For Official Use **DEELSA/ELSA/MIN(98)2/ANN**

Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

OLIS : 05-Jun-1998
Dist. : 10-Jun-1998

Or. Eng.

DIRECTORATE FOR EDUCATION, EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

Meeting of the Employment, Labour and Social Affairs Committee at Ministerial Level on Social Policy

BACKGROUND DOCUMENTS
THE CARING WORLD: NATIONAL ACHIEVEMENTS
TABLES AND CHARTS

(Note by the Secretary-General)

Paris, 23-24 June 1998

66363

DEELSA/ELSA/MIN(98)2/ANN
For Official Use

Or. Eng.

TABLE OF CONTENTS

CHARTS

Table 2.1 Main social policy priorities and challenges

Australia	Government priorities affecting social policy include: • Promoting economic growth, fiscal consolidation and sound macroeconomic planning • Enhancing employment, education and training opportunities for those of working age • Encouraging greater self-provision by those who have economic resources • Assisting families in periods of vulnerability, hardship or life course transition • Improving the delivery of government services and simplifying payments
Austria	Importance of striking the right balance between economic growth, budget stringency and social expenditures. Pursuit of fiscal consolidation with due regard for social justice.
Canada	Challenge to address changing family structures, an ageing population, employment and unemployment, and learning and education -- while at the same time maintaining fiscal responsibility. Some major areas receiving attention include efforts to preserve and maintain Canada's universal health-care system, child development, youth unemployment and people with disabilities.
Czech Republic	Two principal policy priorities: • Provision of social protection, particularly to vulnerable groups, during the period of transition • Creating new systems of social protection which respond to new conditions and future social, economic and demographic needs.
Denmark	The main priority is to reduce the number of working age people dependent upon transfer income, particularly through gainful employment. Want to reverse early retirement trends and manage significant expected rise in old-age burden. Continue to improve health and social services.
Finland	Priorities in developing the social protection system over coming years include: • Strengthening the connection between social protection and employment • Curbing premature retirement, increasing the older population's working and functional capacity • Linking education and training guarantees into the income security system for the unemployed • Restructuring health and social services, with a focus on client-orientedness and outpatient services • Ensuring coverage of those with atypical employment and career breaks. • Achieve long-term funding stability of pension system • Introduce new technologies in social welfare and health care to improve the quality of services • Clarify and simplify the social security system
France	The main issues and priorities are combating unemployment and work sharing, promoting youth employment and combating all forms of exclusion.
Germany	The most important priority is to bring down the present high-level of unemployment. Further refinement of systems of old-age provision, especially pension schemes, required to achieve medium and long-term viability. Third phase of health reform to be pursued, including securing resources for medical progress, making use of growth and employment opportunities in the health sector.

Table 2.1 Main social policy priorities and challenges (continued)

Greece	Priorities: • To reduce unemployment, especially among youth and the long-term unemployed; • To rationalise social security, especially retirement pensions and social health insurance, through the process of social dialogue; • To target social assistance to the most needy; • To combat social exclusion; • To provide user-friendly services in the field of social care and health. Challenges: • To maintain a satisfactory level of social protection in the face of adverse demographic and labour market trends; • To redistribute available resources so as to enhance their overall social and economic efficiency, by moving from across-the-board programmes towards selective income-tested ones.
Hungary	Major issues for social policy are: • Stop widening income inequalities and reduce the prevalence of deep poverty • Implement social insurance reforms and decentralisation of administration • Respond to major factors of ageing, long-range decline in activity rates and deterioration of health status of the population (including the high mortality rate among middle-aged men)
Ireland	Income adequacy , the low employment rate and social exclusion are the main key issues of direct relevance to social policy. Unemployment is the main cause of poverty in Ireland, but there are also other factors. The financing of social insurance pensions is becoming an issue together with the issue of adequate retirement incomes.
Italy	Social policy reform needs to respond to population ageing and the extent of poverty among the aged, the fall in employment and slow employment recovery creating difficulties for social insurance financing, and the persistence of high unemployment particularly in the south of Italy. In this phase of economic and social transition, there are objectives to reduce the emphasis on social insurance, provide income protection to major sections of the population and control rising expenditures.
Japan	Social policy needs to respond to the decrease in the number of children, ageing of the population, change towards a low-growth economy with budget constraints, and concerns over the burden of caring for the elderly in the context of changing family arrangements. Focus is on structural reform of the social security system, through: • Establishment of long-term care insurance and revision of health insurance • Overhaul of the health-care system • Ongoing review of the pension system
Korea	Sustainable economic growth has been the main way to enhance the welfare of people since the 1960s. In recent years, welfare policy for the poor, disabled and elderly has received less attention. Due to the economic recession stemming from the exchange rate crisis at the end of 1997, unemployment is emerging as the biggest social issue. The current priorities of social policy are: • Expanding coverage and alleviate requirements for unemployment insurance; • Integrating 373 health insurance funds into one; • Reducing benefit amounts of the national pension; • Restructuring the social insurance organisation; and • Establishing a five year plan to improve the welfare of the poor, elderly and disabled.

Table 2.1 Main social policy priorities and challenges (continued)

Luxembourg	Current priorities in the social arena are to: • Improve social protection of those receiving care from a third person, through a dependence insurance scheme • Combat unemployment and poverty • Preserve state pension schemes into the medium and long-term
Mexico	Main priorities and challenges are: • Overcoming poverty and social exclusion • Opening up productive alternatives • Diminishing economic, regional and ethnic inequalities • Responding to demographic trends • Reducing gender inequalities
Netherlands	Has a specific focus on reducing unemployment and promoting employment. Need to address pressures of ageing population on the labour market, pension system and care services.
New Zealand	Priority issues for social policy development relate to: • Establishing a viable and sustainable policy framework for retirement incomes • Reduce the level of income support dependency by the working-age population • Strengthening the functioning of families, especially those at risk • Promoting more positive responses to the ageing population • Ensuring appropriate choices in health-care resourcing and accessibility for health services.
Norway	Currently a specific focus on smaller groups of marginalised and/or disadvantaged people, such as those on social assistance, people with handicaps, long-term unemployed and lone parents. Challenge to prevent social exclusion and long periods on income support. With increasing numbers of older people, there is also some attention to improving services for the elderly.
Poland	Social policy has been responding to the process of economic change as well as the transformation of social and economic systems from the late 1980s. Some of the basic social policy priorities are: • Responding to poverty and exclusion • Establishing a social network providing minimum social standards • Implementing and developing an active employment strategy, to stimulate local labour markets and reducing unemployment • Undertaking pension reform, in response to the ageing of the population • Adjusting systems to enable integration into the EU and reducing the strain of the social security system on the budget

Table 2.1 Main social policy priorities and challenges (continued)

Portugal	General priorities for social policy include: • Widespread review and reform of the social security system, considering aspects of efficiency, sustainability, social justice, effectiveness. • Intensifying the value of solidarity • Providing more support to families as the key element of society • Promoting new social policies against social exclusion • Reforming the health-care system, to achieve greater accessibility, quality and lower costs • Improved access to suitable housing, especially for impoverished populations • Investing in human resources
Slovak Republic	Has a number of priorities: • Supporting the growth of small companies and businesses • Implementing country programmes to support new employment opportunities, especially for disadvantaged jobseekers, and useful public works in districts with few new jobs. • More attention to job linkages for those on social benefits • Social security being changed to operate in new economic environment
Spain	Measures have been implemented to improve the efficiency of protection systems. The main priority is to maintain the current level of protection, in the expectation that future growth, higher employment and lower unemployment would increase the financing of social protection
Sweden	The overall objective is to develop a high-degree of social integration. Within this framework, specific priorities are: • To halve the level of unemployment by the year 2000 • To establish a stable pension system and secure financing of long-term care • Family policy, the rights of people with disabilities and social protection against misuse of alcohol and drugs
Switzerland	The main objective of the federal government is to maintain social insurance arrangements, based on notions of mutual support across the community. Some priority to with improvements in maternity insurance and the health system, in keeping the account of financial capabilities which is limited by the economy.
Turkey	Has a number of social policy priorities: • Extending social security systems to the whole population, with funds responsible for administration and finance • Rebalancing the pension system and encouraging supplementary private pension insurance • Improving services to families and measures to improve outcomes for women • Improving the level of education and vocational training of the potential workforce • Strengthening primary health-care services, with more funds to preventative services • Alleviating poverty and responding to imbalances in income distribution • Promoting housing production and ownership through financing arrangements

Table 2.1 Main social policy priorities and challenges (continued)

United Kingdom	The main aim for all social policy programmes is to ensure they contribute to enhancing opportunity and fairness, as well as promote employment and investment for sustained economic growth. In modernising social security, there is a focus on: • Encouraging financial independence at the same time as promoting social cohesion and well-being • Developing an active welfare policy which supports work savings and honesty • Tackling unjustifiable social and economic inequalities With health care, important priorities are to rebuild the National Health Service as a public service working for patients, tackle the root causes of illness and reduce inequalities in health.
United States	Against the background of progress to rebalance the budget by 2002, major commitments in the social policy area are: • Expanding health insurance for children in need, with a goal to cover 70% of all uninsured children • Expanding work opportunities and increasing incentives to work for those below retirement age • Ongoing commitment to provide income support for the elderly • Expanding post-secondary educational and training opportunities for low and middle income Americans.

Source: Responses to OECD Caring World Synthesis Questionnaire.

Table 3.1 Groups identified at significant risk of social exclusion, selected OECD countries

Australia	Long-term unemployed, indigenous Australians, migrants (especially from a non-English speaking background), people with disabilities, homeless people, carers
Canada	Aboriginals, people with disabilities, children, low-income earners, young people, women
Denmark	Homeless children, drug abusers, criminals, people in institutions, mentally ill, some who retired early and in receipt of social assistance, some refugees and immigrants
Finland	Long-term unemployed, mentally ill, children and young people in vulnerable circumstances, people with disabilities, homeless, alcohol and drug abusers, overdebted persons
Greece	Elderly (especially those living alone), persons with physical and mental disabilities, drug users, travellers (Rom), foreign immigrants
Ireland	The homeless and alcohol and drug users as well as groups at greatest risk of poverty which are the unemployed (particularly long-term unemployed), children (especially those in large families), single adult households, lone parents and people with disabilities
Italy	Long-term unemployed, drug abusers, individuals with HIV, homeless, young people with little education and low skills, individuals with no family networks, those with heavy care responsibilities for seriously disabled children or elderly people, recent third-world immigrants
Japan	Women, children, elderly people, people with disabilities, Dowa problem, Ainu people, foreign nationals, people with HIV and Hansen's disease, ex-prisoners
Mexico	Women, children, urban and rural workers, young people, indigenous groups, people with disabilities
Poland	Orphans, homeless, long-term unemployed, people with long-term sickness or disability, alcoholics, drug addicts, ex-prisoners
Portugal	Families facing economic difficulties, children and young people suffering from difficult social integration, needy elderly people, women at risk, drug addicts, ethnic minorities, single-parent families, homeless people

Source: Responses to OECD Caring World Synthesis Questionnaire.

Table 3.2 Total social assistance expenditure as a proportion of social security, 1980-1992

Country	1980	1985	1990	1991	1992	Change 1980-92[a] (% social security)	Index: 1992/1980[a] 1980 = 100
Australia	67.6[b]	81.2	89.2	90.1	90.3	22.7	134
Austria	5.7	5.2	7.2	6.6	6.7	1.0	117
Belgium	2.3	2.2	2.9	3.1	3.0	0.7	129
Canada	19.6	19.9	18.6	18.5	18.9	-0.7	96
Denmark	n/a	6.1	7.0	7.6	7.8	n/a	n/a
Finland	0.9[b]	1.3	2.0	2.1	n/a	1.2	240
France[c]	3.5	5.2	6.5	6.5	6.4	2.9	184
Germany	7.1	11.0	11.9	n/a	n/a	4.7	167
Greece	1.3	1.2	0.9	n/a	1.1 (1994)	-0.2	85
Iceland	n/a	n/a	1.4	1.3	1.2	n/a	n/a
Ireland	30.9	34.7	39.9	43.9	45.9	15.0	133
Italy	9.1	8.7	8.8	9.6	9.1	0	100
Japan	7.3	5.5	4.1	3.8	3.7	-3.5	51
Luxembourg	n/a	1.1	n/a	n/a	1.4	n/a	n/a
Netherlands	8.3	12.4	11.8	11.2	10.9	2.6	131
New Zealand	82.8	85.5	100.0	100.0	100.0	30.3[e]	137
Norway[b]	2.5	3.7	4.8	4.8	4.8	2.3	191
Portugal	2.3	6.1	4.7	4.1	3.8	1.5	167
Spain	2.1[b]	6.0	8.1	7.9	8.4	6.3	403
Sweden	4.6	6.7[f]	5.4	6.3	6.7	2.1	146
Switzerland[d]	n/a	n/a	n/a	n/a	1.8	n/a	n/a
Turkey	n/a	n/a	n/a	n/a	n/a	n/a	n/a
United Kingdom	21.9	30.2	30.9	30.8	33.0	11.1	151
United States	29.3	32.7	32.8	36.5	39.8	10.5	136

a) Increase to 1991 or 1990 where no data for 1992.
b) 1982.
c) The figures for categorical assistance in France are based on a low estimate of assistance spending.
d) General assistance only.
e) Because of the way the figures in the OECD Household Transfer Database are derived, and because of changes in the tax benefit year, percentages for New Zealand in 1990 and 1992 were greater than 100. The change figures represent the act ual estimate of change since 1980.
f) 1986.

Source: Eardley *et al* (1996a), which also provides details of their definition of programmes included within the scope of "social assistance", and does not generally include family assistance benefits. Estimates for Ireland for 1991 and 1992 from national authorities.

Table 3.3 Summary of social assistance arrangements, selected OECD countries

Highly Centralised Systems		**Highly Decentralised Systems**
Australia Nationally set parameters of assistance and national agency responsible for administration via local offices	**Belgium** Key features of social assistance determined nationally although local level responsible for granting access. Local level responsible for making additional payments where required, and for paying *Aide Sociale* for those who do not qualify for the main social assistance benefit.	**Austria** Every Länder has its own social assistance legislation, to help people with vital necessities, and no overall federal framework legislation
Denmark With the Social Assistance Act, the State must provide for any resident who is in need of care. Cash assistance is uniform all over Denmark, disbursed by local authorities, with the costs split 50/50 between local and national authorities	**Finland** Living allowances are provided through municipalities which receive a State subsidy for the costs. There is broad equality of conditions across the country, but some differences in the amounts provided in each locality as each municipality creates its own practices.	**Canada** Benefits and eligibility criteria vary across the country. There have never been any national assistance standards. Only national requirement is that it cannot be denied because an applicant is not a recognised resident in that jurisdiction.
Czech Republic Social care benefits are provided by local government authorities on behalf of national government who covers the costs. Eligibility criteria and minimum subsistence amounts uniform across the country. Local and regional bodies have only limited responsibility and discretion must be in line with national regulations	**Germany** Statutory measures and eligibility criteria apply to the whole country through the Federal Social Assistance Act. Benefits may vary between individuals because of differing needs. Federal States and local authorities bear increased financial costs.	**Italy** Minimum income assistance lies within the exclusive realm of local authorities in both regions and towns/cities. There is no national legislation, assistance levels vary considerably and rely on powers of discretion. However government is considering introduction of a minimum integration income that could relieve local authorities of some responsibilities, and Parliament is currently considering a framework law on assistance which would establish basic criteria. The minimum income would be financed and controlled at a national level, but administered at the local level. Social pensions, as well as other pensions and allowances, continue to be paid out of the state budget.
Japan The Standard for social assistance is set by the Minister for Health and Welfare, intended to be sufficient to just meet basic needs for a minimum standard of living. Financial responsibility for social assistance is shared by national and local governments on a 3:1 basis.		**Norway** Central Government has given National Guidelines on the sort of expenses which should be covered. Municipalities also generally have their own guidelines with the final amount left to the discretion of social services. Benefits and eligibility may vary somewhat between the different municipalities. Municipalities have financial responsibility for increased social assistance.

Table 3.3 Summary of social assistance arrangements, selected OECD countries (continued)

Highly Centralised Systems		Highly Decentralised Systems
Luxembourg Eligibility for RMG social assistance and benefit levels are determined at a national level. RMG applications may be made to Social Assistance Offices in small municipalities (which can only make provisional/advance payments) but the National Solidarity Fund takes final decisions. Funded 90% from national budget, 10% local municipalities.	**Sweden** Social assistance is based on an individual assessment of need. To assist, the National Board of Health and Welfare has defined a social assistance standard for the guidance of municipal bodies. Benefit levels can vary across the country, but to introduce some equality Parliament has recently specified that social assistance must provide support for certain cost items, adjusted for changes in consumption patterns and prices. Social assistance is financed by municipalities largely through local incomes taxes, although they also receive block grants from the national government.	**Switzerland** Benefits and conditions for social assistance vary from canton to canton and may also occur between communes within a canton. The Swiss Conference of Social Assistance Institutions issues recommendations that are designed to ensure a degree of harmonization between areas and a minimum level of benefits. Cantons and communes have to undertake the increased social assistance costs since 1991.
Mexico All social programmes are managed nationally by the Federal Government using uniform parameters. Some groups (e.g., rural communities) may be the defined target group for some interventions.	**United States** Some social assistance programmes, such as Supplementary Security Income and Food Stamps have Nationally set parameters. Other social assistance programmes, such as Temporary Assistance to Needy Families, Medicaid, most housing assistance, unemployment insurance, workers compensation and several food/nutrition programmes have significant variations across States and local governments.	
New Zealand Nationally set welfare parameters. The cut of basic entitlements in 1991 led to increased role for voluntary welfare agencies to provide supplementary in-kind assistance.	**Poland** Amendments to the social assistance law in 1997 attempt to generate greater cooperation between national government, local government and NGOs. The main burden of funding is on the national government which covers 70% of total costs. Seeking a balance between ensuring essential benefits and services against the trend towards decentralisation and more autonomous local social assistance	
Portugal Social assistance provisions are defined at the national level, provided through the Guaranteed Minimum Income introduced in July 1997.	**Hungary** Social assistance operates within nationally set parameters. Local authorities may increase rates if they wish, with costs covered by national budget/taxpayers.	

Table 3.3 Summary of social assistance arrangements, selected OECD countries (continued)

Highly Centralised Systems		**Highly Decentralised Systems**
Slovak Republic The Act on subsistence minimums defines the detailed conditions required to assess a citizen's minimum needs.		
Greece Programmes funded by the central government. Standards set by the Ministry of Health and Welfare. Benefits increasingly delivered by local government at the prefecture level.		
Ireland Nationally-set parameters for social assistance and national agency responsible for administration via central and local offices.		
Turkey The law 2022 provides social assistance for the elderly and disabled people with state funding. The Green Card Programme (from 1992) provides health care to the low-income household in the hospitals with the Ministry of Health. There are some other services provided by related institutions (SHÇEK (for the elderly and children), Social Assistance and Solidarity Fund(for people not covered by the social security system)) or municipalities.		
United Kingdom The National Government bears the full cost of social assistance and there are nationally set parameters (both benefit levels and eligibility criteria) which do not vary across the country. One exception may be some local targeting of specific pilot initiatives.		

Note: The allocation of countries according to the degree of centralisation and decentralisation is a judgement which seeks to take account of whether there is a national framework for assistance, the extent of local rate-setting autonomy, as well as financial responsibility (to a lesser extent).

Table 4.1 Summary of assistance to families with children, OECD countries

		Greater payments for				
Country[1]	**Age range**	**Low-income families**	**Larger families**	**Age of children**	**cash benefits or tax relief**	**universal or income test**
Australia	to 16, 18 if student	Yes	Yes	cash 13-15, tax 0-4 yrs	both cash and tax relief	means tested
Austria	to 19, 27 if student	Yes	Yes (tax)	10-18, 19+ yrs (cash)	both cash, tax credits	universal
Belgium	to 16, up to 25 if student	Yes	Yes	6-12, 12-16, 16+ yrs	cash	universal[2] and means tested
Canada	to age 18	Yes		0-6 yrs	tax credit	means tested
Czech Rep	to age 16	child <3, single wage		6-10, 10-15 yrs	cash	universal[3]
Denmark	to age 18	Yes		0-6 yrs, more for 0-2	cash	universal
Finland	to age 17	No	Yes	0-2 yrs	cash	universal
France	to age 18		Yes, more if 3 over age 3	10-15, 16-17 yrs	cash	means tested
Germany	to 18, up to 27 if student	Yes	Yes	No difference	cash	universal
Greece	to 18,(basic benefit) to 18, up to 22 if student	Yes	Yes (income tested) Yes	No difference with basic payment	cash tax	employees universal
Hungary	to 16, up to 20 if student	No	Yes	Infant care (IC) 0-2 yrs	cash	universal, IC employees
Iceland	to age 16		Yes	0-6 yrs	tax relief	universal
Ireland	to 16, up to 19 if student	Yes	Yes	No difference	cash	universal
Italy	to age 18 no age limit	Yes Yes	Yes	No difference	cash tax relief	means tested[4] universal
Japan	to age 3	No	Yes	No difference	cash and tax relief	means tested
Korea	to age 20	No	No	No difference	tax relief	universal
Luxembourg	to 18, up to 27 if student	Yes	Yes	6-11, 12+ yrs no difference	cash tax relief	universal means tested
Netherlands	to age 18				cash	universal
New Zealand		Yes		12+ yrs	cash	means tested
Norway	to age 16	No	Yes	0-2 yrs	cash	universal
Poland	to 16, 20 if student	No	No	No difference	cash	means tested
Portugal	to 15, up to 24 if student		Yes	10 mths Nursing allw	cash	employees, SS recipients
Slovak Rep	to 15, up to 26 if student	Yes	No	6-10, 10-15, 15-25 yrs	cash	means tested
Spain	to age 18	No	Yes	No difference	cash and tax	universal[5]
Sweden	to 16, up to 20 if student	No	Yes	No difference	cash	universal
Switzerland	to 16, up to 25 if student	supplements in some cantons	Yes	No difference	both cash and tax relief	employees and the self-employed (according to the cantons)
United Kingdom	to 16, up to 19 if student	Yes			cash	universal

1. United States not included as it does not provide similar benefits, but instead provides block grants to States through the new Temporary Assistance for Needy Families programme.
2. Both a contributory system for employed (not public or self employed) and a means tested system for others.
3. Both employees (not members of agricultural co-operatives) and social insurance recipients.
4. Non-agricultural employed, social insurance and unemployment beneficiaries.
5. Spain has both an contributory system covering employees, pensioners and sickness beneficiaries as well as a means tested non-contributory system which covers Spanish citizens and resident aliens.
6. Turkey does not have a national scheme of family benefits except for national civil servants, though the majority of collective labour agreements is planning to provide family benefits to employees.

Sources: Caring World questionnaire returns, US Social Security Administration (1995), NORSOSEC (1996), Slovak Republic (1996).

Table 4.2 Summary of special cash benefits for disabled children,selected OECD countries

Country	Nature of assistance or special provision for disabled children
Australia	Child Disability Allowance for children which require substantially more care, non means tested, available up to age 16 or older if student
Austria	Additional family allowance payment for permanently disabled child under age 19
Belgium	Family allowance payable until age 21 if disabled, and special supplement paid
Canada	Child Care Expense Deduction available for older children
Czech Republic	Family allowance available up to age 26 for disabled child, special supplement paid
Germany	No age limit on family allowance for disabled child
Greece	Additional benefit according to condition of the child (e.g., blind 32-87,000 drs/month, deaf 29,300 drs/month, thalasseamia sufferers 40,000 drs/month, retarded 37-56,000 drs/month). Further aid may be available from the social security fund of the parents.
Hungary	Special family allowance supplement paid to family for disabled child
Ireland	Domiciliary care allowance for disabled child aged 2-16 living at home
Italy	No age limit and higher income thresholds on family allowance for disabled child. No means test for accompanying income security for a seriously disabled child
Japan	Special child rearing allowance payable until age 20 if disabled, and special allowance for the handicapped payable for those aged 21 years and over
Luxembourg	Special family allowance supplement for seriously disabled child
New Zealand	Handicapped child's allowance, non means tested flat-rate payment
Portugal	No age limit on family allowance if child totally disabled, additional sick child's constant attendance allowance
Slovak Republic	Family allowance available up to age 26 for disabled child
Spain	No age limit on family allowance for disabled child, no means testing of family allowance for child at least 33.3% disabled, special supplements for disabled child which increase with level of disability (33.3+%, 65+%, 75+% disability level)
Sweden	Family allowance available up to age 23 for child attending special school for mentally retarded
Switzerland	Family allowance available for child who gets to have diseases or disability up to age of 18, 20 or 25 according to cantons (cantonal schemes) or up to age 20 and not receiving full disability pension (federal scheme applicable for agricultural workers and small farmers)
Turkey	A person with disability who is a son of the deceased insured continues to receive orphan's pension without age limitation. (In case of daughter, the pension is provided with a condition that she is not married.)

Table 4.3 Summary of child support arrangements, selected OECD countries

Country	Process of determining amount	Government payment	Other comments
Australia	administrative formula, option of court review	no, aside from possible access to social security payments for those with low incomes	Began 1988, already subject to evaluation and parliamentary inquiry. Some limited changes announced in 1997
Austria	court-based process	yes, if parent does not pay on time, does not fully pay or does not pay at all	youth welfare offices will be the legal representatives of under-age children in court proceedings
Canada	court-based process assisted by federal guidelines	no	child support from agreements or orders on/after 1.5.97 no longer taxable income to recipient or tax deductible for payer
Czech Rep	court-based process		
Denmark		Yes, if parent defaults	Minimum maintenance payment (DKr 8700 year) irrespective of income, plus supplementary payment based on income
Finland	parental agreement, then courts if cannot agree	Yes, if parent defaults, municipality will pay	Confirmation of parental agreement required by social welfare board
France	court-based process		
Germany	formula sets minimum, legal enforcement	Yes, if parent defaults, for up to 12 years	
Greece		Means tested payment if father absent, in prison, armed forces, etc.	
Hungary	court-based process, may set up to 50% income	no	
Iceland		yes, if parent defaults	
Ireland	parental agreement, then courts if cannot agree	social welfare payments available as a safety net for people who do not obtain any or adequate maintenance	If liable parents do not fulfil their child support obligations, action by Government is limited to recovering money spent on social welfare payments
Italy	parental agreement, with court ratification	no	
Japan	court-based process	no	
Korea	court-based process	no	Until recently custody of child usually to father, no enforcement
Mexico		social assistance support available in cases of abandonment or serious economic difficulties of one or both parents	

Table 4.3 Summary of child support arrangements, selected OECD countries (continued)

Country	Process of determining amount	Government payment	Other comments
Netherlands	court-based process usually, municipality to decide amount if caring parent on social assistance		
New Zealand	administrative formula, can be varied by courts	no	
Norway	parents agreement, or administrative involvement	Yes, a fixed minimum prepayment if parent defaults, or top up to the minimum amount	
Poland	court-based process	Maintenance Fund established, as many defaults in difficult economic situation	Maintenance Fund benefit amounts are determined by the court but cannot exceed 30 per cent of an average monthly wage
Portugal	court-based process		
Slovak Rep	court-based process	yes, if parent defaults	
Spain	court-based process	Government considering establishment of an Alimony Guarantee Fund	
Sweden	parents, then court-based process	yes, if parent defaults, or top up to set minimum amount	
Switzerland	court-based process	yes, if parent defaults, adequate support from bureau d'aide au recouvrement	Caring parent in financial difficulty may also seek an advance on maintenance from the canton
Turkey	court-based process	no	Father and mother have joint custody with Turkish law
United Kingdom	administrative formula		Recent changes to the formula to gain greater public acceptance
United States	administrative formula, federal guidelines to each state, state variations in formula	no	Federal laws require states to have enforcement strategies

Source: Responses to OECD Caring World synthesis questionnaire.

Table 4.4 Approaches to child care in selected OECD countries

Australia	Assist parents to participate in paid employment, training, study, job search and community activities by ensuring that child care is affordable to low and middle income families and by inputting the quality and support of services provided. Since 1985 has had active child care growth strategies and more extensive subsidy arrangements. A number of different forms of child care are now available, offering parents a number of choices to tailor care services to their circumstances.
Austria	The creation of child care facilities can be subsidized as a means of generating new jobs. Currently, the government has also initiated an extra program designed to create additional child care facilities. The funding level of this ATS 600 million.
Belgium	Day nurseries are the responsibility of communities and regions. Subsidies are available from federal authorities through the *Fonds des Equipements et des Services.*
Canada	The availability of affordable, accessible and quality day care is an area which governments continue to address. British Columbia has injected considerable funds into the development of additional subsidized day care spaces. Quebec recently introduced provinces-wide day care at a cost of $5/child/day for all children 4 years of age. This will be extended to younger children each subsequent year.
Czech Rep.	Families can take advantage of the services provided by pre-school facilities, family constancy centers, and centers dealing with maters of pedagogy and psychology. These services are available at the level of districts.
Denmark	Day care plays an important role in Danish society, one of the benefits being that mother get a chance to work outside the home. The benefits of education and stimulating environments for children are emphasised.
Finland	Since 1996 all pre-school children have had access to municipal day care. Before the right was extended to cover all pre-school children, day care had to be provided for those children who needed day care for social reasons relating to upbringing.
France	Provision of allowances to offset some costs entailed with employing people to look after children aged under 6 years, either in own home or from a registered child minder. Tax relief also available for those employing domestic staff.
Germany	Since January 1997 every child from the age of 3 has a legal claim to a place in a nursery school.
Greece	Transfer of formerly Ministry-run kindergarten facilities to local government at the municipality level. Opening of schools in the afternoon to aid working mothers.
Italy	Since the mid 1970s, substantial effort to offer all children from the age of 3 a kindergarten place. Now cover over 90% of all five year olds. For children under 3, priority in kindergarten and day care (*nidi*) is given to children of lone parents, children with both parents working, and children from poor or dysfunctional families. A proposed reform would make the last year of kindergarten compulsory and part of the elementary school system.
Japan	Comprehensive child-care program (*Angel Plan*) was launched in 1994 to facilitate and future promote day care programmes. This offers more flexibility to users in response to their needs. A revision of the Child Welfare Law will in the future promote day care programmes.

