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Social security under the aegis of the Council presidencies

Dear Reader,

We're coming to the end of an eventful year for European politics. The citizens of the European Union have elected the parliamentarians who will discuss numerous European initiatives with the Council and the Commission over the coming five years. The European Commission will shift several chairs and the Brussels authorities will shine with new faces and a new distribution of responsibilities.

Next year looks to be just as exciting. In July 2020, Germany will take over the Presidency of the Council for six months, following on from Finland and Croatia. This is a good opportunity to provide an overview of the individual aspects of the social systems in these countries. Even though social and labour policy in Europe has become more unified in recent decades, the organisation of social security remains a core competency of each Member State. It is important that this continues also in future. Social security truly highlights the differences between cultural traditions, the history of political systems, policy preferences and economic circumstances. It's worth taking a closer look: how are their systems for health, long-term care, workplace accidents, and old-age pension insurance different to the German system, and what do they have in common? What are the challenges that these systems will face in the future?

Even just comparing three countries shows the diversity of the European systems, but it also highlights the fact that, despite different approaches, there are more things in common than might at first be assumed.

We hope you enjoy reading this edition of ed*!

Yours Ilka Wölfle

Social Security in Finland and Croatia

An overview.

1. Pension Insurance

a) Finland

In Finland, the pension insurance system is built on three pillars. It comprises a pay-as-you-go statutory pension scheme, the state pension and, as a final safeguard, the guaranteed minimum pension. Statutory pension insurance is organised on a decentralised basis and is provided by private institutions. All workers and the self-employed are insured.

Since 1993, workers' contributions have been paid by both the employee and the employer. The worker's share of the contribution is fixed at 6.75 percent (2019) and 8.25 percent (for people aged 53 to 62). The employer's contribution varies depending on the 'performance' of the individual insurance schemes. In the private sector, the average is 17.75 percent. A person's entire earnings are insured without an upper limit. Certain non-contributory periods are financed from the state budget. This includes periods for raising a child. This covers a period of two years, which is less than in Germany. It is also reimbursed less than in Germany: one year spent raising a child increases the pension by about twelve euros.

Unlike Germany, there is no fixed statutory retirement age for **old-age pensions** in Finland. Instead, there is a 'corridor' between the minimum age (currently 63.5) and the maximum age (68) which allows for more flexibility. There is also an adjustment mechanism that ensures retirement age is linked to life expectancy in the future.

Disability pensions are paid differently, depending on the degree of disability. A partial pension is paid at 40 percent reduced capacity and full pension at 60 percent (2019). There are lower thresholds for people aged over 60. In addition, there is the **state pension** and the **guaranteed minimum pension**, which are paid by Kela, the Social Insurance Institution of Finland.

The latter are paid (as a supplement) if a person has not acquired any entitlements or only very few. The amount of the state pension depends on marital status. Singles are entitled to €628.85 per month. Married or cohabiting persons are entitled to €557.79 per month. The guaranteed minimum pension ensures that each person has a minimum income of €784.52 per month (figures for 2019).

More than 1600 euros is enough to enjoy retirement in Finland

You can retire in Croatia at the age of 60 if you've had 35 years of insurance.

b) Croatia

Croatian pension insurance is based on three pillars: statutory pension insurance, compulsory private pension insurance and voluntary private pension insurance.

Statutory pension insurance is a pay-as-you-go system but is subsidised by tax subsidies (over 40 percent of costs), which cover pension benefits for certain groups of persons (such as the military, police, the judiciary). Insured persons are solely responsible for making their contributions of 20 percent. If necessary, this is split into 15 percent for the first pillar and 5 percent for the second. In principle, statutory pension insurance covers all workers, including the self-employed. Non-standard forms of work are also covered if they are subject to income tax. Jobs in particularly dangerous occupations are calculated at up to 150 percent of actual time worked.

