functions: collection of funds for health care, pooling funds (and therefore risks) across time and across the population, and purchasing health services (Kutzin 2001). It also encompasses policies relating to coverage, benefits and cost sharing (user charges). The way in which each of these functions and policies is carried out or applied can have a significant bearing on policy goals such as financial protection, equity in finance, equity of access, transparency and accountability, rewarding good quality care, providing incentives for efficiency in service organisation and delivery, and promoting administrative efficiency([1]).

Collecting funds

All member states use a range of contribution mechanisms to finance health care: public (tax and social insurance contributions) and private (private health insurance, MSAs([2]) and out of pocket payments in the form of direct payments for services not covered by the statutory benefits package, cost sharing (user charges) for services covered by the benefits package and informal payments). A major change since the early 1990s has been the shift from tax to social insurance as the dominant contribution mechanism in many of the newer member states of central and Eastern Europe.

Public expenditure on health dominates in every country except Cyprus, although it has fallen, as a proportion of total expenditure on health, in many member states since 1996. Private expenditure is largely generated by out of pocket payments, which have risen as a proportion of total health care expenditure since 1996, but still account for less than a third of total expenditure in most member states. In 1996 private health insurance was non-existent or made only a very small contribution to total expenditure on health in most of the newer member states and in several of the older member states. While it has grown as a proportion of total expenditure on health in many member states, in most it still accounts for well under 5%. However, its effect on the wider health system may be significant, even in member states where it plays a minor role.

Pooling funds

Pooling (the accumulation of prepaid funds on behalf of a population) allows the contributions of healthy individuals to be used to cover the costs of those who need health care. It is an essential means of ensuring equity of access to health care. In general, the larger the pool and the fewer in number, the greater the potential for equity of access and administrative efficiency.

[1] These are the health financing policy goals adopted by the World Health Organization.
[2] Although none currently uses MSAs on a statutory basis.

In most member states, all publicly-collected funds for health care are pooled nationally, which means there is a single pool. The exceptions are member states in which local taxes are used to finance health care and those in which individual health insurance funds are responsible for collecting their own social insurance contributions. In both cases, systems are usually in place to re-allocate resources to compensate poorer regions with smaller tax bases or to compensate funds with poorer members and/or members at higher risk of ill health. Competition among pooling agents (usually also purchasing agents) is relatively rare in EU health systems (see below).

Purchasing health services

Purchasing refers to the transfer of pooled funds to providers on behalf of a population. The way in which services are purchased is central to ensuring efficiency in service delivery and quality of care. It may also affect equity of access to health care and administrative efficiency and is likely to have a major effect on ability to control costs and financial sustainability. Key issues involve market structure and purchasing mechanisms (for example, contracting, provider payment and monitoring).

Where health care is financed mainly through social insurance contributions, the relationship between purchaser (health insurance fund) and provider has traditionally been contractual. In member states where health care is financed mainly through tax, the purchasing function is usually devolved to territorial entities (regional or local health authorities or specially-created purchasing organisation such as Primary Care Trusts in England). Purchaser-provider splits have been introduced throughout England, Italy and Portugal and in some regions of Spain and Sweden.

Competition among purchasers is relatively rare in EU health systems. It exists in Belgium and during the 1990s it was introduced in the Czech Republic and Slovakia and extended to the whole population in Germany and the Netherlands. Allowing health insurance funds to compete for members gives them incentives to attract favourable 'risks' (that is, people with a relatively low average risk of ill health) and avoid covering high risk individuals, which may affect equity of access to health care. Risk adjustment mechanisms aim to address this by compensating health insurance funds for high risk members. However, risk adjustment is technically and politically challenging and often incurs high transaction costs. A recent review concluded that most risk adjustment mechanisms in the Europe fail to prevent risk selection, and that the benefits of competition were therefore likely to be outweighed by the costs (van de Ven et al. 2007).

In EU health systems, primary care providers are most commonly paid through a combination of capitation and fee for service. Where health care is financed mainly through social insurance contributions, specialists are more likely to be paid on a fee for service basis, whereas in predominantly tax-financed health systems, specialists are often salaried employees. Hospitals are most commonly allocated budgets, but case-based payment is increasingly used either to define budgets or as a retrospective form of payment (with or without a cap on payments).

Coverage, benefits and cost sharing

Residence in a country is the most common basis for entitlement to health care in the European Union, resulting in universal or near universal (98-99%) population coverage in most member states; the main exception is Germany, where statutory coverage is around 88%. EU health systems provide broadly comprehensive benefits, usually covering preventive and public health services, primary care, ambulatory and inpatient specialist care, prescription drugs, mental health care, dental care, rehabilitation, home care and nursing home care. Across member states there is some variation in the range of benefits covered and the extent of cost sharing required. In some member states there may be a gap between what is 'officially' covered and what is actually available in practice.

All member states impose cost sharing for services covered by the benefits package, most commonly to outpatient prescription drugs and dental care. In some member states, the prevalence of informal payments to supplement or in lieu of formal cost sharing has posed a challenge to health reforms (Balabanova and McKee 2002; Lewis 2002; Murthy and Mossialos 2003; Allin et al. 2006).

Which financing reforms are most likely to enhance sustainability?

Many who draw attention to the gap between what we currently spend on health care and other forms of social security and what we may need to spend in future conclude that the only way of bridging this gap is to increase reliance on private finance (Bramley-Harker et al. 2006). We question the validity of this approach. Private financing undermines health system values and presents poor value in comparison to publicly-financed health care. In what follows we summarise some of the key findings of Section 3.

Centralised systems of collecting funds seem better able to enforce collection (in contexts where this is an issue) and may therefore be better at generating revenue than systems in which individual health insurance funds collect contributions. In part, however, this reflects the nature of the collection agent – tax agencies may be more difficult to evade (with impunity) than health insurance funds. Centralised contribution rate setting may be resisted where funds have traditionally had the right to set their own rates, but it is not impossible, as recent Germany reforms show. It is an important step towards ensuring equity and may lower the transaction costs associated with risk adjustment, as the risk adjustment mechanism no longer has to compensate for different contribution rates. It may also help to address resistance to risk adjustment on the part of health insurance funds.

Some of the older member states have taken steps to boost public revenue by **broadening revenue bases** linked to employment. Both France and Germany have increased their reliance on non-earnings-related income through tax allocations, a move that is likely to contribute to fiscal sustainability in the context of rising unemployment, growing informal economies, growing self employment, concerns about international competitiveness and changing dependency ratios. In contrast, during the 1990s, many of the newer member states of central and eastern Europe moved away from tax financing and introduced employment-related social insurance contributions. Unfortunately, the economic and fiscal context in many of these countries is particularly unsuited to employment-based insurance due to high levels of informal economic activity and unemployment. Consequently, governments have usually continued to rely on tax allocations to generate sufficient revenue. In some cases, this has been seen as a failure of the social insurance 'system'. However, it should probably be seen as an advantage. The potential benefits of creating new purchasing entities at arm's length from government and from providers can be maintained, even if tax financing continues. In fact, finding ways to safeguard tax allocations when new contribution mechanisms are introduced might be essential to ensuring sufficient revenue and to addressing some of the limitations of employment-based social insurance.

