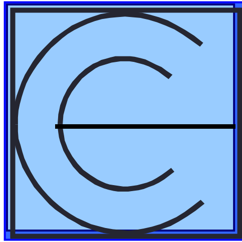


CENTRE FOR EUROPEAN SOCIAL AND ECONOMIC POLICY
Centre de politique sociale et économique européenne Asbl

Summary

"Exploring the synergy between promoting active participation in work and in society and social, health and long-term care strategies"

INVITATION TO TENDER N° 2006/030 (2006 / S 123-130484)

Contract reference VC/2006/0340

February 2008

CESEP ASBL
Coordinator: S. Grammenos
Rue de la Pacification, 65.
B-1000 BRUXELLES
Tel. : 02/230.63.96
Fax: 02/230.63.96
E-Mail : cesep@skynet.be
Website: http://www.cesep.eu/

BBJ Consult AG
Rue des deux Eglises 44
B-1000 BRUXELLES

CREPP ULg
Boulevard du Rectorat, 7
B-4000 LIEGE

Introduction

The EU has set the objective of raising the employment rate of older people. The European Council of Stockholm (2001) defined a target rate of 50% employment for workers aged 55 to 64 by 2010. Furthermore, the Barcelona European Council in March 2002 agreed on the target of gradually increasing the average retirement age by five years over the same period.

The Council, the European Commission and Member States are promoting policies to reduce early retirement and extend working lives, setting up more flexible working hours, and developing access to lifelong learning.

The purpose of this study is to provide information that can help policy discussion on how social, health and long-term care systems can help enhance participation in work and family, social and community activities and how, in turn, participation in paid employment, family, social and community activities can contribute to healthy and autonomous living at present and in the future. The study aims to see whether current policies are feasible and to identify new methods which are compatible with (maintaining a good) the health status of the older workers.

PART I: Overview of existing work regarding the synergy between work and health.

I.a Determinants of work participation and participation in family, social & community activities

There is a bulk of evidence that shows that health status affects general labour market participation and notably the labour supply of older workers. Early studies using health as an exogenous variable find that chronic illness advances retirement for example. Moreover, health effects are stronger than the financial ones. Further research used changes in health instead of health levels. A deteriorating health was found to be an important predictor of retirement decisions. Furthermore, health changes affect work absenteeism in conjunction with working conditions. When taking into account the potential endogeneity of health - on the one hand, health affects work decisions but on the other hand, work and participation may affect health - research results find that health still has a strong impact on labour participation. Consequently, there is a growing consensus that bad health and notably deteriorating health may lead to: a reduction in wages, exit from the labour market notably through early retirement, unemployment, higher absenteeism and up take of disability benefits.

Other researchers argue that labour participation of older workers has fallen because social security provisions provide incentives for early retirement. It seems that working additional years might add little in pension rights, and in certain cases, it may even reduce the present value of net pension benefits. A heavy tax burden on work past the age of early retirement constitutes a strong incentive to withdraw from the labour force. The incentive effect seems to have a strong effect on retirement decisions in all countries studied. Actuarial fairness may be a corrective factor.

A growing literature on the joint labour supply behaviour of husbands and wives examines how married couples coordinate retirement decisions. There is a trend for couples to retire approximately at the same time with the literature suggesting this to be the wish to share leisure time. Concerning health, marriage may provide insurance for those who become chronic sick or disabled. Hence, the healthy spouse may choose to continue working in order to maintain a certain level of income or retire in order to provide care. On the other hand, the poor health of one spouse may lead to the early retirement of the other spouse. In this case, the illness of the husband affects more strongly the retirement decision of the wife, accelerating the retirement of the couple, than the illness of the wife does. Finally, social roles may influence retirement decisions and have an asymmetric impact upon men and women.

Providing long term care can be an important factor determining labour participation of carers. The number of hours spent caring (intensive informal care) has an important impact on labour participation. High levels exert a negative impact on the paid employment of carers (mainly women) and increase the probability of leaving the labour force including through early retirement. Caring reduces the number of paid working hours and the carer's wages, while increasing the use of part-time work if available. It reduces the probability to have a well paid job, promotion prospects and carer's earnings including pension rights. Caring reduces the probability to return to the labour market: heavily involved carers are less likely to be in paid work when caregiving ends. In this context, working part-time increases the probability to re-integrate fully into the labour market when caregiving ends. Also, inside a family, persons out of the labour market or working part-time may assume the caring role. Researchers therefore stress the role of supporting services to carers enabling them to combine work with caring.