Table 4.4 Approaches to child care in selected OECD countries (continued)

Korea	Act of Infant Nursery passed, which ensures integrated care and education services for children under 12 years old. As of 1996, 23.6% of the children whose mothers are working are currently covered, this will increase as result of the administration project. Approx. 1.3 trillion Won has been invested on nursery care services for 1995 to 1997. Workplaces with over 300 female employees should establish day-care centers by 1997.
Luxembourg	Governmental Declaration of 22 July 1994 states that the government supports and encourages the growing supply of such facilities as day nurseries and crèches as this enables both parents to continue working and gives support to lone-parent families.
Mexico	Children are entitled to day-care services to age 4. Unfortunately, the existing capacity cannot satisfy the demand. Steps are being taken in order to enhance current child care services offered by IMSS.
Netherlands	Additional resources are provided to allow better access to day care facilities specifically for lone parents dependent upon social assistance. Measures to expand after-school child care are made.
New Zealand	There is a proposal to review child care policies, with the objective of improving employment incentives for women and included in the Dec. 1996 Coalition Agreement. Aim is to examine how lone parents can be supported to meet child-rearing obligations while in paid work.
Norway	The government has set an aim that all parents who wish to access pre-school care for their children (estimated at 70-75% of all children aged up to 5 years) shall have access to day care centres. In 1996, 55% of all children in this age group went to day care centres. Almost all municipalities give priority to single parent families. When necessary, they also get subsidised child care. For children in compulsory school -from 6 years (1997) - child care is offered for those aged 6 - 10 years before and after school. Approximately 70 000 children have used this care while the total need is estimated at 105 000.
Portugal	Objective: of creation of child care nurseries through a partnership of the central administration, local authorities and non governmental organisations, using financial support from the European Fund of Regional Development.
Spain	Infancy Programme aimed at increasing the supply of child care services for 0-3 year olds, means-tested tax relief for centre-based child care costs, subsidies for Childhood Care Programmes implemented by NGOs
Sweden	Social support to lone-parent families aims at making it possible for the parent to (...) earn a living by working. Access to child care is an important part.
Switzerland	*Federal commission for Women's Issues* reports that nurseries play a key role to enable parent to meet work and family responsibilities. It has however, received low priority by local authorities. Experts believe that greater provision is a priority.
United Kingdom	Access to child care is recognised as a major potential barrier to lone parent moving into work; child care is a significant feature of new measures to help lone parents into work. 1998 Budget announced intention to introduce a new childcare tax credit within the new Working Families Tax Credit (to replace the childcare disregard within Family Credit)
United States	More families with young children entering work (also a result of the welfare reform), putting increased pressure on the child care system. Expansion of child care facilities is necessary to help families transitioning from welfare assistance to work. An increased federal funding for States to child care $4 billion (Fiscal Year 1997-2002) additional a total of 22 billion allowing states flexibility and design a comprehensive, integrated child care system.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 4.5 Summary of maternity and parental benefits, OECD countries

Country	Birth Payment	Maternity Benefit	Paternity/Parental Leave
Australia	3 instalments, link to child immunisation	some employers provide paid leave (17% female workers), unpaid leave otherwise	12 months unpaid parental leave available for all workers
Austria	yes	100% salary, 16 wks if insured	flat rate payment with two year parental leave, funded from UI, children born after July 90
Belgium	yes	82% salary first month, 75% salary further 11 wks if insured	
Canada	no	55% salary up to max limit, for 15 wks, part of UI scheme	55% salary available for 10 wks for parental care, with UI scheme
Czech Rep	yes	69% earnings for 28 wks if insured	
Denmark	maternity grant if insured	60% earnings for 30 wks if insured	
Finland	yes	earnings replacement declines with income, for 155 workdays if insured	parental allowance available to either parent for further 158 weekdays. Unpaid care leave available until child turns 3
France		100% of earnings to max limit if insured, 16 weeks if first child, 26 weeks for subsequent child, up to 46 weeks for multiple birth	
Germany	maternity grant if insured	100% earnings for 6 wks then 80% earnings for 8 wks	
Greece	Lump sum cash benefit for mothers if insured. Benefit level varies according to scheme. Supplements may be available for multiple births, labour complications, etc.	50% of refernece salary for 16 weeks to working mothers. Full salary paid to civil servants. Some employers (e.g., in banking sector) supplement maternity benefit to provide full income replacement. Limited to employees (self-employed not covered).	
Hungary		100% earnings, 24 wks if insured	
Iceland		flat rate for 6 months for all mothers, supplement to previous workers	working fathers also eligible after first month
Ireland	maternity benefit if insured	70% of earnings up to a ceiling, minimum payment, for 14 weeks if insured	
Italy	no	80% earnings for 5 months if insured	Additional 30% salary for 6 months for either parent (can be extended to 3 yrs if child disabled); alternatively a working parent can take time off work in lieu of financial payment; 30 days a yr paid leave until child age 3
Japan	birth grant if insured	60% basic wage for 98 days if insured	25% earnings for child care leave during first year
Korea	no	paid maternity leave for 60 days if previously employed	public employees can access leave without pay up to 1 yr (public school teacher who has public employee status for 3 yrs) as family leave. Previously employed mothers or fathers can access unpaid child care leave, which cannot exceed one year, including paid maternity leave, after the birth.

Table 4.5 Summary of maternity and parental benefits, OECD countries (continued)

Country	Birth Payment	Maternity Benefit	Paternity/Parental Leave
Luxembourg	cash benefit in 3 instalments	100% earnings for 16 wks if insured, alternative flat-rate payment for 16 wks	
Mexico		100% average earnings for 84 days if insured	
Netherlands		100% earnings for 16 wks if insured	
New Zealand		means tested, sickness benefit rates, for 6 months, mainly single women eligible	
Norway	Maternity grant for women not entitled to maternity benefit. Home birth payment	100% earnings for 42 wks or 80% earnings for 52 wks	fathers can use mother's unused maternity benefit, also have their own 4 wks (within the 42/52 wk limit) non-transferable to mother
Poland	maternity grant if insured	100% earnings for 16 wks for first birth if insured, longer period for subsequent births	flat-rate benefit available for leave up to 24 months after maternity benefit
Portugal	yes	100% earnings, minimum payment 50% minimum wage, for 98 days with 60 days after confinement if insured	father can access maternity benefit if mother unwell or parents decide
Slovak Rep	yes	90% earnings, up to max amount, for 28 wks if insured	father can access extended parental leave for child under 3
Spain		100% benefit base payable 16 wks if insured	
Sweden		reducing earnings replacement, payable 450 days	maternity benefit is a shared entitlement for both parents
Switzerland	11 cantons pay a birth allowance	10 cantons provide means-tested benefits to mothers; the employer is obliged to pay 3 wks salary during the first year of service and after that there are wide disparities in practice ; in some cases there may be insurance against loss of earnings	6 cantons provide full or reduced benefits to fathers
Turkey	• Employees: Child-feeding Allowance • National civil servants (active): Birth Payments (Both can be provided to father or mother)	• Employees: 66.7% earnings for 12 wks • National civil servants (active): 100% earnings for 9 weeks (including 6 weeks after the childbirth). In addition, a leave (1.5 hour per day) is granted for child-feeding.	• Employee: Upon request, the insured can have up to 6 months unpaid leave. • National civil servants (active): Upon request, the insured can have up to 12 months unpaid leave.
United Kingdom		90% average earnings for 6 wks, flat rate further 12 wks if insured. Lower flat-rate benefit for 18 wks if not eligible for above	
United States		variable earnings replacement, maximum amount, payable up to 52 wks, available in 5 states	12 weeks unpaid leave available for specified family/medical reasons, including birth and care of newborn child; 24 hours paid leave for federal employees for child related activities

Source: Response to OECD Caring World synthesis questionnaire, US SSA (1995) *Social Security Programs throughout the World*.

Table 5.1 Selected features of unemployment benefit programmes

Country	Benefit type	Prior employment qualification	Fixed or earning related payment	Payment taxable[1]	Maximum duration of payment
Australia	UA	Nil	Fixed	Yes	Indef
Austria	UI	26 wks/12 mths; 52 wks/2 yrs if first claim, max benefit duration if 156 wks/3 yrs	ER	No, UI and UA set as % of after-tax income	30wk[2]
	UA	Nil	ER		Indef
Belgium	UI	312 days/18 mths[3]	ER[4]	Yes	Indef
Canada	UI	420-700 hrs/yr	ER	Yes	45 wks
	SW	Nil	Fixed		Indef
Czech Republic	UI	12 mths/3 yrs	ER	No	26 wks
Denmark	UI	26 wks/3 yrs	ER	Yes	5 yrs
Finland	UI	26 wks/2 yrs	ER	Yes	500 dys in 4 yrs
	UA	Nil	Fixed	Yes	Indef
France	UI	91 days/12 mths	ER[5]	Yes	60 mths
	UA	5 yrs/10 yrs	Fixed		Indef
Germany	UI	360 days/3 yrs	ER	No	78-832 weekdays[7]
	UA	150 days/yr or exhausted UI benefits	Fixed	No[6]	Indef
Greece	UI	125 days/14 mths	ER[8]	Yes	12 mths
	UA	60/days/2yrs	ER	Yes	3 mths
Hungary	UI	48 mths emp	ER[9]	Yes	2 yrs
Iceland	UI	400hrs/12 mths	Fixed[10]	Yes	5 yrs
Ireland	UI	39 wks/12 mths	Fixed	Yes	15 mths
	UA	Nil	Fixed	No	Indef
Italy	UI[11]	1 yr/2 yr	ER	Yes	180 days
Japan	UI	6 mths/ 12 mths	ER[12]	No	90-300 days[13]
Korea	UI	6 mths	ER	No	30-210 days
Luxembourg	UI	6 mths/12 mths	ER[14]	Yes	1 y/2yrs[15]
Netherlands	UI	26 wks/39 wks for basic benefit and 4 yrs/5 yrs for extended	ER	Yes	6 mths-4.5 yrs[16]
	UA	3 yrs/5 yrs	Fixed	Yes	12 mths
New Zealand	UA	Nil	Fixed	Yes	Indef
Norway	UI	Prior earning requirement	ER	Yes	3 yrs
Poland	UI	180 days/yr[17]	ER	Yes	9-24 mths[18]
Portugal	UI	540 days/2 yrs	ER	No	10-30 mths[19]
	UA	180 days/1 yr	Fixed	No	10-30mths[19]
Slovak Republic	UI	1 yr/3 yrs	ER		6 mths

Table 5.1 Selected features of unemployment benefit programmes (continued)

Country	Benefit type	Prior employment qualification	Fixed or earning related payment	Payment taxable	Maximum duration of payment
Spain	UI	12 mths/6 yrs	ER	Yes	up to 24 mths[20]
	UA	Exhausted UI or worked 6 mths	Fixed	Yes	6 - 18 mths
Sweden	UI	5 mths/12 mths	ER	Yes	300 days[21]
	SW	Nil	Fixed	Yes	150-450 days[21]
Switzerland	UI	6 mths during a base period of 2yrs	ER	Yes	150-400 days[22]
United Kingdom	UI	1 yr/2 yrs[23]	Fixed	Yes	26 wks
	GI	Nil	Fixed	Yes	Indef
United States[24]	UI	Yes[25]	ER	Yes	26 wks

Source: US Social Security Administration (1997), *Social Security Programs Throughout the World*, OECD*(1998); Benefits and Incentives in OECD countries 1995*, OECD *Caring World Synthesis Questionnaire responses*, OECD *Economic Surveys* (various issues).

1. While payment may be treated as taxable income, tax scales may mean no tax is payable on this income.
2. In special cases, up to 52 weeks. If minimum employment contribution duration only 20 weeks.
3. Qualifying conditions rise with age of claimant up to 600 days in last 36 months.
4. Earnings related ratio declines after initial 12 months, with supplement for those with dependants, term fixed rate thereafter 30% replaceable when annual income exceeds 1.5 times maximum insurable earnings. Remainder taxable.
5. Earnings related amount declines incrementally as unemployment duration increases
6. UI and UA set as proportion of after-tax earnings.
7. Varies according to insured employment period and age of recipient.
8. Supplement for dependants, and total amount subject to a 66.6% wage unskilled worker.
9. Earnings related declines after first yr., subject to national minimum/maximum amounts.
10. Amount increases according to period of prior employment, supplement for dependent children.
11. Other, more generous payments are also available for some without work, such as wage supplementation payments, CIGO and CIGS, but they are not included here within the scope of unemployment benefits as the employment contract is generally not severed. Those displaced as a result of industry restructuring may also be eligible for a more generous mobility allowance.
12. Higher earnings replacement for prior lower income earners, subject to minimal/maximum limits.
13. Time increases with age, length of insurance, poor employment prospects.
14. Amount reduced if living with person whose wage exceeds 2 times social minimum wage.
15. Extension possible for further 6-12 months for hard-to-place and/or older unemployed.
16. Payment for up to 4.5yrs requires contributions for 3 yrs in last 5 yrs.
17. No employment history requirement for those having completed studies, relieved from military service, completed maternity leave or released from prison
18. Shorter period for young persons without employment history, period increases as prior employment history increases and/or firm bankrupt. 12 months is the norm for most workers (except young, women with 25 years prior employment and men with 30 years employment.
19. Maximum duration of payment depends on age of recipient.
20. Payment duration increases with prior contribution history.
21. Payable up to 450 days if age 55-64 for UI; for SW benefit payable up to 150 days if below age 55, 300 days if age 55-59 and 450 days if age 60-64.
22. Maximum payment period for passive benefits of 150 days if under age 50, 250 days if age 50-60 and 400 days if over age 60. Can be extended to 520 days in total for all through participation in active labour market programmes.
23. Special earnings related contribution history required, rather than just employment qualification.
24. States have own laws, some differences between schemes.
25. About 3/4 of States have minimum earnings requirement over last year, remainder require employment of approx. 15-20 wks in last yr.

Table 5.2 Net replacement rates for four family types at two earnings levels in the first month of benefit receipt, 1995

Country	APW-level				66.7% of APW-level			
	Single	Married Couple	Couple, 2 children	lone parent, 2 children	Single	Married Couple	Couple, 2 children	lone parent, 2 children
Australia	37	50	72	57	50	67	82	60
Austria	57	60	71	69	57	62	77	73
Belgium	65	57	60	63	86	76	76	82
Canada	61	63	68	66	61	64	68	66
Czech Republic	54	76	77	78	60	74	76	77
Denmark	65	68	77	77	90	94	95	95
Finland	68	71	87	86	83	86	92	88
France	76	74	79	80	85	85	87	87
Germany	70	66	80	80	73	74	76	80
Hungary	67	67	74	75	86	86	90	91
Iceland	55	46	59	69	73	66	81	86
Ireland	33	49	64	59	45	64	72	71
Italy	36	42	47	45	35	42	46	44
Japan	63	61	59	67	72	69	67	75
Republic of Korea	55	55	54	54	54	54	53	53
Luxembourg	86	86	90	90	85	85	91	91
Netherlands	75	81	82	75	86	90	86	86
New Zealand	37	41	64	59	52	71	77	74
Norway	66	67	73	74	65	67	75	77
Poland	34	36	42	41	49	52	61	58
Portugal	79	78	77	78	89	88	87	87
Spain	73	74	76	75	71	71	73	74
Sweden	75	75	85	87	78	78	85	87
Switzerland	73	73	84	84	72	72	84	84
United Kingdom	52	63	67	56	75	88	80	63
United States	58	60	59	60	59	59	50	52

Note: Waiting periods are assumed to have already been met, refers to after-tax comparisons, and includes unemployment benefits, family and housing benefits.
Information supplied by Greece suggests a net replacement rate of between 50-58% of the minimum wage, depending on marital status and the length of the contribution period.
Source: OECD Data-base on Taxes, Benefits and Incentives, Table published as Table 4.1 in *Benefits and Incentives in OECD Countries.*

Table 5.3 Recent developments with benefits for the unemployed

Country	Benefit administration	Arrangements which affect work incentives
Australia	• More stringent application of rules requiring active job search by the unemployed, including: - Employer Contract certificates to be signed by employers to verify job search activity; - Jobseeker Diary for the unemployed to record their jobsearch activity, particularly in first3 months; - Stricter and more comprehensive guidelines for staff administering the activity test. • Changes to legislative provisions on acceptable reasons for declining a job offer; • Greater simplicity of penalties to apply if breach activity test, and increase in average penalty period. (Penalties are now 18% payment reduction for first breach, 24% payment reduction for second breach, 8 week non- payment for third and subsequent breach in a 2 -year period; 26 week non-payment if move to an area with lower employment prospects. They were previously set according to unemployment duration, with 2-6 weeks non-payment for the first breach, with an additional 6 weeks non-payment for each additional breach within a 3 year period; 13 week non-payment if move to an area with lower employment prospects) • Dedicated telephone service for employers to assist in the administration of the activity test. • Introduction of pilot "workfare" type arrangements for young unemployed aged 18-24 years.	• Modification of allowance income test withdrawal rate to lower the withdrawal rate from 100% to 70% for income over A$140 a fortnight from July 1995 • Individualised payment for each member of a couple and changes to income testing to encourage workforce activity by both partners since July 1995 • Employment Entry Payment of at least $100 provided to long-term unemployed, lone parents and people with disabilities who get a full-time job • Temporary retention of health care card when long-term unemployment beneficiaries and lone parent and disability pensioners enter work.
Austria	• Recipients of unemployment payments and social assistance have to demonstrate they are willing to work, but intensity of requirement depends on employment offices. • Job search requirement suspended for about one-quarter of unemployed (mainly older unemployed) • Job and training offers also used to test work availability • All jobs (including temporary ones) paying collective agreed wage must be accepted; lack of child care only valid excuse if job far away from home • Benefits cancelled for 6 weeks for first job refusal, 8 weeks for all subsequent occasions.	• Reduction in maximum benefit levels in 1993. • Basic unemployment insurance benefit withdrawn if earnings exceed Sch 3,600 a month (15% of APW) • Unemployment assistance means-tested on family income, 100% withdrawal rate applies to private income above Sch 5,621 a month (limit doubled for those aged 50-54, doubled again for those aged 55+ yrs) • Entitlements to social assistance withdrawn when earnings exceed Sch 1,400 a month. Entitlements can be based on financial position of extended family. • Qualifying period for unemployment benefits has increased from 26 to 28 months and earnings history used to calculate benefit rates increased from 6 to 12 months. Working hours averaged over time to deal better with seasonal unemployment.

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
Belgium	• Tighter policing of job search for the unemployed. • From early 1996, easing of conditions under which older unemployed (aged 50+ years) may be exempted from job search	• Unemployed in a 2 -income household who are less than 50 years old, have a combined household income of more than BF600,000, can be suspended from unemployment benefit if their benefit spell is "abnormally long". • Further tightening of rules governing exclusion from unemployment benefit on grounds of abnormally long duration of unemployment in early 1996 • Cuts in employers's social security contributions if they hire low-skilled workers, young unemployed and long-term unemployed (November 1993), extended further in October 1995).
Canada	• Ontario government has introduced a workfare programme for SA recipients deemed to be employable. Municipalities negotiating terms with province; recipients generally required to participate in employment support, community involvement or employment placement.	• Reduction in benefit amount for couples in 1993. • New Employment Insurance (EI) program replaced the Previous Unemployment Insurance program in July 1996, including: - reduction in maximum insurable earnings to C$39,000 a year (130% of average earnings, reduction in premium rates); - tax-back of benefits from high income earners (over C$48,750, or C$39,000 with more than 20 weeks benefit duration in the previous 5 years) - Coverage of people engaged in part-time jobs. - New labour force participants require 26 weeks rather than 20 weeks employment before eligible - Increased averaging period for calculation will result in lower benefits for some part-year workers - Decrease in maximum benefit duration from 50 to 45 weeks, with corresponding increase in length of social assistance -EI Family Income Supplement provides a top-up to the basic benefit for claimants with children, to be phased in up to the year 2000, and worth on average about $8000 a year per family, to give a final replacement rate of 80% compared to the basic benefit of 55%. • Ontario province has cut SA rates by 21% since 1995 to reduce generosity of benefits (which had increased significantly in mid 1980s), bringing rates more into line with other provinces and improve work incentives
Czech Republic	• Direct eligibility criteria for Social Assistance recipients that they must be registered as jobseekers with the labour office.	

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
Denmark	• Compulsory activation of unemployed after 2 years on benefit, with private or public job offers, education or training. • For unemployed youth under age 25 without vocational education/training, activation starts after 6 months unemployment and includes training over subsequent 18 months • Rise in eligible age for access to UI from those over 16 to over 18 years. • Failing to accept a reasonable job offer results in one-week's loss of benefit, repetition can lead to exclusion by UI fund. • To qualify for cash assistance, the recipient must have suffered changed circumstances which mean they are no longer able to support themselves (and their family), they must be available for work and aim to return to work as soon as possible.	• For unemployed youth, benefits reduced by 50% when reach 6 months duration • Required period of prior employment for access to unemployment benefits has been doubled (now 52 weeks work over 3 years), maximum duration of payments firstly increased to 7 years (1994) then reduced to 5 years, public sector jobs placement no longer restore benefit eligibility • Early withdrawal scheme, allowing unemployed 50-59 year olds to retire permanently from the labour market discontinued in February, 1996, now only available to those aged 60 years or more.
Finland	• A person on living allowance who is able to work must be registered as an applicant in an Employment Office. The right to unemployment security or the possibility to participate in the labour market or other training will be considered. • Labour market benefit is part of the system of unemployment security. Young persons under 25 without work experience are not entitled to labour market benefit unless they participate in education or vocational training.	• From January 1997, UI participants now required to work for 10 months before requalifying for UI (subsidised job of up to 6 months can contribute to meeting this requirement), previously could requalify for full benefit after solely participating in a 6-month subsidised job. • New rules also stipulate that the new benefit level will be calculated on basis of most recent earnings rather than pre-unemployment earnings (with maximum decline in benefit limited to 20%). • Automatic extension of UI benefit duration for unemployed people aged 55+ reduced from 5 years to 3 years (benefit duration limited to 500 days for other jobseekers) • Those on LMS have greater incentive to earn more, through reducing impact of spousal income. • From 1989, full benefits paid for entire duration of UI, removing the 12.5% reduction which applied at 200 days (maximum duration of UI remains at 500 days) • 1994, eligibility for UA requires six-months work within last 2 years and duration limited to 500 days • New Labour Market Support Programme, providing means-tested flat-rate benefits, to those who are new labour market entrants and those who have exhausted UI/UA entitlements. • Reforms of the social security system have been made to ensure that income from work will always be higher than social security benefits. This includes reform of the system of support for the care of small children, co-ordination of unemployment security and salary arrangement as well as reforms to the living allowance. • Cuts in social security and changing the burden of taxation have made it more profitable for people to take up low paid jobs. Only in the lowest income families is it financially advantageous for one parent to care for children at home. The taxation reductions involve general tax scale reductions as well as reductions in municipal taxation aimed at low -wage groups and reductions in the insured person's burden of contributions.

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
France	• Tighter eligibility for unemployment benefits led to substantial reduction in proportion of job seekers accessing benefits (from 55.8% in 1993 to 47.8% in 1995) • Sanctions by the placement service against unemployed people unwilling to accept a job offer are weak as they can only delay unemployment benefits. The local agencies of the Ministry of Labour terminate payments on rare occasions.	• Mid-1995 increase in minimum wage (Salaire minimum interprofessionel de croissance) at twice the rate of legislated indexation provision -- universal rate irrespective of age, region • Lowering of social security contributions for low-wage earners, young people and long-term unemployed (financed by raising other taxes). • Change in structure of reductions to unemployment payment as duration increases -- produced higher payment for shorter duration spells (second year) and lower payment for very long-term spells (fourth and fifth year)
Germany	• Job offers can no longer be refused on grounds that they do not match the vocational qualifications of the unemployed; narrower definition of acceptable wage. • Internal auditing of labour office, together with tighter controls on eligibility criteria. • Since April 1997, can continue to receive unemployment benefits if engaged in training beneficial to labour market prospects, and training costs reimbursable • Benefit levels cut by 25% for recipients who refuse a suitable job offer	• Insurance benefit reduced by 3% points for single people and 1% point for couples in 1993. • Redundancy payments are now generally credited against unemployment benefits up to a limit (measure to be phased in) • Minimum age for receiving unemployment benefits for more than one year has been increased by 3 years and subject to transitional process -- only affects those who become unemployed after March 1999) • Assistance to cover living expenses also includes "assistance for work", a set of measures aimed at the re-integration of assistance recipients into the labour market. • Social assistance rates are set with regard to the earnings payable to a full-time employed labourer. • Someone on social assistance with earnings has some of these earnings disregarded in calculation of social assistance to ensure they have a higher disposable income.
Greece	• Unemployed have to register with employment organisation	• Partial unemployment benefits available for persons working up to 3 days/week under a part work, part benefit programme. • Consolidation of system of employment incentives and unemployment benefits through the introduction of multi-use vouchers (for training, wage subsidy or unemployment benefits)
Hungary		• Maximum duration of unemployment insurance benefits reduced from 2 years in 1991 to 1 year in 1993. • Maximum duration of unemployment assistance benefits now 2-years was previously unlimited • Unemployment insurance benefits modified in 1993 to provide higher benefits in initial 3 month period and lower benefits thereafter • Reverted back to single (intermediate) rate in 1997. • Prior to 1996, beneficiaries were allowed to earn up to the minimum wage without loss of benefit. Limit has now been set at half minimum wage, with earnings above this level leading to complete benefit withdrawal. • Maximum amount of social assistance is below the minimum wage.

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
Iceland	• Beneficiaries must register each week with the employment exchange, and benefits may be withdrawn if they refuse a job offer. • This decision is made by the Benefit Allocation Committee, comprising union and employer representatives. • Unemployment benefits system managed by the social partners and the government in 56 municipal employment exchange offices. Plans to consolidate into 8 regional offices and benefit allocation committees. Also provide job counselling and placement services, and information on education and training opportunities. • New legislation in March 1997 to clarify and tighten eligibility criteria • Full benefits now require 52 weeks prior employment rather than 1700 hours (currently equivalent to around 34 weeks of 50 hours per week) • Within 10 weeks of initial registration, unemployed person must have a contract with the agency outlining job search and training plans as well as services to be provided by the agency.	• Programme eligibility expanded in 1993 beyond union members to include other wage and salary earners who have worked 425 hours in last year (minimum benefits) or 1700 hours (full benefits), and also self--employed who have closed their businesses and made prior social security contributions. • Workers on short-time working may be eligible for a partial benefit • Full basic benefit previously set to be equivalent to full-time ordinary day-time wage in ordinary fish processing for someone with 7 years experience. This link was severed in 1997. Child benefits also payable. • Benefits payable for 52 weeks, whereupon either a 16 week waiting period is applied or attending training can restore benefit eligibility. Has recently been changed to 5 year maximum payment period, with eligibility restored after working for 6 months in a 12 month period.
Ireland	• Entitlement to unemployment payments is conditional on being available for and genuinely seeking work, with claimants being monitored on the frequency of applications made for work and training. Assistance is provided by the Employment Support Services with job-search, part-time work in Community Schemes, education and training, and in certain cases, continuation of benefit after return to work.	• From 1996, an employee's first £Ir 80 a week of earnings exempt from the Pay Related Social Insurance contribution, to encourage low-skilled persons to work. A lower rate of employer contributions also applies to wages up to around the average manufacturing wage. • Unemployment insurance and unemployment assistance payments equalised in July 1994 with removal of earnings-related components in insurance benefits and increase in assistance benefits. • Long-term unemployed who start work can retain the dependent allowance for 3 months at which stage they are eligible for the Family Income Supplement. Can also keep the medical card for 3 years, irrespective of their level of earnings. • Eligibility for Family Income Supplement to be based on income net of social security contributions and levies and, from 1999, net of income tax • Part-time Job Incentive Scheme provides long-term unemployed (15 months or more) who work less than 24 hours/week with a flat-rate payment of £Ir 40/week for singles and £Ir 66 for one-earner couples to replace means-tested unemployment assistance.

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
Italy		• Basic unemployment benefit was increased in stages to 30% and then 40% of prior average earnings over the previous 3 years. • Mobility Insurance benefit introduced in 1991 for industrial workers with at least 1 year of insurance and six months of employment. Provided duration of benefits according to age: under 40 years (12 months), up to 50 years (24 months), over age 50 (36 months), with benefit rate equivalent to 100% of prior earnings in the first year and 80% thereafter. Now provides benefit equivalent to 80% of salary for 1-4 years, depending on worker's age and location of firm. • Income support provided by the Wage Supplementation Fund (Cassa Integrazione Guardagni) extended to include banks, trade and public utilities employees
Japan		• Recipients of public assistance who earn income from work have approved income calculated after su btracting basic deduction from the income, which takes into account clothing, belongings, social expenses and other work-related expenses. The deduction is increased in proportion to the income earned to enhance the recipient's incentive to work.
Luxembourg	• RMG claimants have to be available for work or community activity, with integration contract agreed within 3 months of initial benefit receipt (although 80% of RMG recipients in 1995 exempted from activity requirements).	• Employment fund will pay all employer and employee social security contributions for newly hired people aged 50 years or more and long-term unemployed aged 30 years or more (represents around 25% of total labour costs) • When the RMG benefit is being calculated, employment earnings are disregarded until they reach 20% of the household's total possible benefit. Benefit withdrawal rate is then 100% on additional earnings.
Netherlands	• Work test for social assistance was tightened in 1996. • Social services and social security benefits agencies are being converted into agencies which can help people back into work. In the future, benefits agencies and the employment offices will work together in Employment and Income Centres.	• Conditions for receipt of earnings-related insurance benefits tightened in 1993. • Experiments to help 20,000 long-term unemployed benefit recipients find work by using benefit money on a temporary basis, to be completed in 1998.
New Zealand	• Work tests tightened and sanctions for non-compliance increased. • Unemployment benefit, and domestic purposes and windows benefits (part population) have work test requirements, including registration with the NZ Employment Service.	• Reductions in benefit levels in 1991, and waiting periods increased. • Changes to benefit targeting have made a mix of part-work/part-benefit more viable.

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
Norway	• Some limited tightening of job search requirements • Sanctions have been increased for those who refuse suitable employment. Access to benefits can be suspended for 8 weeks with first refusal and 12 weeks with second refusal. After 3 refusals within a 12 month period, benefit can be suspended for 6 months. (previous maximum was 12 weeks) • Social economic assistance is a supplementary or subsidiary benefit, and people able to work must be registered at the local employment office and take on any work. Does not apply to disabled people and may not apply to lone parents on transitional allowance.	• Practice of requalifying for unemployment payments through moving onto active labour market programme to cease -- instead need to qualify through working (to apply to be benefit cohort from January 2000) • Discontinue practice of reducing benefit by 10% for those unemployed for more than 93 weeks. • Access to unemployment benefit tightened, with lowest yearly insurable earnings to be raised from NKr30,750 to Nkr51,250 -- mainly excluding young unemployed • Maximum duration of unemployment benefit extended from 2 years to 3 years, with new regulations on unemployment benefit introduced in January 1997 • Period of time lone parent can access transitional allowance reduced from 10 years to 3 years (may extend up to 5 years if undertaking education/training).
Poland	• Social assistance centres are obliged to co-operate with local labour offices and local authorities to persuade beneficiaries to undertake action to help them in the labour market.	• Unemployment insurance changed from an earnings-related payment which declined with unemployment duration, to a flat-rate allowance equivalent to 36% of average wage. • Link to average wage severed in March 1996, with introduction of quarterly indexation to CPI changes • School leavers no longer eligible to receive unemployment benefits but a lower stipend conditional upon participation in an active labour market programme • Duration of unemployment benefit limited to 12 months • Regulations/rules on social assistance lead to higher incomes in work than from social assistance.
Portugal	• The RMG sets out the obligations and responsibilities of the parties, and is established by an agreement of the household with the local community. • Obligations on the beneficiary include: - acceptance of work or vocational training; - attendance at an educational institution; - participation in temporary/community jobs.	• Eligibility criteria of 540 days of prior contribution over previous 2 years before eligible for unemployment compensation is tight • The value of benefits is currently insufficient to exceed salary levels, but may be of some concern in the future. • The RMG minimum income introduced in July 1997 is a social integration programme as well as a cash benefit. The Social Integration aspect deals with social and professional integration (including access to vocational training and employment).
Slovak Republic	• To be considered socially dependent and get access to social assistance, one needs to be registered by the relevant territorial labour body. Encourages citizens to remain registered as unemployed with the applicants' register in district labour offices.	