The clear trend towards creating a **national pool** of publicly-generated health care resources witnessed in newer and older member states is a welcome one. A single pool of health risks is the basis for equity of access to health care. It also enhances efficiency by counteracting uncertainty around the risk of ill health and its associated financial risk. In addition, minimising duplication of pooling may improve administrative efficiency.

Another welcome trend related to pooling is the move away from allocating pooled resources (to health insurance funds or to territorial 'purchasers') based on historical precedent, political negotiation or simple capitation towards **strategic resource allocation** based on risk-adjusted capitation.

This move can address some of the inequalities associated with local taxation or collection by individual health insurance funds and is a major step to ensuring that resources match needs and that access to health care is equitable.

Some newer and older member states have introduced **competition among purchasers** (health insurance funds). This may seem like a good way to stimulate active purchasing. In practice, however, the costs of this form of competition may outweigh the benefits due to the incentives to select risks it creates. Evidence from Belgium, France and Germany shows how risk adjustment mechanisms may weaken these incentives, but fail to eliminate them (van de Ven et al. 2007).

The move away from passive reimbursement of providers towards **strategic purchasing** of services also represents a step towards matching resources to needs and ensuring value for money. Health care providers are ultimately responsible for generating a large proportion of health care expenditure, so ensuring that their services are delivered equitably, at an appropriate level of quality and for an appropriate cost is central to securing both economic and fiscal sustainability. However, in many member states reform of purchasing has been under developed. In some cases, purchasing agents have not been given sufficient incentives or tools to attempt strategic purchasing. With regard to provider payment, the move away from pure fee for service reimbursement towards more sophisticated, blended payment systems that account for volume and quality is promising. Again, however, reforms have not always been implemented appropriately and more needs to be done, particularly in terms of linking payment to performance in terms of quality and health outcomes.

Several countries have made efforts to expand **population coverage**. Consequently, most member states now provide universal coverage. However, the scope and depth of coverage are as important as universality, and the trend in some countries to lower scope and depth undermines financial protection. Efforts to define the scope and depth of coverage should be systematic and evidence based to ensure value for money. Health technology assessment is beginning to be used more widely to assist in reimbursement decisions and defining benefits. However, its application is still limited in many member states. In some cases this is due to financial and technical constraints. In others, implementation is limited by political constraints such as opposition from patient groups, providers and product (usually pharmaceutical) manufacturers.

Cost sharing has been introduced and expanded in many member states and reduced in others. Although cost it may be used to encourage cost-effective patterns of use, overall there is little evidence of efficiency gains and, where it is used to curb direct access to specialists, there is some evidence of increased inequalities in access to specialist care (as those who can afford the user charges have better access). There is no evidence to show that cost sharing leads to long-term expenditure control in the pharmaceutical or other health sectors. Additionally, due to the information asymmetry inherent in the doctor-patient relationship, patients may not be best placed to 'purchase' the most cost-effective care. Given that the bulk of health care expenditure (including pharmaceutical expenditure) is generated by providers, efforts should focus on encouraging rational prescribing and cost-effective provision of treatment. One lesson from the reform experience is that cost sharing policy should be carefully designed to minimise barriers to access. In practice, this means providing exemptions for poorer people and people suffering from chronic or life-threatening illnesses. With careful design, cost sharing can also be used to ensure value for money.

Markets for **private health insurance** in EU health systems generally serve richer and better educated groups and present barriers to access for older and unhealthier people. They are also often fragmented, resulting in weak purchasing power. Due to the fact that many of them exist to increase consumer choice (or to reimburse cost sharing), insurers have limited incentives to engage in strategic purchasing and link provider pay to performance. However, they may have strong incentives to select risks, to the detriment of equity and efficiency.

In general, private systems incur substantially higher transaction costs than public systems and may therefore be accused of lowering administrative efficiency.

Overall, we identify two broad reform trends. First, member states have made significant attempts to promote equity of access to health care – by expanding coverage, increasing regulation of private health insurance, improving the design of cost sharing and making the allocation of resources more strategic. Second, there is a new emphasis on ensuring quality of care and value for money – for example, through increased use of HTA, efforts to encourage strategic purchasing and provider payment reforms that link pay to performance. While cost containment remains an important issue, in many member states policy makers are no longer willing to sacrifice equity, quality or efficiency for the sake of curbing expenditure growth. Several of the reforms introduced more recently are in part an attempt to undo the negative effects of prioritising cost containment over health financing policy goals.

Is there an optimal way of financing health care?

We argue that public finance is superior to private finance. This is not surprising given the need to secure sustainability without undermining values such as equity in finance or equity of access to health care. However, our argument is based on efficiency grounds too. Publicly-generated finance contributes to efficiency and equity by providing protection from financial risk and by detaching payment from risk of ill health. In contrast, private contribution mechanisms involve limited or no pooling of risks and usually link payment to risk of ill health and ability to pay. Public finance is also superior in its ability to ensure value for money which, as we have argued, is central to securing both economic and fiscal sustainability. Overall, the experience of the United States suggests that increasing reliance on private finance may exacerbate health care expenditure growth, perhaps due to the weak purchasing power of private insurers and individuals against providers. Among the older member states of the European Union, those that have relied more heavily on private finance, either through private health insurance or through higher levels of cost sharing, are also those that tend to spend more on health care as a proportion of GDP (notably, Austria, Belgium, France, Germany and the Netherlands).

Of course, public finance is not without its problems. Where social insurance contributions dominate, there are likely to be concerns about the high cost of labour and the difficulty of generating sufficient revenue as informal economies and self employment grow, and as population ageing leads to shifts in dependency ratios. Concerns may also focus on generating sufficient revenue where capacity to enforce tax and contribution collection is weak. The reluctance of certain groups to pay collectively for social goods and to subsidise the costs of care for others may exacerbate resistance to paying higher taxes or contributions. However, these problems can be addressed – for example, by broadening the revenue base to capture non-employment-based income, by investing in efforts to strengthen public sector capacity, and by making the social and economic case for collective financing. Equity in finance may be compromised if health systems become increasingly dependent on consumption taxes (VAT), if ceilings on contributions are lowered, or if tax and contribution evasion is rife. On balance, however, these concerns are outweighed by gains in terms of equity of access to health care.