I.b Participation and its impact on health

The prevalence of chronic illness increases with age. Moreover, various studies find a significant difference in health levels, life expectancies (with or without disabilities) and mortality between people with high and low education levels at all ages. This health inequality seems to persist through time. Education and income are also positively related to health. Education might affect health through different channels (health knowledge, working conditions, life styles and income).

Working conditions play a significant role (not associated with income) on workers' health. Unskilled and manual workers systematically have the lowest life expectancies (higher mortality rates). Hard physical and mental conditions (physical effort, psychological stress, accidents and toxic agents) are advanced as explanatory factors that have an important and cumulative impact on health even well beyond retirement. Overtime work and unusual working hours have a detrimental impact on health: an increased risk of hypertension, cardiovascular disease, fatigue, sleep problems, stress, depression, musculoskeletal disorders, chronic infections, diabetes, general health complaints, accidents and injuries and all cause mortality. Also, working conditions and job satisfaction are closely related. In general, Mediterranean countries are characterized by a low job satisfaction. Job satisfaction seems to exert a strong impact on retirement decisions with a high job satisfaction postponing retirement. Furthermore, whilst bad working conditions negatively impact on health, unemployment and involuntary retirement are associated with psychological distress and can aggravate existing health problems. A strong attachment to work (full-time jobs, long work histories) and a lack of control over the transition are predictors of difficult adjustment. Hence, flexibility and control over the retirement process may improve health after retirement.

Cognitive capacity declines with age but many elderly people keep high cognitive functions, even at extreme ages. Recent research finds that education has a positive impact on cognitive functions, but so does professional and leisure activities (occupational activities, community work, leisure/social activities, and physical activity). Keeping one's occupational activities for as long as possible may contribute to maintain cognitive functioning at old age. Similarly, maintaining physical activity is important although it may depend on the frequency of these activities. These positive effects on health are lightly greater for non-professional activities compared to professional activities. Globally the results show a positive relationship between activity and health (physical and mental). It may be that good health also influences activity and participation so that the relation is reciprocal.

Volunteering has a positive impact on health, though part of the association between volunteering and health might be due to the better health of those who volunteer. Volunteering may have a positive impact on health through self-identity, sense of community and belonging, commitment (sense of purpose in life), reciprocity (social interactions) and active life styles. It reduces social isolation. Further research indicates that the positive impact may be increased if volunteering is face-to-face, voluntary, non-stressful and provides a chance to carry on formal roles and valorise existing skills and experience. Social capital (e.g. civic trust, social participation, family links) may have a direct positive impact on health through the availability of help and health information in cohesive social units.

Family care is a crucial component in care in all European countries (although at a lesser extend in the Scandinavian countries). The findings concerning the health impact of caring on carers are often contradictory. Generally, it is thought that ‘intensive’ caring may generate physical and mental stress (physical strain and exhaustion, musculoskeletal problems, heart trouble, emotional strain and depression). However, ‘light’ carers might declare an improvement of their health (including mental well-being). Several studies therefore note the important role of supporting services in decreasing any negative impacts on health.