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
Sweden	• Access to transfer payments is regulated through strict enforcement of eligibility criteria • Benefit sanction increased from 20 days to 60 days if an unemployed person declines a job or training offer	• Replacement rate on unemployment benefits reduced from 90% in early 1990s to 75% as of January 1996 (partially reversed to 80% in January 1998) • Large outflow from unemployment related to take-up of active labour market programmes to re-establish unemployment insurance benefit entitlement. • Waiting period of 6 days introduced for unemployment benefits • Membership of UI fund now available only for youths aged over 20 years and subsidised employment no longer qualifies a person for first-time benefits • Introduction of 3 year benefit duration limit, with forth year possible if jobseeker has had long periods of unsubsidised work or education participation.
Switzerland	• Rigorous application of work tests and tight controls of benefit entitlements • From January 1996, more stringent definition of suitable work: work at 70% of previous earnings suitable (was 80%), travel time of up to 2 hours each way is acceptable. • The Latin cantons, worst hit by unemployment, have developed their social assistance programmes more along the lines of minimum integration schemes, establishing a contract between the canton which undertakes to provide integration measures to participate, or else is penalised.	• Increase in unemployment insurance contribution rate from 2% to 3%, split between the employer and employee, combined with higher (indexed) wage ceiling introduced in 1995. • Introduction of general 5-day waiting period before start of unemployment benefit payments. Unemployed school leavers who have never contributed to unemployment insurance have 120-day waiting period • Reduction of duration of income support for short-time working (24 down to 12 months) and bad weather (12 to 6 months) within a 2 year period • Job seeker on wages less than unemployment benefits can claim intermittent pay supplements from unemployment insurance. • Payment of benefits limited to 150-days (longer for those aged 50+) and extended for up to further 370 days (520 days total for all) conditional on participation in active labour market programmes if places available. • Participation in active labour market programmes no longer generates new benefit entitlements, as was previously the case for temporary employment placements. • Level of social benefits (both unemployment insurance and social assistance) set so that people are not discouraged from getting a job. • In order to encourage the unemployed especially the long-term unemployed, to accept a wage that is lower than their benefit, benefits are adjusted and still available.
United Kingdom	• Jobseekers Allowance introduced in October 1996 requires recipients to demonstrate they are available for and actively seeking work. They must sign a specially tailored agreement, which sets out the details of their intended job search activity.	• Young unemployed restricted from receipt of income support without participation in active labour market measures Introduction of Jobseekers Allowance reduced the maximum duration of social insurance benefit from 12 months to 6 months. • Recipients of Jobseekers Allowance or Income Support working less than 16 hrs/week can retain an amount of earnings before benefits start to be reduced. • Several changes aimed at assisting the transition from benefits to work: - For those on Income Support or Jobseekers Allowance for at least 6 months, continuing payment for 4 weeks after get a job, irrespective of earnings; - Back-to-work bonus provides cash lump sum to those on benefits for at least 3 months who move from part-time to full-time work; - Parents receiving child maintenance and receiving Income Support or Jobseekers Allowance who leave benefits for work can accrue a lump sum bonus.

Table 5.3 Recent developments with benefits for the unemployed(continued)

Country	Benefit administration	Arrangements which affect work incentives
United States	• Recent reforms to public assistance programmes have included mandatory work provisions. Changes to the primary program of cash assistance to low income families (primarily lone mothers) require single parents to participate in work activities for at least 20 hrs/week rising to 30 hrs/week. Single parents not able to find childcare cannot be penalised for not meeting this requirement. States can exempt single parents with a child under 1 year from this work requirement. • Limit on the receipt of federally - funded benefits of 5 years. • Reforms to Food Stamps programme limits participation to 3 months in a 3 year periods for able bodied adults without dependent children who have not worked at least 20 hrs/week while on benefits.	• All major social assistance programmes are structured so those with earnings have higher net benefits than those who do not work. Law passed in 1996 to raise minimum wages, not expected to have large impact.

Source: Responses to OECD Caring World Synthesis Questionnaire, OECD (1997) *Making Work Pay*, *OECD Economic Surveys* (1996, 1997, 1998), various countries.

Table 5.4 Recent disability benefit trends - selected countries

Country	Benefit Trends as Reported by Countries	Policy Parameters
Australia	Significant growth in number below standard retirement age receiving disability benefits. People aged 20-65: 1985 246 747 1996 483 986 Largest increase over 30-49 year age group from: 78 367 to 173 039 Recent internal study predicts total numbers could reach 935 000 by the year 2006 if current growth rates are maintained.	• November 1991 New assessment process, including Impairment Tables, and revised (tighter) eligibility criteria for the new Disability Support Pension, to apply to new claimants. • Increased programme places for rehabilitation, training and jobs support and linkage of service delivery between employment, health and social security, government departments, to try to improve job prospects and assist the transition into employment. • Availability of employment entry payment and education entry payment if commence employment or recognised course of study. • Able to retain Health Concession Card for a further 12 months after gaining employment and leaving pension. • If subsequently lose employment, can be reinstated onto pension within a 2 -year period without full review of medical eligibility. • 1997 Those automatically transferred to Disability Support Pension in 1991 will be reviewed using current eligibility criteria and impairment tables.
Belgium	Gradual increase over recent years: Employees: 1992 164 424 1994 166 192 1996 168 .69 Self-employed 1992 17 723 1994 17 328 1996 17 041	
Canada	Since 1988, the Canada Pension Plan Disability Benefits caseload has grown by 50%. Rate of caseload growth has started to fall since 1994-95.	• 1994-95 Range of measures introduced to manage the growing pressures on the disability programme. • Policy guidelines for eligibility were revised to put more weight on medical factors and de-emphasise socio-economic factors. • A new structure of administrative review and review tribunals were established. • New incentives to work, including opportunity to retrain without cancellation of benefits, opportunity to undertake voluntary work, 3 -month continued receipt of benefits after entry into work, and special attention given to the requirements of those who had been on disability benefits at a previous time. • Workers' Compensation arrangements paying more regard to future earnings capacity as well as disability, and greater availability of physical and vocational rehabilitation.

Table 5.4: Recent Disability Benefit Trends - Selected Countries (continued)

Country	Benefit Trends as Reported by Countries	Policy Parameters
Czech Republic	No increase in proportion of people below retirement age receiving invalidity benefits. Share of invalidity pensions in all pensions paid has remained around17% since 1980	• So far has been no change in policies with respect to benefits or other support for people with disabilities. • Current eligibility criteria requires prior insurance record of at least 5 years in last 10 years (if aged 28 years or more, less if the person is younger) or the full invalidity is due to occupational injury or disease. Partial pension also available but must have at least 33 1/3 % reduction in work ability.
Finland	Overall stability in disability pension numbers, some growth in 60-64 year olds in association with retirement age changes.	• Focus on maintaining working capacity through emphasis on rehabilitation and training. Benefit increased by 33% if person undertakes rehabilitation. • Possible to work temporarily while receiving pension, accrue pension rights during rehabilitation and training. • Higher unemployment has led to reduced number applying for disability payments. • Some discretion in determining eligibility for disability payments, but indication of more stringent assessment with increased rejection rate on new claims.
Greece	Fall in the share of disability pensioners in total new pension grants from 30% in 1990 to around 15% in 1997.	• Level of disability pensions (provided by Social Security funds) linked to the level of disability in 1990, with lower level disabilities only attracting 75% maximum payment • Level of disability benefits (excluding invalidity pensions) granted by Ministry of Health and Welfare raised by over 40% in real terms since 1995 • Stricter eligibility criteria applied since 1998. Uniform criteria and registration procedure to be applied to rationalise benefits and to prevent fraud.
Italy	Decline in applications for benefit	• Verification of assessment of medical impairment by Medical Commission (established in 1990). • Provide statement of income and hospital follow-up to competent local authorities. • Registration with Provincial Labour Agencies on special job placement lists. • Benefits relatively low and subject to very low income ceilings. • Finance law of December 1997 helps disabled people acquire cars and increase mobility, to take advantage of labour market opportunities. Exempted from road tax, VAT reduction on purchase, special help for required modifications. Do not have to be the driver of the car: assistance also available if they are transported in the family car.
Luxembourg	Increase in disability pension grants over last 10 years. Reduction in average age of person qualifying for disability pension.	Draft legislation being prepared – Introduction of 2 -tier disability scheme to distinguish between general and work-related disabilities. – Encourage more active participation in vocational training. – Maintain high level of protection for those with general disability.
Mexico	Growth in disability payments, such that they now represent 43% of all pension payments (in 1994).	• Increased protection to disabled workers, together with decrease in average contributions by both workers and employers. • Initiatives to reduce level of fraudulent claims as well as incentives for firms to invest in safety and new technology.
Netherlands	Decline in benefit numbers as % of labour force: 1991 = 14.6% 1993 = 14.4% 1994 = 13.8% 1995 = 13.0% 1996 = 12.7% Decline in applications for benefit since early 1990s	• 1993 TAB act (“Restriction of claims on the Disablement Benefits Regulations ”) • New stricter criterion of disability to apply to all new claims and existing recipients below age 45. – Revised assessment process. – Benefit level adjusted. • Seek to promote participation in employment (less successful than had hoped). • 1998 measures will introduce experience-rating into the disability premia for employers, to encourage prevention and re-integration.

Table 5.4 Recent disability benefit trends - selected countries (continued)

Country	Benefit Trends as Reported by Countries	Policy Parameters
New Zealand	Increase in invalids benefit numbers	• Increase in allowable earnings (from NZ$50 to NZ$80 without any reduction in benefit, and then additional NZ$100 only reduces benefit by 30%). • Increase in retirement age from 60 to 65 over 10 years to 2001 accompanied by increase in number on invalids benefit. • Invalids benefit currently under review.
Norway	Number of disability pensioners increased in the 1980s, declining new claims in the early 1990s before growth again since 1994 (at least partly due to time limitation on rehabilitation arrangements).	• January 1989 Special rehabilitation for persons with substance abuse and psycho-social problems. • January 1990 Repeal of rules making it possible for disability pension to be granted due to old-age impairment. • Assessment of the capacity for work to encompass ability to do any kind of work. • January 1991 Greater requirements can be placed on person to undertake vocational training and be available for jobs in other locations. • June 1991 Requirement that the disability and reduction of work capacity should be predominantly due to medical conditions. • More attention has been given to prevention, early intervention, medical and occupational rehabilitation and integration of disabled persons into the ordinary labour market. • 1994 Responsibility for occupational rehabilitation transferred from National Insurance Administration to the Public Employment System, with suggestions this has proved successful. • 1997 Combination of work and disability benefit to become more likely and easier return to benefit if employment experience fails.
Poland	Rapid reduction in employment of disabled people since 1989. Considerable change in grants of disability pensions: 1985 174 079 1989 187 542 1990 243 328 1991 318 669 1992 243 124 1995 171 673	• New economic conditions associated with economic transition, limited employment opportunities for disabled people. • 1991 Act on employment and occupational rehabilitation encouraged employers to create new jobs for the disabled, provide unemployed disabled with occupational training, access to job placement and vocational guidance, and made available loans to establish own enterprise • Also established sheltered work opportunities for those disabled people not able to find work in the open labour market.
Portugal	Progressive decrease in number of people receiving invalid pensions prior to age 65: 1992 446 651 1995 390 599	• Opportunity for disabled people to work in sheltered employment. • Firms who employ disabled workers can benefit from a 50% reduction in social security contribution rates for those workers. • Permanent Incapacity Control system established to better review and maintain veracity over pension grants and ongoing entitlement.

Table 5.4 Recent disability benefit trends - selected countries (continued)

Country	Benefit Trends as Reported by Countries	Policy Parameters
Slovak Republic	Decreasing number of disability persons between 1992 and 1996	• Social Insurance Agency makes regular investigation of the medical condition of recipients as well as the earnings of those in receipt of a partial pension.
Spain	Progressive decline in number of disability pensioners: 1987 797 512 1990 760 707 1993 744 497 1997 729 700 Noticeable decline for those close to statutory retirement age.	• July 1997 Measures within the Consolidation and Rationalization of the Social Security System. – Account taken of diminished work capacity in professional categories, not just previous job. – No access to benefit if over age 65. – Establish list of how particular illnesses may impact on work capacity and earnings capacity. • Improvements have been made more generally with determining entitlement to benefits as well as review processes. • Plan to set up multi-disciplinary Incapacity Assessment Teams (EVIs) in provincial directorates, to assess incapacity for work, assist with monitoring processes and provide technical assistance and advice.
Sweden		• No recent changes to disability benefits.
Switzerland	Has been recent growth in the number below retirement age who receive disability benefits. An internal study suggested the impact of unemployment on new disability recipients was less than anticipated.	• New legislation on Disability Insurance has recently gone to the Parliament for consideration, consisting of reforms to benefits, changes to administrative processes, and increasing scheme funds. • Other cost-containment measures expect to be put before Parliament later.
Turkey	Has been no observable increase in the number of people below standard age of retirement getting disability payments. • Expenditure on invalidity benefits (million TL) 1994: 2, 420/ 1995: 4,670/ 1996: 13,453 • The number of people on disability benefits 1994 1995 1996 Employees : 98,870 99,040 99,539 Self-employed : 11,099 11,441 11,499 National civil servants : 23,080 23,934 24,749	• Establishments with 50 or more workers required to have 2% of their employees with handicaps (and 2% released prisoners) -- otherwise sanctions can be applied. • A special retirement system has been developed for those disabled with no ability to work. • Those in receipt of disability payments can work and earn income, and may be subject to frequent medical reviews.
United Kingdom	Numbers on invalidity benefit: 1980-81 570 000 1994-95 1 809 000 Number of people on disability benefits is greater in areas with declining traditional industries: 1993 680 000 1997 1 162 000	• Disability Working Allowance (DWA) introduced in April 1992, as an in-work benefit for those on low incomes. • Disability Living Allowance provides extra assistance to disabled people under 65 with care and mobility needs. Introduced in April 1992, merged and extended previous benefits. • April 1995 All-work test introduced to determine extent to which the impairment affects work-related activities. • July 1996 Before grant highest rate of DLA, will require independent medical evidence. • Benefit Integrity Project will review 425 000 recipients of DLA over the next 2-years. • March 1998 New announcement of Disabled Person's Tax Credit in Budget designed to help sick and disabled people take up work

Table 5.4 Recent disability benefit trends - selected countries (continued)

Country	Benefit Trends as Reported by Countries	Policy Parameters
United States	Both the Disability Insurance (DI) Program and the means-tested Supplemental Security Income Program recipient numbers grew steadily between 1982 and 1992, levelling off somewhat since then. Economic analysis suggests that there is a strong link between the business cycle and Disability Insurance applications.	• Some features of DI Program design attempt to encourage work participation. Can retain benefits during a 9-month work trial, have cash benefits reinstated when earnings below US$500 month, can deduct impairment-related costs in determining income for benefit eligibility, retain benefits while on rehabilitation and 30-weeks Medicare coverage following work trial period. • Alcoholism and drug addiction no longer considered disabling conditions. • Planning a study of functional assessments and medical assessments of disability

Source: Responses to the Caring World Synthesis Questionnaire.

Table 5.5 Recent sickness benefit trends - selected countries

Country	Benefit trends as Reported by countries	Policy Parameters and Relevant Environmental Factors
Australia	Growth over recent years in the number of people receiving public benefits on account of temporary illness or incapacity	• 1991 Sickness Allowance generally limited to 12 months duration (extension to 24 months in special circumstances) with grater emphasis on rehabilitation and facilitating return to work • March 1996 Unemployed people who become temporarily sick will remain on Newstart Allowance rather than transferring to Sickness Allowance • September 1997 various measures to extend the degree of means testing which applies to new claimants for Sickness Allowance (and all other Allowance payments), taking greater account of employer leave payment and available liquid assets.
Austria	Sickness benefit expenditures 1990 ATS 3,070 million 1995 ATS 5,340 million 1996 ATS 4,929 million	• Employer provides full wage for initial 4-12 weeks of illness, then statutory health insurance will provide sickness benefit at rate of 50-60% of prior wages • Poorer economic conditions since 1995 has reduced claims for sickness benefits because of more precarious employment tenure • No significant policy measures, only slight reduction in maximum sickness benefit duration and better checks on those workers on sickness leave.
Belgium	Number of days reimbursed by the benefits insurance scheme for employees 1992 21.077 million days 1994 19.733 million days 1996 20.248 million days	• No obvious change to policy arrangements • Employer responsible for meeting first 30 days of costs for most employees (only 7 days for blue collar workers, then supplementary payment for further 23 days) • Can be health checks on the worker receiving income support, from an accredited medical unit or adviser to the medical fund.
Canada	No growth in Sickness Benefits payable as part of the Unemployment Insurance scheme	• Maximum total sickness benefits remains at 15 weeks, as it has since 1971. Sickness benefit rate differs according to total earnings in previous 26 weeks and a factor reflecting regional unemployment • Recent reform changed eligibility to 700 hours of insured employment in previous 52 week, to provide cover to part-time workers and multiple job holders.
Czech Republic	Between 1989 and 1997, the percentage of sick workers on any average day has risenfrom 4.8% to 6% Average period of absence from work because of sickness has increased form 17 to 26 days. Number of cases about unchanged.	• A number of measures are being considered in their policy area: - reduce income replacement for low and high income earners; - reduce benefit for person with spells of incapacity below one month; - more stringent checks that treatment is being pursued. - take action against medical practitioners too benevolent in sickness assessments • No shift in responsibility to employers, who can already reduce earning bonuses in line with days of absence.
Denmark	Public expenditure on sickness benefits 1994 DKr 6.0 bn 1996 DKR 7.0 bn	• Growth in 1995 largely accounted for by increased payment for long-term illnesses and switch from the time-limited unemployment benefits to sickness benefits • Sickness benefits also have a one-year time limit but exemptions are granted to people who have applied for an early retirement pension, are in the process of rehabilitation or waiting to start on a rehabilitation programme • April 1997 higher priority is given to follow-up of sickness benefit cases. Local authorities also have significant incentive for early follow up as they are responsible for 50% of the sickness benefit expenditure after 8 weeks (was 13 weeks)

Table 5.5 Recent sickness benefit trends - selected countries (continued)

Country	Benefit trends as Reported by countries	Policy Parameters and Relevant Environmental Factors
Finland	Absence from work because of sickness has remained stable	• Daily allowances, paid according to collective agreements by employers for up to 1-3 months are trending towards reduced amounts • 1990/91 increased emphasis on early rehabilitation, develop action plan for occupational health and safety
Germany	Decline between October 1996 and March 1997 of at least 15% compared to same period in previous year	• Difficult labour market environment discouraging use of sickness entitlements. • October 1996 reduction in value of statutory payment from 100% of wage to 80%, payable by employers for first 6 weeks • January 1997, sickness benefit reduced from 80% to 70% of wage and time limited to maximum of 78 weeks in any 3 year period for same illness
Greece	Number of days reimbursed by the main scheme for employees (IKA): 1993 6,412,366 1994 6,289,248 1995 5,895,030	The main scheme for employees (IKA) pays no benefit for the first 3 days of absence due to sickness. Thereafter, benefit is 25% of the reference wage for the following 15 days and 50% of the reference wage for the next 15 days.
Hungary	Reduction in number of sick days: 1994 73.9 million 1995 63.1 million 1996 45.2 million Expenditure on sickness benefit: 1994 40,833 million HUF 1995 39,805 million HUF 1996 32,977 million HUF	• Increase in amount of sickness benefit payable per day has increased: 1994 552 HUF 1995 631 HUF 1996 730 HUF • Employees entitled to maximum of 15 days sickness leave in a year, provides 75% of previous earnings paid by employer • Senior supervisory medical staff established by government to review determinations, detect unjustifiable leave and direct person to available treatment.
Italy	Recent decline	• Tenuous overall labour market conditions and reductions in average age of employees discourages take-up of benefits. • Some reductions in benefit levels, particularly in public sector.
Mexico		• Increased protection during period of illness, together with decrease in average contributions by both workers and employers
Netherlands	Rate of Sickness Absence (excl. maternity) 1993 6.2% 1994 4.9% 1996 4.6%	• 1994 employers given responsibility for paying first 6 weeks of sickness absence. • 1996 employer responsibility extended to first 52 weeks. • Each company required to subscribe to ARBO-services which monitors sickness absence and provides advice/recommendations to companies
New Zealand	Sickness Benefit June 1990 19,511 June 1996 33,386	• 1991 longer wait of up to 2 weeks before eligible for payment • 1995/96 tighter administration with more extensive information on medical difficulties, reduced time between medical reassessment, need for second opinion with long-term cases • Sickness benefit currently under review
Norway	Over the period 1990-94, absences from the labour force was reduced by 17%. Since then 3 has been some increase in longer sickness absences	• 1980s. Employer responsible for first week of sickness pay, extended to cover first 2 weeks, • 1990s. Government and social partners have co-operated to try to reduce sickness absence - intervention and research programmes focused on common illnesses and injuries - greater attention to supervision of those claiming benefits - focus to get people back to work

Table 5.5 Recent sickness benefit trends - selected countries (continued)

Country	Benefit trends as Reported by countries	Policy Parameters and Relevant Environmental Factors
Poland	Over last 3 years has been relative stability in sickness absenteeism, but has been a switch towards social insurance fund responsibility for payment rather than employers (now 60/40 rather than 40/60)	• Currently investigating the processes, including medical documentation and conformity with sickness regulations • Employer responsible for payment for first 35 days in a calendar year (at rate of at least 80% of salary, which collective agreements can raise up to the 100% level).
Portugal	Days of sickness allowance paid during the year: 1992 66,124,786 1996 59,324,288 General decline although some variability from year to year.	• More intensive control and review activities to be performed by the Expert Medical Council working within the Social Security Regional Centres • Corresponding focus on improving return to work rates.
Spain	Some increase in expenditures on sickness benefits, to 1992: 1988 290,903 millions pesetas 1990 413,813 millions pesetas 1992 565,141 millions pesetas 1997 560,801 millions pesetas	• 1992 Employers have paid temporary incapacity benefit between 4th and 15th days for non-work-related accidents and illnesses. Employee receives nothing for first 3 days, as was the case previously. With work related accident/illnesses, employer responsible for the entire costs. • Employers have a duty to co-operate with social security management, plus Social Security Work-Related Accidents and Illness Provident Associations also assist in this process. • 1997 Recent measures to manage and monitor temporary incapacity, including greater opportunity to terminate absences from work, more precision into certification of illness and its impact on work ability, new medical reports, greater monitoring of illnesses and medical review at least before 12 months of payment.
Sweden	In recent years of increasing unemployment, the number of people receiving sickness benefit has fallen.	• 1991: Compensation 65% for first three days, 80% for day 4-90, and 90% thereafter • 1992: Employers pay first 14 days • 1993: One day waiting period, compensation reduced to 70% after a year • 1994: Reduced compensation to 75% day 2-3, 90% day 4-14, 80% day 15-365 • 1995: Reduced compensation to 75% day 4-14, regulations were introduced to increase powers of social • insurance office to investigate cases • 1996: Reduced compensation to 75% • 1997: Employers period extended to 28 days • January 1997: Sickness benefit, sickness pay and rehabilitation allowance increased from 75% to 80% of previous income. • Regulations introduced to increase co-operation between agencies and make rehabilitation more effective. • April 1998 Employers responsible for first 14 days of sickness pay (was 28 days)
Turkey	• Expenditure on sickness benefits (million TL) 1995: 1,093,686.6/ 1996: 2,536,040.7 • The number of beneficiaries in 1995: 637,892	• Public and private workplaces required to have a workplace doctor once they reach a certain size • Regular investigation of the workplace environment • Rehabilitation services encouraged to accelerate the return to work
United Kingdom	Changes to expenditure on statutory sick pay paid by employers (for absences of < 28 weeks) 1986/87 £ 179 m 1994/95 £ 342 m	• Statutory sick pay (SSP) paid by employees was extended to cover absences for < 8 to < 28 weeks in 1986 • Refunds to employers reduced from 100% to 80% in 1991 and then to nil in 1994 • With changes to SSP, has been some action by employers to manage absence levels

Source: Responses to OECD Caring World Synthesis Questionnaire.

Table 5.6 Changes to labour market measures

Country	Broad developments
Australia	• Significant changes to the structure of active labour market programmes, with competition to be introduced into the employment services market, greater flexibility on the type of intervention provided (with payment to providers on the basis mainly of outcomes), and some reduction of overall expenditure • Jobs, Education and Training (JET) programme for sole-parent pensioners, voluntary programme providing access to advice, training, education, job finding assistance, child care • Disability Reform Package for disability pensions also includes access to labour market assistance on a voluntary basis, as well as rehabilitation
Austria	• Range of measures intended to promote integration of disadvantaged groups into the labour market, with a special priority on the long-term unemployed. • For the disabled, financial subsidies for employers, grants for on-the-job training, financial reimbursement of work environment adaptation provision of technical equipment and assistance to start own business • Those disabled who cannot get a job in the regular labour market may be employed in an "integrative enterprise" to prepare them for employment in the regular labour market or be directed to vocational training centres
Belgium	• Integration into the labour market is one of the Public Social Assistance Centre's (CPAS's) main concerns. Law of 1976 requires centres to take all steps to find a job for someone who has lost qualifications for social security. If necessary CPAS must itself act as the employer and is exempt from social security contributions. • Centres also encourage collaboration with other service providers, and take the role in concluding training agreements. • Number of pilot studies approved by Council of Ministers to provide job integration opportunities. • Local Employment Agencies have been established to complement existing job finding arrangements. Those on unemployment or social assistance benefits for at least 3 years may be directed to work up to 40 hrs a month for public services, non-profit organisations and private firms.
Canada	• C$800m a year from savings due to new EI programme reinvested into additional employment benefits. Five streamlined active employment measures including targeted wage subsidies, pilot of earnings supplements, job creation partnerships providing work experience in community economic development priorities), self-employment assistance, and loans and grants for skill development. • Employment benefits are now available to persons not currently receiving EI income support but who had received benefits over the previous 3 years. • Federal government has signed agreements with the provinces on the design & delivery of new active programmes, with greater responsibility to provincial governments reflecting their responsibility for labour market training • Improved information on job opportunities, with the labour market information system also enabling people to march their skills against available jobs. • Provincial and territory social assistance programmes include a number of labour market measures: – training, academic upgrading and job placement – compulsory participation in employability enhancement (young people) – earnings disregards – special cash assistance to cover work-related costs. – special allowances or tax exemptions for those who wish to operate their own business – lowering the age of children who entitle the lone-parent to benefit • Provinces may also offer local income tax reductions and working income supplements for families with children to make work pay for social assistance recipients • Strategic Initiative Programme introduced in 1994 to test some innovative approaches to improving employment prospects, such as providing literacy and life skills, skills training and academic upgrading. Five year Federal Provincial shared cost programme.
Czech Republic	• Has public employment programmes and other measures to assist people back into work.