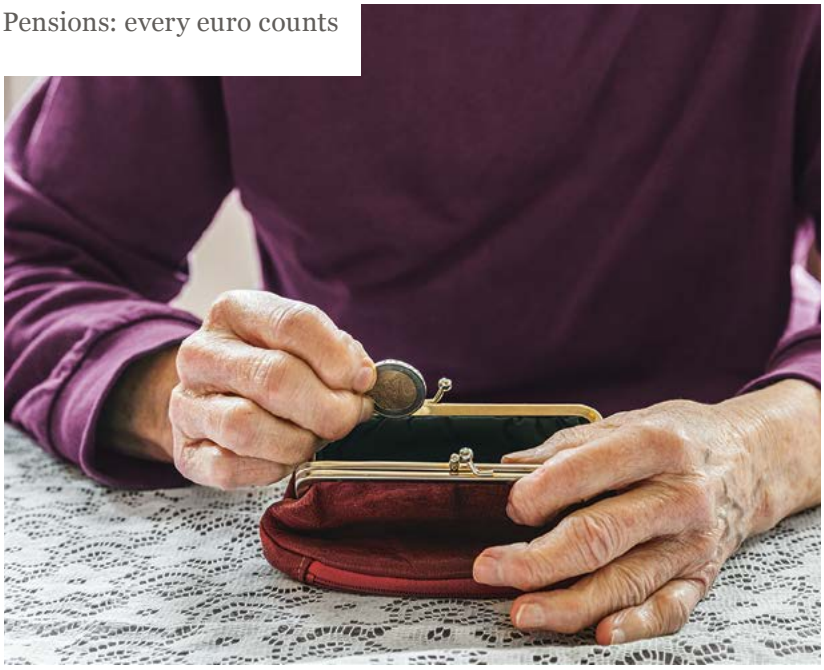
A person must have made at least 15 years of contributions to be entitled to an **old-age pension**. Starting in 2028, the retirement age will be gradually raised to 67 for all people. As it currently stands, a person can retire early at the age of 60 if they have made contributions for at least 35 years. The pension is reduced if you retire early and increased if you postpone retirement. Reductions are 0.3 percent per month with a maximum of 18 percent; supplements are 0.34 percent per month with a maximum of 20.4 percent. A person who has had 41 years of pension insurance can retire at the age of 60 without any penalties.

If all other requirements are met, mothers with their own or adopted children are credited an additional six months per child to their insurance periods. Notwithstanding this, insurance is compulsory during parental leave in the first year of a child's life.

Croatia has both full and partial **disability pensions**. In addition, persons with reduced earning capacity must have been at least one third insured since the age of 20. Pension entitlements are reviewed every three years.

The pension insurance system is also responsible for cases of reduced earning capacity due to an accident at work or an occupational disease. The Croatian **formula for calculating pensions** is comparable to the German one. The pension is supplemented by an amount of 27 percent for periods in which contributions were made exclusively to the first pillar, or 20.5 percent for periods in which contributions were also made to the second pillar. The minimum pension entitlement depends on the number of years of insurance.

Pensions: every euro counts



There are survivors' pensions for widows and widowers as well as orphans. Under certain conditions, parents and cohabiting partners may also be entitled to a survivor's pension.

c) A look at Germany: similar challenges, different paths

Demographic change poses challenges for all pension insurance systems. Each country is going its own way. Generally speaking, people are being encouraged to work longer and retire later. Finland and Croatia, as well as Germany, use the same methods, albeit in different forms: increasing the regular retirement age, reducing pensions in the event of early retirement and increasing payments if retirement is postponed.

Germany has raised the retirement age to 67, with transitional periods. This also happened a few years ago in Croatia. However, unlike Germany, the trade unions in Croatia have reacted with the launch of the '67 is too high' campaign. Following increasing pressure, a draft law has recently been put forward which revokes or amends parts of Croatia's pension reform. It is intended to maintain the retirement age of 65 and to reduce pension penalties in the event of early retirement. The other extreme is Finland which has gone so far as raising the retirement age to 68 and has stated that this is an interim step. In future, the retirement age will be linked to life expectancy.

Germany has made it possible for people who have paid into the system for a particularly long time to retire early at the age of 65 without any reductions.

The Croatian system provides for a similar possibility at the age of 60. Finland, on the other hand, has responded to the issue of early retirement by creating a 'corridor', beyond which early retirement is only possible to a very limited extent. Whereas Germany does not offer the possibility of early retirement for particularly hazardous occupations (other than in the public service), this is possible in Finland and Croatia.