In some countries, public sector resource allocation has contributed to inequalities in access, while purchasing has been non-existent or weak. Nevertheless, there are few cases in which private health insurers have been able to demonstrate better purchasing skills (in part due to their need to enhance consumer choice).

In determining an optimal way of financing health care we might ask what type of financing system is best placed to adjust to changing priorities. In recent years there has been increased demand for some types of health services, notably mental health care, long-term care and care of chronic illnesses.

Demand for these services, and for integrated forms of delivering care, is likely to grow as populations age. The type of financing system best able to respond to shifts in demand is one with the ability to enhance pooling, co-ordinate and direct strategic resource allocation, match resources to need, shape the nature of supply and create incentives to enhance provider responsiveness. We suggest that systems based on public finance stand a much greater chance of rising to this challenge than alternatives such as private health insurance.

Policy recommendations

Reforms that aim to secure the economic and fiscal sustainability of health care financing in the context of social security should focus on ensuring equity of access and value for money. Our recommendations are based on the analysis of health financing arrangements and reforms in Section 2 and Section 3. We should point out that evidence about the impact of some arrangements and reforms is lacking, so we cannot be sure of all outcomes. Nor can we be sure whether a reform will have the same effect in different countries. With this caveat in mind, we make the following recommendations.

- The starting point for any reform should be careful analysis of the existing health (financing) system to identify weaknesses or problem areas, combined with understanding of the contextual factors that may contribute to or impede successful reform.
- Policy makers may find it worthwhile to try to communicate the aims and underlying rationale for reforms to the wider public.
- Policy makers should consider the whole range of health financing functions and policies, rather than focusing on collection alone (contribution mechanisms).
- Find ways to enforce collection to ensure sufficient revenue and to restore confidence in the health financing system.
- Health systems predominantly financed through employment-based social insurance contributions may benefit from broadening the revenue base to include non-earnings-related income.
- In addition to contributing to efficiency and equity, enhancing pooling by lowering the number of pools or (better still) creating a single, national pool can facilitate strategic direction and co-ordination throughout the health system.
- Limit reliance on private finance (private health insurance, MSAs, user charges) and ensure that there are clear boundaries between public and private finance so that private finance does not draw on public resources or distort public resource allocation and priorities.
- If user charges are imposed, pay careful attention to the design of cost sharing policy, which should be systematic and evidence based.
- Avoid introducing MSAs as they do not involve any pooling across groups of people. They also suffer from many of the limitations of user charges.

- Tackling informal payments is central to increasing public confidence in the health system. Informal payments may present a major challenge to successful implementation of other reforms.
- Encourage strategic resource allocation to ensure that health resources match health needs.
- Encourage greater use of HTA, particularly in decisions about reimbursement and in defining the benefits package, but also in improving clinical performance.
- Design purchasing and provider payment systems to create incentives for efficiency, quality and productivity.
- Encourage administrative efficiency by minimising duplication of functions and tasks.
- Avoid confusing efficiency with expenditure control. Spending on health care should not be unconditional – rather, it should always demonstrate value for money.

EUROPEAN PARLIAMENT

2004 2009

Committee on Employment and Social Affairs

Pension policy challenges in European countries

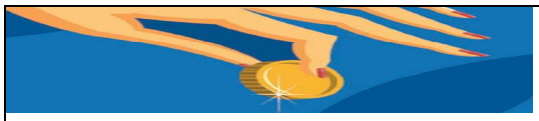
Asghar Zaidi
Social Policy Division, OECD

PUBLIC HEARING

"Future of social security systems and pensions:
Their financing and the trend towards individualisation"
June 3, 2008

Structure

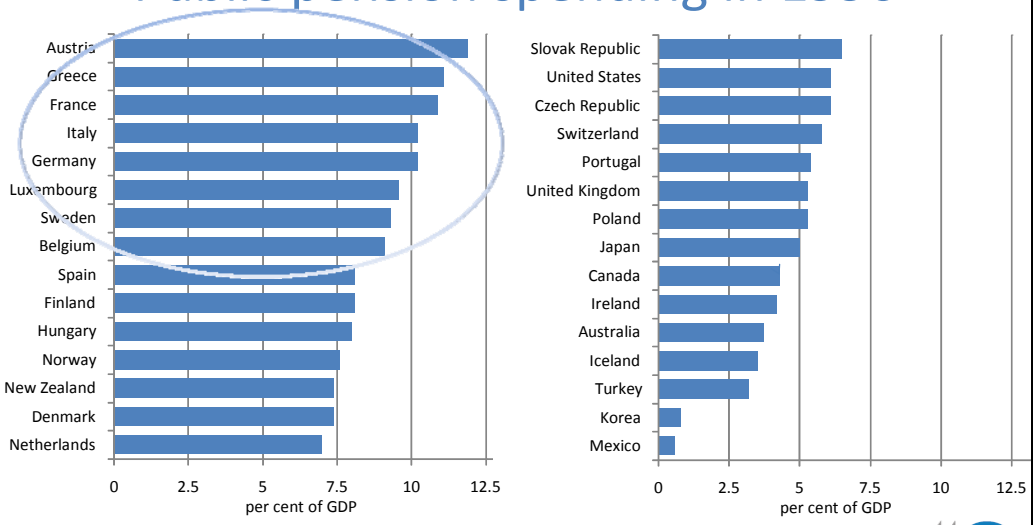
1. Which countries reformed?
2. What did countries do (since 1990)?
3. What fiscal impact (impact on public pension expenditures)
4. What social impact (impact on pension benefits and progressivity)
5. What role for private pensions?
6. What future pension policy directions?