Table 5.6 Changes to labour market measures (continued)

Country	Broad developments
Denmark	• Those aged over 25 can get an individual action plan six months after they receive cash assistance, with "activation" after 12 months receipt of cash assistance • They may also participate in adult or supplementary education after they have received cash assistance for 6 months.
France	• New package of initiatives announced in France in March 1998 of a programme of prevention and fight against exclusion (*le programme de prévention at de lutte contre les exclusions*). Some of the specific labour market measures include: • up to 18 months training and employment assistance for disdvantaged young unemployed (*TRACE*), • increasing employment opportunities (through the *nouveaux emplois nouveaux services* programme, expansion of the *les contrats emploi-solidarité* programme and reconfiguration of the *le contrat emploi consolidé* programme), • seeking to improve the qualifications of adults aged over 26 years who have been unemployed for at least six months, • as well as a new initiative to allow *RMI*, *ASS* and *API* recipients to continue receiving social security payments in addition to their earnings for up to 12 months (of decreasing amounts after three and nine months) after they enter work paying less than the minimum full-time wage.
Finland	• Targeted measures are in most cases aimed at the youngest or the oldest labour market groups. • An employer who takes on a long-term unemployed person is entitled to a subsidy which lowers their social security contributions for 10 months. • In August 1997, an Education Guarantee will be introduced, to expand training mainly to the long-term unemployed. Provides the equivalent of the daily unemployed allowance, to those unemployed for 12 of the previous 18 months, for approved courses only. • The Ministry of Labour and the Ministry of Social Affairs and Health are co-operating to study the employment history of 15,000 long-term unemployed, and their needs for education, training and rehabilitation.
	• The Act on Job Alteration, introduced January 1996, allows an employee to get a labour market benefit (temporary job allowance) if they shift to part-time employment and share the job with a formerly unemployed person. • The Council of State encourages working hours experiments in municipalities. Working hours are shortened together with the hiring of unemployed job seekers to make up the reduced hours, with 20 municipalities participating in these experiments.
Germany	• Federal government introduced part-time work offensive in June 1994 to attract both employers and employees to the idea of part-time work but no general financial support. Steadily improved the framework of legal conditions for part-time workers over the last few years.
Greece	• Most social welfare bodies are moving increasingly towards the direction of labour market integration. Services range from occupational skills training to counselling and job placement. • Some of the measures include: – full computer system for The Manpower Employment Organisation (OAED) and extension of the employment promotion centre network – integration of unemployment subsidies and employment promotion through the issue of Employment Coupons – extension of training organisations with the involvement of businesses – special measures to advance employment and vocational training of women • Training and employment programmes are targeted at high exclusion risk groups, including compulsory job placement of some individuals with special needs into private/public sector jobs. • Also establishment of special part-time Employment Programmes for groups (such as those with special needs, people from detoxification centres, young offenders) to facilitate a progressive integration into the labour market. • Also other programmes under development which would – improve the skills of the unemployed – encourage self-employment and subsidise new entrepreneurs – subsidise the employment of disadvantaged jobseekers

Table 5.6 Changes to labour market measures (continued)

Country	Broad developments
Hungary	• Benefits in kind include personal social assistance such as family assistance, labour market training and retraining
Ireland	• Expansion of the Back-to Work Allowance scheme – The Back to Work Allowance scheme enables the long-term unemployed to retain a declining portion of their welfare entitlements for a period of three years (75%, 50% and 25% respectively) when they enter employment. Since January 1998, the self-employment strand of this Allowance has been improved to allow participants to receive support over a four-year period commencing with 100% of their unemployment payments for the first year. Technical and other supports are also provided to self-employed participants on the scheme. – In 1997, 1000 places on this scheme were designated for people with disabilities, i.e., people in receipt of a Disability Allowance or a Blind Person's Pension .
Italy	• Reform of employment agencies, the introduction of interim work, the introduction of different kinds of work contracts (temporary jobs, contractors) and reduced time in earning integration. • "Treu package" is a series of measures regarding development of employment and interventions in the labour market. – promotion of useful work (e.g., national heritage, environment protection, urban refurbishment), including – vocational training and retraining – support for small and medium sized enterprises – and private personal services. Has to be of value and last some time.
Japan	• Employment promotion benefits (re-employment allowance, outfit allowance for disabled persons who get regular jobs, moving expenses and wide area jobseeking expenses and capacity development benefits/skill acquisition allowance, lodging allowance, training extended benefit) provided to reduce exclusion from the labour market. • If a recipient of public assistance gets a job they can get occupational aid to cover necessary expenses up to a ceiling and case workers assist them with employment guidance and other matters.
Korea	• Job training and small business loans are 2 measures intended to promote poor people's integration into the labour market • Job training provides various supports to trainees, including family support, during the training period. In 1995, 3,400 persons completed training of whom 50% got a job after training • Small business loans, provided to 5,000 households loan of 9 million won per household with repayment of 5 years after 5 year period of grace and at 6% interest.
Luxembourg	• The Law on RMG contains various complementary measures designed to foster access to employment, for those recipients of working age who are fit to work – recipients of RMG are obliged to work on projects of use to the community and for non-profit organisations. Can be assigned to work for 40 hrs/week and receive an integration income (same as minimum social salary) – recipients of RMG may be sent on training programmes in private enterprises, to reacquaint themselves with working conditions in the market sector, acquire professional skills or update vocational skills. Employers promise them preferential recruitment if a suitable position comes available. – recipients under re-training contracts may attend courses and undergo training to improve labour market prospects.
Mexico	• System for Integral Family Development provides tax breaks for businesses that employ disabled persons • National Service for Employment and the Program for Training Scholarships granted 254,500 scholarships for unemployed to enhance working abilities and skills. • Short-term employment programme (Programme de Empleo) introduced in 1995 to address chronic severe poverty in rural areas as well as provide basic infrastructure and support for decentralisation. Created 550,000 temporary jobs in 1995, 673,000 in 1996, target of 1 million in 1997
Netherlands	• Paths towards employment streamlined and improved through Integration of Unemployed Persons Act, and the (re) Integration of Disabled Persons Act which includes subsidies for employers who hire disabled people • Aiming to generate an additional 40,000 extra regular Council jobs and jobs in the care sector, to be filled by long-term unemployed, and fully implemented by 1998 • Social activation experiments started in 1997 for persons living a considerable distance from the labour market.
New Zealand	• Programmes aimed at encouraging and supporting labour market attachment include training incentives for lone-parents, subsidised childcare and action plans for benefit recipients

Table 5.6 Changes to labour market measures (continued)

Country	Broad developments
Norway	• For several years, the government has given priority to labour market measures in order to assist peoples' efforts to re-enter the labour market. Special emphasis on gaining qualifications for people without relevant training • National government has encouraged municipalities to introduce measures aimed at work/activity by those on social assistance. Municipalities may require them to work for the municipality if it will help them become self-reliant.
Poland	• Government created the "Productive Employment and Limiting of Unemployment Programme ". Has a focus on training the unemployed in skills in demand in the labour market • Provision of equipment for work to enable establishment of own workshop • Cash benefits and loans, may be available to assist unemployed people to generate their own income.
Portugal	• National Flight Against Poverty Programme involves 131 projects with more than 1,000 partners to: – promote the social integration of risk groups – support self-employment, including development of arts and crafts – construct and restore buildings • RMG programmes developed first provide education and psychosocial support followed by health and employment & vocational training. Sub-programmes Integrate which aims to promote economic and social integration of more fragile groups
Slovak Republic	• New Act on employment amends the provision of public services and has objective to improve integration of citizens into the labour market: – free of charge job agency and advisory services, performed by district labour offices – retraining of the unemployed and employees – active labour market programmes aimed to support, sustain and create new job opportunities – State delegated some activities to the public-legal National Labour Office, which includes representatives of employers, employees and the State.
Sweden	• Overall objective of Swedish social policy is to develop a high degree of social integration. • Close like between social policy and labour market policy with the "work strategy", which aims that every adult citizen according to personal capacity can work to earn a livelihood and pay tax. • Health care, social services and education are being straightened financially in order to promote employment, including: – 10,000 new adult education places for long-term unemployed aged over 25 – labour market policy strengthened to reduce the risk of alienation and social exclusion • Social service has also begun to assume responsibility for a variety of job creation measures, rather than just measures designed to help individuals • Public Employment Services manage active labour market programmes – job placement and workplace introduction which provide partial subsidies for 6 months of a 12 month placement – runs rehabilitation programme to help those with serious labour market disadvantages, including the long-term unemployed • Strong presumption that those out of work on benefits should attempt to re-enter the labour market as soon as possible. • Work seeking activity must be demonstrated through frequent, regular contact with the employment office.
Switzerland	• Introduction of job placement offices and active labour market programmes in 1996. Active labour market programmes (e.g., training, retraining, work experience) need to help the unemployed return to work. • Social assistance does not solely seek to provide decent material living conditions, but also sets out to persuade the recipient to take active steps to achieve vocational and social integration.

Table 5.6 Changes to labour market measures (continued)

Country	Broad developments
Turkey	• The Project of Education and Employment (from 1993) to aim at giving job replacement to 73,200 people though determining job standards, carrying out certifications, developing job information systems, etc. • The National Office of Employment and Replacement (IIBK) provides various services such as compensating or giving advises to the unemployed because of privatisation, providing training courses, seminars, etc. IIBK also provides training courses for women living in the migratory ranges from some large cities, for disabled people, etc.
United Kingdom	• The government plans a new employment and training programme called the "New Deal" – The New Deal will offer subsidies to employers of £75/week if they hire people aged 25 or more who have been unemployed for at least 2 years. These very long-term unemployed over 25 year olds may also be able to study full-time for a year while remaining on benefits. • Plans to improve the incomes and employment prospects of lone-parents through – offering help and advice on job search, training and child care for lone parents with school age children in receipt of income support – introducing the National Childcare Strategy including a network of after school clubs – consolidation of help and advice for lone parents in the one location – ensuring that absent parents pay proper maintenance, and help lone parents out of welfare dependency
United States	• Beginning in the late 1980s, increased federal subsidy for childcare assistance • Many programmes, including the State Temporary Assistance for Needy Families programmes, the Food Stamps Program, and housing assistance programmes include funding for education, training and employment services • In addition the U.S. Department of Labor manages job training programmes.

Source: Responses to OECD Caring World Questionnaire.

Table 5.7 Special measures for young and older jobseekers

Country	Supporting the transition from education to work	Special measures assisting older unemployed people
Australia	• Reforms to apprenticeships and traineeships to foster closer linkages between vocational education and the schools sector: – increased number and quality of vocational education programmes in schools, and opportunity to start apprenticeship while at school – School to Work Programme – Jobs Pathway Programme, funds brokers to find jobs for school leavers, with priority for regions with high youth unemployment. • Proposed New Youth Allowance from July 1998 would provide greater incentive for young people to continue in education and training, with strict restrictions on job search activity by 16 & 17 year olds who have not completed schooling.	
Austria	• Integration of school leavers into the labour market is a major policy concern • Special programmes have been introduced to generate additional training places. • Approximately 20% of all active labour market programme expenditure is devoted to these programmes.	
Canada	Four major programmes to assist young people make the transition from education to work: • Youth Internship Canada, providing 25,000 youth at risk below the age of 30 with skills enhancement and work experience designed to help them get their fir job. The majority of places are in the public sector. • Youth Service Canada provides 5,000 young people with work experience and personal skills development through participation in community service projects. • Student Summer Job Action provides summer employment opportunities for secondary and post-secondary students, delivered in partnership between the public, private and not-for-profit sectors, approximately 60,000 • Youth Information Strategy aims to give young people better access to information, services and resources related to the workforce.	• Pilot programmes, NB Job Corps, began in 1994 to run over 5 years to test the cost-effectiveness of helping displaced workers over the age of 50 remain active through community work projects. Participants receive a guaranteed annual income of C$12,000 in lieu of social security benefits, on the proviso they work at least 6 months during the year. Work placements provided meaningful work experience, contributed to improvements in community well-being as well as increasing quality of life participants.
Denmark	• Recipients of cash assistance below age 25 who have not completed vocational training and not qualified to join an unemployment fund have a right to be "activated" for 18 months for at least 30 hrs/week, and receive an offer of "activation" no later than 13 weeks after they started to receive cash assistance. • Those with vocational training qualifications get "activated" for 6 months for a least 30 hrs/wk no later than 13 weeks after they started to receive cash assistance	
Finland	• Recession of the 1990s made it important to improve labour market opportunities for particularly young long-term unemployed.	• Council of State decision of February 1997 to introduce measures to improve the employment of older people. Specific National Programme for Ageing Workers to be operational from 1997-2001, including information, education, experiment and development activities.

Table 5.7 Special measures for young and older jobseekers (continued)

Country	Supporting the transition from education to work	Special measures assisting older unemployed people
Germany	• Young people trained in the dual system still stand a relatively good chance of finding a job after completing training. In 1995, for those who successfully completed training in Western Germany about 80% entered a job immediately while in Eastern Germany the success rate was around 67% • Employment Promotion Act provides support for young people who cannot gain employment after completing training in some circumstances, with participation in a part-time job creation scheme or support while working part-time and studying part-time. • A number of collective agreements allow for continued employment on a temporary basis, special entry wages or gradual integration for those who have completed training.	• Some public assistance when older people move from full-time to part-time employment, but only if employer takes on unemployed person and continues social security contributions on the basis of 90% of full-time earnings.
	• Recruitment Promotion Act makes it possible for companies to have temporary employment contracts for up to 24 months (and possibly longer) with persons who have completed vocational training.	
Greece	• Special incentives available for the employment of young unemployed • Five programmes implemeted to help 50,000 jobseekers under the age of 27. They include a choice of a partiaqlly subsidised job, vocational training in accredited institutions, self employment/entreprenurial opportunity, work experience.	• Employment programmes offer more favourable terms for the employment of older unemployed compared to other unemployed people • Implementation of pre-retirement programmes for the older unemployed.
Italy	• Special measures for young people living in particular areas (such as the South), including support for creating enterprises and co-operatives, work scolarships (which are strongly sought after). • Vocational training being expanded (most responsibility with regional authorities) – first level training for those who completed first grade secondary school, to provide practical skills – second and third level training provides vocational training – class-room/workplace training provides on-the-job apprentices for those with professional skills but are not recognised	• Employers who hire older unemployed are exempted from paying social security contributions for one year, further supports from worker co-operatives and training-retraining opportunities. Employers get incentives only if older workers in receipt of wage supplementation or mobility allowance.
Netherlands		• Government is to provide financial inducements for employers to train employees above the age of 40 • Combat unjustified age discrimination in employment recruitment practices.
Norway	• Special institution has been established to assist young people leaving primary school without other education or work to assist them in their search for work.	

Table 5.7 Special measures for young and older jobseekers (continued)

Country	Supporting the transition from education to work	Special measures assisting older unemployed people
Portugal	• Employers will benefit from social security contribution exemptions for 36 months if they permanently hire unemployed young people aged 16-29 looking for their first job or long-term unemployed.	
Sweden	• Responsibility for employment services for under 20 year olds passed to local governments in July 1995 to achieve better links to education, which is a municipal responsibility. • Special measures being introduced for young unemployed aged 20-25 years.	
Turkey	• The National Office of Employment and Replacement (IIBK) provides training courses to the elderly and young job-seekers. The Project of Education and Employment provides professional consultation services for students.	
United Kingdom	• The New Deal will help young unemployed people who have been unemployed for at least six months to get back to work. It will offer four options, each of at least 6 months duration: – job with an employer, employer gets wage subsidy of £60/week for 6 months – work for 6 months in the voluntary sector – 6 months place on the Environment Task Force – full-time education or training for up to 12 months	New welfare to work programme will include older unemployed as a target group
United States	• Some training programmes include components that assist with the transition from school to work.	

Source: Responses to OECD Caring World Questionnaire.

Table 5.8 Range of in-work benefits

Australia	• Family payment and rent assistance available to families with dependent children with low-moderate incomes on broadly the same basis as for social security recipients without earnings. Income threshold for maximum family payment of A$23,400 for a one-child family plus A$624 for each additional child. Family Tax Initiative available for low-middle income families (excludes only those families in the top 20 per cent of incomes) • Low income earners can get access to a health care card, providing access to cheaper pharmaceuticals and some state/territory government concessions. • Mobility allowance for those with disabilities unable to use public transport • Continued availability of concessions card for 12 months following entry into work for lone-parent pensioners and disability support pensioners.
Canada	• Budget proposed enhancements to the Child Tax Benefit, to apply from July 1998, with increased spending on Child Benefit increasing from C$5.1 billion to C$6 billion – As an initial step, the Working Income Supplement (only available to those in low-wage work) was restructured in July 1997 to provide benefits on a per-child rather per-family (C$500 year) basis. Maximum benefits are now C$605 for the first child, C$405 for the second child and C$330 for each additional child. No change to income thresholds. • Pilot programme on earnings supplementation for lone-parents who are long-term welfare dependent to take up full-time paid work, began in 1992. Results so far indicate higher participation in full-time paid work, higher earnings and reduced reliance on welfare, however, it is still too early to assess what happens when the supplement ceases after 3 years for the individual. The pilot is funded to the year 2000-01, with a final report due in 2001.
Germany	• When a social assistance recipient takes up employment, they can be granted a digressive subsidy for up to six months.
Greece	• Housing benefits for low income earners (subsidised interest rates in mortgages, buy-out options on long-term leases), rent assistance for low income families • Subsidised tickets for theatres, workers' holidays ("social tourism")
Ireland	• Family Income Supplement available if work at least 19 hours a week, provides 60% of the difference between the family income before tax and a threshold of IR£165 plus IR£20 per child, with a minimum payment of IR£5. Paid through the social security department to families with children • Back to Work Allowance provides long-term unemployed people aged 23 or more and lone-parents with ongoing benefits when they take up self-employment or a new job, equivalent to 75% of the standard means-tested unemployment or lone-parent benefit in the first year, 50% in the second year and 25% in the third year.
Italy	• Family Benefits for Employees provides maximum benefit of Lit 2.76 million a year, with withdrawal rate set at 10% of gross income once earnings reach Lit 15.948 million. Paid as cash benefit through the social security administration. Tax allowance for the cost of producing income is higher for low income earners, and recent reforms have increased the difference in benefit between lower and higher income tax brackets.
Japan	• Re-employment Allowance is paid when a person on public assistance obtains a stable job and they had more than 45 days and one-third of their scheduled payment days remaining. Receive a bonus equal to between 30 and 120 days allowance, plus until end March 1998 an additional 20 days if the number of remaining payment days is in excess of half of the scheduled payments.

Table 5.8 Range of in-work benefits

Luxembourg	• An employee meeting the general qualifications for RMG is entitled to some benefit if the RMG ceiling is greater than their earnings.
Netherlands	• More financially attractive to work through supplementary single-parent tax allowance, the standard professional expense allowance in the tax system and incentive premiums in national assistance.
New Zealand	• Independent Family Tax Credit introduced in 1996 to ensure financial incentive (for those with dependent children) to be in work rather than on benefit. Provides a benefit equivalent to NZ$15 plus per child, which is withdrawn at the rate of 18% above NZ$20,000 income and 30% above income of NZ$27,000. Total annual cost around NZ$210m, assisting 150,000 families.
Poland	• Benefits in-kind or cash benefit can be granted to an individual or family on social assistance in order to establish economic independence.
United Kingdom	• Family credit available to around 500,000 families with dependent children, where a parent works in a low-paid job for at least 16 hours a week, with a supplement if they work at least 30 hrs/week. Earnings threshold of £73 per week above which is a 70% withdrawal rate on net income. Benefits are adjusted in line with the age and number of children. • Certain benefits are available to those in low-income work as well as those not in work, including Housing Benefits, Council Tax Benefit, Disability Working Allowance • Changes to in-work benefits include: – help with the cost of childcare in the range of benefits (childcare disregard) – extra assistance now available through Family Credit and Disability Working Allowance – introduction of pilot scheme, Earnings Top-Up, aimed at people without children in low-paid jobs of at least 16 hrs/week and operating in selected regional areas. The 1998 United Kingdom government budget has announced a substantial change to its in-work benefit, replacing the existing cash payment, *Family Credit*, with a more generous tax-based measure, the *Working Families Tax Credit (WFTC)*, from October 1999. Families on low incomes where the main earner works more than 16 hours a week will be entitled to a basic tax credit of £48.80 a week, with additional tax credits for each child (of £14.85 if aged 0-11, £20.45 if aged 11-16, £25.40 if aged 16-18), with an additional credit of £10.80 if the adult works for 30 hours or more. The *WFTC* is withdrawn at the rate of 55 per cent for each pound of net earnings above net family income of £90 a week (not including the *WFTC*). A separate childcare tax credit will also be available to those families eligible for the WFTC, subsidising 70 per cent of eligible childcare costs up to set limits, replacing the lower value childcare disregard in *Family Credit*.
United States	• Earned Income Tax Credit provides tax breaks to low-income earners with children. In 1996 a taxpayer with 2 children and earnings between US$8,890 and US$11,610 could receive a refundable tax credit of US$3,445. Credit began to decline above US$11,610 and ended at earnings of US$28,495, with an average withdrawal rate of around 21%. Income thresholds are indexed annually for inflation.

Source: Responses to OECD Caring World Synthesis Questionnaire, and OECD (1997) *Making Work Pay*.

Table 6.1 Public flat-rate pension programmes in Member countries

Country (1)	Pensionable age	Eligibility requirement (for full pension) (2)	Amount of benefit (full pension, unless otherwise indicated) (3)	Rate of contribution (4)	State Subsidy	Supple-ment (5)
Australia (1908*)	65 (M) 61 (W) (Jul.1997)	10 yr continuous residence (means-test) (5 yr continuous residence if total years exceed 10)	A$ 173.90 a week (for single) A$ 290.10 a week (for couple) (Mar.1997) (27.4%*)	None	All cost	O (means-test)
Austria	65 (M) 61 (W)	(means-test)	Amount to raise pension to 7,887 schillings a month for individuals, 11,253 schillings for couples, plus 840 schillings per child (30.5%)	None	All cost	
Belgium	65 (M) 61 (W)	(means-test)	BF 246,076 a year (for single) BF 328,098 a year (for couple) (Aug.1997) (28.7%*)	None	All cost	O (means-test)
Canada (1951)	65	40 yr residence after age 18 (means-test)	C$ 405.12 a month (Sept.1997) (14.4%)	None	All cost	O (means-test)
Czech Republic	65	(means-test)	Up to 2,460 crowns a month (Jan.1995) (36.0%)	None	All cost	
Denmark (1891*)	67	40 yr residence between 15 and 67 (means-test)	3,810 kroner a month (n/a)	None	All cost	O (means-test)
(ATP, for wage earners only) (1964)	67	Having paid contributions from 1964 (the year when the scheme was introduced)	14,500 kroner a year for those who have paid full contributions (n/a)	Up to 894 kroner a year (ip) Up to 1.788 kroner a year (er)	None	
Finland (1956)	65	40 yr residence (means-test)	2,140 - 2,547 marks per month, according to municipality, marital status, other income received, etc. (24.5%)	None (ee) Up to 20.4% (sp, as of Jan.1996) 2.4-4.9%(er, private) 3.95% (er, public)	about 36% (as of Jan.1996)	O (means-test)
France (6) (1941*)	65	(means-test)	Up to a basic minimum (41,196 francs a year) (45.4%*)	The fund for this scheme is largely funded by the General Social Contribution (3.4% of 95% income).	Much of the taxes on alcohol and non-alcoholic drinks finances the fund for this scheme.	

Table 6.1 Public flat-rate pension programmes in Member countries (continued)

Country (1)	Pensionable age	Eligibility requirement (for full pension) (2)	Amount of benefit (full pension, unless otherwise indicated) (3)	Rate of contribution (4)	State Subsidy	Supplement (5)
Greece (OGA: for agricultural workers) (1961) (7)	65	• 25 years of employment in agriculture or other rural activities • Not in receipt of a social security pension	34,000 drs/month (15.8%)	None	All cost	O (for disabilities)
(For non-insured) (1982)	65	• No household member should receive a social security pension • Family income should be no higher than the equivalent of an OGA pension.	34,000 drs/month (15.8%)	None	All cost	O (for dependent members and for disabilities)
Hungary	60 (M) 56 (W)	(means-test)	80% of the minimal old-age pension (The amount of minimal pension is 40% of the net average earnings.) (n/a)	None	All cost	
Iceland (1909*)	67	At least 3 years residence at ages 16-66	Up to IKr 13,640 a month (n/a)	None (ip) 3.88-6.28% (er)	Remaining costs	O (means-test)
Ireland (1908*)	65 (retirement) 66 (old-age)	Insurance coverage before age 56 or 57, 156 weeks of paid contribution, etc. (Maximum pension -- yearly average of 48 contributions, paid or credited from date of entry; Minimum pension -- average of 24, if retired at age 65; average of 20, if retired at age 66)	Up to £Ir 75.00 a week (weekly allowances paid for adult and child dependants) (29.0%)	5.50% of covered weekly earnings plus some addition (ip) 5.0% of covered weekly earnings plus some addition (sp) Up to 12% (er)	Any deficit	O (means-test)
Italy	65	(means-test)	Up to 390,300 lire a month, with additional 125,000 lire a month available for those who live alone with no other means of support or if spouse only receives equivalent of the social pension. (18.1% for basic benefit)	None	All cost	O (means-test)
Japan (1985)	65	40 years of contribution	¥785,500 a year (23.5%)	¥12,800 a month (Apr.1997) (sp) (8)	1/3 of the payment cost, plus administrative cost	
Luxembourg	60	Residence of at least 10 yrs during the last 20 yrs (means-test)	The amount which will fulfil, with other income, the guaranteed minimum income set out by the state (RMG) (n/a)	None	All cost	
Netherlands (1957)	65	Residence from age 15 through 64	1,542.21 guilders a month for single person 1,069.79 guilders for each of couple (37.2%)	15.40% of income (ip) None except for supplement (er)	Fund needed to bring low benefits up to social minimum	

Table 6.1 Public flat-rate pension programmes in Member countries (continued)

Country (1)	Pensionable age	Eligibility requirement (for full pension) (2)	Amount of benefit (full pension, unless otherwise indicated) (3)	Rate of contribution (4)	State Subsidy	Supple-ment (5)
New Zealand (1898*)	62	10 yrs residence (7 yrs since 50)	NZ$249.50 a week (single) NZ$368.66 a week (couple) (gross) (42.0%)	None	All cost	O (means-test)
Norway (1936*)	67	40 yrs residence	Base amount: 42,500 kroner (May 1997) (150% for aged couple) (18.6%)	Up to 7.8% of income (ee) 7.8-10.7% of income (sp) Up to 14.2% of wage (er)	Any deficits	
Portugal (1980)	65	(means-test)	21,000 escudos a month (n/a)	None	All cost	O (means-test)
Slovak Republic	60 (M) 53-57 (W)	(means-test)	2,180 Sk (single) 3,850 Sk (couple) (Jul.1997) (n/a)	None	All cost	
Spain (1991)	65	10 yrs residence from 16 to 65, with more than 2yrs continuous residence at the time of application (means-test)	Decided annually by the Law on the General State (n/a)	None	All cost	
Sweden (1962)	65	40 yrs residence (or 30 yrs pension points)	SEK 34,245 (single) SEK 28,003 (married) (1998) (15.4%)	None (ee) 6.83% (er) 6.83% of assessable income (sp) (1998)	About 25% of cost	O (means-test)
Switzerland	65 (men) 62 (women)	(means-test)	Up to SFR 28,488 (for a single person residing in an institution) Up to SFR 47,760 (for a couple residing in an institution) (43.5%*)	None	All cost	
Turkey (The law 2022: 1976)	65	(means-test)	TL3,201,000 (1.5 times for those who married) (1998) (n/a)	None	All cost	
United Kingdom (9) (1946)	65 (men) 60 (women)	50 weeks of paid contributions or equivalent (The amount of base earnings varies)	Up to £62.45 a week (19.9%)	2% -10% (ee) £6.15 a week plus some addition (sp) 3%-10% of employee's total earnings (er)	None	O (means-test)
(Non-contributory retirement pension) (1971)	80	Ineligible for contributory pension Residence in the UK for the last 10 years	60% of the above rate	None	All cost	O (means-test)

Table 6.1 Public flat-rate pension programmes in Member countries (continued)

Country (1)	Pensionable age	Eligibility requirement (for full pension) (2)	Amount of benefit (full pension, unless otherwise indicated) (3)	Rate of contribution (4)	State Subsidy	Supple-ment (5)
United States	65	(means-test)	Up to $470 (single) Up to $705 (couple) (21.9%)	None	All cost	O (means-test)

Source: *Social Security Programs Throughout the World - 1997* (Social Security Administration, US), country responses for "Caring World" synthesis questionnaire, etc.

* All of the items are as of 1 January 1997, unless otherwise indicated.

* The above schemes are distinguished from minimum benefits by public earning-related schemes that are employed in some countries and described in Table 6.2.

* In some countries, such as Poland, break-down of the benefit explicitly consists of flat-rate portion ("social part") and earnings-related portion ("individual part"), with the former serving as a similar scheme of flat-rate basic pension scheme. However, that is not included in the above chart because it is not an independent system for income maintenance and is considered to be the same as the lower limit of pension benefit which is decided implicitly in relation to the lower limit of income which is covered and contribution is imposed for.

* Some countries such as the UK collect a single rate of contributions which combines flat-rate benefits and earnings-related benefits.

(1) The number in the bracket indicates the year when the current scheme was established, or when the first scheme was introduced (with asterisk).

(2) Other than a certain length of residency in the country or contribution to the scheme, many countries require particular residency status, such as citizenship or permanent residency status.

-- This chart classifies reduction of benefit for relatively rich elderly as means test, though some of them are not explicitly referred as such in the country which has the system.

(3) Figures in the brackets indicate the percentage of the amount of the benefit (for single when specified) against the average annual wage (1995, local currency - manufacturing. The data with asterisk is calculated with the data in 1994 for the average income.)

(4) Basis of contributions is "earnings" in case of insured persons/employee/self-employed persons, "payroll" for employer, unless otherwise indicated.

-- (ee):employee / (er): employer / (sp): self-employed persons / (ip): insured persons

(5) "Supplement" is provided in case the overall income level of a person is certifiably low (income-test) in some country, or for particular purposes (for house rent, expenses in living in remote areas, etc.) in others.

(6) France has a 2 -tier flat-rate scheme (AVTS(AVTNS) for the elderly not eligible for contributory scheme, and a supplementary benefit which covers all the elderly to raise their income level to the basic minimum).

(7) This scheme is to be gradually phased out over the next 10 years as a new contribution-related scheme is phased in.

(8) Only self-employed persons have to pay the contribution explicitly for the basic pension; in case of other enrolees for other earnings-related schemes such as Employees' Pension, the contribution to the scheme implicitly includes the portion for the basic pension.

(9) April 1997.