It is worth noting that the minimum old-age pension is determined in completely different ways, for example with regard to means testing/income credits. There are also considerable differences in the level of contributions. Whereas the total contribution rate is almost the same in Germany and Croatia, it is well over 30 percent in Finland.

A late retirement secures monetary gains

Each country is dealing with demographic change in its own way.

In Croatia, the employee is significantly more involved in paying contributions, in Finland it is the employer.

Furthermore, while in Croatia and Finland all self-employed persons are in principle obliged to make contributions to pension insurance, in Germany this only applies to certain occupational groups.

Finally, it should be pointed out that in Croatia, unlike in Germany and Finland, statutory pension insurance is responsible for workplace accidents. A separate branch of statutory accident insurance does not exist in Croatia.

Finland's primary medical system also provides occupational medical care.

Thanks to digitalisation it doesn't have to be this way

2) Health Insurance

a) Finland

The Finnish health care system is mainly tax-financed as a type of 'citizens' health insurance'.

Finland's 300 municipalities are responsible for the provision of primary medical care. Private health facilities are the exception in the system. Price and quality competition are increasingly being fuelled by nationwide tenders for health services, in which private institutions can also participate. The public health system also includes services for long-term care.

Approximately 80 percent of health expenditure is **financed** from public funds and administered by municipalities along the entire spectrum of healthcare. The municipality levies a tax of between 18 percent and 22.5 percent of taxable income per municipality to ensure the provision of healthcare. In addition, the municipalities receive discretionary tax subsidies from the federal government. Part of health-related expenditure, particularly sickness benefits after salary continuation has expired, is financed by the national health insurance system, which also includes the self-employed and pensioners. Deductions amount to between 1.5 percent and 2.1 percent.

A unique feature in Finland is the provision of **occupational medical care** by hospitals in the primary medical care system. In Finland, about one third of the population has access to this parallel system – 87 percent of the working population. Occupational medical care is an important competitive element for employers, as waiting times or gatekeepers (official first points of contact) in the public system can be reduced or completely circumvented. Continuing to pay wages for up to two months in the event of an illness is also a competitive factor for employers.

In addition, the Finns pay for private healthcare or take out **supplementary private insurance**. This supplementary insurance is used to finance certain benefits or co-payments not covered by the public system, which are quite significant in Finland. The average co-payment is €718 per person (2015).

By further opening up freedom of choice, waiting times are to be reduced and accessibility improved. The strict rules

Continued income and sick pay are also available in other countries

In Croatia, a voluntary system protects against co-payments

on minimum numbers and concentration of specialised services in hospital care show that quality clearly takes precedence over accessibility.

b) Croatia

The Croatian Ministry of Health defines the strategic regulatory framework for financing, providing and guaranteeing healthcare and charges the Health Institute (HZZO) with the operational provision of healthcare.

The HZZO administers approximately €2.9 billion per year (2016) for the **financing** of the country's healthcare system.

The Croatian public health system is financed from three sources. The largest share (91 percent) is generated through **payments** as a result of employment subject to social insurance contributions. Contributions are paid entirely by the employer. Since 1 January 2019, the contribution rate has been 16.5 percent. Insured persons have the option of taking out voluntary supplementary insurance to protect themselves against co-payments. This supplementary insurance is offered by the HZZO itself. The income from the premiums for supplementary insurance total around €210.6 million. This corresponds to 7.3 percent of total revenue. The premium is €14.63 per month.

The **third source of financing** for the HZZO consists of subsidies of €45 million generated by taxes. This is due, among other things, to challenges in collecting contributions as a result of contribution reductions or exemptions, as well as missing contributions due to undeclared work.

Persons insured in the public health system make **co-payments** for all health services, except in emergencies. Insured persons make an additional payment of two euros per prescription or per visit to a general practitioner. Additional payments are also stipulated for specialist, dental, physiotherapeutic and rehabilitative services, which cover the treatment costs proportionately. A hospital stay incurs a co-payment of 20 percent of the costs, at least €20.90 per day. In total, the co-payments per treatment occurrence are capped at the equivalent of €418 purchasing power parity. A treatment occurrence comprises a visit to a physician in private practice and a stay in hospital.