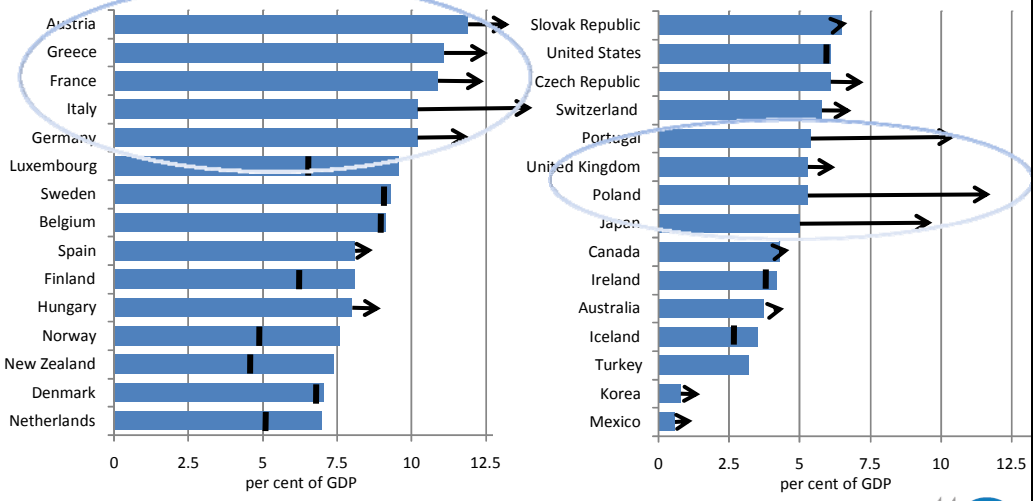
1

Public pension spending and pension reforms

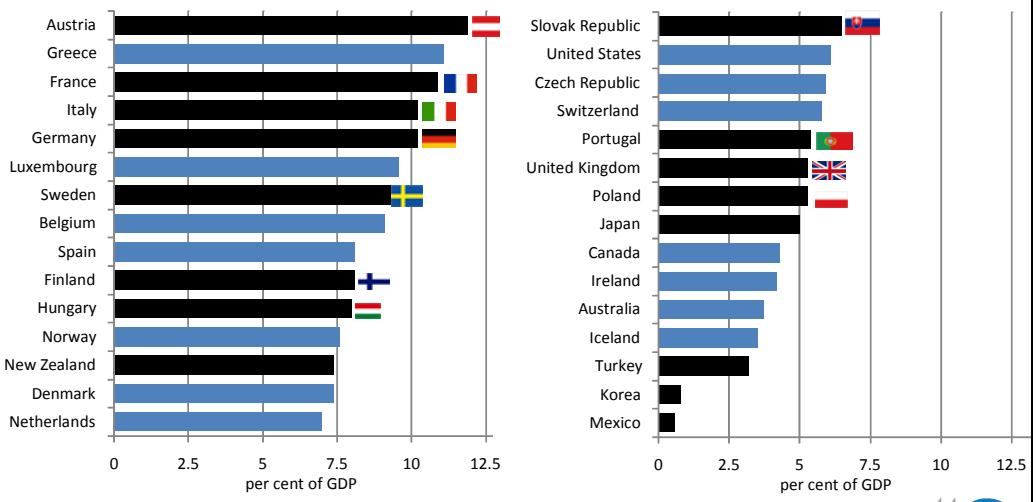
Public pension spending in 1990

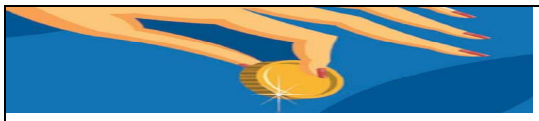


Public pension spending: 1990-2005



Which countries reformed?





2

What did countries do?

Pension reform packages

	Pension age	
	M	F
Austria	●	●
Finland		
France		
Germany		
Hungary	●	●
Italy	●	●
Japan	●	●
Korea	●	●
Mexico		
NZ	●	●
Poland		
Portugal		●
Slovakia	●	●
Sweden		
Turkey	●	●
UK		●

Pension reform packages

	Pension age		Retirement
	M	F	incentives
Austria	●	●	●
Finland			●
France			●
Germany			●
Hungary	●	●	●
Italy	●	●	●
Japan	●	●	
Korea	●	●	
Mexico			
NZ	●	●	
Poland			●
Portugal		●	●
Slovakia	●	●	
Sweden			
Turkey	●	●	
UK		●	●

Pension reform packages

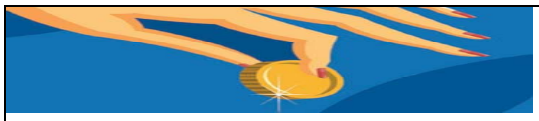
	Pension age		Retirement	Calculation	
	M	F	incentives	measure	revaluing
Austria	●	●	●	●	
Finland			●	●	●
France			●	●	●
Germany			●		
Hungary	●	●	●	●	
Italy	●	●	●		
Japan	●	●		●	
Korea	●	●			
Mexico					
NZ	●	●			
Poland			●	●	
Portugal		●	●	●	●
Slovakia	●	●		●	
Sweden				●	
Turkey	●	●			
UK		●	●		

Pension reform packages

	Pension age		Retirement	Calculation		Indexation
	M	F	incentives	measure	revaluing	
Austria	●	●	●	●		●
Finland			●	●	●	●
France			●	●	●	
Germany			●			
Hungary	●	●	●	●		●
Italy	●	●	●			●
Japan	●	●		●		
Korea	●	●				
Mexico						
NZ	●	●				
Poland			●	●		●
Portugal		●	●	●	●	●
Slovakia	●	●		●		
Sweden				●		
Turkey	●	●				
UK		●	●			

Pension reform packages

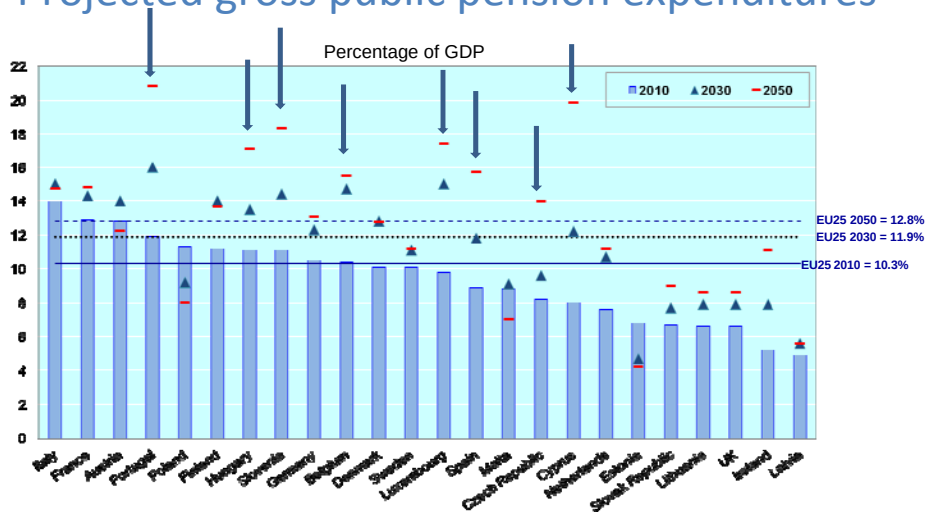
	Parametric						Paradigmatic		
	Pension age		Retirement	Calculation		Indexation			Life
	M	F	incentives	measure	revaluing		DC	NDC	Expectancy
Austria	●	●	●	●		●			
Finland			●	●	●	●			●
France			●	●	●				●
Germany			●						●
Hungary	●	●	●	●		●	●		
Italy	●	●	●			●		●	
Japan	●	●		●					
Korea	●	●							
Mexico							●		
NZ	●	●							
Poland			●	●		●	●	●	
Portugal		●	●	●	●	●			●
Slovakia	●	●		●			●		
Sweden				●			●	●	
Turkey	●	●							
UK		●	●						



3

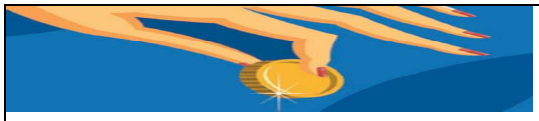
What fiscal impact?
(how will public pension expenditures be affected?)