Table 6.2 Public earning-related pension programmes in Member countries

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
Austria (1956)	Coverage:(a) • Special systems for public employees, self-employed persons, etc. • Lower earnings limit for coverage of employee	65 (M) 60 (W)	At least 180 months of insurance coverage in the last 30 years or 180 months of contribution	1.83% of average earnings in best 15 yrs for each of first 30 insurance yrs, plus 1.675% for each insurance yr from 31-45 • Maximum limit of earnings in calculating benefits	Max: 80% of average covered earnings	10.25% (ip) 12.55% (er) • Maximum limit of earnings in calculating contributions	Any deficits
Belgium (1967)	Coverage: (a) • Special systems for public employees, self-employed persons, etc.	65 (M) 61 (W)	45 years (M) or 41 years (W) of coverage	Based on the salary earned during the recipient's working life and on the length of working career	Max: 60 % (75 % for couple) of average lifetime earnings	7.5% (ip) 8.86% (er)	Annual subsidies
Canada (Canada Pension Plan) (1965)	Coverage: (b) • Casual employment, brief agricultural employment, etc. are excluded from coverage. • Lower earnings limit for coverage (5)	65	Having made at least one year of contribution	25% of average covered earnings • Maximum/minimum limit of earnings in calculating benefits	Max: C$736.81 a month	3% (ee) 6% (se) 3% (er) • Maximum/minimum limit of earnings in calculating contributions	None
Czech Republic (1906*)	Coverage: (b)	60 (M) 53-57 (W)	At least 25 years (at year of age 65) of insurance • Substantial limitation of work is ordinarily needed during the first 2 yrs after the retirement age.	920 crowns plus earnings-related portion of 1.5% of average indexed earnings for each yr of insurance after 1985 • Maximum limit of earnings in calculating benefits	Min: Basic flat rate plus 770 crowns	6.5% (ip) 19.5% (er)	Any deficit

Table 6.2 Public earning-related pension programmes in Member countries (continued)

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
Finland (TEL) (1961)	Coverage: (a) • Special systems for public employees, self-employed persons, etc. • Lower earnings limit and minimum employment period for coverage of employee	65	40 years coverage • Retirement from covered employment	1.5% (2.5% for years at age 60 or older) of average pensionable earnings times years of coverage until age 65 • Pensionable earnings are calculated by modifying average earnings with a certain formula.	Full pension when the coverage lasts 40 years from age 23	4.5% of taxable income (ee) 9.46% to 25.34% (er) • Maximum limit of earnings in calculating contributions	The portion for self-employed and farmers not covered by their own contributions
France (Régime Général) (1930*)	Coverage: (a) • Special systems for public employees, self-employed persons, etc.	60	At least 150 quarters of coverage	50% of average earnings in 25 highest years (in 2008) • In the meantime, the year is increasing from 11 ('94) to 24 (2007). • Maximum limit of earnings in calculating benefits	Max: 50% of maximum earnings for contribution Min:38,524.90 francs per yr if have 150 quarters of coverage	6.55% of pensionable earnings + General Social Contribution of 3.4% of 95% income (ip) 8.2% of covered earnings plus 1.6% of total payroll (er) • Maximum limit of earnings in calculating contributions	Variable subsidies
(ARRCO, Association des régimes de retraites complémentaires) * There are other compulsory occupational schemes such as AGIRC.	Coverage: (b)* Compulsory for "non-cadre" personnel as well as "cadre" personnel, some farm workers, etc. • Special systems for public employees, etc.	65 (60 when the require-ments for Régime Général (minimum contributions, etc.) are fulfilled)	Retirement (Beneficiaries can take up gainful employment with certain conditions)	(Defined-contribution scheme) Acquired pension points (accumulated annually) multiplied by current point value	Average: 1,316 FF (monthly: 1994)	Compulsory portion: 6.875% (The ratio between employer/employee is 3:2.) (1998: will be 7.5% in 1999)	
Germany (1957)	Coverage: (b)* • Special systems for public employees, self-employed persons, etc.	65 (M) 60 (W)	At least 5 yrs coverage	Individual "earning points" related to average earnings and the age at the beginning of the pension multiplied by the actual pension value	Target rate: About 70% of current average net income when completed 45 working years	10.15% (ee) 18.6% (sp) 10.15% (er) • Maximum limit of earnings in calculating contributions	Annual subsidy of about 20 % of total cost of pension insurance

Table 6.2 Public earning-related pension programmes in Member countries (continued)

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
Greece (IKA) (1934*)	Coverage: (b)* • Special systems for public employees, agricultural workers, etc.	65 (M) 60 (W)	At least 15 years of coverage	80% of average earnings of last 5 years for 35 years of coverage • Maximum limit of earnings in calculating benefits (For those entering the labour market after 1993, the rate is 60% and the maximum limit of calculation is not applied.)	Max: Earnings on which pension has been calculated Min: 86,940 drachmas a month, increased by dependants' supplement	6.67% (ee) 13.33% (er) (d) • Maximum limit of earnings in calculating contributions (not applicable to those entering the labour market after 1993)	Any deficit, plus 10% of earnings of those entering the labour market after 1993
Hungary (1928*)	Coverage: (b)	60 (M) 56 (W)	At least 20 years of employment	(For 20 yrs coverage) 53% of net earnings during best 4 year period in 5 years preceding retirement. Earnings of the next 15 yrs are differently evaluated for full benefit. • There are other variations according to coverage years and amount of earnings.	Min: 6,400 forints a month	6% of gross earnings (ip) 24.5% (er)	Any deficit
Iceland (1909*)	Coverage: (b)	67	40 yrs residency	Depends on paid contributions		4% (ee) 10% (se) 6% of employee's wages (er)	None
Italy (*Old-age Pension*) (1919*) (6)	Coverage: (a) • Special systems for industrial managers, civil servants, self-employed farmers, etc.	(Old system) 63 (M) 58 (W) (New system) 57-65	(Old system) At least 18 years of coverage (New system) For retirement before 65, at least 5 contributory years and earned pension 1.2 times equivalent to the social allowance. Otherwise, 40 years of contribution enables the provision regardless of age.	(Old system) Coefficient (0.9-2) times salary and years of service (New system) Amount of accumulated contributions times coefficient (4.72 (age 57)-6.136(age 65)) • Maximum limit of earnings in calculating benefits (for the new system)	Min: 685,400 lire a month	33 % (for wage workers in public and private sector: includes the portion for family allowances) 20% (sp) 10% (others) * Those rates are used to calculate the benefit amount. The rate for collection is decided differently. • Maximum/minimum limit of earnings in calculating contributions (Maximum limit is for the new system)	Any overall deficit and means-tested allowance

Table 6.2 Public earning-related pension programmes in Member countries (continued)

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
Japan (*Employees' Pension Insurance*) (1941)	Coverage: (a) • Special systems for public employees, private school teachers, etc.	60 (M) 59 (W)	At least 25 years of coverage	(1-0.75)% of indexed monthly wages times the number of months of coverage (7) • Minimum/minimum limit of earnings in calculating benefits		8.675% (ip) (d) 8.675% (er) (8) (9) • Maximum/minimum limit of earnings in calculating contributions	Cost of administration
Korea (*National Pension Scheme*) (1988)	Coverage: (b) • Special systems for public employees, private school teachers, etc.	60	At least 20 years of coverage	2.4 times the sum of average monthly earnings of all insured persons in the preceding year plus some additions for each insured year in excess of 20		3% from 1998 (ee)6% from 1998 (er) (sp): 3% (1995-2000) 6% (2000-2005) 9% (2005-) (d)	Partial cost of administration and flat-rate subsidy (W2,200) for farmers and fishermen
Luxembourg (1987)	Coverage: (b) • Special systems for railway and public employees	65	At least 120 months of coverage	Lump-sum of 9,474 francs per month if insured for 40 years plus increments equal to 1.78% of adjusted lifetime covered earnings per yr of complete insurance coverage • Maximum/minimum limit of earnings in calculating Benefits	Max: 179,435 francs per month Min: 38,758 francs per month if insured for 40 years	8% (ip) 8% (er) • Maximum/minimum limit of earnings in calculating contributions	8% of earnings
Mexico (10) (RCV) (1943)	Coverage: (b)* • Special systems for petroleum workers, public employee, etc.	65	At least 500 weeks of contributions	35% of average earnings during last 250 weeks of contributions, plus 1.25% of earnings per year of contribution beyond 500 weeks • Maximum/minimum limit of earnings in calculating benefits	Max: 100% of earnings if 2,000 weeks of contributions or more Min: 100% of minimum salary in the Federal District	2.075% (ip) 5.810% (er) • Maximum/minimum limit of earnings in calculating contributions	0.415% of payroll

Table 6.2 Public earning-related pension programmes in Member countries (continued)

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
Norway (1936*)	Coverage: (b) • Special systems for railway, public employees, etc. • Lower earnings limit for coverage	67	20 years of coverage (increasing to 40 years)	42% of the current base amount multiplied by the enrolee's average annual number of pension points in 20 years with the most points. • Minimum limit of earnings in calculating benefits	Full pension with 20 years of coverage	Up to 7.8% of income (ee) 7.8-10.7% of income (sp) Up to 14.1% of wage (er)	Any deficit
Poland (*General Social Insurance Fund*) (1982)	Coverage: (b)* • Special systems for police, and independent farmers	65 (M) 60 (W)	At least 25 years (men) or 20 years (women) insurance. • Partial retirement necessary.	24% of average national salary with some earnings-related addition which reflects the coverage yrs (1.3% of workers earnings base multiplied by the number of contributory years (0.7% for the periods when contribution is exempted)) • Maximum limit of earnings in calculating benefits	Min: 274.02 zlotys a month	None (ip) 45% (er)	None
Portugal (General contributory scheme run by IGFSS) (1935*)	Coverage: (b) • Special systems for miners, railway workers, etc.	65 (M) (Pensionable age for women was 62 in 1993, and will be 65 in 1999.)	At least 15 years of contribution (120 days of contribution at least by year).	2% of average annual earnings during highest 10 of last 15 years times year of insurance.	Max: 80% of average earnings Min: 30% of average earnings or 30,100 escudos, whichever is higher	11% (ee) 25.4% for mandatory coverage, 32% for voluntary coverage (sp) 23.75% (er)	Subsidy for social pension and health care
Slovak Republic (*Pension Fund*) (1906*)	Coverage:(b)	60 (M) 53-57 (W)	At least 25 years of employment (20 years for women) • Substantial retirement usually necessary	50% of average earnings during highest 5 of last 10 years plus 1% of earnings per year of employment between 26 and 42 years • Maximum limit of earnings in calculating benefits	Max: 5,650 crowns a month for all pensions Min(with full career): 550 crowns a month plus amount necessary to bring total monthly income to 2,507 crowns	5.9% of revalued earnings (ee) 26.5% of revalued earnings (sp) 21.6% (er)	Any deficit

Table 6.2 Public Earning-related Pension Programmes in Member Countries (continued)

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
Spain (general regime) (1919*)	Coverage: (a) • Special systems for agricultural workers and small farmers, self-employed, etc.	65	At least 15 years of contribution, including 2 years in last 8 years. • Retirement necessary.	60 % of benefit base plus 2% per year of contribution over 15 years • Maximum limit of earnings in calculating benefits	Max: 100% of benefit base with 35 years contribution Min: 54,825 pesetas a month for single	4.7% of covered earnings (ip) 23.6% of earnings (er) • Maximum limit of earnings in calculating contributions	Annual subsidy
Sweden (ATP) (1960)	Coverage: (b) • Lower earnings limit for coverage	65	30 years coverage	60% of the current base amount multiplied by enrolee's average annual number of pension points in 15 years of most points. • Maximum limit of earnings in calculating benefits	Full pension for 30 yrs of coverage	1% of assessable income (ee) 13.0% (er) • Maximum limit of earnings in calculating contributions	None
Switzerland (AVS) (1948*)	Coverage: (b)	65 (M) 62 (W)	Contribution during all years from 21	Flat-rate portion plus earnings-related portion based on annual income (2 different formula according to the income level)	Max: 1,990 francs a month Min: 995 francs a month	4.2% (ee) 7.8% (sp) 4.2% (er) * Also covers the risk of survivorship	Annual subsidies covering about 20% of the old age benefit
Turkey (Wage earners scheme by *Social Insurance Institution*) (1945)	Coverage: (a) • Special systems for public employees, self-employed people, etc.	55 (M) 50 (W)	1) At least 5000 days of contributions 2) 15 years of coverage and at least 3,600 days of contributions 3) 25 (M) or 20 (W) years of coverage and at least 5,000 days of contributions	(For persons who fulfilled the eligibility requirements) 60-85% of average indexed earnings during last 10 years (1998) • The above beneficiaries also receive "social contribution" of 4,690,000 TL a month. • Maximum/minimum limit of earnings in calculating benefits	Max: 75,209,485 TL a month Min: 39,726,400 TL a month (January 1, 1998)	9% (ip) 11% (er) • Maximum/minimum limit of earnings in calculating contributions (d)	Social contributions (4,690,000 TL a month for one pensioner) Any deficits
United Kingdom (State Earnings-Related Pension Scheme) (11) (1975)	Coverage: (a) • Lower earnings limit for coverage • "Constact-out" is possible when the insured person belongs to a private scheme that fulfills certain requirements	65 (M) 60 (W)	Contributions paid as an employee on earnings between the lower and upper earnings level in any tax year from April 1978	25% of average earnings over notional working life of best 20 years		2% - 10% (ip) £6.15 a week plus some addition (sp) 3% - 10% of employee's total earnings (er) • Maximum/minimum limit of earnings in calculating contributions (e)	None

Table 6.2 Public earning-related pension programmes in Member countries (continued)

Country (1)	Coverage of the Program (2)	Pensionable Age (standard)	Eligibility Requirements (3)	Amount of Benefit	(Maximum/ Minimum Benefit)	Rate of Contributions (4)	Coverage of State Subsidy
United States (Old Age, Survivorship, and Disability Insurance) (1935*)	Coverage: (b) • Casual agricultural employment, domestic employment, limited self-employment, etc. are excluded from coverage.	65	At least 40 quarters of coverage	Average earnings are calculated over a certain period. They are divided into 3 parts according to the amount and multiplied by different coefficients. • Maximum limit of earnings in calculating benefits	Max: $1,326 a month	6.2% (ee) 12.4% (sp) 6.2% (er) • Maximum limit of earnings in calculating contributions (e)	Cost of special monthly old-age benefit for persons aged 72 before 1968

Source: *Social Security Programs Throughout the World - 1997* (Social Security Administration, US) , *Corporate Pension Schemes in the World: Recent trends and developments* (in Japanese) (ed. by Pension Fund Association, Japan, 1996), and country responses to "Caring World" synthesis questionnaire. Information also comes from *Syntheses: Suivi Annuel Des Retraites (réaultats 1995)* (INSEE, France) as well as the Internet home page of Association des régimes de retraites complémentaires, France.

* Information is as of Jan. 1997, unless otherwise indicated.

* Recent trends of changing pensionable age are described more in details in Table 6.10.

* Those pension programs are often managed by semi-autonomous institutions and funds which are usually self-governing with bipartite or tripartite boards; otherwise, the governmental organs directly manage the program. Notably, ARRCO (and other compulsory occupational pension schemes) in France is included in this table because, in spite of its origin as a private scheme, it has been integrated in the System of National Accounts as a public scheme, with PAYG funding and national-level financial co-ordination.

(1) The number in the brackets indicates the year when the current scheme was established of when the first scheme was introduced (with asterisk). Also, the name of the scheme referred to in the table is indicated.

(2) Coverage: (a): employees / (b): (a) + self-employed people / "(b)*" means that only the specific portion of the self-employed people are eligible for the program.

(3) For full entitlement unless otherwise indicated.

(4) Those countries with (d) has a certain amount of surcharges in the contribution rate, as well as certain exceptions for the pensionable age and benefit amount in some cases, for some industries where the work is deemed "arduous" or "unhealthy." Also, there are some cases such as in Slovak Republic and Spain where earlier retirement or other favourable treatments are granted without surcharge.

-- In terms of rates of contributions, "ip" is for insured persons, "ee" for employee, "er" for employer, and "sp" for self-employed people.

-- Basis of contribution is "earnings" in case of insured person/employee/self-employed persons, "payroll" for employer, unless otherwise indicated.

-- Those contributions are usually not collected only for retirement pension; the fund is usually used for disability and survivors' benefits. The countries with (e) includes funds for health services for the elderly (e.g. US) or whole population (e.g. UK)

-- Some countries such as the UK collect a single rate of contributions which combines flat-rate benefits and earnings-related benefits. In the same way, the General Social Contribution, imposed in France, funds non-contributory flat-rate pensions and other benefits.

(5) Canada Pension Plan (CPP) does not cover the residents in the Province of Quebec; they are covered by Quebec Pension Plan, whose eligibility and benefit rules are basically the same as those of CPP.

(6) Italy introduced a new system in 1995, which covers new entrants to labour market from 1996 (fully) and those who had contributed to the old system for less than 18 years at the time of the reform (partially: coverage from 1996 is based on the new scheme). Therefore, "old system" and "new system" are both described in the Table. In addition, about "seniority pension," see Table 6.10.

(7) In addition to this earnings-related benefit, flat-rate pension is paid out of the same scheme (1,625 yen times (1.875-1.000) times the number of the month of coverage) to its enrolees, as well as additional allowances for those having spouse and children. Those ratios with brackets are decreasing according to the beneficiaries' date of birth. (Note: This special payment continues until the pensioners become eligible to the flat-rate basic pension at their age 65.)

(8) On top of the contributions, employees and employers pay 0.5% each from "bonus," or periodical lump-sum payment of wage/salaries.

(9) A certain portion of the contributions is used to finance the flat-rate basic pension.

(10) Mexico introduced a new mandatory private pension system in July, '97. The old system still remains and the insured people can enrol in either of them. The new scheme imposes different contribution rates (1.125% specifically for old-age benefit (ip) and 2% - 3.15% (er)).

(11) April 1997.

Table 6.3 Replacement rate of public pension programmes

Country	Description
Australia	As there is only a flat-rate scheme which is need-based, there is no target replacement rate. However, the maximum payment rate is equivalent to 25% male average total weekly earnings for a single person and 40% for a couple.
Austria	At maximum, 80% of average covered earnings are covered by earnings-related pension.(*) There is no target replacement rate.
Belgium	A target replacement rate is 60% for single persons. In case of married couple, this rate increases to 75% after fulfilling some requirements.
Canada	A target replacement rate (statutory) is 25% for individuals (earnings-related scheme only). Combined with flat-rate pension, about 40% (53 % for one-earner couple) is currently insured.
Czech Republic	Current old-age pension benefit is composed of 920 crowns plus earnings related portion of 1.5% of average indexed earnings for each year of insurance after 1985.(*) (The base amount is 1,260 crown from 1 Aug.1997.) No target replacement rate is provided.
Denmark	A current replacement rate is nearly 80% for single, a little over 50% for married or cohabiting couple, in 1994, for basic and supplementary pension inclusive. (a) No target replacement rate is provided.
Finland	A target replacement rate is 60% of earnings for 37-42 years of coverage. In practice, an actual replacement rate is usually 40-50%. As to public sector, the target rate is 66%.
France	Depending on age and duration of insurance coverage, 25-50% of average salary for the best 25 years, as of 1 Jan. 2008. In the meantime, the length of the best years vary between 11 and 24 years.(*) A net replacement rate (public and occupational/compulsory schemes inclusive) in the private sector in 1993 is about 78%. (b)
Germany	A target replacement rate is about 70% after insurance period of 45 working years. This is envisaged to be reduced to 64% in about 30 years.
Greece	80% (basic pension for employees (IKA): 60% for those entering the labour market after 1993) and 20% (supplementary pension for employees (IKA-TEAM)) of pensionable earnings are ensured after 35 year of insurance.
Hungary	There is no target replacement rate. The rate varies according to the covered years, etc., but currently 55-60% of national average earning is prevalent. Because of the recent reform, this rate would be 66% (for old system) or 48.8% (for new system) to the gross average earnings from 2013.
Iceland	A current replacement rate is a little over 80% in 1994, for basic and supplementary pension inclusive. (a)
Ireland	As there is only a flat-rate scheme, there is no target replacement rate. Currently the social insurance pension represents 26% of national average earnings for a single person and 45% of national average earnings for a couple.
Italy	Prior to the '95 Reform, maximum replacement rate could be 80% (2% for each contribution year, with full-benefit for 40-year contribution). After the reform, a replacement rate is expected to be about 60%.
Japan	A replacement rate is 68% of covered earnings. (c)

Table 6.3 Replacement rate of public pension programmes (continued)

Country	Description
Korea	A target replacement rate is 70% (40%) for 40 (20) years coverage (respectively).
Luxembourg	There is no target replacement rate. An old-age pension is made up with flat-rate elements of 1/40 for every year (maximum of 40) and of proportional elements representing to 1.78% of total taxable income taken in to account.
Mexico	A current replacement rate is 35% of average earnings during last 250 weeks of contribution, plus 1.25% of earnings per year of contribution beyond 500 weeks. (*)
Netherlands	Benefits of public pension are related to net minimum wage: 100%, 90%, 70% for couple, single parents and single persons respectively.
New Zealand	As there is only a flat-rate scheme, there is no target replacement rate. The current scheme provides a retired couple with maximum payment a benefit equivalent to just under 70 % of net average earnings.
Norway	A current replacement rate is nearly 70% for single, a little less than 60% for married or cohabiting couple in 1994, for basic and supplementary pension inclusive. (a) There is no target replacement rate
Poland	A current replacement rate is 24% of average national salary, plus 1.3% of worker's earning base multiplied by the number of contribution years (and 0.7% of worker's earnings base multiplied by the number of credit years (e.g. for bringing up children)). (*) No target replacement rate is provided.
Portugal	The amount of retirement pension corresponds to 30% (minimum) to 80% (maximum) of average earnings. Non-contributory supplement is added when the calculated benefit amount is less than the minimum rate.
Slovak Republic	A target replacement rate is 40% of previous incomes from which the insurance fee was paid (though calculation basis could be different from actually earned income).
Spain	A replacement varies according to the length of working years, amount of salary, etc. Currently, for example, a pensioner with dependent spouse, having had average salary and worked for 35 years, receives 90% of income (net replacement rate).
Sweden	A current replacement rate is nearly 70% in 1998, for basic and supplementary pension inclusive . There is no target replacement rate.
Switzerland	There is no target replacement rate. A basic pension scheme and an occupational pension scheme (private but compulsory) together ensure currently about 60% of gross annual income.
Turkey	A target replacement rate varies from 60% to 100% depending on the schemes. That also varies based on the period of insurance.
United Kingdom	As to earnings-related schemes, 25% of average earnings over notional working life of best 20 years is ensured. This is planned to be reduced to 20% of average earnings over entire working life, for pensioner reaching pensionable age between April 1999 and April 2009. (*) There is no target replacement rate.
United States	There is no target replacement rate. Historically, about 40% of prior income has been ensured.

Source: Country responses to "Caring World" synthesis questionnaire, and *Social Security Programs Throughout the World - 1997* (Social Security Administration, US)

* The information with asterisk is taken from the SSA report. Others are from national responses, unless otherwise indicated.

(a): *Social Security in the Nordic Countries; Scope, expenditure and financing 1994* (Nordic Social Statistical Committee, 1996), p76.

(b): SESI. échantillon interrégimes de retraités. reproduced in *Syntheses: Les Revenus Sociaux 1981-1995* (Institute National de la Statistique et des Études Économiques, 1996)

(c): A current standard method of calculation is different in Japan; "Bonus," or a lump-sum payment usually paid a few times in a year, was not a basis on which contribution is imposed (though '94 reform has introduced the 1% contribution on the bonuses, split between employer and employee.), nor is included in the usual calculation of replacement rate. When the method is adjusted according to the ILO standard, it becomes 55.7% (1995).

Table 6.4 Funding arrangements of selected public pension programmes

	Financial Arrangements	Comparison of accumulated assets to current annual payment	Recent change of Amount	Projected change of amount	Recent/Projected Reforms	Note
Canada	PAYG with "buffer" fund	2 .44 years ('96)		The ratio is projected to decrease to 1.54 yrs by 2030, according to the '93 estimate.	1997 Funded portion increases from 2 yr to 5 yr worth of total yearly payment, with advancing a current schedule of raising contribution rates.	
Denmark (ATP)	Fully-funded (defined-contribution)		80.6 → 116.3 ('90) ('94) (bil.kroner)			
Germany (former West Germany only)	PAYG	0.05 year ('96)	38,697→14,204 ('93) ('96) (mil. DM)			
Japan	Partially funded	5.4 years (FY'95)	76.9 → 111.8 (FY'89) (FY'95) (tril.yen)			
Sweden	Partially funded	5.1 years ('98)	320,064→639,226 ('87) ('98) (mil.kronor)		New system (from 1999) allocates 2.5% of contribution specifically to funded management.	
United Kingdom (1)	PAYG	0.06year (FY'94)	4,897 → 1,008 (FY'92) (FY'95) (£ mil.)			
United States (2)	PAYG with "buffer" fund	1.48 years ('94)	155,063→413,460 ('89) ('94) ($ mil.)	It is expected that, under the current formula, the Social Security Old Age and Survivors Trust Fund will have payroll revenue which fall short of obligations in 2011, and will be exhausted in 2034.		

(1) The numbers used as "accumulated asset" and "current annual payment" are "Excess of Receipts over payments" and the sum of expenditures for retirement pension, widows benefit and invalidity benefit, respectively.

(2) The fund for disability benefit is independent and excluded from the calculation.

Source: Turner, J. and Noriyasu Watanabe (1995), *Private Pension Policies in Industrialised Countries*, W.E. Upjohn Institute for Employment Research, Kalamazoo, Michigan: *Social Security in the Nordic Countries: Scope, expenditure and financing 1994* (Denmark), *Rentenversicherungsbericht* (Germany), *Annual Report on Health and Welfare* (Japan), *Social Insurance Statistics* (Sweden), *Social Security Statistics* (the UK), *Social Security Bulletins* (the US). Information also comes from country responses to "Caring World" synthesis questionnaire, and the internet homepage of the Department of Human Resources Development, Canada.

Table 6.5 Selected private pension programmes for employees

Country	Name of the programme	Establishment (1)	Age of eligibility for benefits	Contribution	Benefit	Funding	Tax treatment	Regulation/ security measures	Relation with public pension
Australia	Superannuation	Voluntary/ Compulsory (91.5%: 1993) *A basic portion is compulsory under the Superannuation Guarantee (SG)	55 (will be 60 by 2025) to receive full tax-assisted benefits	(SG) 6% (employer, will be 9% in 2002)	DB or DC 98 % of all the superannuation funds are managed on DC basis.	Private schemes fully funded. Some schemes for public employees are PAYG. (A$198bil., 1995)	Tax concessions	1999 Introduction of new superannuation regulations, key responsibility of Insurance and Superannuation Commission	Supplement largely to means-tested pension, will replace public pension for those with large payments
Canada	Registered Pension Plans	Voluntary (45%, 1993, all employer-sponsored pension plans)	Usually 65	Majority: (employee) 5% (private sector) 7-9% (public sector)	DB or DC * DB schemes are majority, but DC schemes are increasing rapidly.	Funded ($ 272,387 mil. : 1988)	Tax concessions	"Prudent man" concept for portfolio regulations	Supplement to public pensions
Denmark	Labour Market Pension	Compulsory (based on the collective agreements) (65% in 1994)	60	Majority: 12% (for workers with intermediate education) * Majority of new schemes (for workers at low education) reaches 9 % in 8 to 12 yrs.	DC	Funded (20.1% of GDP, 1993)	Tax concessions	Regulation on asset allocation	Supplement to public pensions

Table 6.5 Selected private pension programmes for employees (continued)

Country	Name of the programme	Establishment (1)	Age of eligibility for benefits	Contribution	Benefit	Funding	Tax treatment	Regulation/ security measures	Relation with public pension
Germany	Regulatory framework: "BetrAVG"	Voluntary (About 50%, without public sector)	65, in principle	Maximum tax exemption is 8,610 DM for single person (employee)	DB or DC (More than 90% is based on DB)	PAYG	Tax concessions	Insurance for payment of benefit was introduced in 1974. This insurance is managed by PAYG scheme.	Supplement to public pensions
Ireland	Occupational and private pension schemes	Voluntary (46% of workforce: 1995)	Almost 65 (men) 64 (women) * average figure	Average: 4.43% for employee	DB or DC	Funded in most cases (46% of GDP, 1996)	Tax concessions	Minimum funding standard, disclosure of information, etc.	Supplement to public pensions
Italy	Complementary Pension	Voluntary	The same as statutory schemes	2% for employers 2% for employees	DC or DB (self-employed) DC (employee)	Funded	Tax concessions (taxable base: 87.5% of total annuity)	L 241/92 L 335/95	Supplement to public pensions
Japan	Corporate pension Major schemes: * Employees' Pension Funds (EPFs) * Tax Qualified Pensions (TQPs)	Voluntary	Usually 60	EPFs: 3.2-3.8% (split between employers and employees) for the contracted-out portion Others: No regulation	DB (Introduction of DC is being considered)	Funded (44.7% of GDP, 1993)	Tax concessions (EPFs and TQPs)	The Federation of EPFs ensures payment of the benefits by EPFs to a certain extent.	Supplement to public pensions
New Zealand	Superannuation	Voluntary (23%, 1987)	As a general trend, the age is lowering from 65 to 60.	Majority (1990): 4.1-5.0% (employee) 0.1-5.0% (employer) * As for DC schemes, majority of the employers do not pay contributions.	DB or DC 87% are DC in 1990 (excluding Government Superannuation Fund and personal saving plans)	Funded (In very rare cases based on PAYG) (NZ$ 11,093 mil. in 1990)	No tax concession (From 1987 Reform)	"Prudent man" concept for portfolio regulations	Supplement to public pensions

Table 6.5 Selected private pension programmes for employees (continued)

Country	Name of the programme	Establishment (1)	Age of eligibility for benefits	Contribution	Benefit	Funding	Tax treatment	Regulation/ security measures	Relation with public pension
Sweden	Industrins Tilläggs Pension (ITP) (for white-collar) Särskild Tilläggs Pension (STP) (for blue-collar)	Compulsory (based on the collective agreement)	65	5-20% (ITP) 3.30%:'95 (STP) * for schemes managed by insurance	DB	PAYG ("book-reserve") or Funded (over 10% of GDP,'90, for funded schemes only)	Tax concessions	Schemes based on "book-reserve" management must belong the payment insurance system.	Supplement to public pensions
United Kingdom	Occupational pension funds	Voluntary (48%, 1991)	Mostly 65 (60 for women) * 50-75 is possible according to the tax regulations.	Maximum tax exemption is 17% of salary. (In 1991, 9.75% (employer), 5.5% (employee), on average)	DB or DC (Proportion of DC is increasing)	Full-funded (supported by tax system) (79.4% of GDP, 1993)	Tax concessions	1995 Pension Act guaranteed payment to the 90% income, in case of fraud or misappropriation)	* Contract-out * Supplement to public pensions
United States	Regulatory framework: Employee Retirement Income Security Act (ERISA) of 1974	Voluntary (58.8%, 1988)	Majority is 65. Most of other cases are 62 and 60.	Maximum amount of tax exemption varies among plans.	DB or DC (DC is promoted by favourable tax treatments)	Full-funded ($59.1% of GDP, 1993)	Tax concessions (2)	Benefits of DB schemes are ensured by the Pension Benefit Guaranty Corporation.	Supplement to public pensions

Source: *Private Pensions and Public Policies* (OECD, 1992a), *Private Pensions in OECD Countries*: *The United States* (1993a), *New Zealand* (1993b), *Ireland* (1994c), *Canada* (1995d), *The United Kingdom* (1997e), *Australia* (1997f). *Supplementary Pensions in Denmark: A description of the future pension system* (The Danish Labour Market Supplementary Pension Scheme, 1995). *Corporate Pension Schemes in the World: Recent trends and developments* (in Japanese) (ed. by Pension Fund Association, Japan, 1996). Information also comes from the Ministry of Health and Welfare, Japan.

(1) The number in the bracket indicates the proportion of coverage against the total population of employed persons.

(2) Employee contributions are exempted from taxes when the scheme matches several requirements under the Internal Revenue Code and the Tax Reform Act (401(k) plan).

Table 6.6 Examples of major personal savings programmes

Country	Name of the programme	Benefit and Eligibility	Contribution	Tax treatment	Note
Canada	Registered Retirement Saving Plans (RRSPs)	In principle, the saving can be withdrawn for pension at age 60 -71.	Maximum contribution is 18% of income of the previous year annually (tax deductible)	Contribution deductible. Invest income not taxed. Taxes paid on withdrawal.	In 1990, tax treatment for RRSPs was equalised with other corporate pensions, and maximum tax exemption was increased.
United Kingdom	Personal Pension	The plan can start providing pension anytime for the ages 50 -75.	Maximum contribution varies (17.5-40%) according to income (tax deductible)	Contribution deductible. Invest income not taxed. Taxes paid on withdrawal.	In 1992/93, 24% of employees were contracted out of the public earnings-related pension with personal pension. This contracting out was promoted with rebate by the government.
United States	Individual Retirement Accounts (IRA)	When withdrawn before 59 and 1/2, penalty tax of 10% usually applies. Distributions must commence by April 1 of the calendar year following the calendar year in which the individual reaches age 70 and 1/2.	Maximum contribution is $2,000 per year (tax deductible)	Contribution deductible. Invest income not taxed. Taxes paid on withdrawal.	1998 revision introduced penalty-free early withdrawal with the reason of college education expenses, first-time home purchase with up to $10,000.

Source: *Private Pensions and Public Policies* (OECD, 1992), *Private Pensions in OECD Countries*: *The Unites States* (1993), *Canada* (1995), *The United Kingdom*(1997). Also information on IRA comes from Employees Benefit Research Institute, US, and on RRSPs from a country response from Canada.