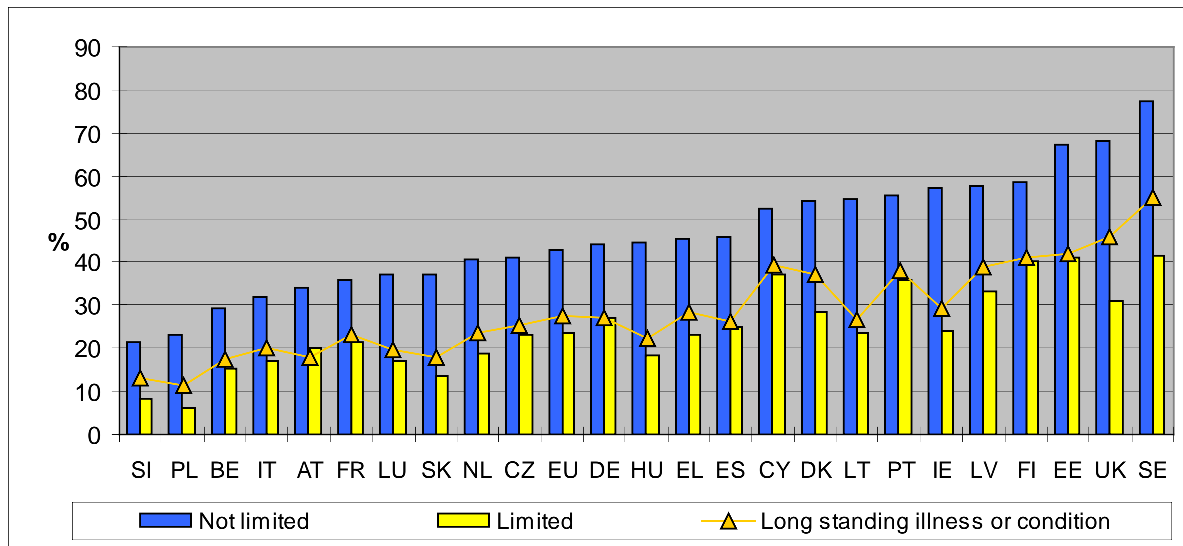
PART II: *Statistical analysis*

II.1 Health and labour market participation

The statistical and econometric analysis confirms that age, education, marital status, occupation and relative income are significant factors in determining health status. Indeed, lower education level, occupational level (current or previous) or relative income increases the probability to report a longstanding health problem or condition. Note that the prevalence of chronic illness or condition varies significantly among Member States.

Generally, countries with a high overall labour force participation also have a high labour force participation of people with chronic illness. However, there is an important gender difference. One hypothesis is that work conditions affect differently men and women.

Figure 1: Employment rate of people aged 55-64 in 2005



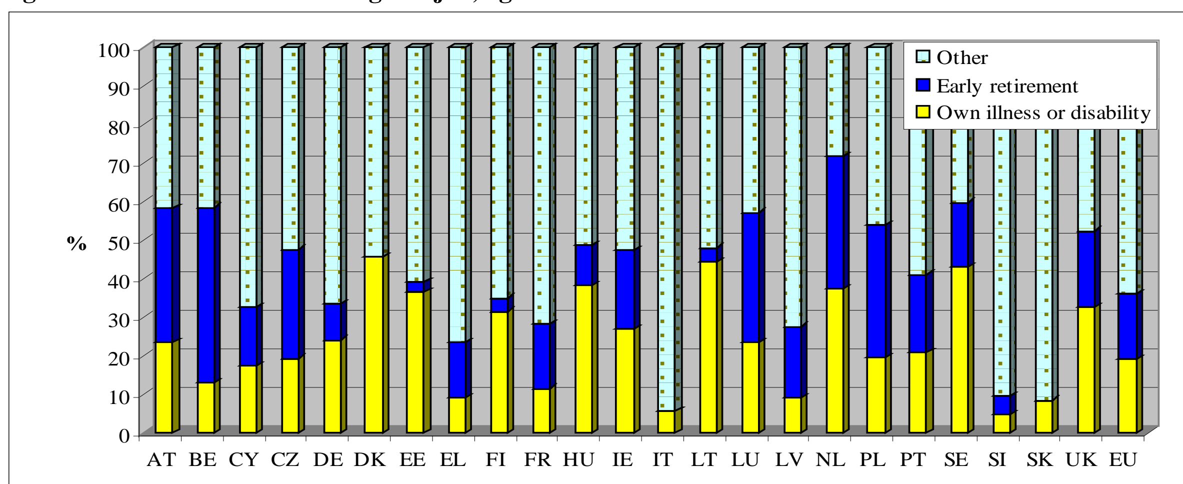
Note: The Lisbon objective of 50% refers to all people aged 55-64. Source: SILC 2005 (ranked by employment rate).

Statistical and econometric analysis of labour participation show that there are fewer 55-64 year old women participating in the labour market than there are 55-64 men and that the presence of children reduces the labour market participation of women especially young women, whilst increasing the labour market participation of men at all ages. Analysis indicates that a higher level of experience, education or occupational skill increases the probability to participate on the labour market. Finally, health status (chronic illness) is found to bear a strong negative impact on labour.

People who exit the labour force report a higher prevalence of chronic illness or condition compared to those who stay in the labour force. Hence, a deterioration in health status results in early departure from the labour market i.e. most individuals in bad health will stop working at an early stage, while individuals in good health will retire later. Exits due to ill health increase with age but after 55/60 we observe a change in the direction. This might result from the fact that people with chronic illness or condition might just take early or normal retirement after the age of 55/60. Concerning movements by marital status, we may note that separated people have a relatively high rate of (re) entries compared to exits into the labour market (both for people with and without chronic illness or condition). People with mental health problems and "other progressive illness" constitute the most vulnerable groups. They have the lowest participation rates on the labour market, the exit rate of this group is relatively high and the (re) entry rate is low.

From the statistical analysis it appears that health and education are the most important factors affecting exits and entries in the labour force. Further analysis of those who exit the labour force reveals that they have a long history of unemployment.