Projected gross public pension expenditures



What fiscal impact?

- Reforms improved long-term financial sustainability of a number of countries that reformed their system (e.g. Italy, France, Poland, Finland, Germany)
- Serious concerns of financial sustainability for others (e.g. Portugal, Slovenia, Luxembourg, Spain and Cyprus)
- But, the question of interest are:
  - who is affected by this fiscal squeeze?
  - What social cost for this improvement in fiscal balances?



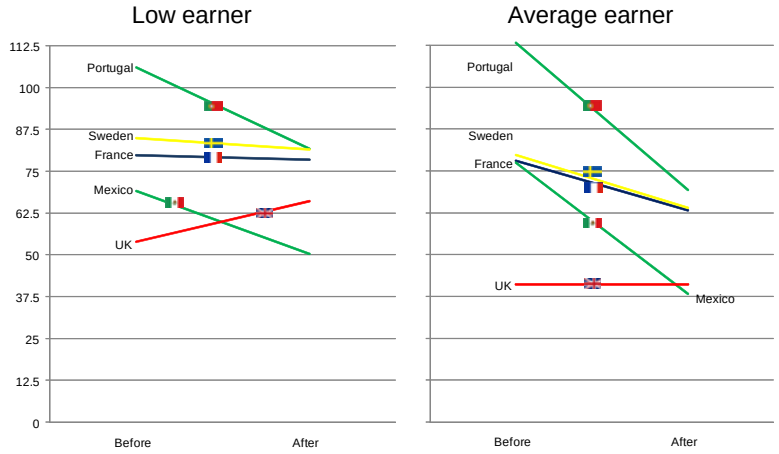
4

What social impact?

(how will pension benefits and system progressivity be affected?)

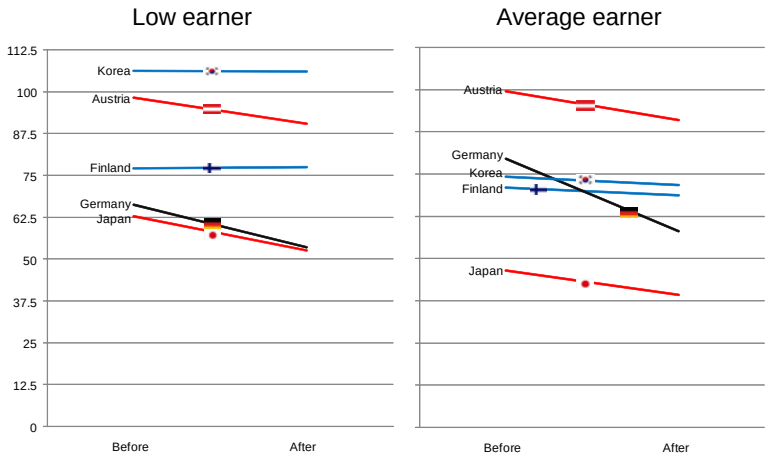
Impact on net replacement rates

2a. Reforms that protected low earners



Impact on net replacement rates

2b. Across the board cuts in benefits



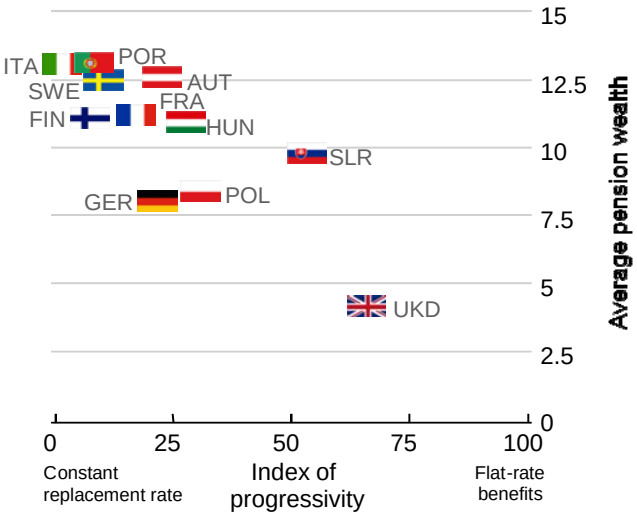
Impact on net replacement rates

2c. Reforms that strengthened the link between contribution and pension

Overall impact

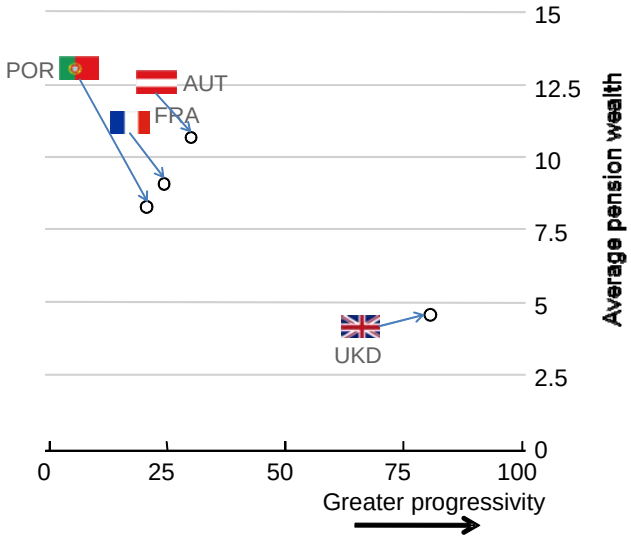
- Reforms affect workers at different earnings levels differently
- Two measures:
  - Pension wealth: "size" of the system
  - Progressivity: degree of targeting benefits to low income workers