Table 6.7 Tax concessions for pension benefits and other income/savings

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Australia	Income Tax • Benefits of Age Pension (funded by general taxation) are taxable. • Pensioner Tax Rebate (ensuring that a pensioner does not pay tax until private income exceeds the value of the pension and the income test free area)	Income Tax • Tax-rebate for low-income self-funded retiree phased in to provide same tax concession as for pensioners • Superannuation contributions with tax concessions (though there will be a tax surcharge of up to 15% on contributions by the wealthy) • Savings rebate (from July 1998) will apply to (undeducted) superannuation contributions, or net income receipt from savings and investment, or a combination of both, up to an annual cap of A$3,000. The full rebate will be A$450 a year in 1999-2000 income year. Capital Gains Tax • Concessions from Capital Gains Tax on the income received from selling the small enterprise for the reason of retirement
Austria	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer, including additional voluntary contributions), though benefits are taxed as earned income. • Pensioners Tax Credit of ATS 5,500 per annum • Only 25% of the pension secured by additional voluntary contributions is taxed.	Income Tax • Tax credit for extraordinary costs entailed by physical/mental disability (The elderly people are major beneficiaries of the credit. This credit is not available when the applicant receives such benefits as long-term care benefit (*Pflegegeld*), though special, partially lump-sum amounts for expenses for some chronic diseases or for some specific devices (such as wheelchairs) can still be claimed.) Contributions to Social Security Programmes • Retirees only have to pay social security contributions to the health insurance scheme. Moreover, the rates are smaller than those for younger persons.
Belgium	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as replacement income. • Pensioners are awarded of tax deduction, based on the number of dependants and the level of income. Contributions to Social Security Programmes • Other than "solidarity contributions"(imposed on pension benefits above certain amount), pensioners do not have to pay contributions to the social insurance schemes.	

Table 6.7 Tax concessions for pension benefits and other income/savings (continued)

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Canada	Income Tax • Benefit of Old Age Security basic pension (funded by general taxation) is taxable. • Guaranteed Income Supplement and Spouses Allowances are not taxable. (Old Age Security basic pension and Guaranteed Income Supplement are going to be merged, along with the Age and Pension Income Tax Credits, into non-taxable Senior Benefit from January 2001.) • Employer contributions to Canada Pension Plan (CPP) are tax deductible. Employee contributions are not directly deductible, but subject to a tax credit. Benefit of CPP is taxable. • Some provincial income-tested supplements to pensioners are also non-taxable.	Income Tax • Age Credit (deduction of "old age" amount from federal tax payable) -- The amount in full is C$3,482 in 1995. -- There is an income limit for the credit (C$25,921). The excess amount will also be a base for the claim of the credit reduced at a rate of 15%. The credit, or a portion of the credit, may be transferred from one spouse to the other in cases where one spouse does not require the full credit to reduce his/her tax to zero. • Pension Income Credit (Taxfilers with pension income from employer-sponsored pension or Registered Retirement Savings Plan annuity may claim a credit depending on the amount of the income. C$1,000 maximum.) • In case of annuities purchased with no tax-assisted savings, only the portion of investment earnings is taxable.
Czech Republic	Income Tax • Contributions are tax deductible, and benefits are tax free.	
Denmark	Income Tax • Contributions to the ATP scheme are tax deductible (for both employee and employer). Benefits of the old-age pension (*folkepension.* funded by general taxation) and ATP pension are taxed as earned income. Supplementary benefits to pensioners are not taxable.	Property Tax • Tax related to owner-occupier housing is reduced by 50% for persons from age 67

Table 6.7 Tax concessions for pension benefits and other income/savings (continued)

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Finland	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as earned income with the exceptions of supplements (for a child or spouse, etc.) to the basic pension benefits. [Concession from tax on specific income deriving from pension benefit] • Pension benefit, when below the average amount, is subject to less taxation compared to other source of income of the same size. When above the average, it is subject to more taxation than other source of income of the same size. [Concession from tax on income in general for the reason of being pensioners] • Pension income deduction, in municipal and state taxation, which ensures that no income tax is paid from the pension benefit in case the pensioner has no other taxable income.	Income Tax • Tax allowance for the disabled (A rather large part of pensioners are entitled to this allowance.)
France	Income Tax • Contributions to the scheme are tax deductible (for both employer and employee), though benefits are taxed after deduction of allowances similar to those applied to salary.	Income Tax • Pension benefits from individual plans are normally partially taxed on a fixed scale, based on the pensioner's age.
Germany	Income Tax • Contributions to the scheme are tax deductible (for both employee (up to a certain amount) and employer). • Statutory pension benefits are only taxable for the portion which corresponds to the notional interest for the pension saving. • Civil servants' pensions are fully subject to income tax except for base amount reduction ranging from 40% of the benefits to 6,000DM per calendar year.	Income Tax • Income from sources other than pensions is fully subject to income tax except for base amount reduction ranging from 40% of such income to 3,720DM per calendar year.

Table 6.7 Tax concessions for pension benefits and other income/savings (continued)

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Greece	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as income.	Income Tax • Contributions to private saving schemes are tax-deductible. Maximum tax allowance: 200,000 drs/year or 15% of premium expenditure (whichever lower) • Presumptive taxation provisions do not apply to professionals over the age of 65 who have been practising for at least 10 years.
Hungary	Income Tax • Pension benefit is tax-free, because contributions to the scheme are taxed.	
Iceland	Income Tax • Pension benefits (including supplementary benefits) are taxable income.	
Ireland	Income Tax • Employer contributions to the social security scheme are in general tax deductible, but employee contributions are not. Benefits are usually taxed as earned income. • Employer and employee contributions to occupational and private pension schemes and income from the investment of the contributions are tax deductible up to certain limits. Benefits are taxed, but part of the supplementary pension can be received as a tax free lump-sum payment up to 1.5 times of final salary. • Other social security benefits from public authorities may be exempt from taxes.	Income Tax • Income Tax Age Allowance (£Ir400 for single/widowed persons and £Ir 800 for married couple) • Exemption limits for rent allowances become higher at the age of 55, 65, and 75. Contributions to Social Security Programmes • Those aged 66 or over do not have to pay contributions to the pension scheme, even if they are in employment/self-employment.
Italy	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer). • Benefits are usually taxed, except for disability benefits. Contributions to Social Security Programmes • Pensioners do not have to pay contributions to the Health Care Services out of their pensions.	

Table 6.7 Tax concessions for pension benefits and other income/savings (continued)

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Japan	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as miscellaneous income. • There are several deductions for pensioners, thus making the majority of pensioners not having to pay taxes.	Contributions to Social Security Programmes • Contribution rules for National Health Insurance (for self-employed people, etc.) are favourable to the elderly
Korea	Income Tax • Public pension benefit is tax-free (though the contribution to the scheme is not exempted from income tax base).	Income Tax • Contributions to private pension schemes are exempted from income tax base.
Luxembourg	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as income.	
Mexico	Income Tax • Employer contributions to the scheme are tax deductible, but employee contributions are not. Benefits are usually not taxed.	Income Tax • Maximum tax free benefits are established in some cases such as savings funds and social welfare
Netherlands	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as income.	
New Zealand	Income Tax • Benefits of NZ Superannuation (funded by general taxation) are subject to personal income tax. • Tax base increase test (surcharge) for those receiving NZ Superannuation: removed from April 1998	
Norway	Income Tax • Employer contributions to the scheme are tax deductible, but employee contributions are not. Benefits are taxed as earned income. Supplementary benefits to pensioners are not taxable. Contributions to Social Security Programmes • Old-age pensioners only have to pay contributions to the Health Insurance Scheme.	Income Tax • General tax relief rule (income-tested, includes generally the elderly and some other groups) • Special deduction in taxes due to age

Table 6.7 Tax concessions for pension benefits and other income/savings (continued)

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Poland	Income Tax • Employer contributions to the scheme are tax deductible. (Note: no employee contributions in the current scheme) Benefits are subject to income tax.	
Portugal	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed income. • Retirement pension income follows a different tax processing from that of income tax in general (more advantageous deduction than other category of income). In terms of tax benefits, they are provided when the debtor is disabled. • The social security general system pensions are exempted from the Individual Tax up to a certain amount. (There are further favourable concessions to invalidity pension.)	
Slovak Republic	Income Tax • Contributions are tax deductible, and benefits are tax free.	
Spain	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are usually taxed as earned income. • Disability pensions are tax exempt.	
Sweden	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), though benefits are taxed as income. • Special basic deduction for those whose basic pension exceeds SEK 6,000 a year → Maximum amount of deduction is equal to the sum of basic pension and pension supplement, reduced if there are other sources of income such as ATP, employment pensions, etc. • Supplementary benefits to pensioners are not taxable, such as means-tested housing supplement.	

Table 6.7 Tax concessions for pension benefits and other income/savings (continued

	Concessions for Pensioners of Public Schemes	Other Concessions for Aged People
Switzerland	Income Tax • Contributions to the public scheme (AVS, 1st pillar) are tax deductible (for both employee and employer), though benefits are taxed. This is the same as the private compulsory scheme (occupational provident fund, 2nd pillar). • Supplementary AVS (old-age and survivors' insurance) and AI (disability insurance) benefits are non-taxable.	Income Tax • A person who have made a saving under the linked individual provident fund (3rd pillar) benefits form preferential tax treatment (reduced rate at the time of the payment from the funds when the insurance risk occured, and contributions deductible from income). • In some cantons, if retirees are in need of care, they may deduct associated expenses from their taxable income (though there are some restrictions).
Turkey	Income Tax • Contributions to the scheme are tax deductible (for both employee and employer), and benefits are tax free.	Property Tax • Estate duty (tax) on retirees is exempted when they have only one house.
United Kingdom	Income Tax • Employer contributions to the scheme are tax deductible, but employee contributions are not. Benefits are usually taxed as earned income. • Benefits that are more likely to be received by pensioners are subject to different treatment in the tax system (e.g. Some of the disability benefits are not taxable).	Income Tax • Higher personal allowance in income tax for the elderly (£5,220-5,440 against £4,045 as a standard), as well as higher married couples allowance (£3,185-3,225 against £1,830 as a standard) • These age-related allowances can be tapered away at the rate of 50% when income rises above £15,600. Contributions to Social Security Programmes • Elderly do not have to pay the National Insurance Contributions after the state pension age.
United States	Income Tax • Employer contributions to the scheme are tax deductible, but employee contributions are not. Benefits are taxed after some favourable adjustment. • Some social security benefits are non-taxable. (They are not limited to the elderly, though they are the majority.)	Income Tax • Larger standard deduction for the elderly -- $1,000 for unmarried person, and additional $800 per person aged 65 or older in case of married couple -- However, people rather select itemised specific deductions on various grounds such as home mortgage interest payments and charitable contributions. • There is a relatively small program of special tax credit for very low-income elderly and disabled people (most beneficiaries are under age 65). Property Tax • In many States and local governments, property tax is favourably applied to elderly homeowners.

Source: PENSION FUND ASSOCIATION (1996), *Corporate Pension Schemes in the World: Recent Trends and Developments* (in Japanese), Social Research Institute, Tokyo; WILLIAM M. MERCER LIMITED (1995), *International Benefit Guidelines*, William M. Mercer Limited, Brussels; NORDIC SOCIAL STATISTICAL COMMITTEE (1996), *Social Security in the Nordic Countries: Scope, Expenditure and Financing 1994*, NORSOSCO, Copenhagen; and Country responses to Caring World Questionnaire.

Table 6.8 Current retirement income concerns and processes

Country	Financial viability of public pension system	Low effective age of retirement	Other concerns/Issues	Recent reforms undertaken and when	Current processes established
Australia	Yes		• Adequacy of public benefits • Complexity of pension arrangements	1991-98 (-2025)	
Belgium	Yes	Yes	• Regulating public pension schemes • Adequacy of public benefits, minimum entitlements	1995 1996 1997 (-2005)	
Canada	Yes			1998	
Czech Republic	Yes	Yes	• Adequate level of pensions • Consistency of pension arrangements	1990-92 1996 (-2007)	
Denmark		Yes	• Want more effective labour market incentives for older workers		
Finland	Modest concern	Yes	• High rate of unemployment for older people • Improved pension coverage of workforce	1993-96 1997	
France				1993 (-2013)	
Germany	Yes	Yes	• Promote company pensions Intergenerational equity	1992 (-2020) 1997 (-2012)	

Table 6.8 Current retirement income concerns and processes (continued)

Country	Financial viability of public pension system	Low effective age of retirement	Other concerns/Issues	Recent reforms undertaken and when	Current processes established
Greece	Yes	Yes	• Intergenerational equity • Adequacy of minimum entitlements • Evasion • Coverage of immigrants	1987 (farmers) 1990-92 1996	"Social dialogue" on the future of social insurance, in particular pensions (1997-)
Hungary	Yes	Yes	• Adequacy of benefits • Improved work incentives with pension system.	Early 90s 1998/9	
Ireland	Yes		• Adequacy of basic pension • Supplementary pension coverage	1988 (self-employed); 1990/91 (part-time employee); 1995 (public servants)	National Pension Policy Initiative launched in 1996. Report to be published, May 1998
Italy	Yes	Yes	• Improved work incentives with pension system • Greater equity of systems across industries and individuals • Labour market outcomes may lead to inadequate pension accumulation	1995 1997 (-2008)	
Japan	Yes		• Intergenerational equity • Worsening overall fiscal deficit • Extension of private pensions	1994	• National Pension Council, advisory organisation to Minister for Health and Welfare, started extensive discussion to consider fundamental pension reform.
Korea	Yes	Yes	• Desire to extend coverage, including urban self-employed • Reforming benefit structure (amount, retirement age, etc.) for the long-term financial soundness		• National Pension Reform Committee was operating during 1997. Government is revising the current law.

Table 6.8 Current retirement income concerns and processes (continued)

Country	Financial viability of public pension system	Low effective age of retirement	Other concerns/Issues	Recent reforms undertaken and when	Current processes established
Luxembourg	Yes		• Greater convergence between pension schemes	1991	
Mexico			• Setting upper limit (in relation to pension income) for imposing income tax		
Netherlands	Yes	Yes	• Affordable private pension funds • More freedom of choice for individuals and increase coverage rates for private pensions		
New Zealand	Yes	Yes		1990 1991 (-2001)	• Current review of retirement income policies with a focus on the financial sustainability of the system • Referendum on compulsory retirement savings scheme (not supported: Oct.1997).
Norway	Yes	Yes	• Intergenerational equity	1997	• Inter-Ministerial working group to evaluate greater retirement flexibility, committee to investigate alternative early retirement schemes • Government commission investigating alternative financing methods, to report July 1998.
Poland	Yes	Yes	• Highly redistribute pension system	1995/1996	• Legislation for major reform being developed, anticipate it to operate from 1999 (phased in over 20-30 years)

Table 6.8 Current retirement income concerns and processes (continued)

Country	Financial viability of public pension system	Low effective age of retirement	Other concerns/Issues	Recent reforms undertaken and when	Current processes established
Portugal	Yes			1994	• Retirement pension issues: an important aspect of work of the Social Security White Book Committee
Slovak Republic			• Improved work incentives with pension system • Extension of private pensions	1993 1996 1998	
Spain	Yes	Yes	• Maintain benefit adequacy • Improved work incentives with pension system	1997 (-2002)	
Sweden	Yes		• Overall concern that fiscal consolidation has impacted harshly on older people	1990 1993 1995 1998	• Legislation on reformed pension system due to be operational January 1999 (phased in over 20-25 years) (The first payments will be done in 2001)
Switzerland	Yes		• Exclusion of part-time workers from pension coverage of the compulsory occupational provident fund (2nd pillar)	1997	• Inter-Ministerial working group have analysed the social and financial consequences of extending or reducing benefits
Turkey	Yes	Yes	• Non-collection of social security premiums because of non-registration to the schemes.	1998 (planned)	• Current studies on the social security bill

Table 6.8 Current retirement income concerns and processes (continued)

Country	Financial viability of public pension system	Low effective age of retirement	Other concerns/Issues	Recent reforms undertaken and when	Current processes established
United Kingdom			• Adequacy of income, rising income inequality • Decline in quality and coverage of supplementary pensions • Want to develop second-tier pension for those not covered by employer schemes, including carers	1986 1995	• Government leading a wide-ranging pensions review
United States	Yes		• Encourage private pensions	1996	• Social Security Advisory Council, officially appointed body of outside experts, recently reported findings

Source: Country responses to "Caring World" synthesis questionnaire.

Table 6.9 Directions of recent pension reforms in Member countries

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
Australia	O (W) * Equalising with the age for men (1)	1997 Deferred Pension Bonus Plan	1997 Pension rate now linked to community living standards			1992 • Establishment of compulsory private pension (Superannuation Guarantee) DC, full-funded, tax con cession. Voluntary schemes still remain, generally with higher benefits. 1996 • Improved supervision, regulation of private funds 1997 • Retirement Saving Accounts or other supplementary measures			
Austria		Reduced access to early retirement option				Harmonisation of scheme for public employees with system for other workers			
Belgium	O (W) * Equalising with the age for men	1997 ↑ Required no. of working yrs for early retirement	1996 ↓ Revaluation coefficient for the benefit						
Canada		1987 Flexible retirement age to 70	1997 Reduction of some benefits related to disability		1997 To 9.9% in 2003 and held steady (2) (3)	1996 New basic pension with means test, by 2001	1997 funded portion ↑ (2 yrs → 5 yrs)	Tax concessions, available within limits	1997 More aggressive investment policy with pension reserves to generate higher earnings
Czech Republic	O (M,W) * Difference between men and women is shortened.		Price indexa-tion of payments, capacity for adjustment in line with living standards		Considering increase	Convergence of payment rates available through different schemes	System of voluntary supplementary pension provision, based on employer contribution, no tax relief.		
Denmark					Yes (3)	Compulsory occupational pension (second-tier) is managed by DC schemes. Coverage rate of that program increased from about 1/3 (1987) to about 4/5 (1993).			1994 Pensioners taxed in the same way as other taxpayers

Table 6.9 Directions of recent pension reforms in Member countries (continued)

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
Finland	Retirement age raised from 63 to 65	1997 Raising the lower age limit for early retirement benefit (from 55 to 58 yrs). Lower level of early retirement benefit.	1993-1996 Reduced benefit, changed indexation arrangements, basic pension means-tested.		Gradual raise of the contribution rate until 2030s (3)			Gradual implementation of private sector pension scheme	1997 Financing and solvency reform to strengthen solvency of funds and allow new investment strategies
France			1994 Base period for benefit calculation from 10 → 25 years (by 2008/2013)	1994 37.5 yrs → 40 yrs by 2003					
Germany	O (W) * Equalising with the age for men * Other exceptions are also amended.		1992 Net-income indexation (4) 1997 ↓target replacement rate (70% → 64%) (in 30 yrs)		(3)		• Corporate schemes are promoted with legislation, dating back to 1974 and recent reforms. • Wanting to further expand private schemes		Attempted to share the burden of ageing equally between pensions and contributors
Greece	O (W) * Equalising with the age for men	Benefits more proportional to contributions (5)	1992 Elimination of the special treatment on the bonus salary * calculation rate: 80% →60% (5)	1990 13.5 yrs → 15 years	• Major increase in 1992 • State contributions equal to 10% of earnings (5)	* Pensionable age of special schemes is eqalised with IKA (2001 (W) and 2007(M)) * Uniform contributions and replacement rates (5)			1996 income-tested pension supplement Farmers scheme to provide contribution-related benefits in place of current flat-rate non-contributoy pensions (a)

Table 6.9 Directions of recent pension reforms in Member countries (continued)

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
Hungary	O(M,W) * Equalising the ages of men and women	Raising the lower age limit and minimum no. of contribution yrs for early retirement 1997 Replace Labour Market Fund with less generous scheme	1998 Higher benefits available to long contri-butors and high earners 2001 Less generous indexation arrangement 2013 Pensions calculated on the basis of gross earnings		1998 A new mixed public-private system. 3/4 of the system is based on traditional PAYG system, with 1/4 is based on the newly established funded portion managed by private sector. Tax allowances encourage voluntary savings in supplementary pension funds. The new system is mandatory for new labour market entrants; existing workforce can elect to switch to the new system.				1998 Pensions became taxable income. Want to keep PAYG scheme deficit to below 1% of GDP
Ireland			Pension rate increased to more than adjust for prices in periods of economic growth			Majority of National Pensions Board in Final Report (1993) recommended against second tier PAYG pensions.		January 1991 New regulatory system for occupational pensions introduced to safeguard pension rights	
Italy	O (M,W) * 5 yr difference remains between men and women • New system →(6)	Yes (6)	Reduction of benefits	For seniority pension and old-age pension	Yes (3)	1995 Greater equity for workers in different industries	1995 Complementary funded scheme, DC scheme	Yes	Surviviors pension now means tested 1995 Harmonisation of regulations governing different pension systems
Japan	O (M,W) * Partial pension is also introduced.		1994 Net-income indexation (4)		1994 Introduction of contribution imposed on bonuses (3)	Private pension is promoted, including discussion for introduction of DC schemes, etc.			(a)

Table 6.9 Directions of recent pension reforms in Member countries (continued)

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
Korea	O (M,W)		Replacement rate: 70% →55% on the basis of 40 yrs' contributions	15 years to 10 years	Gradual raise by 2025 (3)			1995 Individual private pension introduced 1998 Firms can have an option to take pension scheme or severance payment .	
Luxembourg						Pursuing convergence between general scheme, special public sector scheme and railway scheme			
Mexico						1997 A new mandatory private pension system (DC, funded) • The old (public) system still remains and the insured persons can enrol either of them. • Voluntary deposits can be made to the individual account of the workers.			
Netherlands					(3)	* Promotion of private pension • Wishes to raise the coverage rate of private schemes • Transition from PAYG to funded schemes supported by government • Making the scheme more affordable by changing final-salary pension to average salary pension			• Introduction of the OAP Savings Fund • Wants to encourage the workers to voluntary contribute to building up the pension right during "care-leave"
New Zealand	O (M, W) * To 65		1990 Link to 80% average wage (for couple) was abolished. Relative value now below 70%			Promotion of private provision (by public education. no tax concession introduced.) Introduction of compulsory private pension was proposed, but denied in the referendum (Sept. 97)			

Table 6.9 Directions of recent pension reforms in Member countries (continued)

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
Norway		1997 Reduced level of deduction from pension payable due to income from work (67-70)	1992 Reduced benefit rate, reduced rate of accumula-tion of pension entitlements for each yr of work			Under discussion			* Increased public revenues from petroleum industry is allocated to the State Petroleum Fund.
Poland	O (W) * Equalising with the age for men	Raising the lower age limit for early retirement (planned)				1999 1st pillar PAYG, DC (state subsidy for subsistence) 2nd pillar: funded, universal coverage 3rd pillar: private pension schemes			1991 Method of calculation was changed to count in only half of the portion the period of temporary withdrawal from labour force for the purpose such as of parental leave, sick leave, etc.
Portugal	O (W) * Equalising with the age for men		1994 Reduced pension accumulation rate by 10%	1994 10→15yrs contribution to establish pension rights	(3)			Possible but not so prevalent now	
Slovak Republic					(3)			Related legislation was passed in 1996.	1995 DB scheme introduced with new tax system

Table 6.9 Directions of recent pension reforms in Member countries (continued)

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
Spain	Phasing out previous scheme with lower retirement age		1997 Automatic price indexation of benefits Stronger linkage of benefit rates to contributory yrs.						
Sweden		1999 Abolish upper limit for deferred retirement, actuarial pension increase	1993 ↓ benefit amount Reduced indexation arrangements 1999 Transfer from a benefit-defined system to a contribution-defined system ("life-income' principle)		1990 Payroll tax for employers 1995 1% contribu-tion for employee (3)	1999 Introduction of DC scheme	1999 2.5% out of 18,5% contri-bution will be allocated to funded system.		1990 phase-out survivors' pension Individual financial funds in reformed scheme will grow as buffer fund declines. (b)
Switzerland	O (W) * Difference of the age between men and women is shortened.		1997 Abolish some special benefits						1997 • Those caring for children and close family relatives receive notional income at the time of calculating pensions. * The rate of state subsidy has been adjusted in recent years.
Turkey	Raising the pensionable age	Raising the minimum no. of contribution yrs for early retirement (considered)		Remove amnesty for unpaid contributions	Raising the contribution rate (considered) State contributions	Considering universal scheme		Considering encouraging greater private pensions	(a)

Table 6.9 Directions of recent pension reforms in Member countries (continued)

	↑ pensionable age	Promoting longer employment	Changed benefit rate	↑ required contribution period	↑ contribution rate	convergence of schemes	greater reliance on funded schemes	promoting private schemes	Others
United Kingdom	O (W) * Equalising with the age for men (from 2010)	1986 Flexible retirement age to 70 ("Personal Pension")	1986 Reduction of value of public earnings-related scheme (calculation basis: 20 yrs → all the working yrs; replacement rate: 25% → 20%)				* Permitting "contract-out" of state schemes with private schemes	• Tax concessions • Introduction of Personal Pensions • The 1995 Act also enhanced the regulation of private schemes	
United States	O (M,W) * To 67					Legislative requirement (ERISA) that all pension coverage should be non-discriminatory within a workplace where it is provided	DC scheme is tax-favoured for corporate pension	Tax concessions	Pension trust fund now in surplus, revenues lower than payments from 2011 and into debt in 2030.

Source: Country responses for "Caring World" synthesis, and *Social Security Programs Throughout the World - 1997* (Social Security Administration, US).

* Year of the reform indicates that of the implementation unless otherwise indicated.

* Breakdown of "others" : (a) reform for more efficient management, such as introduction of "Basic Pension Number" in Japan (1997)
(b) closer linkage between work and benefit, such as introduction of wage indexation in Sweden (1999)

* "M": men, "W": women, "DC": defined-contribution, "PAYG": pay-as-you-go,

(1) Australia's recently established Superannuation Guarantee (compulsory private pension) also envisions increase of the age of eligibility from 55 to 60.

(2) The original plan was to increase to 14.2% by 2030.

(3) Some countries raised the contribution rate from 1995 to 1997.

(4) Germany and Japan have introduced a scheme of "net-income indexation." The base of this adjustment is a disposable income, the remain after subtracting taxes and social security contributions from gross income.

(5) Those measures are only applied to those workers entering the labour market after 1993.

(6) A new system in Italy (introduced in 1995) has a flexible retirement age (57-65) and does not have an early-retirement arrangement. For more details on pensionable age, see Table 6.10.

Table 6.10 Pensionable age and early/deferred retirement

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
Australia	65 (M) 61 (W)	61 → 65 (W) (1997) (2013)	(c): Mature Age Allowance (MAA, introduced in 1994) 60 - 64 (M) 60 (W)	• MAA now provides lower benefit entitlements rather than pension entitlements. • Phased increase in age at which makes possible an access to tax-assisted private pensions, from current age 55 up to age 60 by 2025.		• Deferred Pension Bonus Plan (lump-sum) ... (proposed) 65-70 (M) 61-66 (W) • Can continue contributing to private pensions up to age 70 if employed at least 10 hours a week		Eligibility for Service Pension (for veterans) is 5 years earlier than Age Pension.
Austria	65 (M) 60 (W)		(a): 60 -64 (M) 55 - 59 (W) Needs 35 years insurance, meet means test		(a)			
Belgium	65 (M) 61 (W)	1997 61 → 65 (W) (1997) (2009)	(a): 60 -64 (M) 60 (W) Needs 20 working years	1997 No. of working yrs will be ↑ from 20 (1997) to 35 years (2005)	Pension system allows continued employment with earnings limits			General principle that people should stop work at retirement age
Canada	65		(a): 60-64 (for earnings-related pension, introduced in 1987) Needs substantially ceased employment Introduction of partial pension is being considered.		(a): 65-70 (for earnings-related scheme, introduced in 1987)		62 (median, 1995. from about 65 in 1976)	Pensioable age for Spouses Allowance Benefit is 60. Change of pensionable age (65→67) was proposed but not supported in 1997.

Table 6.10 Pensionable age and early/deferred retirement (continued)

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
Czech Republic	60 (M) 53-57(W)	1996 60 →62 (M) 53-57→57-61(W) (1996) (2007)	(a): from 3 years before pensionable age with 25 yrs insurance (c): within 2 yrs of retirement with 25 yrs insurance and 180 days unemployment, temporary benefit reduction until age 60	1996 4 years before(2001) → 5 years before (2006)	(a)			
Denmark	67		(b): 60-66 Needs contribution of over 10 yrs in last 20 yrs Needs to continue working as part-time	From July 1998: Local authorities required to first try rehabilitation training, and other reintegration measures which prove unsuccessful before an early retirement pension is granted			61.5 (Sep.1997, from about 65 in 1977)	
Finland	65		(a): 60-64 (Early-retirement pension) (b): 58-64 (Part-time pension) (c): 53-60 (unemployment daily allowance) (c): 60-64 (unemployment pension)	1997 Lower age limit for unemployment daily allowance became from 53 to 55	(c): 65- (no upper limit) 1% pension bonus for each month deferred after age 65 for public sector workers			
France	60							Under certain conditions, part-time work is permitted after the pensionable age (since 1988)

Table 6.10 Pensionable age and early/deferred retirement (continued)

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
Germany	65 (M) 60 (W)	1992 and 1996 60 → 65 (W) (2000)(2004)	(a): Needs partial cessation of employment	From 2012: Lower limit: 62 years Needs 35 years insurance	(c): 0.5% bonus for each month working beyond age 65			There are some exceptions for pensionable age, 63 for long-term insured and 60 for severely handicapped. They are also gradually increased to 65 and 63 respectively.
Greece	65 (M) 60 (W)	60-65 (W) for those entering the labour market after 1993	(a): 60-64 (M) 55-59 (W) Needs 4500 days of insurance * Full seniority pension is granted at age of 58 for those with 35 years of contributions.					There are many exceptions of pensionable age. (3)
Hungary	60 (M) 56 (W)	1997 60 → 62 (M) (1997) (2001) 56 → 62 (W) (1997) (2009)	• Employer-based scheme available within five yrs of retirement (employers bear the full cost) • Labour Market Fund for those exhausted UB and within 3 yrs of retirement • Those with 40 yrs service get full pension	• Access to early retirement now from age 60 (M) , 55(W) • Value of Labour Market Fund payment reduced (by around 20%) to flat-rate benefit	(c): 3.6% annual bonus for working beyond age 62			1997 With employer-based early retirement scheme, employers will be required to provide full advance funding rather than current instalment payment.
Iceland	67		(a): 65-66 (for corporate pension)					
Ireland	65 (retirement) 66 (old-age)		(c): 55-64 or -65 Needs to be unemployed for 15 or more months, means-tested, payment equal to long-term rate of UA	Special one-off early retirement scheme for civil servants introduced in late 1980s no longer available				

Table 6.10 Pensionable age and early/deferred retirement (continued)

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
Italy	(Old system) 63 (men) 58(women) (New system) 57-65 (3)	(Old system) 63 →65 (M) 58 →60 (W) (1997)(2000) (3)	"Seniority pension"(within the old system; used to be provided with 35 years of contribution and with no age requirements) is provided with 35 years of contributions and age requirement of 52 (1997).	Required contribution period for "seniority pension" becomes 40 years in 2008, which is the same as that of the new system when age requirement is exempted. (3)	(a): 64-65 (M) 59-65 (W)			Want to abolish public subsidies for early retirement
Japan	60 (M) 59 (W)	1994 60 → 65 (2001)(2013) (M) (2006)(2018) (W)	(a): 60-64 (basic pension) * Earnings-related pension: (4)		(a): 65-70			Pensionable age for Basic Pension is 65 years old. As to earnings-related pension, pensionable age for seamen and miners is 56.
Korea	60	60→65 (by 2033)	(a): 55-59 Needs 20 working years Lose 5% benefits for each yr below age 60		When retirement is deferred to 65, basic pension is provided with reduced amount of 50% at 60, with 10% increases for a year more.			
Luxembourg	65		57 -. Needs 40 yrs contributions; or age 60 if 40 yrs effective coverage	---	(a): 65-68	Not a policy priority		Pensionable age for non-contributory plan is 60.
Mexico	65		(a): 60-64 The early retirement benefit was intended for unemployment situations.					
Netherlands	65		Only private pension has those arrangements based on collective agreements		Not a policy priority			

Table 6.10 Pensionable age and early/deferred retirement (continued)

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
New Zealand	62	62 → 65 (1997)(2001)	No. Only transitional measures for those close to new increased retirement age expires in 2003. Relaxed work test for unemployment beneficiaries aged 55 and are unemployed for at least 6 months					Mandatory retirement is illegal.
Norway	67		(a): 64-66	Lower limit becomes 62 in Mar. 1998.	(a): 67-70	1997 * Those working between these ages can also retain more of their pension, up to set earnings limits.	About 60 (Aug.1997)	Easier access to early retirement contrary to Government objectives
Poland	65 (M) 60 (W)	It is planned to increase pensionable age for women to 65.	Early retirement generally available 5 yrs before retirement age. No actuarial reduction of benefit.	It is planned to make the lower limit of early retirement at 62.			59 (M) 55 (W) (1996)	
Portugal	65 (M) 64(W)	62 → 65 (1993)(1999)	Early retirement at age 60 if involuntary unemployed over age 55. Pension payable at 60 if UB depleted.					Pensionable age for miners (50), seamen, fishermen (55).
Slovak Republic	60 (M) 53-57 (W)		2 year before the pensionable age (* without actuarial reduction if retirement due to retrenchment)	A scheme of allowing early retirement 3 years before pensionable age, with actuarial reduction of the benefit, is being considered.	(c): Legal regulations allow later retirement. 1% bonus for extra 3 months work			Pensionable age for workers in unhealthy or arduous work is 55 - 58.