In the event of temporary incapacity to work, the employee is entitled to **continue receiving their salary**. During the first 42 days of sick leave, the employer makes payments in the amount agreed in the work contract or collective bargaining agreement. However, this must be at least 70 percent of the average income for the last six months. From the 43rd day of sick leave, the employer charges the continued salary payment to the HZZO.

Bottom line: despite the financial challenges posed by a lack of income due to undeclared work, comprehensive exemptions from contributions and co-payments, uneconomical supplementary insurance contracts and a

All heathcare systems are focusing on digitalisation.

volatile economic situation, the scope of benefits has been gradually extended. This is now comparable to that of other Member States.

The strategic trends in healthcare are to ensure the connectivity and continuity of healthcare, to standardise and improve the quality of healthcare, to optimise the efficiency and effectiveness of healthcare and ultimately to ensure the long-term financial viability of healthcare.

c) A look at Germany: the path to modernising health systems

The overview of the health systems shows that the reforms initiated in Finland and Croatia are aimed at securing the financing of the systems over the long term.

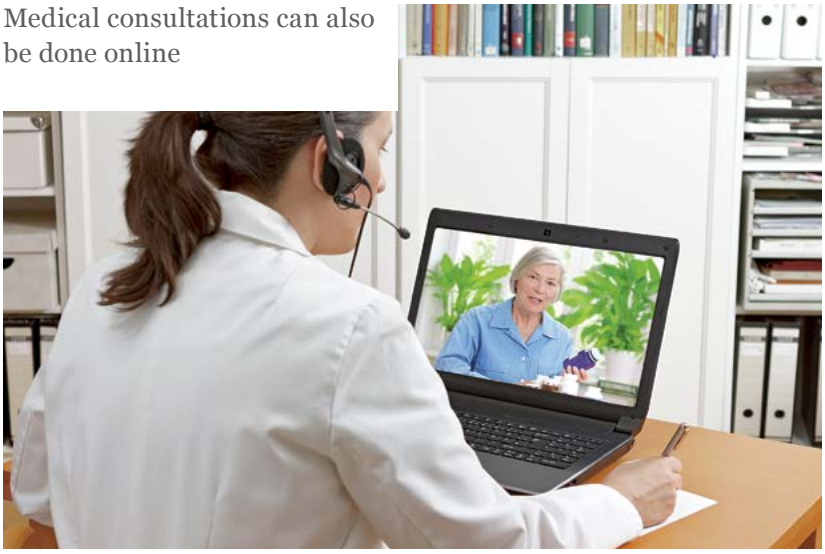
Whereas in Finland the socio-geographical situation is the catalyst for regional, financing, health and social reforms, in Croatia a fledgling health system is developing which is gradually expanding its supply structures. Thus, the focus of the reforms is different in each country. The Finnish system must optimise its health care structures in order to mitigate the expected increase in expenditure, while in Croatia a long-term strategy is needed to provide the system with missing revenues.

The German healthcare system is also going through a period of diverse reform initiatives. The legislative proposals from the Federal Ministry of Health include the law for more safety in the supply of medicines; the protection against measles Act; and the implant register Act as well as numerous occupational laws and the Act to strengthen rehabilitation and intensive care.