Pension Benefits and progressivity before reform



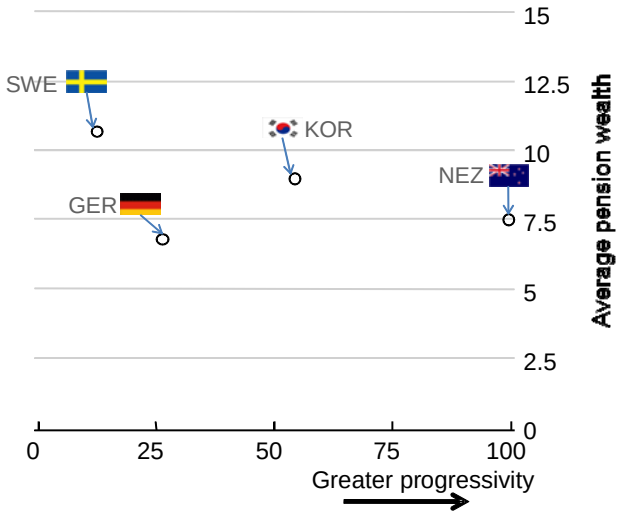
Overall impact

Falling benefits, but with greater progressivity



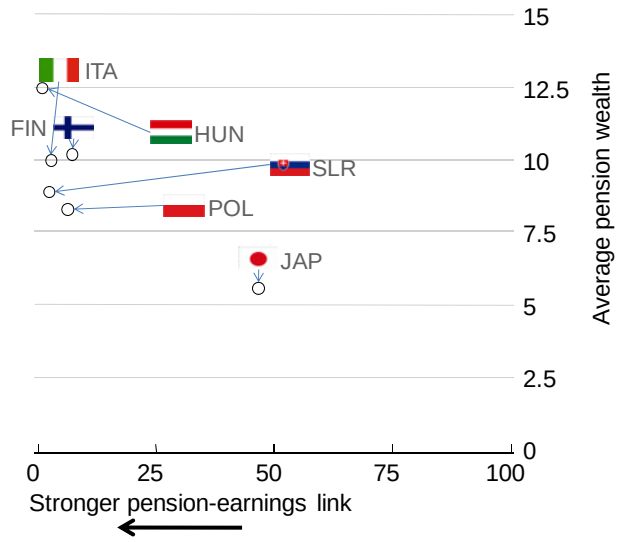
Overall impact

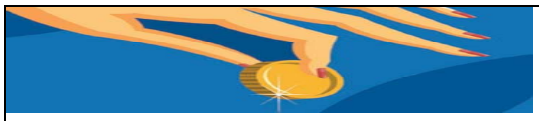
Falling benefits, but little or no change in progressivity



Overall impact

Stronger pension-earning link (less redistribution)





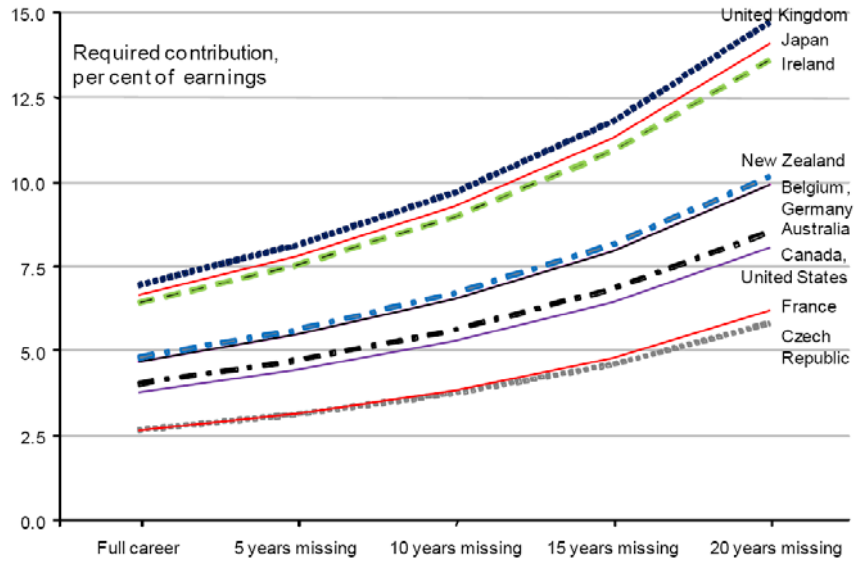
5

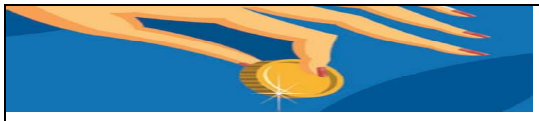
A growing role for private pensions

Why has the role increased?

- Mandatory private pensions as substitute for part of public provision
  - Hungary, Poland, Slovak Republic, Sweden
- Cuts in public pensions leave a bigger role for private pensions
  - Germany, Japan
- Many countries have always had a bigger role of voluntary private pensions (with broad coverage)
  - Ireland, United Kingdom

Contributions needed filling the pension gap





6

Where next in pension policy strategy?

Where next in pension reform?

1. Fiscal sustainability concerns
   - Early birds: many countries have improved future financial sustainability problems: Italy, France, Germany, Sweden, Poland, Austria
   - Slow movers: transition to new rules is too slow in some countries (Austria and Italy)
   - Lacking reforms: Belgium, Luxembourg, Cyprus and Spain have high public pension spending but no "major" reforms

Where next in pension reform?

2. Social sustainability
   - cuts in low earners' pensions risk resurgence in old-age poverty in Germany, Poland and Slovak Republic
   - public-pension cuts mean individual savings needed to maintain retirement incomes: in France and Germany plus Ireland and the United Kingdom

Where next in pension reform?

3. Early retirement and its costs remain a problem
   - many pension systems still experience early retirement
   - as a result, average effective retirement ages are below 60 in eight OECD countries: Belgium, France, Hungary, Italy

Where next in pension reform?

4. Private savings inadequate
   - Compulsion – but oversaving possible
   - Tax incentives ineffective
   - Financial education largely a gimmick
   - Facilitating access (e.g. employers requirement)
   - Automatic enrolment is unproven

Where next in pension reform?

5. Adequacy of income in old age

- A stronger safety-net will be needed to avoid resurgence in old-age poverty (social pensions, minimum pensions)
- Private individual savings will have to improve to avoid excessive fiscal costs and reduction in living standards in retirement

Further information

- www.oecd.org/els/social/ageing/PAG
- e-mail: asghar.zaidi@oecd.org
  edward.whitehouse@oecd.org

Financing health care in the context of social security

Report prepared for the European Parliament at the request of the Committee on Employment and Social Affairs