Figure 2: Main reason for leaving last job, age 55-59



Source: LFS 2005

The review of the literature revealed that part-time work might be a desired solution in cases where health problems restrict activity. The SILC survey (2005) indicates that part-time work is important for women and people with chronic (longstanding) illness or condition. It reveals that part-time work is a preferred or imposed way to (re) enter the labour force of those who were previously inactive. This is true both for people with and without chronic illness or condition.

The SILC survey (2005) indicates that for the age group 60-64, about 55% of those working less than 30 hours advance "illness or disability" and "do not want to work more hours as the reason". For men, mental health problems and other progressive illness are the more restrictive types. For women, speech, other progressive illness and skin appear to be the most disadvantaging.

II.2 Financial (dis) incentives

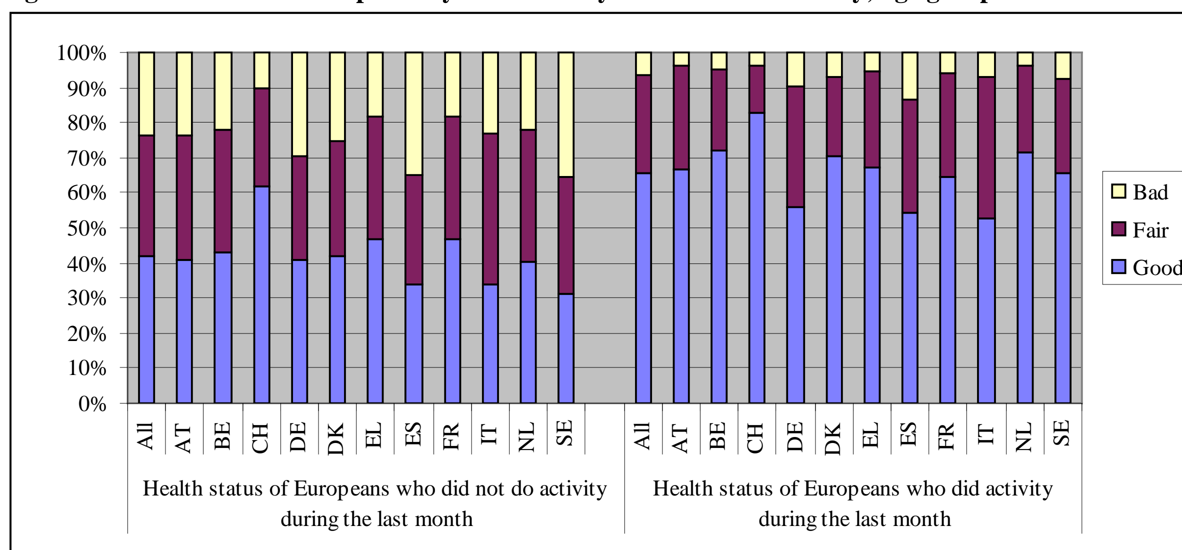
Absenteeism due to health problems is significant. This is important because it may be an important cost for the employer. Older workers are not those with the higher absenteeism rate. However, the average duration of sickness of older workers may be longer compared to younger workers. There are no significant gender differences among people with a longstanding health problem or disability. Persons with "Other progressive illness or disability" experience the highest absenteeism due to illness. Illness has a much stronger impact on absenteeism than other variables such as education, age or marital status.

The number of people receiving disability benefits varies sharply across member States. It is very high in Nordic countries. The public debate focuses on whether disability benefits impede employment (or labour participation). The participation rate of recipients with a moderate activity limitation varies between 1% (Luxembourg) and more than 30% in Sweden. Consequently, there is a potential to increase labour participation in a certain number of Member States.

II.3 Active ageing

Europeans who were active (did at least one of the following activities: participating in clubs, participation in educational or training courses, moderate or vigorous activity) during the last month are healthier. "Inactive" Europeans are in less good health compared to active Europeans. However, this might be due to the fact that Europeans in better health participate more in different activities.

Figure 3: Health status of Europeans by whether they did or did not activity; age group 50+



Source: Share wave 1 release 2, weighted results

Volunteering is a specific form of active ageing. The level of volunteering varies between countries. However, in some countries lower volunteering may be related to a high prevalence of informal care. Among volunteers, females and males contribute as many hours. Volunteering increases with education. Volunteers are found to have relatively good health; however, one has to keep in mind that in certain cases good health might be a factor enabling volunteering.

II.4: Labour market participation and informal caring

Available data indicates that the vast majority of carers are women. A high number of carers are in the age group of 55-64, where labour participation is low. Caring responsibilities and labour market participation thus compete for available time budgets. Caring for a dependent adult decreases labour market participation (notably for women). This is particularly clear in ages where child rearing is an additional time constraint. Also, caring pushes the informal carer into part-time jobs.