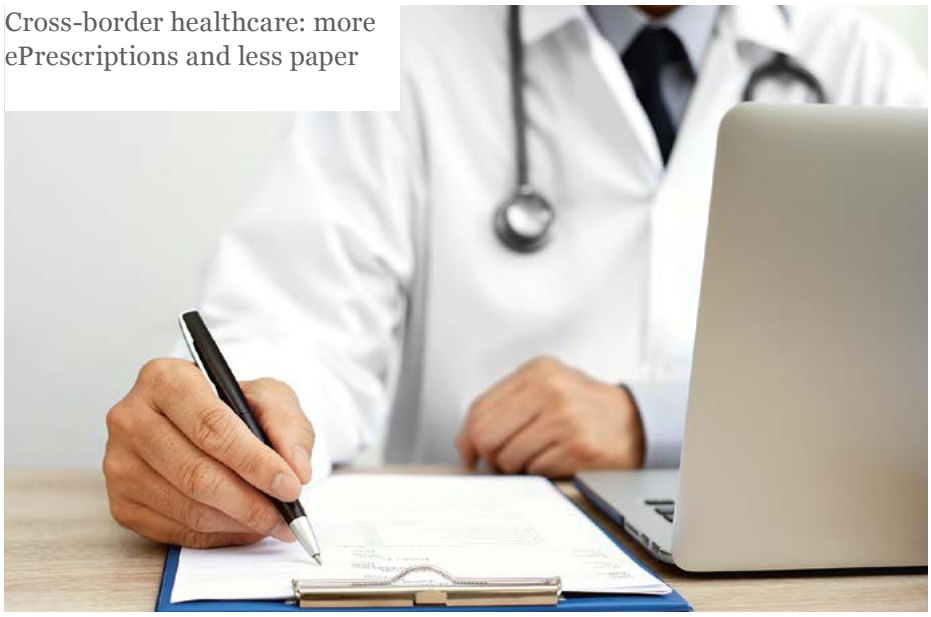
The three systems are united through their efforts towards modernisation of their systems using digital solutions. ePrescriptions have been gradually rolled out in Finland since 2010. The ePrescription is now fully established. Finns have been able to use ePrescriptions in Estonia since January 2019, and in Croatia since April 2019. From 2022, the ePrescription will be supplemented with individual medication data. The Finns are taking things a step further with the Act on the Secondary Use of Social Welfare and Health Care Data. The Act forms the basis for the safe and effective processing of health and social security data and paves the way for the data economy, which is part of Finland's national strategy. Croatia has set out action areas in its 'e-Croatia 2020 Strategy'. The vision is to establish a public administration for the benefit of its citizens. This includes the national health institute HZZO as well as cross-border healthcare (ePrescriptions).

Since 2016, statutory health insurance in Germany has provided financial resources via the Innovation Fund to

Medical consultations can also be done online



Cross-border healthcare: more ePrescriptions and less paper



In Finland, private companies provide statutory accident insurance.

promote innovative forms of healthcare, which are to be incorporated into mainstream healthcare. The Digital Healthcare Act (DVG) provides for the continuation of the Innovation Fund until 2024. The DVG also provides for the increased use of telemedicine, the entitlement of insured persons to digital health applications (apps) and the obligation of health insurance funds to offer their insured persons an electronic patient file.

Looking at the respective Council Presidencies of these countries, there has been a clear focus on digital data exchange and data processing via artificial intelligence. This includes expanding the cross-border exchange of medical records and the establishment of a European Health Data Space.

In terms of the EU-wide digital exchange of information, competences are already being bundled across borders in electronic reference networks in order to exchange knowledge of rare diseases and their treatment.

3. Accident Insurance

a) Finland

Although the Finnish statutory accident insurance system is governed by public law, a distinctive feature of the system is that it is provided by private insurance companies. The choice of insurance company is left to the employer.

All employees in Finland are insured against accidents at work and occupational diseases from their first day of employment. Persons who are employed for more than twelve working days within a calendar year and receive an annual income of at least €1200 must be insured.

Persons subject to compulsory accident insurance include not only employees but also farmers and recipients of scholarships. There are special provisions for students, apprentices and trainees. Government employees are a further exception because the Ministry of Finance is responsible for funding these benefits.

Self-employed persons have the option of taking out voluntary insurance in Finland. In principle, however, this is only possible if the self-employed person is also covered by the old-age pension system (compulsory or voluntary).

Contributions for accident insurance are borne in full by the employer. The amount of the contribution is based on the salary of the person to be insured and the risk of an accident at work.

Accident insurance covers the costs of any necessary **medical treatment** and **compensation for loss of income** in the form of daily allowances, disability pensions or rehabilitation allowances following an occupational illness or an accident at work or on the way to and from work. The daily allowance for the first four weeks is equal to the salary during the period

Self-employed persons can take out voluntary insurance against work accidents in Finland.