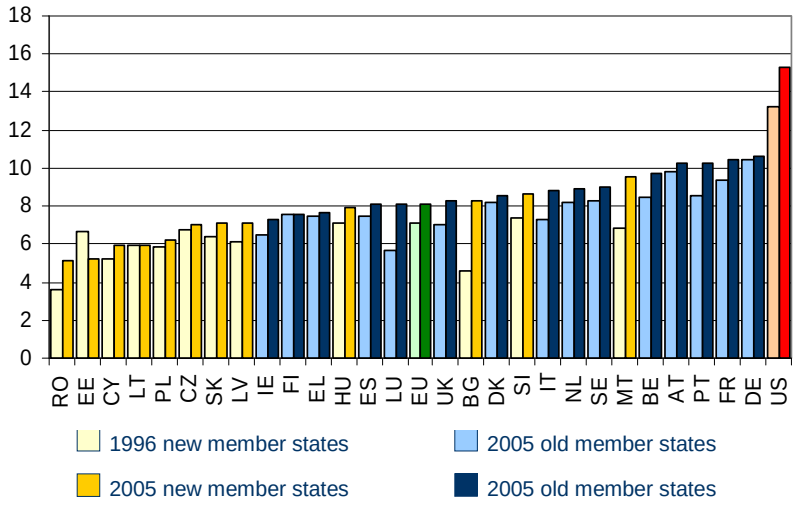
Brussels, 3rd June 2008

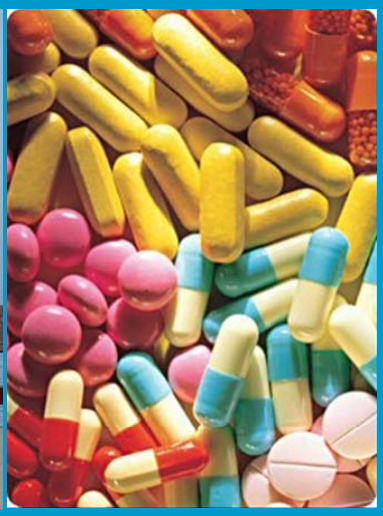
Sarah Thomson, Thomas Foubister, Elias Mossialos, LSE Health

LSE European Observatory on Health Care Systems

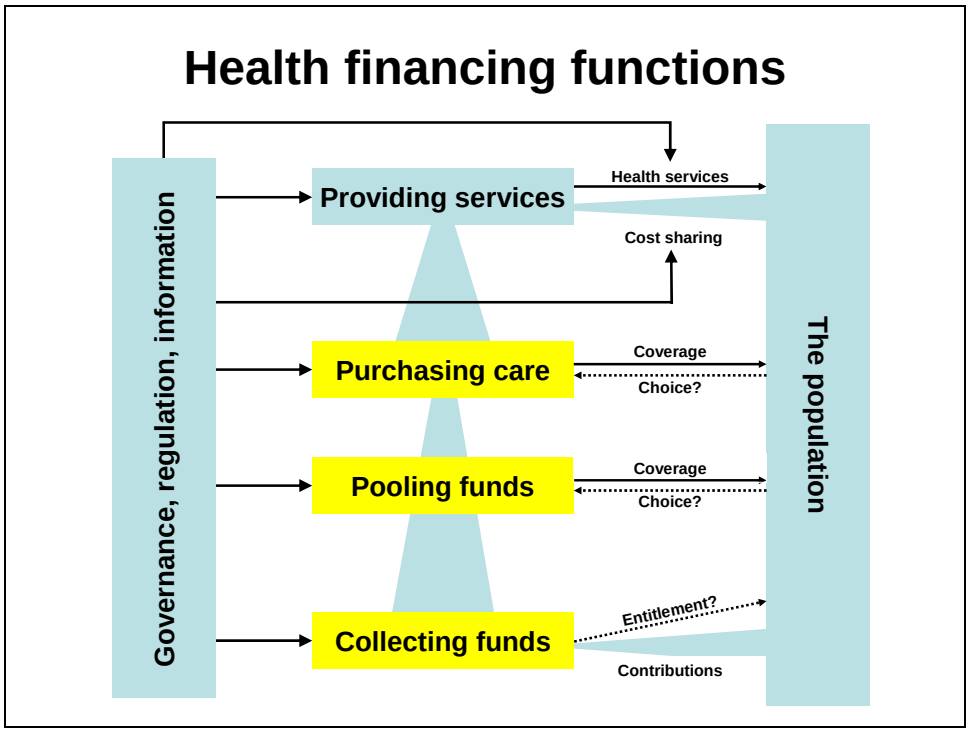
Total expenditure on health as a % of GDP, 1996 and 2005