Table 6.10 Pensionable Age and Early/Deferred Retirement (continued)

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
Spain	65	Previous pension system which had retirement age of 60 being phased our (no new entrants after 1967)	(a): 60 - 64 • Full benefit when the age is 64 or more and there is a replacing worker who has been unemployed. • Phased retirement at 62-64 with part-time work and new recruitment of part-time worker		(a)		63.1 (Aug.1997)	Can retire earlier if work in harsh, dangerous jobs Little incentive to work more than 35 yrs as already get 100% pension
Sweden	65		(a): 60-64 (b): 61-64 (with reduced working hours) Reduction of 0.5% of benefits for every month prior to 65	1999 Pensions available from age 61 with actuarial adjustment	(c): 65-70 Employer's consent is required. Bonus of 0.7% for each month deferred	A measure to ensure the right to work until 67 is being considered. 1999 Plan to remove upper age limit from pension bonus and to introduce actuarial adjustment		
Switzerland	65 (M) 62 (W)	62 → 64 (W) (1997) (2005)	(a): Up to 2 yrs before the pensionable age (first-tier pension) * As to the second-tier compulsory private pension, the rules and regulations of the insurance company determine whether there can be early or late retirement and on what conditions (but the federal authorities will not accept this when it is more than five years under or over the legal retirement age).	Early retirement linked to increase of retirement age (1st pillar)	(a): 65-70 (M) 62-67 (W) In case of the private compulsory scheme (2nd pillar) , pensioners may also remain in employment in order to accumulate maximum pension			There is another early retirement scheme within unemployment insurance: it provides supporting benefit to the employers if they fill the job of the pre-pensioner with someone unemployed for at lease 6 months.

Table 6.10 Pensionable Age and Early/Deferred Retirement (continued)

	Pensionable age (1)	Changes to Pensionable age	Provision on early retirement (2)	Changes to early retirement provisions	Provision on deferred retirement (2)	Changes to deferred retirement provisions	Effective retirement age	Note
Turkey	55(M) 50(W)		(a): The benefit is provided from the age of 38(W) or 43 (M) only if the requirements of 20 (W) or 25 (M) working years and 5000 days of contribution are fulfilled.	Limiting of early retirement by increasing working years is being considered.				Pensionable age varies according to the schemes, e.g. age 50 for underground miners
United Kingdom	65 (M) 60 (W)	1988 60 → 65 (W) (2010)(2020)	(a): 50-64 (M); 50-59 (W) ("Personal Pension" introduced in the 1986 Act, also available up to age 75)		(a): 65-70 (M); 61-70 (W) (state schemes) * From 2010 can defer indefinitely			
United States	65	1983 65 → 67 (2002) (2027)	(a): 62 -64 Reduction of benefits 5/9 of 1% every month prior to age 65					• Mandatory retirement is illegal. • Funds withdrawn prior to age 59 and 1/2 are subject to a tax penalty.

Source: Implementing the OECD Jobs Strategy: Member countries' experience (OECD, 1997), Social Security Programs Throughout the World - 1997 (Social Security Administration, US) and country responses for "Caring World" synthesis questionnaire.

* (M): men, (W): women, "UB": unemployment benefit,

* Subsequent changes of the ages of eligibility in case of early/deferred retirement, corresponding to the change of pensionable age, are not explicitly indicated in the column.

* As to the early retirement arrangement, the benefit in the form of usual disability pension is not included in the column, though in come countries it serves as *de facto* early retirement pension.

* In some countries, workers in certain industries (miner, seamen, etc.) or mothers of young children have earlier retirement age or special option for early retirement.

(1) Standard pensionable age is as of July 1997.

(2) In the column for provisions on early/deferred retirement, (a) is for actuarial adjustment of benefit, (b) for partial pension, and (c) for other schemes such as unemployment benefits.(3) Lower pensionable age of special schemes is to be gradually equalised to that of IKA: 65 (M) from 2007, 60 (W) from 2001. In addition, in 1990, a minimum pensionable age was introduced in the public sector (for those hired from 1983).

(3) A new system in Italy (introduced in 1995) has a flexible retirement age (57-65). This system does not have an early-retirement arrangement.

(4) Pensionable age for Japanese system needs more elaboration. Although pensionable age for the basic pension is 65 years old, the earnings-related pension has provided both basic and earnings-related portions of the benefit to the elderly of age between 60 and 64, on the conditions of retirement or reduction of income to a certain extent. In the 1994 Reform, it was decided that this "special provision" by earnings-related pension from 60 would be abolished. This means standard pensionable age would increase to 65. Instead, a partial pension benefit is decided to be introduced which covers only earnings-related portion of the benefit and payable from 60. The replacement of the "special provision" by the partial pension takes place gradually during the period of 2001-2013 (M) and 2006-2018 (W). The basic pension benefit is still payable from 60 with actuarial reduction, on top of the partial pension benefit.

Table 6.11 Pensions and employment: linkage in selected countries

*** Before standard pensionable age**

Denmark	• Part-pension available to employees and self-employed aged between 60 to 66 (Introduced in January 1987). Pension provides a supplement to pay, if meet conditions regarding current and prior labour market attachment as well as a reduction in working hours.
Germany	• Some reforms in August 1996 which improved the opportunity for gradual transition from work to retirement. The reforms encouraged part-time work by older people over the age of 55 years who cut their contractual hours by half. An employer who tops up earnings from part-time work by 20% and pays contributions to pension insurance on the basis of 90% of the full time wage has. These additional costs reimbursed if the employer recruits someone else to fill the job vacated.
Italy	• Rules for concurrently drawing a pension and working although it is moving to limit this opportunity.
Japan	• Reduced pension to those aged 60-64 who are phasing down their work attachment, in the same type of job or with a different job.
Luxembourg	• Permits half salary and half pension to be received.
Portugal	• No restriction on employment activity for those in receipt of a pension.
Slovak Republic	• Draft legislation which proposes that people not be able to work while drawing an old-age pension.
Sweden	• Possibility for early retirement from 61 years. This implies life-long reduction of pension by 0.5% per month of retirement age below 65 years.

*** After standard pensionable age**

Belgium	• Allows retirees to take jobs while still drawing pensions as long as earnings are below set national limits (with the limits adjusted according to the presence of family dependants).
France	• Graduated pension scheme since 1988, available to wage earners, craftsman, industrialists and traders who are at least 60 years of age, qualified for a full pension on basis of contributions and hold a part-time job. They can combine a fraction of their pension with income from part-time work.
Greece	• Pension reduced in proportion to earnings if they exceed a limit. Current arrangements under review.
Poland	• Allows a person granted a retirement pension to continue working but there may be partial or total suspension of benefits depending on the level of earnings.
Sweden	• Postponed retirement possible until the age of 70. This implies life-long increase of pension by 0.7% per month of retiring age over 65 years.
Turkey	• Once pensioners start working, retirement pensions are not provided and they have to continue paying contributions. However, the benefits are maintained if they request for it and pay the contributions to support social security (rate: 24%) (for the scheme for employees) or if they enroll in other schemes (for the scheme for national civil servants).
United States	• Liberalised the earnings test in 1996 to encourage pensioners to work more. Those aged 62-64 can earn US$8,460 (in 1997) before they face 50% pension taper, those aged 65-69 can earn US$13,500 before they face a 33 1/3 % pension taper and those aged 70+ have no limit on earnings.

Source: Responses to OECD Caring World Synthesis Questionnaire

Examples of international social security agreements for pension totalisation

(1) Bilateral Agreements

Items usually included:

a) Elimination of dual coverage
-- To exempt foreign workers (temporarily "detached" from their home country) from paying contributions to the country of current residence (maximum period of the "detachment" is specified in the agreement, for example, five years in the majority of agreements where the US is involved)

b) "Totalisation" of the benefit
--- To allow people who do not fall under the above a) to count the coverage year in one country in claiming for the benefit in the other. Partial benefit can be paid when the combined year of coverage meets the requirements. This also means that (a part of) the accrued pension benefit in one country can be portable to the other.

Example in some countries:

Australia: Austria, Canada, Cyprus, Ireland, Italy, Malta, New Zealand, the Netherlands, Portugal, Spain and the UK

Canada: Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Cyprus, Denmark, Dominica, Finland, France, Germany, Greece, Guernsey, Iceland, Ireland, Italy, Jamaica, Jersey, Luxembourg, Malta, the Netherlands, New Zealand, Norway, the Philippines, Portugal, St.Kitts and Nevis, St.Lucia, Spain, Sweden, Switzerland and the US.

The US : Italy, Germany, Switzerland, Belgium, Norway, Canada, the UK, Sweden, Spain, France, Portugal, the Netherlands, Austria, Finland, Ireland, Luxembourg, Greece

* Agreements between Australia and New Zealand/the UK are different from others: they have "host-country" agreements, which means that the country of residence takes a charge of the social security for the foreign labour. Significantly, those style of agreements provides very limited portability of the benefits, which has been improved by recent measures such as unilateral action of allowing their portability.

(2) Multilateral Agreements

a) EC Regulation 1408/71(substantive) and 574/72 (procedure), backed up by Article 51 of the EC Treaty. Aggregation of (the period of) contributions is enabled in the regulations.

* This agreement is enforced in the European Economic Area (EEA), which includes: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Italy, Liechtenstein, Luxembourg, the Netherlands, Norway, Portugal, Ireland, Spain, Sweden, the UK
* Significantly, this agreement is only applied to European Union citizens, not to people with other countries citizenship.

Source: Responses to OECD Caring World Synthesis Questionnaire, internet home pages of UK and US governments.

Table 7.1 Health care expenditures as a share of GDP, 1985-1995

Countries	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**
Canada	8.4	8.7	8.6	8.5	8.7	9.2	9.9	10.2	10.2	9.9	9.7
France	8.5	8.5	8.5	8.6	8.7	8.9	9.1	9.4	9.8	9.7	9.9
Germany	9.5	9.4	9.4	9.6	9	8.9	9.6	10.2	10.1	10.3	10.4
Italy	7.1	7	7.4	7.6	7.7	8.1	8.4	8.5	8.6	8.4	7.7
Japan	6.7	6.6	6.6	6.3	6.1	6	6	6.3	6.6	6.9	7.2
United Kingdom	5.9	5.9	5.9	5.8	5.8	6	6.5	6.9	6.9	6.9	6.9
United States	10.7	10.9	11.1	11.5	12	12.7	13.5	14.1	14.3	14.1	14.2
Average, G7	*8.1*	*8.1*	*8.2*	*8.3*	*8.3*	*8.5*	*9.0*	*9.4*	*9.5*	*9.5*	*9.4*
Australia	7.7	8	7.8	7.7	7.8	8.2	8.6	8.6	8.5	8.4	8.6
Austria	6.7	6.9	7	7	7.2	7.1	7.2	7.5	7.9	7.8	7.9
Belgium	7.4	7.5	7.6	7.6	7.6	7.6	8	8.1	8.2	8.1	8
Denmark	6.3	6	6.3	6.5	6.5	6.5	6.5	6.6	6.8	6.6	6.4
Finland	7.3	7.4	7.5	7.3	7.4	8	9.1	9.3	8.4	7.9	7.7
Greece	4	4.4	4.3	4.1	4.1	4.2	4.2	4.5	5	5.5	5.8
Iceland	7.3	7.7	7.9	8.5	8.5	8	8.1	8.2	8.3	8.1	8.2
Ireland	7.8	7.7	7.4	7	6.5	6.6	6.8	7.1	7.1	7.6	6.4
Korea	3.9	3.8	3.8	3.7	3.9	3.9	3.8	3.9	3.9	3.8	3.9
Luxembourg	6.1	6	6.6	6.3	6.2	6.6	6.5	6.6	6.7	6.5	7
Netherlands	7.9	8	8.1	8.1	8.2	8.3	8.6	8.8	8.9	8.8	8.8
New Zealand	5.3	5.3	5.9	6.5	6.6	7	7.5	7.6	7.3	7.1	7.1
Norway	6.6	7.1	7.6	7.9	7.7	7.8	8.1	8.2	8.1	8	8
Portugal	6.3	6.9	6.7	7.1	6.6	6.5	7.2	7.4	7.7	7.8	8.2
Spain	5.7	5.6	5.7	6.3	6.5	6.9	7.1	7.2	7.3	7.3	7.6
Sweden	9	8.7	8.8	8.7	8.8	8.8	8.7	7.8	7.9	7.6	7.2
Switzerland	8.1	8.1	8.3	8.4	8.4	8.4	9	9.4	9.5	9.5	9.7
Average without G7	*6.7*	*6.8*	*6.9*	*7.0*	*7.0*	*7.1*	*7.4*	*7.5*	*7.5*	*7.4*	*7.4*
Average, Total OECD[1]	**7.1**	**7.2**	**7.3**	**7.4**	**7.4**	**7.5**	**7.8**	**8.0**	**8.1**	**8.0**	**8.0**

1. Not including Czech Republic, Hungary, Mexico, Poland, and Turkey. Source: *OECD Health Data 97* Averages are calculated arithmetic averages.

Table 7.2 Characteristics of health care systems--administration and financing

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Australia	Taxation with mainly public providers. Two thirds publicly funded, many private providers.	State & territory governments responsible for planning, provision, and administration of public hospitals & community health services. Health Insurance Commission (national) processes & pays Medicare claims & pharmaceutical benefits.	Responsibility for the funding of health services in Australia is shared between all levels of government as well as the non-government sector. Diverse sources of funds with Commonwealth government as the largest financer. Commonwealth government raises revenue through general taxation & income-related health tax levy (not a hypothecated tax). Small amount of funding provided by local government authorities. Funding by non-government sector comes from individual's out-of-pocket expenses, registered health benefits organisations, workers' compensation, and compulsory motor vehicle third party insurance.	Commonwealth government distributes funds through: general purpose grants to states to fund health services; specific purpose grants for hospital services; subsidises users for private medical services including in public hospitals.	At the Federal level health policy is co-ordinated through executive government; at bureaucratic level through inter-departmental committees, bilateral discussions.
Austria	Social insurance with mixed public and private providers; large private insurance sector.	Provinces: regulation & implementation of health services; operate hospitals. Also social assistance (home care nursing). Health insurance agencies & Chamber of physicians regulate number of doctors. KRAZAF planning instrument.	Social Insurance scheme covers 99% of population. Insurance contributions vary by profession: In 1997, contributions were: 3.95% for blue collar workers; 3.4 percent for white-collar workers (plus employer contributions for both groups), and 3.75 percent for the elderly. Contributions determined by legislature.	Funds given to KRAZAF to distribute to hospitals, based on shortfall between costs & insurance premiums (around 50% of hospitals eligible.)	School physicians perform examinations for children 6-18 years.
Belgium	Social insurance with mixed public and private providers.	Five mutualités (private non-profit sickness funds or friendly societies) plus a single public fund provide insurance coverage. Regional governments responsible for hospital. accreditation standards; health education & preventive medicine. Communautés responsible for primary prevention and health education. INAMI--overall management & targets	**(in 1992) 58%:** Social security contributions split between employee and employer:. (Pensioners & self-employed pay percentage, to an upper limit.) **42%:** State subsidies. Government assumes risk pool of mutualités.	42% of revenue for mutualities in 1992. 39% of total health care costs, of which 1/3 goes to public health	Co-ordinated through inter-ministerial conferences & permanent consulting groups.
Canada	Taxation with mainly private providers	Interlocking 10 provincial & 2 territorial health insurance schemes. Linked through adherence to national principles.	Provinces as single payers; Federal Government provides financial support (some). Financed through a progressive tax system.	Block grant funding for health, post-secondary education, social services.	Most health services under control of provinces. Federal, provincial, territorial conference of Ministers, Deputy Ministers and Advisory Committees.

Table 7.2 Characteristics of health care systems--administration and financing (continued)

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Czech Republic --	Compulsory insurance, with mixed public and private providers	Ministry of Health responsible for HC legislation, research, licensing of pharmacy & medical technology, and medical education. Directly manages regional hospitals, specialised facilities. Ministry of Internal Affairs & Ministry of Defence have own systems. Largest insurance company (GHIC) has 76 district branches. Has supervisory boards along with other companies to liaise with employees, providers, and employers.	Employees: 4.5% contrib. Employers: 9%. Self-employed: 13.5%. State contribution for those w/o taxable incomes. Independently wealthy pay own insurance.	Grant system for capital investment for health care facilities. System of redistribution across insurance companies to match health needs of insurance companies' population, based on a capitation formula, whereby insurees >60 given 3 times weight of those < 60	Education and social services collaborate for inoculation of children & health education in "healthy child programme."
Denmark	Taxation with mainly public providers	Government provides funding & guidelines. Counties administer block grants. Choose services within boundaries set by government. Health Care reimbursement scheme at county level.	Most health care expenditures financed by taxes at Federal or County level. In 1997, 17% covered by private insurance, mainly related to pharmaceuticals, dentistry, and physiotherapy.	Block grants from Federal Government, ranging from 29 to 66%. Supplemented by county taxes.	System is decentralised, so goals not spelled out. However, health services are offered to children at school, and "health visitors" offer maternity care at home.
Finland	Taxation with mainly public providers	Municipalities have active role in planning; state has reactive. But State implements broad health care policy. Primary care provided in public health centres in municipalities	financed by Federal & municipal taxes.	Allocation formula to municipalities based on population, age structure, morbidity, population density, land area, & financial capacity.	"Health for all" strategy contributed to intensive involvement by other sectors. Entitlement to day care; home health personnel.
France	Social insurance with mixed public and private providers.	National control over fees & prices -- regulates insurance contribution rates, budgets for public hospitals, drug prices, number of pharmacies & medical students. Insurers negotiate fee schedule for GPs and specialists.	Social insurance system covers 99% of population with contributions from wages. (70% of HC expenditures.) Voluntary insurance (mutuelles) cover 80% of pop & 6% expenditure. (in all, 1/5 of earnings). Out-of-pocket = 17%.	Federal Government subsidise public health clinics & some capital funding for public hospitals.	Reinforced by a debate in 1996 re: social coverage.
Germany	Social insurance with mixed public and private providers.	1,000 autonomous sickness funds negotiate with physician associations for payments to GPs. Regulation diffuse through National, State, & local levels.	Sickness funds funded by compulsory employee/employer contributions, depending on financial standing. Government subsidies cover unemployed, disabled, & pensioners	State Governments give subsidies to hospitals for infrastructure. Cross-subsidies from National government to insurance funds for proportion of old employees covered.	
Greece	Social Insurance system, though taxation funds a major portion.	About 40 Social insurance organisations make payments to providers. Primary and secondary care provided by public providers.	Taxes pay for public hospitals, social insurance organisations funded from employee and employer contributions. Social insurance contributions cover 77.5% of all revenues in 1997. Rest is government contributions and revenues from ear-marked taxes.	Ministry of Health covers cost of provincial surgeries & health centres, subsidises public hospitals. Funding distributed to 51 prefectures for administrative costs, hospital subsidies, health centres, rural MDs and emergency services, public health.	Patients' rights committee contains health care professionals & national legal counsel. Offices of school health in each region co-ordinate with local government, teachers associations and other social services to promote educational & social development of kids.

Table 7.2 Characteristics of health care systems--administration and financing (continued)

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Hungary	Compulsory health insurance with mixed public and private providers	Health Insurance Fund (HIF) primarily responsible for paying sickness benefits & invalidity pensions. Local governments administer most hospitals and outpatient clinics	Source of HIF funds: Employer and employee contributions. Tax-financed social budget also plays key role.	Some hospital & other operating costs funded by government	
Iceland	Taxation with mainly public providers	Ministry of Health responsible for overall administration of health affairs. Director General of Health oversees health professions; collects statistics. 8 medical areas with health councils administer Health affairs. Health Centres provide Primary and Specialty care.	State Social Security Institution (SSSI) funds & operates health centres -- salaried by State. In 1992, was 80% State; 20% local, but State role has decreased. (Private 12%)	State assumes operating costs of health centres & staff in the centres.	
Ireland	Taxation with mainly public providers	Department of Health, Voluntary Health Insurance Board, 8 health boards; General Medical Services Boards.	75% publicly financed in 1997, majority from Exchequer grants. Remaining 25% comprises expenditure by health insurance companies and private spending by households. Each board responsible for allocating its resources to the services it provides. Funding is also provided for voluntary hospitals and agencies which provide services on behalf of health boards. Funding levels are related to the volume and nature of services provided.	National funds are allocated to the health boards.	National Consultative Committee on Health Promotion works to promote multi-sectoral co-operation, representing other government departments, boards, voluntary organisations, academic organisations. In addition, Interdepartmental committees provide cross-sector focus. Regional and Local Child Protection Committees operate at health board level and community care level to enhance interagency and inter-professional approaches to Child Protection. National Partnership agreement Partnership 2000 (negotiated between government and the Social Partners (representatives of employers, Trade Unions, farmers and voluntary / community groups) contains a number of health-related commitments aimed at reducing social exclusion

Table 7.2 Characteristics of health care systems--administration and financing (continued)

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Italy	Social Insurance (52%) and taxation. Mainly public providers	National Health Fund give funds to Local health Offices (USLs) Decentralised management. USLs contract with providers, and administer 75% of Public Hospitals (comprising 57% of beds in public hospitals). In total, Public Hospitals represent 60% of accredited hospitals, and 81% of the beds. The management of structures is delegated to the local level, which is in turn charged with guaranteeing services provided for the population.	National Health Fund is financed by: a) general revenues (38.6%); b) regional taxes on manufacturing; c) payroll taxes, (52.7%); and; d) through regional participation via special legislation and through revenues from the health care industry. Private health sector financed by direct payment and reimbursement. USLs pay for services by physicians registered with them. Responsibility for expenditures is shared by the Region, the USL Directorate and the Hospital Agency Directorate.	Overall financing determined at national level, then re-distributed to the Regions on a per capita basis, adjusted for needs. Distribution now matches characteristics of the resident population (e.g., frequency of health consumption by age & gender, mortality rates, and local epidemiological indicators)	National Health Plan provides functional co-ordination of all assistance services for each sector, National health plan defining framework projects-- "progetti obietto."
Japan	Social insurance with mixed public and private providers	Ministry of Health & Welfare provides overall goals & guidance on health affairs. Public health care centres run by prefectures and some municipalities	56% Insurance contributions, 25% government subsidies, 7% local government, 12% copays. Government subsidies vary by plan	Varies depending on schemes. e.g., 50% subsidy for NIH, 13% for government-sponsored EHI, etc. (1994)	
Korea	Social insurance with mainly private providers	373 health insurance funds which are composed of 227 regional funds (for the self-employed), 145 occupational funds (for employees) and 1 civil servants and private school teachers' fund. The Ministry of Health and Welfare oversees the management of these funds.	Financed by compulsory insurance Employees: 3% (1.5% employee; 1.5% employer; no ceiling on income level Civil servants and teachers: 3.8% (1.65% employee, 1.65% government; no ceiling Self-employed: premiums according to income, property and family size Risk Sharing among the 373 funds.	A government subsidy exists only for regional funds. In 1996 a subsidy covered total administrative costs and 26.3% of total benefits. A subsidy is allocated according to the average income level and old-age dependency ratio of individual funds.	
Luxembourg	Social insurance with mixed public and private providers	9 sickness funds organised around professional links.	Premiums = 5% of salary; capped. State funds certain benefits; subsidises pension fund and poor health insurance	40% of total health insurance financing. State gives 10% to currently employed; 25% to pensioners.	
Mexico	Parallel system of either Social insurance or taxation with mixed public and private providers	Several vertical systems in place. Ministry of Health (SSA) is generally the public assistance system (tax-funded health care institutions) and the Social Security Institute (IMSS); ISSTE, and PMEX insurance systems.	Ministry of Health provides services to 31% of population & funded through taxes & user charges. IMSS ISSSTE and PMEX funded through compulsory contributions. Some private voluntary insurance.		

Table 7.2 Characteristics of health care systems--administration and financing (continued)

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Nether-lands	Compulsory Social Insurance with mainly private providers	Insurers negotiate with providers re: provision of care & rates. Minimal level of care guaranteed by law. Government sets quality standards; ensures access, and controls costs.	85% compulsory income; paid by government to insurers. 15% flat rate, paid by subscribers to insurers.	Central fund pays risk-related premiums to insurers based on the individual	
New Zealand	Taxation with mainly public providers	In 1994, Ministry of Health: overall strategic & health policy; funding management, information services. Regulates service providers: (Crown Health Enterprises (CHE); community trusts; vol. private. providers). Regional Health authorities (4) purchase from service providers.	Government principle funder of health care. Gives funds to regional health authorities, who contract with service providers. Get funds based on contract with the Ministry of Health.		
Norway	Taxation with mainly public providers	Ministry of Health & Social affairs authorises county health services plans. Municipalities (439) provide primary care services-- GPs, nursing, physical therapy (PT) environmental health, mental health & nursing homes. Counties (10) administer hospitals. (5 regions in each, with hospitals.)	Tax-based, funded by local taxes, state grants, social security contributions and user charges. In 1997, 35% financed by county & 55% financed by State, 10% user charges. National Insurance Scheme pays part of costs for MDs, Physical Therapists; county & municipality pays rest. Counties fund institutional care and home care services hospital services (fixed budgets or DRGs) National Insurance scheme pays counties & municipalities for primary care.	Block grants distributed to counties based on number of inhabitants, age distribution, mortality rates, etc.	School-based clinics & child health centres co-operate with social security services, childhood welfare services, educational/psychological services, school staff, clubs, police, etc.
Poland	Taxation with mainly public providers, moving towards social insurance by 1999	Ministry of Health and Social Welfare formulates health policies, monitors Public Health; administers health programmes; directs clinical research. Other ministries (Ministry of Defence, Transport & Marine Economy, and Ministry of Industry & Commerce) have parallel health duties. Voivoships (49) provide regional planning & oversee 400 ZOZs (health & social care centres.)	Funded by taxes at State level. MOH funds drugs, clinical hospitals & national sanitoria. Some public health programmes. Voidvoships funded directly by Finance Ministry, co-ordinated by MHSW. ZOZ's get funds from voivoships. 10% private system.	Funds distributed to voivoships based on their population makeup	"Family Policy Programme" contains strategic objectives that co-ordinate community, social and school services.
Portugal	Taxation with mainly public providers; moving towards social insurance	5 regions to administer system, develop maximum & minimum charges. Will administer local health centres & co-ordinate with hospital services. Public services may be managed by private companies under contract.	Region's health services financed by taxation; incentives to move towards private insurance with premiums subsidised by the government. Private insurance = tax deduction		

Table 7.2 Characteristics of health care systems--administration and financing (continued)

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Slovak Republic	Social insurance with mixed public and private providers	Government provides overall regulation of providers and system. Health Insurance fund negotiates with providers.	13.7% contribution of which 3.7% paid by employee; 10% by employer. Slovak government pays insurance premiums on behalf of civil servants, children, and retirees.		
Spain	Taxation with mainly public providers	17 regional health services within a national system (Instuto Nacional de la Salud). Health Council co-ordinates policy & planning between regions. Created primary health care teams for treatment	Compulsory social security taxes ("insurance premiums") with a fixed contribution rate. Federal subsidies financed by taxes take up slack. Nursing homes funded by another branch of social security.	Subsidies to INSALUD hospitals	
Sweden	Taxation with mainly public providers	23 county councils and three municipalities (outside county councils) **Required** responsibility for inpatient, outpatient, dental, and drugs. Environmental health & Mental Health at Municipality level (290 altogether). National government monitors overall objectives & efficiency. 6 regions for hospital care & co-ordination.	County councils (etc.) collect taxes (70%). Fed government grants: 19%.	National government grants of two types: 1) formula-based grants, and 2) reimbursement for certain services (like dental care.)	Co-ordinated at National level -- "all ministers have a say in Government policy." National Public Health Institute co-ordinates promotion of health child & youth development.
Switzerland	Compulsory insurance with mainly private providers	Confederation responsible for health insurance, fighting communicable diseases, medical license exams, and protection against radiation, environmental toxins, and food safety. Cantons: health services; preventive care; public health regulations. Negotiations between insurance companies and providers to fix payment rates. Communes: elderly, social assistance, home care	Compulsory insurance. Health insurance funded through contributions of insuree. Confederation distributes subsidies to cantons to offset cost of premiums and cost sharing for low income people.. Cantons must add a minimum contribution for this purpose.	Subsidies given to cantonsto encourage premium reductions for low income people, based on population, the financial capacity of the canton, and the premium rate in each canton.	Inter-cantonal co-operation. Difficult to co-ordinate because health policy done at cantonal level..