About 25% of persons looking after children or adults declare that this prevents them from undertaking the amount or kind of paid work which they otherwise would do. In countries with high overall labour market participation, the participation of carers is high too. Providing demanding help seems to exert a negative impact on labour participation. Women provide relatively more demanding help than men. Also, the importance of personal care is much more important in Southern countries, both for women and men.

Caring brings several constrains to the carer. These include an adverse impact on his/her health. However, the impact of providing long term care to an adult has an uncertain impact on carer's health depending on the hours of caring provided. For the age group 30-35, there is a clear health deterioration which may be the result of cumulating care for children and care to adults. Econometric analysis indicates that providing long term care deteriorates health only in a limited number of countries. This poses the question of efficiency of available services to carers in these countries.

PART III: *Cross-country comparison of national approaches*

III.1 Health and labour market participation

European countries encourage age oriented policies both at national and company level. We may note: Denmark and Sweden focus on working conditions/ environment (requirements); Germany and France adopt a disability approach; Netherlands focuses on improving the disability pension schemes; Finland adopts a global health approach; France and the UK favour improvements in working conditions.

Nordic countries and in particular Denmark, Finland and Sweden have invested in health management of older workers through many programs and policies. These policies and programmes favour the transfer of older workers to less physically demanding tasks, part-time, ergonomic posts, etc. Also, they promote a consensual approach between all involved parties (notably social partners). Working conditions and ergonomic aspects have been favoured by most countries. In addition, France and Belgium have focussed on financing the improvement of working conditions.

The gender gap has received little attention in national policies reviewed here.

All European countries have part-time programs for older workers but only a few focuses on older workers with health problems (e.g. Nordic countries). In Denmark, collective agreements have special clauses concerning part-time employment of older workers. Agreements between workers and employers are also promoted in Belgium, while in France and Germany, certain industrial sectors provide for part-time work for older workers. Suppression of impediments to part time work has been favoured in Spain and the Netherlands; The balance between 1) work and private life (Austria) or 2) work and care (Netherlands) is an important dimension for time budgets. Austria, The Netherlands and Finland compensate income losses due to reduced work hours. Several countries (notably Poland and Sweden) make it possible to draw at the same time a pension and income from work. National policies aiming to guarantee equal rights with full time workers might help maintain people with chronic health problems on the labour market.

III. 2. Financial (dis) incentives

Member States apply earnings tests. Earnings tests concern workers who benefit from some types of benefits and would like to supplement these benefits by working and earning some income. However, earnings test and implicit taxation on prolonged activity are both ways of discouraging elderly workers from remaining active.

In certain countries accepting a job might be a very risky initiative for a disability pensioner. In case of loss of the job, the beneficiary might be unable to recover his pension without undertaking a new long process of administrative recognition. Concerning disability pensions and work earnings accumulation is possible in several countries. Sweden (and in a lesser extend Finland) allow disability pensions to remain dormant during periods of employment to help people with disabilities enter the labour market.

The UK and Finland have granted work credits to employed disabled. This is a way to decrease the implicit tax rate on work and favour labour participation of older workers. Recent policies to abolish early retirement schemes may increase the number of people asking for a non-contributory allowance (or minimum resource guarantee). Recent, reforms in Denmark, Netherlands and Sweden aim to reduce disability pensions. Despite several national reforms to reduce disability pensions, we may note a sharp increase of contributory disability pensions in Austria, France and Sweden.

High replacement rates and flexible conditions of eligibility have played a role in making disability the main means for achieving early exit from the labour market in the Netherlands and Sweden. In France, the reduction of early retirement schemes might be the reason for the continuous increase of invalidity pensions. With the reduction of possibilities for early retirement, invalidity benefit might become one of the main reasons for early retirement in certain Member States. Critics contend that withholding benefits until a later age hurts those with shorter life expectancies, and shifts more retirement wealth to those with longer lives.

In comparison, the number of pensions for work accidents and occupational diseases is generally stable or decreasing (notably in Sweden). But it continues to increase in certain Mediterranean countries. We may note here the low job satisfaction in these countries.

III.3 Active ageing

Several European countries have developed active ageing policies during the last years. They aim to help older people to stay mentally and physically healthy. The principle of active ageing has been recognised in several countries and ad hoc programmes have been implemented (e.g. Austria, Germany, Finland, and Sweden). Generally, these initiatives combine community interventions and personalised actions. Several countries, e.g. Sweden, Austria, Finland, Germany and the United Kingdom have adopted the concept of independent living and integrated it in specific programmes. The idea is to delay the onset of disease and the referral to care services.