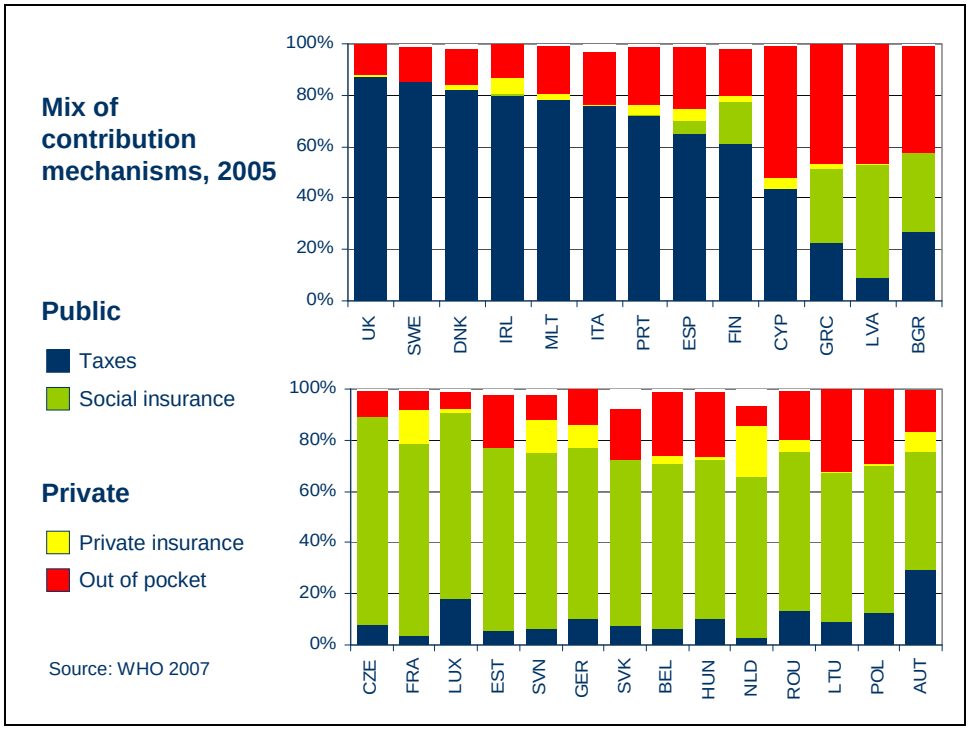
Source: WHO 2007

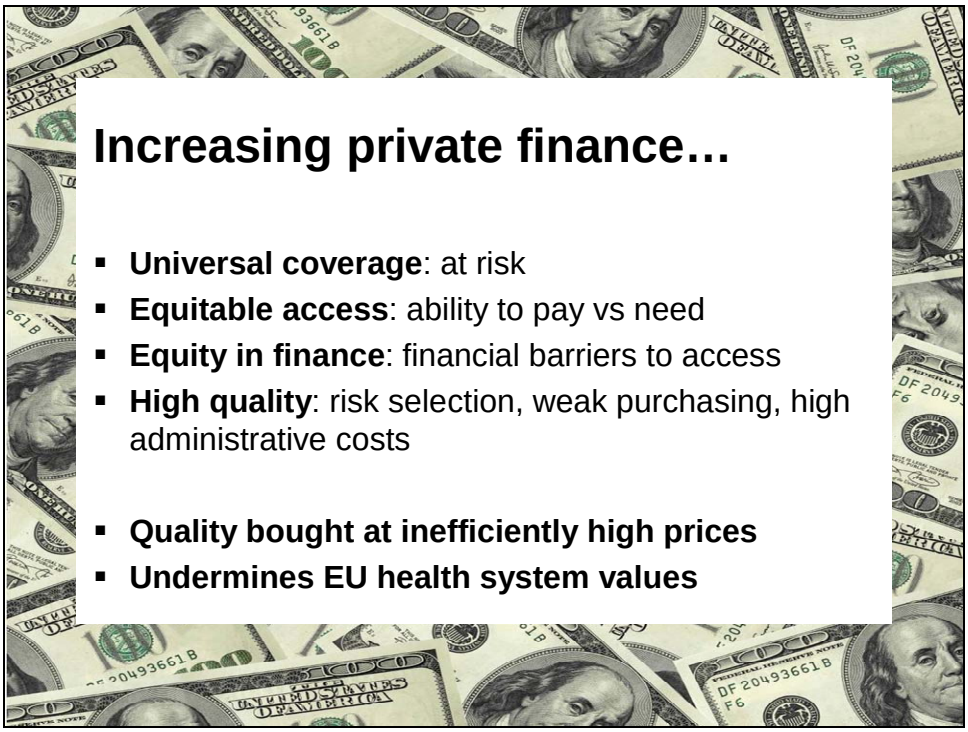





TAXES


Health financing functions
Governance, regulation, information
Providing services
Purchasing care
Pooling funds
Collecting funds
Health services
Cost sharing
Coverage
Choice?
Coverage
Choice?
Entitlement?
Contributions
The population


Mix of contribution mechanisms, 2005
Public
Taxes
Social insurance
Private
Private insurance
Out of pocket
Source: WHO 2007
100%
80%
60%
40%
20%
0%
UK
SWE
DNK
IRL
MLT
ITA
PRT
ESP
FIN
CYP
GRC
LVA
BGR
CZE
FRA
LUX
EST
SVN
GER
SVK
BEL
HUN
NLD
ROU
LTU
POL
AUT



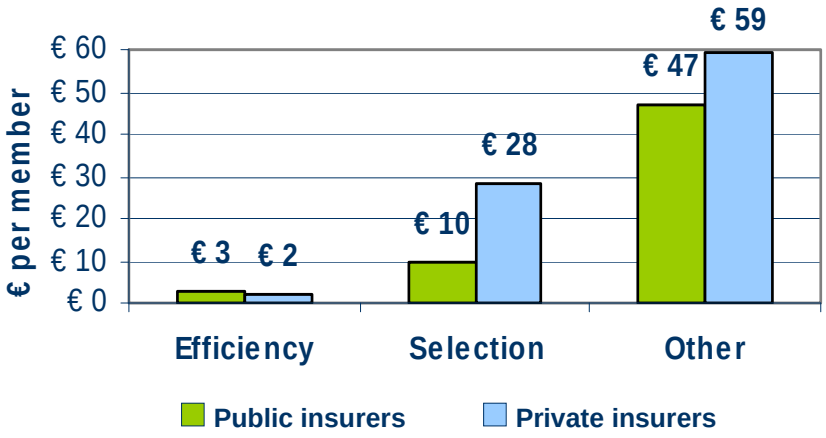
Private vs public insurance (Germany), 2001-2005

Prevalence of:	Public	Private
People aged 65+	22%	11%
Chronic disease*	23%	11%
Self-reported poor health*	21%	9%
GP contact*	81%	55%
Specialist contact (outpatient)	47%	45%
Difficulty paying for outpatient prescription drugs*	26%	7%
Waiting time for gastroscopy	36 days	12 days

*Statistically significant after controlling for differences in age, gender and income (Mielck and Helmert 2006, Schneider 2003, Lungen et al 2008)

Dutch insurers spend more on risk selection than efficiency

Insurers' non-medical costs (1998)



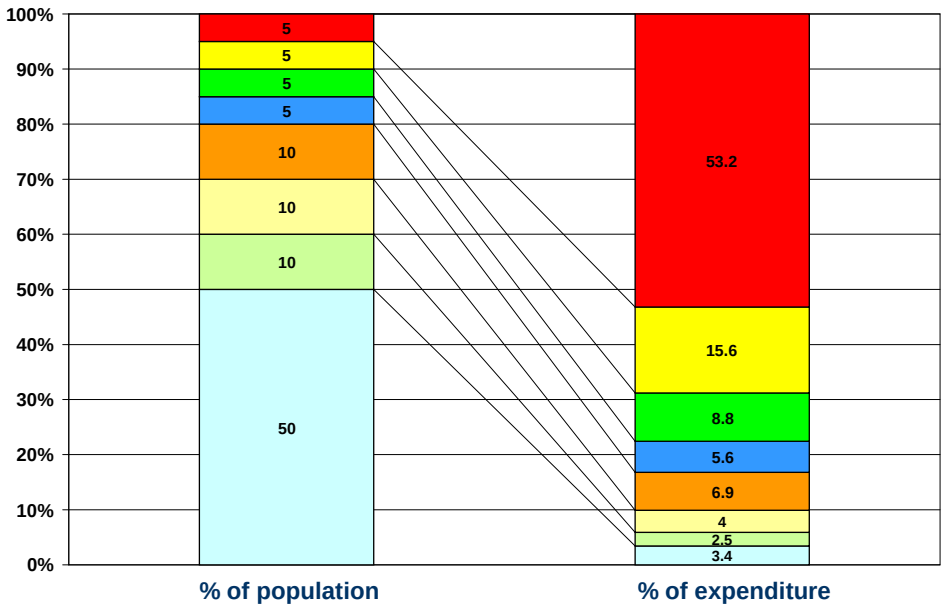
Source: Douven and Westerhout 2000

Ensuring value for money…

- **Collection**: generate sufficient revenue
- **Pooling**: avoid fragmentation
- **Purchasing**: move away from passive reimbursement
- **Provision**: improve continuity and co-ordination

- **Reforms should match resources to need**

Distribution of health care expenditure (Germany)



Sustainability =

Increased private finance? Unlikely

Solidarity + value for money? More likely

… technical and political challenges