A timely return to work is vital following an accident

of sick leave. The amount is then determined on the basis of annual income. If the employee is still unable to work one year after the accident, he or she receives a full or partial disability pension. Daily allowances, disability pensions and rehabilitation allowances count as taxable income.

In the event of death, both the widow/widower and the children receive a survivor's pension. This is regarded as taxable income. A funeral benefit is also paid.

Patients have freedom of choice (in both the public and private sectors). However, the insurer is entitled to determine the hospital where treatment is carried out and a one-off treatment with a doctor.

Finish legislation lays down the requirements that employers must implement with regard to **occupational safety and health**.

b) Croatia

Croatian accident insurance is characterised by the fact that it does not exist – at least not as an independent branch of social insurance. In the event of a work accident or occupational disease, a person is covered by the statutory health and pension insurance systems. Pension insurance covers long-term benefits such as reduced earning capacity pensions, while health insurance covers short-term benefits such as treatment costs and benefits in kind. Work accidents, commuting accidents and occupational diseases are all **covered**.

Insurance is compulsory for employees and the self-employed. Under special circumstances, students doing an internship, members of the voluntary fire brigade and natural disaster responders are also covered.

The system is funded by both **contributions and taxes**. The portion to be paid into the pension insurance system is divided into income-related contributions and taxes for the first pillar and employee contributions plus yields for the second pillar. The portion paid to health insurance consists of employer contributions and taxes.

The cause of the health impairment can determine the **scope of benefits** and the **prerequisites for benefits**. At first, the catalogue of benefits provided by health and pension insurance also apply after an accident at work or in

the event of an occupational disease. Health insurance covers all costs for medical treatment and rehabilitation as well as the payment of injury benefits. The costs for occupational rehabilitation are initially covered by pension insurance. Vocational retraining, on the other hand, is financed by unemployment insurance. Following an accident, reduced earning capacity pensions are calculated according to the principles of pension insurance, taking into account the years of employment. However, entitlement is not subject to the usual insurance requirements. In addition, there are disability benefits in the event of work-related damage to health.

The Croatian Institute for **Occupational Safety and Health Protection** is responsible for integrating and promoting occupational activities into occupational safety and health in order to improve working conditions and prevent workplace accidents and occupational illnesses.

c) A look at Germany: difficult to compare systems

The accident insurance systems could hardly be more different: Germany with its public system, Finland with its mandatory but privately administered system, and finally Croatia with almost a complete absence of an independent institution. Although they have different organisational structures, all three countries want to offer their workers the best possible health and safety at work and the best possible care. The German statutory accident insurance system is the only one of the three countries to have an independent pillar in the overall structure of the social insurance system. In contrast to the Finnish accident insurance system, German accident insurance institutions are public entities with statutory powers. Whereas Croatia delegates responsibility to the pension and health insurance systems, Finland engages private insurers, which compete with each other.

Differences can also be seen in the group of persons subject to compulsory insurance. Only in Croatia is it compulsory for self-employed persons to take out insurance. In comparison, Finland and Germany with their 'illusory' accident insurance systems rely to a large extent on voluntary insurance for the self-employed, albeit in differing ways.

All three systems provide health, rehabilitation and cash benefits in the event of reduced earning capacity, as well as survivors' benefits. From an international perspective, Germany's statutory accident insurance serves as a very important role model. Intensive work in prevention and public relations raises awareness of the subject. In the Finnish system, employers are required to comply with certain occupational health and safety regulations and to take preventive measures. However, each insurer also has the right to decide how this is to be done.

Croatia, a comparatively young social security system, requires employers to

Commuting accidents in Finland and Croatia are also covered

The accident insurance systems could hardly be more different.

ensure occupational safety and health. The need for public relations work and campaigns has been acknowledged and is on the rise.

The different systems can learn from one another. For example, Germany could do more to ensure that self-employed persons are insured, whereas the German principles of solidarity and 'all appropriate means' could find acceptance in Finland and Croatia, at least among potential insurance beneficiaries.

A more detailed description of the Finish and Croatian systems can be found in the background document.

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