Health prevention and healthy lifestyles are part of several national programmes (notably Austria, Netherlands, Poland, Sweden and Finland). Healthy lifestyles in France focus on nutrition. Social contacts are promoted notably by Belgium and Spain favours the creation of local centres. Cognitive activation has been promoted notably by Germany. The UK, Finland, Sweden, the Netherlands and Austria focus on promoting physical activity of seniors. Other activities include voluntary activities (notably Germany, Netherlands and United Kingdom), and training and education of elderly (notably Germany, Spain, France and Finland).

Several countries have noted the need to complement national strategies by specific actions aiming at reducing health related inequalities. Such policies are proposed notably in the UK, France, Netherlands and Sweden.

The economic value created by volunteering is huge and public authorities and businesses recognise the utility of volunteering both for society as a whole and for the individual volunteer. The importance of the personal dimension of volunteering is rather new. Volunteering in Austria and the UK has a long tradition. In Austria its value is accepted by both the government and business. Volunteering is seen as vital to fulfil a range of public interest objectives (e.g. United Kingdome) or viewed as a necessary complement to the State (e.g. France). To ensure sufficient participation of older people in volunteer work, various organizations - including local authorities - have developed new initiatives.

Other strategies seek to enhance opportunities for older people to provide support and advice to younger volunteers (e.g. Netherlands). Similarly, certain countries (e.g. Belgium) have taken into account expressly the role of senior citizens in their programmes (as consultants and assistants to younger and older persons).

III.4 Labour market participation and informal caring

In Denmark, Sweden and Finland professional services are provided on such a high level that caring is more a choice than an obligation. Further, working reduced hours is very common anyway which facilitates the combination of work and care. In Sweden, Denmark and Finland there is a well-developed system of formal care services for older people, which reduces their need to rely on family carers. Home help services are extensive. Services are organised at local level. This has rendered possible a policy of de-institutionalisation. However, this later policy has reinforced the role of informal carers. Also, the UK, Germany, Austria, and the Netherlands have well developed services and allowances for long term care.

In relation to support structures for carers, flexible working time arrangements adhered in general labour laws have been promoted in France and Germany. The Netherlands and Spain grant carers special rights like extra leave in emergencies for care reasons. Austria addresses mainly the dependents but in addition also the carer in their policies. There, carers can reduce their working time due to care obligations and have the right to raise hours again when the caring spell is over.

Income support and care allowances are becoming more common. Relatedly, the caregiver may be engaged by the municipality (Denmark).The possibility to use a long-term allowance to pay an informal carer may push certain persons into the formal labour market (for example a formal contract is required in the Netherlands) but at the same time it may be an incentive for carers to leave their job. In certain countries, it may not pay a spouse carer (France).

PART IV: ***Examples of best practice that may be transferable across Member States***

IV.1 Health and labour market participation

Innovative policies cover notably:

- senior or age management policies centring on job rotation/ mobility within the company and assigning older workers with health problems to less physically demanding tasks and shorter working hours schemes (e.g. part-time), as well as ensuring skills training (including for managers), skills-transfer through mentorship and career planning (notably at older ages).
- health promotion and disease prevention programmes at work and disability and activity limitations management including regular health check-ups in the workplace
- better working conditions in companies, notably through better workplace ergonomics and shift plans
- raising employers' awareness and providing financial incentives and technical support to companies to introduce age management policies.

Supporting employers to introduce senior policies at the firm level has proved to be a promising channel. Negotiated procedures through agreement between social partners have been promoted. This helps to design measures which can be incorporated into the company's normal routine ensuring a higher chance for success. Certain functions such as the Case-Manager or the Disability-Manager in enterprise play an important role. By attracting and retaining talent to the organisation staff turnover can be reduced and sickness absence decrease.

Technical assistance to SMEs was also important. Small and medium sized enterprises are an important vehicle for such initiatives. Projects that were carried out showed, that it is necessary for enterprises of this size to have easy access to information and help. Available evaluations indicate that such initiatives are profitable to companies. Results to date are very encouraging and demonstrate that poor or moderate work ability can be improved, while good work ability can be maintained.

Helping workers in bad health by adjusting their working time to their working capacity may avoid some early retirement. Hence, best practices identified include law adaptations that guarantee equal rights for part-time workers.

IV.2 Financial (dis) incentives

One important way to increase the employment of older workers is to reduce the cost of hiring older people with fragile health. This health gap has been compensated by reduced employers’ contributions.

Recent measures focus on work ability rather than work incapacity. Previously, the focus was on a person’s deficiencies, illnesses, and incapacities i.e. what a person is not able to do. Currently, the focus is put on the persons’ “working ability”. The general idea is that all possible types of active measures should be tried before retirement pension (passive income transfer) is awarded.

Allowing accumulation of invalidity pensions with income from work for a specified time period is another incitement. When sickness/activity compensation is paid for at least a year and the person wants to try to see whether he/she can cope with working, the person can apply for a trial period in which he/she receives compensation and pay at the same time. If the trial is successful, the person can apply to have his/her compensation made dormant.

Decrease the implicit tax on any continuation of activity by providing tax credits to disability pensioners desiring to work and by granting advantages to those who retire later. Tax deductions and tax credits are used in order to incite people with chronic illness and disabilities to (re) enter on the labour market.

Actuarial fairness is a relatively new instrument. Also, notional defined contribution schemes give more flexibility than traditional, defined benefit pension schemes.

IV.3 Active ageing

Several programmes favour the creation of social centres for seniors where they can participate in activities with others seniors. Other programmes aim at improving the communication capabilities of the elderly through the development of Internet cafés for seniors and a communication and discussion platform, supported by Internet training. These local centres often propose activities and favour communication among the elderly at a local level facilitating personal development, social participation, healthy lifestyles and positive attitudes towards ageing.

Training senior citizens as consultants and mentors recognises and valorises the skills and abilities of elderly people. The training actively contributes to the ability of older citizens to live their life according to their own wishes as long as possible. The use of the experience of older people is aimed at older people who can act as multipliers.

Programmes of health promotion and health prevention set the targets and work out the lines of action. The aim is to get as close as possible to the everyday environment in which people live and work. Also, they incorporated prospective assessment in municipal decision-making. Other more targeted programmes were aiming at promoting regular physical activity and independence for older people in the transitional phase and frail elderly people. Trips for seniors and health assessment through home visits are other policies proposed by Member States.

An increasing number of Member States acknowledges that volunteering play an important role for an active and healthy ageing. Consequently, recent national health programmes promote volunteering among elderly people. Volunteering by senior citizens has been strengthened through, notably programmes enabling old volunteers to continue their job through volunteering. Other programmes were aiming at developing intergenerational activities at neighbourhood level, notably, through the use of mentoring and other one-to-one activities. A certain number of recent initiatives aim at sensitizing employers to promote company volunteering.

IV.4 Labour market participation and informal caring

Innovative practices focus notably (raising employers' awareness and developing consensual approaches between parts. Other practices include carers access to part-time schemes and flexible work hours.

Local authorities favour the extension of local support services to carers and the dependent persons including support centres (that provide counselling and training), day care centres and respite care. Allowances and personal budgets formalise informal caring, while insurance and pension credits are granted to carers in order to avoid long-term negative impacts on the carer. Generally, the different measures aim to improve the quality of services provided to dependent people and also improve the work life balance of carers.

PART V: ***Policy implications***

V.1 Health and labour market participation

Health is acknowledged to play an important role. Poor health and notably a deteriorating health (physical or mental) lead to labour market exit including early retirement, absenteeism, unemployment, disability and low job satisfaction. This impact may be immediate but certain effects may be distributed through the life cycle.

Several European countries developed national programmes and in these programs health management is a key point. However, current policies aiming at those people already aged 50 or more have a limited impact. Those who exit the labour force have a long history of unemployment. Consequently relevant policies ought to target people at younger age groups too. They ought to prevent marginalisation instead of tackling it once it appears at an advanced age.

Future policies might focus on 1) Developing health promotion and diseases prevention in general and in the workplace in particular; 2) The improvement of the working conditions; 3) The elaboration of individualised and flexible work schedules for people with chronic illness or disability; 4) Raising employers' awareness regarding age and disability and thus encourage consensual solutions inside the company; 5) Providing technical assistance to social partners to develop health and age management policies. 6) Implementing legal devices to fight

discrimination (in particular on age and health). 7) Increasing the female labour participation through investing in the system of care and long-term care and support for carers.

The gap in life expectancy between lower and higher level occupations poses a serious problem to the policy maker. Activation policies of older workers and social participation of elderly people ought to take into account this life expectancy differential. Uniform policies might benefit only educated people, hurt those with shorter life expectancies and favor those with longer lives.

V. 2 Financial (dis) incentives

There are wide differences across countries both in current practices and in reforms. Raising employment rate should result from many interconnected policy measures. Strengthening work incentive in social protection systems is important. But at the same time, it is crucial to ensure better health in working life and provide lifelong learning. These interconnected initiatives cannot be taken at the same time. Some are more difficult to implement and involve long lags. Improving lifetime working conditions with the objective of working longer and in better health will take time.

In many European countries social protection discourage prolonged activity well before the statutory age of retirement, by prohibiting paid activity after retirement. Reforms that lead to higher activity rates among elderly workers have to be accompanied by a strengthening of disability and health insurance for those workers who cannot work longer for either frail health or work hardship. At the same line, progressive and not sudden retirement ought to be recommended. Also, one has to make the whole social protection system less distortive. Those reforms would make the whole social protection system actuarially neutral towards the retirement decision.

Such an evolution must be welcomed with caution for two reasons. First, it is important to keep everywhere a safety net program for those workers who have been unable to accumulate enough pension rights. Second, it is important to maintain an effective disability insurance for those who are unable to prolong their activity even before the statutory age of retirement.

Allowing people to work generally part time after retirement should be allowed. Activity past the pensionable age is not restricted to market work. It can also include non market work within the family or in the non profit sector. What makes difficult the intervention of public authorities in family solidarity and volunteering is the risk of crowding out. A partial solution is to make the provision of subsidies and social services at the local level. Finally, it is interesting to note that activities after retirement, either market or non market one, have a depressive effect on the age of retirement particularly when they are attractive. This shows the complexity of labour force participation in old age. It also shows that public authorities face an arbitrage between market labour and a variety of non market activities.

V.3 Active ageing

Active ageing (remunerated work, community work, leisure activities, fitness training/ physical activity, etc.) has a direct positive impact on the formation and preservation of the cognitive reserve, whist for example social isolation has a negative impact. Elderly individuals may delay his/her cognitive ageing by several years if they continue working and perform physical activities. A number of key dimensions appear to be highly correlated with active ageing and, for this reason, representing the most important fields for policy implementation. These are:

- Education: educational attainment is by far the main driver in favour of active and healthy ageing. Recommendations in this direction include: 1) Increasing the participation in education and training programs among elderly people and 2) Developing E-learning possibilities in order to reduce the age-related technological (numerical) gap.
- Lifestyle patterns: Maintaining aged people at work, in professional or non-professional activities, at later ages is a natural way to keep them active and healthy. Suggestions include 1) Information campaigns on healthy ageing and 2) focus on disadvantaged groups.
- Professional activities: Good and healthy working conditions may encourage aged workers to delay retirement. Also, career-planning for older workers is desirable.
- Other activities: Regular exercise of physical activities as well as the participation to social and cultural activities is synonym of active ageing.

Voluntary work presents many advantages. Policy makers may focus on a certain number of factors which are important for volunteering. Recommendations include, notably, 1) Senior training initiatives; 2) Inter-

generational support programs; 3) Financial support. At a European level, general guidelines could be proposed. In addition, in order to enhance the volume of volunteering, the promotion of volunteering should begin before retirement age. Proposed programmes ought to pay a special attention on ways to reach the most disadvantaged people. One important factor is to avoid costly activities and enable the reimbursement of costs generated by volunteering. Finally, the exercise of a benevolent activity ought not to constitute a cause for revising incapacity rates.

V.4 Labour market participation and informal caring

Enabling informal carers to work and care at the same time is one of the big future challenges in long term care. The different studies agree that all European countries are expected to remain dependent on family care. However, the availability of home care services is differing from country to country.

Flexible working arrangements are important to keep carers in touch with the labour market and to ease re-employment once caring spells come to an end. On the other hand these measures have to be implemented carefully as their effects on the career prospects of women are ambiguous: part-time work might negatively influence wages and career prospects.

Allowances to carers play an important role. Most flexibility is achieved by “Personal or Individual Budgets”. The Dutch evaluation of the scheme notes the increasing “monetisation” of family relations. Persons who were previously providing intra-family assistance are now asking for a financial payment. This raises the question of the distribution of caring tasks between social security and family. Informal carers should be supported with respite care and by information and counselling services. This should include care techniques, health aspects but also information on how to organise work and health.

Policies to promote the reconciliation of work and long term care should set incentives for men to take on care obligations as well, notably, by removing obstacles to men’s use of long-term care benefits. Also, national policies ought to design measures assisting dependent people which are neutral in their labour market implications. Mediterranean countries and New Member States face a double challenge: developing infrastructures for the heavily dependent people and expanding home help. This double direction may liberate informal carers from heavy tasks which keeps women in a disadvantaging situation.

Long-term care could be developed as a separate axe for insurance. Dependency may be seen as a separate risk. Public funds could bring a complement in order to guarantee a minimum quantity and quality of long-term care services to disadvantaged groups. Allowances and the role of informal carers could be organised in this context. This might help assist carers of disadvantaged groups.