Table 7.2 Characteristics of health care systems--administration and financing (continued)

Country	Dominant Financing System	Administration of System	Financing System	Federal Subsidies -- How is it distributed? (Formula-based?)	Involvement of other sectors
Turkey	No dominant source of finance; mixed public and private providers.	The scheme for employees (SSK) insures health care services in their own hospitals. National hospitals are connected to the Ministry of Health. There are other hospitals connected to the Ministry of Defence, universities, municipalities and private organisations. National hospitals are at the level of prefectures, health centres are at the level of villages.	About 4% of Federal budget: 45% taxation, 20% premiums; 35% out of pocket (1997) • Funding of hospitals connected to the Ministries of Health and Defence: from the national budget • Hospitals of the scheme for employees: by the Social Insurance Institution • University hospitals: autonomous budget of the university • Municipal hospital: budget of the municipality	All Ministry of Health hospitals are subsidised up to the amount of 60 % of actual costs.	Co-ordinated through opinions & discussions on policies prior to implementation. Intersectoral co-ordination bodies co-ordinate policies between departments.
United Kingdom	Taxation with mainly public providers	Administered by the National Health Services (NHS). Regional health authorities administer and fund family health service authorities and provide funds to District health authorities, who fund hospitals. GPs may negotiate directly with hospitals.	NHS Financed by general taxation. There is a small private sector.	Money allotted separately for family health services (demand led) and hospital and community health services (cash-limited, based on size, demographic composition, morbidity, mortality, and deprivation.) The 1997 reforms envisage that all GP's and primary care will mostly become budget holders for hospital services in groups covering a population of about 100,000.	New Minister for Public Health recognises public health impact of unemployment, poverty, poor housing, etc. Is working to co-ordinate cross-government policy.
United States	Voluntary insurance with mainly private providers	No centralised administration. Policies made at many levels of state, local, and national governments. Medicare policy made at Federal level.	Medicare: social insurance system. Medicaid & Children's Health Insurance Program funded by taxation, with a shared financial responsibility at Federal & State level. Private insurance funded by a variety of employer-employee contributions	Medicaid: Federal match based on per capita income in State, ranging from 50-83%. Children's Health Insurance Program: based on number of uninsured kids in State.	Education co-ordinates with HHS re: school based clinics & immunisations. Administration for Children and Families & Health Care Financing Administration co-ordinate on eligibility policy for Medicaid. Housing and Urban Development and Health and Human Services co-ordinate on grants for hospitals. Labour co-ordinates on coverage for workers leaving jobs.

Sources:

1. OECD (1992b) *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries,* Health Policy Studies No 2, Paris. (Belgium, France, Germany, Ireland, Netherlands, Spain, United Kingdom)
2. OECD (1994d) *The Reform of Health Care: A Comparative Analysis of Seventeen OECD Countries,* Health Policy Studies No 5, Paris. (Australia, Austria, Canada, Denmark, Finland, Greece, Iceland, Italy, Japan, Luxembourg, New Zealand, Norway, Portugal, Sweden, Switzerland, Turkey, United States)
3. OECD (1995) *Economic Survey: Mexico*
4. Filer, Randall K; Veprek, Jaromír, Výborná, Olga; et al. (1995), "Health Care Reform in the Czech Republic" *The Czech Republic and Economic Transition in Eastern Europe.* Svejnar, Jan, Ed. London, Academic Press, pp. 395-426
5. World Bank (1992), *Poland Health System Reform: Meeting the Challenge.* Human Resources Sector Operations Division.
6. World Bank (1995a), "Issues in Health Care Delivery: The Case of Korea." *An International Assessment of Health Care Financing: Lessons from Developing Countries.*
7. World Bank (1996) *Health Care Systems in Transition: Czech Republic* Regional Office for Europe, Copenhagen.
8. World Bank (1995b) *Hungary: Structural Reforms for Sustainable Growth. A World Bank Country Report.*
9. World Bank (1994b) *Slovakia: Restructuring for Recovery. A World Bank Country Report*
10. Caring World questionnaires

Box A: Characteristics of health finance/insurance systems

Types of Insurance arrangements

Private insurance systems cover individuals or groups, setting premia on the basis of their risk characteristics. They are flexible, providing a range of insurance packages with different degrees of risk. High-risk individuals may find it difficult to obtain cover. Only two countries (the United States and Switzerland) have private insurers covering major health-care risks for the bulk of the population (In Switzerland, however, health insurance coverage is compulsory for the entire population. This insurance covers a comprehensive range of health benefits. In addition, insurers are heavily regulated and required to provide community rather than individual risk rating) In most other countries private schemes can complement public schemes at the margin. In some, higher-income groups (Germany) or certain groups (civil servants in Spain) can opt for private insurance often at lower premia.[1] In other countries, supplementary insurance is available from private insurers or "friendly societies" to cover patient cost-sharing (user charges) in state schemes (e.g. France), for better physical surroundings (private rooms), for care as private patients of hospital specialists (e.g., the United Kingdom, Australia, Austria, Denmark and Ireland) or for risks not covered by state insurers (e.g., Canada and Australia). In many countries these premia are tax deductible.

The **social insurance** systems are based on statutory sickness funds most often governed by the social partners and overseen and tightly regulated by the government. Risks are pooled in the fund and premia are income-related over some range. Premia sometimes vary across funds to allow for differences in risk structure of the membership; in some cases, these premium differences are offset by government support or transfers from their funds. Membership is compulsory for certain groups (e.g., those with lower incomes) and in some cases cover virtually the whole population. There are generally numerous funds organised on corporatist (e.g., blue or white collar), industry, religious or geographical lines (Japan, Germany, France, Austria, Belgium, Luxembourg and the Netherlands).

There are two types of **tax finance**. In the first, the state insures and supplies health care in the same organisation and finances it as part of the budget. However, responsibility of production/provision is often delegated to lower levels of government (Italy, the United Kingdom (until recent reforms), Denmark, Finland, Greece, New Zealand (Until recent reforms), Norway, Spain, and Sweden.] Alternatively, in some countries (Canada[2] and, to a lesser degree, Australia) the government acts as a single insurer raising the necessary revenue through the tax system and paying largely private (mainly non-profit) suppliers.[3]

1. In Germany, one-quarter has the option of taking out private insurance which can, in certain cases, be cheaper. However, those with higher risks, and with difficulty in getting low-cost private policies, take out insurance with the statutory sickness funds. Only about 8 per cent are privately insured.
2. In Canada the "single insurer" agency is on the provincial level, with Federal subsidies..
3. In Australia, the Federal government acts as a single insurer, but pays block grant subsidies to the state level to fund hospital care. This system differs from the other tax financed systems in that specific taxes are earmarked as insurance payments, rather than the system being financed out of the general tax fund. (Though the system makes up the difference out of the general fund between the revenue gathered from the public and the funds needed to run the system). In Canada the "single insurer" agency is on the provincial level, with Federal subsidies.

Source: OECD Health Policy Studies #7, (1995b), updated by Member country questionnaire, 1998

Table 7.3 Cost sharing policies in Member countries[1] (US dollars)

Country	General Practitioner	Specialist	Drugs	In-patient care	X-ray and pathology
Australia	For 25% of bills average of $5.	For 71% of bills average of $8.	Maximum $11 per prescription.	None.	Included in specialists' bills.
Austria	20% of the population pay 10% or 20%.	$2.50	$6	Same as doctors.	
Belgium	25% reduced to 10% for vulnerable groups.	Same as for GPs.	Flat rate plus 100/80/60/50% 0% for drugs on negative list.	$5-$6 per day, $2-$3 for vulnerable groups. Increased after 90 days.	
Canada	None.	None.	Discretion of Provinces.	None.	None.
Denmark	None except for under 3% of the population.		Flat rate plus: 50/70/100%	None.	None.
Finland	$17	$17	60% in excess of $8.	$22	None.
France	25%[3]	25%[3]	0%; 35%, 65% for "comfort" drugs and 100%.	$5-$6 per day plus 20% of total cost for first 30 days.	35%
Germany	None	None.	Charge of $3per medicine prescribed (many exemptions).	$3 for the first 14 days (many exemptions).	
Greece	None	None.	0/10/25%	$15	--
Iceland[4]	$9	$17 plus 40% of the rest of the cost.	0, 12.5%, 25%	None.	$13
Ireland	None for Category I, (35% of population) Those in Category II pay for GP services[7]	As for GPs.	No charge for Category I; reimbursement for Category II of any cost over $21 per month	No charge for Category I Category II: $17 per day subject to a maximum of $166 in any 12 month period[9]	None for Category I.
Italy	None.	Maximum of $41	Free for Category I medication; 50% for Category II; $0 for both Categories I & II for exempted people; 100%. for Category III medication	None	Up to a maximum of $41
Japan	Employees, 20% of all costs; dependents, 30%, self-employed and their dependents 30%.		Outpatients in EHI and NHI pay copayments from zero yen for one drug prescribed to $0.85 for six or more drugs prescribed for internal use, and $0.40 (for one) to $1.20 (for three) drugs prescribed for external use.	Employees, 10% of all costs; dependents, 20%, self-employed and their dependents 30%.	Employees, 10% of all costs; dependents, 20%, self-employed and their dependents 30%.
Korea	"outpatient fees" as follows: 30% if seen in clinic, 40% if hospital; 55% if general hospital			20% of inpatient care ("hospitalization fees")	
Luxembourg	5%	5%	0% or 20%	Flat rate.	

Table 7.3 Cost sharing policies in Member countries[1] (US dollars) (continued)

Country	General Practitioner	Specialist	Drugs	In-patient care	X-ray and pathology
Netherlands	None for publicly covered patients. Private patients variable depending on policy.[5]	As for GPs.	Flat rate per drug with an annual ceiling of $67 per household (public insurance).	Flat rate.	
New Zealand	Extra billing.	Out-patients $3-$17.	$2-$8 with stop loss.	None.	Out-patients $3-$17.
Norway	$11	$16	25% if on blue ticket, maximum $43 per prescription.	None.	X-ray $11
Portugal		$91-$213	0/30/60/100%	$30	
Spain	None.	None.	0%, 40%. Pensioners and long-term ill largely exempt.[8]	None.	None.
Sweden[4]	$6-$19		First drug $15 then $1 each.	$8	--
Switzerland[6]	10%	10%	10%	10 SFR per day (about $7)	10%
Turkey	None.	None	10% retired; 20% active	None	None.
United Kingdom	None	None.	$4-$5 per prescription or free with a "season ticket" of $65. Many persons exempt.	None.	None.
United States[2]	20% in excess of the $100 deductible.		100%	$676 deductible first 60 days.	Same as doctors.

1. Approximate amounts in US dollars, converted at nominal exchange rates. Some changes arising from most recent reforms may not have been included for countries covered in OECD (1992 *b*).
2. Lower deductibles if in HMOs.
3. 25% of the agreed fee schedule (doctor conventionné) and more if there is overbilling. Co-payment may be less if covered by complementary insurance which normally covers part of the co-payment including the overbilling. Complementary insurance covers over 80% of the population. Vulnerable groups and long-term ill may have zero co-payment.
4. Maximum for the year in the charging scheme.
5. Whole population covered for chronic care. 70% of the population is compulsorily insured and 30% by private for acute care. Privately insured patients can choose the deductible and co-payment policy they wish.
6. Yearly deductible of SF 230 ($160) (1998). From 1986 higher deductibles can be chosen.
7. About 40% of the population has private health insurance that generally covers General Practitioner fees above a relatively high threshold, consultant/specialist fees above a certain threshold and private and semi-private accommodation. Tax reli ef at the marginal rate is available on unreimbursed medical expenses above a certain threshold.
8. Patients with chronic illness pay 10% up to maximum of 400 ($2.75) pesetas per prescription
9. Reflects an increase from the previous charge of $13 per day; in effect from 1 January 1998.

Sources: OECD, (1995) *Health Policy Studies no. 7, New Directions in Health Care Policy,* World Health Organization Regional Publications (1997) *European Health Care Reform: Analysis of Current Strategies* European Series, No. 72. Also updated by Member countries in March 1998

Table 7.4 Principal payment methods for health care services in 1997: main scheme

	Integrated	Contracted	Payment of first-contract doctor
Australia		Private hospitals, public hospitals, ambulatory care facilities, medical practitioners and other health care providers.	Fee-for-service (Referral) with extra billing
Austria		All Services	Fee-for-service (Referral) plus capitation
Belgium	Public hospitals	Specialists, GPs,	Fee-for-service
Canada		All Services	Fee-for-Service (Referral)
Czech			Salary for state employees, per episode payment
Denmark	Hospitals	GPs, specialists outside of hospitals, pharmacies	Fee-for-service or capitation (Referral [1])
Finland	Hospitals, health centres	Private hospitals, pharmacies, private outpatient care centres	Salary for doctors in municipalities (Referral) some capitation
France	Hospitals		Fee-for-service; salaries in health centres
Germany	Hospitals		Fee-for-service (Referral)
Greece	Doctors, dentists, hospitals	Private hospitals and pharmacies	Salary (Referral) or Fee-for-service
Hungary	GPs	Public hospitals, specialists	Capitation or salary (Referral)
Ireland	Public hospitals	pharmacies, private hospitals, private beds in public hospitals	Group 1: Capitated Group 2: Fee-for-service
Iceland	Hospitals, health centres	Private doctors, private hospitals, pharmacies	Salary plus fees, private doctors on fee-for-service
Italy	Public hospitals and specialists	Private hospitals, GPs and private specialists	Capitation (Referral)
Japan		All services	Fee-for-service; per episode payment
Korea			(Referral) Fee-for-service, salary for hospital doctors.
Luxembourg		All services	Fee-for-service; access to specialist limited by overall number of visits.
Mexico			
New Zealand		GPs, pharmacies, some non-profit rest homes and hospitals	Fee-for-service (Referral) with extra billing
Norway	GPs	Some GPs, some specialists, (private only) dentists, midwives, physiotherapists	Salary for doctors in municipalities, Fee-for-service, user charges- (Referral)
Poland	Hospitals		Salary
Portugal	GPs, some specialists, public hospitals	Private hospitals, some doctors in rural areas, pharmacies, labs for X-ray and pathology	Salary (Referral)
Slovak		Hospitals	
Spain			Salary; capitation (age-differentiated fee) (Referral)
Sweden	Hospitals		Salary (Referral)
Switzerland		All services	Fee-for-service (lower premium if agree to referral)
Turkey	All services (The scheme for employees (SSK): both the services and contracted (when necessary))	The scheme for the self-employed The scheme for national civil servants	Salary (Referral) No payments to the billing
United Kingdom		All services	Capitation, Fee-for-service
United States	GPs under HMOs	All services	Fee-for-service; Salary in HMOs (Referral in HMOs; PPOs)

1. Group 2 beneficiaries pay higher copays in return for not needing a referral.

Sources: OECD (Forthcoming), *Report on International Comparative Study of Factors of Health Care Expenditure Increases and Control in OECD Member Countries,* Paris; OECD (1994d); OECD (1992d), World Health Organization Regional Publications (1997)*European Health Care Reform: Analysis of Current Strategies* European Series, No. 72 Also updated by Member countries in March 1998

(Referral) Access to specialist services by referral

Table 7.5 Cost containment measures in Member countries

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Australia:	• Slowing increase in doctor numbers • Developing and implementing structural reform, particularly in the areas of general practice, pathology and diagnostic imaging • Penalties for cost shifting	• Reviewing schedule fees and increasing some charges. • Capping of pathology expenditures under Medicare benefits arrangement to predetermined amounts -- more systematic approach to pathology • A variety of limitations on Medicare coverage, such as limited access to Medicare for new practitioners; freeze on schedule fees,	• Pharmaceutical Benefits Scheme: Increased maximum patient contribution for general and concessional patients; no access to scheme for non-Australians; reassessment of pharmaceutical lists • A variety of limitations on Medicare coverage, including reduction in coverage of some benefits	• **Public Finance:** To encourage people to take out private health insurance, the Government has allowed more diversity in the insurance products on offer and has established rebates on premiums paid for private health insurance, and tax penalties on higher income earners who do not take out private insurance. • **Technology Evaluation:** Australian Health Technology Advisory Committee (AHTAC). **This year, assessment will be strengthened to ensure subsidies are only paid for effective technologies.** National planning system ensures effective distribution of resources
Austria	• Shifted hospital financing into Länder funds to have nation-wide planning of optimum capacity; service provision structure. (Länder defray increased hospital costs themselves.) • Resolve cross-border issues with Länder • Definition of access rules to individual health care facilities to relieve burden of hospital stay	• Previously, hospitals got a flat per-day payment and passive financing of hospital debts. Now, a DRG system. • Linkage of budget increases to overall economic development. • Restrictive contract policy: agreement with doctors' chamber that increases in honoraria & patient rates must not exceed, in sum, the increases in revenues of the social health insurance.		• **Technology Evaluation:** 1-1-97 plan defined by Federal Government and Länder contains location-related recommendations and a planning framework for the number of costly medical appliances & therapeutic equipment for hospitals & practising physician sector

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Belgium	• decreased acute care beds; shift to nursing homes	• Adjust daily hospital rates -- reimbursed in full & limited according to number of days utilised. • Flat rate for various services nursing care in residential nursing homes, outpatient hospital visits, lab tests & drugs for inpatients • controls on lab tests; pharmaceuticals, MRIs • Overall 1.5% limit on growth in health care expenditures	• Increasing means-tested contributions patients make to hospitalisation expense	• **Public Finance**: Strengthening role of Budget and Finance counsellor • Changing insurance resources by raising certain taxes
Canada	• Territories & provinces have implemented cost containment measures, using their "monopsonistic power." • Restructuring in the hospital sector: Merging hospitals; fewer hospitals & beds; changing acute care facilities to community-based care facilities; more outpatient services & outpatient surgery • Replacing institutional & other structures of governance and management with regional health structures • Introducing contractual services for non-medical care (janitorial; laundry)	• Limiting total & individual physician reimbursements & using alternative payment schemes (e.g., salary)	• Decrease insurance cover for "non medically necessary" services • Introduce or raising copays, fees for supplementary benefits	• **Public Finance:** New block grant funding in place until 2002-03 for health and social services consisting of tax transfers and a guaranteed cash component. • **Technology Evaluation:** Canadian Co-ordinating Office for Health Technology Assessment (CCOHTA) assesses the big ticket items, like expensive diagnostic equipment. Generally, regulated through provincial/territorial control.
Denmark		• On a regional level, the health care sector is run by a publicly integrated model where the personnel receives a fixed salary and there are budgetary restrictions. • More wide-spread use of DRGs for monitoring and evaluating health care		• **Technology Evaluation:** National Institute for Evaluation of Medical Technologies is established, under the responsibility of the National Board of Health

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Finland	• Total health expenditure was reduced during the economic recession in early 90s. • State subsidy system revised in 1993 to improve economy and efficiency in the system		• House holders' share of expenses rose from 16 to 22%	• **Public Finance:** State subsidies for municipalities cut yearly since 1992. in 1993 and 1994, municipalities cut their own budgets. • **Technology Evaluation:** Finnish Office for Health Care Technology Assessment (FinOHTA) founded in 1995. However, only deals with new technology.
France	• development of medical and professional benchmarks, and the good-practice recommendations associated with them • computerisation for all those working in medicine, and the introduction of a personal smartcard common to all insurance schemes and containing information on medical history; • establishment of national and regional health conferences • a new re-orientation and modernisation fund for doctors in private practice, to promote early retirement, for instance, and the installation of computers in surgeries • more closely co-ordinated health care via the introduction of experimental channels and networks, and the distribution of a carnet de santé (health record) to every patient; • obligation for doctors to undergo further medical training to improve medical practice	• development and strengthening of medical controls in the health insurance system; • introduction of targets for health insurance expenditure, broken down into individual sectoral targets (hospital care, ambulatory care, prescriptions) and geographical areas. When targets are not met, the profession must make up the difference.	• restrictions on the reimbursement of certain forms of medication;	• **Technology Evaluation:** Agence Nationale pour l'Accréditation et L'Evaluation en Santé (ANAES), instituted in 1997 during the last reform. Evaluated on whether their utilisation improves the quality of care and professional practice. Appraisal of medical treatment, services and supplies prior to their reimbursement by health insurance
Germany	• 1st and 2nd steps of health care reform act on the reorganisation of self-government boards and self-responsibility in statutory health insurance to establish a sound foundation for the performance and financing of social health insurance. • Structural contracts make the contracted general practitioner or network of contracted general practitioners and specialists (“networked practices”) selected by the insured responsible for ensuring the quality and economic efficiency of the medical provisions and performances prescribed by contract physicians. May also agree on budgets -- expenditure for drugs, bandages and cures and other health services initiated by the physician • The new Länder has been receiving annual subsidies to cope with increased financial demands of hospitals.	• Strengthening of the financial responsibility of the individual health insurance funds and of the self-responsibility of insured persons	• In 1996, a shortfall of 6.3 Billion Deutch marks, so copayments by patients increased to DM 5 • sanctioning mechanism introduced. Co-payments by insured rise if contribution rate to insurance fund increases. Insured may terminate insurance agreement if contribution rate increases and choose another	• **Technology Evaluation:** Second reorganisation act dealt with this -- allows pilot projects to test effectiveness.

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Greece	• New parameters have been introduced to ensure distribution of health funds to Regions better matches characteristics of the resident population (e.g., frequency of health consumption by age & gender, mortality rates, and local epidemiological indicators)	• **A new price list** for pharmaceuticals to take effect in Fall 1997. The pharmacists' profit margin is to be applied to a lower base, given by the ex-factory price plus the (reduced) wholesaler's margin. The overall cost reduction is expected to be 20%.	• Copays (25% on drugs) 1990; charge of 1,000 GRD levied on outpatient visits to public hospitals and of 5,000 GRD on inpatient admission.	• **Technology Evaluation:** New agency created under new law
Hungary	• Decrease superfluous hospital beds (by 10%)	• Restrict hospital capacity; • strengthen primary care (closing down & privatising hospitals, and shifting care to home care)		
Ireland	• Health Strategy contains a requirement on those providing services to take explicit responsibility for the achievement of agreed objectives and mechanisms to ensure accountability. • Specific accountability legislation -- to promote effectiveness; efficiency through expenditure control procedures in health boards. • The legislation requires all health boards to prepare and adhere to an annual service plan which is approved by the Minister in line with agreed levels of expenditure. • Nationally co-ordinated initiatives on materials management • a variety of value-for-money initiatives at health board level	• Indicative drug target saving schemes at GP and community level • Linking the allocation of base funding and new development funding more closely with activity, cost analysis and quality measures in acute hospitals and generally throughout the health care system		• **Technology Evaluation:** Expert advice on individual technologies, developing a policy

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Italy	• Structural reorganisation of the National Health Service in co-operation with the hospital network, and a re-prioritisation of hospital beds--to close beds with low occupancy rates. • Trend towards "day hospitals," in which patients go to the hospital during the day for treatment, but goes home at night. • "Hospitalisation at home." After hospitalisation, care may be continued in the patient's home, with continuation of professional care in conjunction with family care. • Rationalisation measures designed to share responsibility among actors in the National Health Service ntroduced to ensure appropriate use of health resources and respect for expenditure objectives by making new instruments avail. to regions	• Hospital payment: A system of payment per in-patient day (production factors) has been replaced by a system based on hospitalisation episodes (activities)	• Identification of three categories of medication, of which one is paid for by the National Health Service in full, one whose cost is only partly reimbursed, and one that is paid by the patient • Review of contribution rate to health expenditure and payment methods (including an increase in the proportion paid by the patients	• **Technology Evaluation:** Development of cachement areas -- PLANNING
Japan	• Reduce length of stay in inpatient settings	• Medical fee revision, April 1997	• **Revision of Employees Health insurance Law**: • Changes in the percentage of partial cost sharing by the insured person and in the amount of partial cost sharing by the recipients of the health care services for the elderly, • introduction of partial drug cost sharing by patients	• **Technology Evaluation:** Medical Technology System evaluates technology
Korea		• **Pilot program for DRG-based system** for 5 disease cases in several hospitals. The project will continue until 2000.		
Luxembourg	• Modernisation of hospitals; cutting the number of acute care beds • Introduction of a new method of financing insurance for maternal & child health	• **Introduction of a new system of financing hospitals.** (1992 law.)		

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Mexico	• Cost containment not urgent, but taking measures • Effective allocation formula to distribute funds equitably and efficiently to States • Working to avoid duplication	• Charges on drugs to promote use of generics	• Promote managed care & cost sharing for those who can afford it.	• **Technology Evaluation:** "Resources and Inputs for Health" programme covers planning, evaluation of the advancement of clinical knowledge, control of quality and prices, creation of an information system of new requirements & the modernisation of storage & distribution, rationalisation of acquisitions of medical equipment.
Netherlands		• Modified global budget system for hospitals has been introduced, and a non-binding target for health care expenditures has been set..	• Cost sharing on pharmaceuticals and dental care; and recent coinsurance on health insurance	• **Technology Evaluation:** Technologies limited to a few specialised hospitals for testing at first. After that, can be generally available, (but needs government approval for putting into hospitals,) or, stays in a few specialised hospitals if no general need for distribution.
Norway		• Counties control hospital expenditures, Government distributes block grants. **As of 1/7/97,** an activity-based component in the financing sector for hospitals.		• **Technology Evaluation:** Central Institute for Medical Technology Assessment
Poland	• Resource allocation formula between regional centres changed recently, providing for financing in accordance with demographic criteria and standardised index of deaths. • Also, money can now follow the patient outside his own medical zone, allowing of free flow of resources from one voivodeship to another • Decreased number of health care institutions in 1995 compared to 1989, due to budget cuts.			• **Public Finance:** Change of the financing system aiming at replacement of the health care system financed by the budget by an actuarial system.
Portugal			• Has new copays	• **Technology Evaluation:** Some type of evaluation through legislative process

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Spain	• Internationally recommended performance rates and quality standards are being applied and each year objectives are set in terms of the improvement of such rates and standards over prior years	• Royal Decree 164/97 -- reduce mark-up applied by wholesalers in pharmaceutical distribution • Article 169 of Act 13/96, use, in National health System, generic pharmaceutical products proven to be therapeutically equivalent to the reference preparation	• Royal Decree 83/93: Selection of medications on the basis of criteria of rationality and efficiency and reduction of medication costs for the system. • Royal Decree 63/95-- delineates benefits guaranteed to citizens by public system on basis of efficiency and rationality.	• **Improve Public Finance**: Profits from sales of pharmaceutical products to the National Health system revert back to it if wholly or partially financed by the system • **Technology Evaluation:** Technology Evaluation agency
Sweden	• Increased State grants to the county councils and municipalities from 1997 and onwards (State grants frozen at nominal levels for several years) • Responsibility for financing of pharmaceuticals transferred from health insurance to the county councils as of 1 January 1997. Advisory pharmaceutical committees have been established in all county councils.	• Special studies to be finalised this autumn. concerning the price mechanism and the distribution and marketing of pharmaceuticals. • Strict cost containment measures through global controls • County councils and municipalities forbidden by law to increase local tax charges	• Changed co-payment scheme - -patient must pay full cost of pharmaceuticals up to SEK 400, with a yearly ceiling of 1300 SEK.	• Technology Assessment board
Switzerland	• There is some hospital overcapacity has caused certain cantons to explore new solutions, such as: inter-cantonal collaboration, incentives for health providers to form themselves into networks, and a needs clause for technical infrastructure and the health treatment record card. • Hospital planning constitutes one of the main instruments of cost containment under Health Insurance Act. Cantons should determine both their needs in terms of hospital services and the capacity necessary to cover these needs.			• **Technology Evaluation:** Policies outlined for what will be reimbursed

Table 7.5 Cost containment measures in Member countries (continued)

Country	Encourage Efficient Use of Resources	Price & Volume controls	Redistribute Costs to Consumer	Improve Public Finance & Implementation of Technology Evaluation
Turkey	• According to Social Security Reform study realised in 1995, major concept is the separation of the financing from provision of services. It is expected to promote efficiency through cost-consciousness and control of expenses from the insurance point of view and promote quality by introducing competition in service provision • Give public hospitals autonomy to encourage efficient and effective management. • Payment for excessive use of insured medications for the purpose of reducing costs	• Introducing the effective functioning of a referral system	• Introduction of co-payment on drugs to control health care expenditure; from 20% in active labour market to 10% for retired.	
United Kingdom	• Annual target for efficiency gains	• No additional measures -- fixed budgets		• **Technology Evaluation:** Health Technology Assessment Programme. A cost-effectiveness criterion is to be applied systematically to all new technologies, in addition to the current criteria of safety, efficacy and quality.
United States	• 1998 budget contains $116 b in Medicare savings; $13 b in Medicaid savings. • In 1995, "Operation Restore Trust" was launched, to investigate the amount of fraud and abuse in the Federal health insurance programmes, Medicare and Medicaid This project has identified almost $188 million owed to the Federal government.	• 1993 budget contained cost saving for Medicare: lower limits on prices paid by Medicare to nursing homes and home health agencies, lower capital cost reimbursement to hospitals, and extensions of provisions in existing law in which Medicare recovers from private insurers amounts Medicare pays for individuals 65-70 who are working.		• **Technology Evaluation:** Evidence-based practice management practised by individual insurers.

Source: Responses to OECD Caring World Synthesis Questionnaire

Box B: Quality improvement initiatives in Member countries

Ireland

Ireland's Strategy for Health, launched by the Minister of Health in 1994, states that it is important to develop a framework in the management and organisational structures of the health care system by creating more accountability for the regional health boards and then to directly link this concept to better methods of performance management. Though this project is in the early stages, the eight regional health boards must assume responsibility for the delivery of services and for health status and outcomes in their respective areas based on recent legislation. The directors of each area must compile a comprehensive annual report on activity and health status in their region as well as propose for the coming year how to measure the effectiveness of upcoming services.

Australia

In Australia, a revised set of national goals, targets and strategies were proposed in the *Better Health Outcomes for Australians* report. The approach of the Health Outcomes Policy Section is to apply these goals and targets in an effort to improve health status by focusing on practices across the health continuum, from prevention and early intervention through to the development of best clinical practice. And, as outlined by the National Health Policy, these goals and targets in the future will be linked to health financing. If certain performance targets are achieved annually by the States and Territories, bonus funding would be available. Five performance targets, measuring efficiency in the system, have been set and will be monitored:

- the first and second targets are: admitted and non-admitted activity maintained at the levels of service that the states were providing prior to the introduction of the new bonus funding arrangements (targets for admitted patients: number of DRG weighted discharges; targets for non-admitted patients: occasions of service per 1000 population-weighted by age and sex);

- waiting times for elective surgery (no patient should wait longer than clinically appropriate for elective surgery);

- access to emergency departments based on classification of urgency; and

- quality of service measures (in development).

1995-1996 was the first year in which performance targets were agreed to and these levels will effectively become the baseline against which performance targets will be set in 1996. As of March 1997, reporting indicates that states and territories achieved the targets set for 1995-1996.

Other performance type indicators are being developed. In response to the 1994 Australian Health Ministers' Conference, the National Health Ministers' Benchmarking Working Group (NHMBWG) was established to develop a set of indicators and benchmarks designed to provide incentives for improved efficiency, effectiveness, and equity in the health sector. Performance indicators will measure key processes and outputs in health service delivery in the areas of efficiency, productivity, quality, and access in order to gain an understanding of the comparative performance of states, territories, regions, and institutions. The group is made up of State, Territory, Commonwealth government representatives and a representative of the Australian Institute of Health and Welfare.

The five quality-of-care indicators on acute hospital primarily relate to the clinical process of care and measure potential adverse outcomes of care:

- rate of unplanned patient readmission within 28 days;
- rate of unplanned return to operating room;
- rates of hospital-acquired infection;
- rate of post-operative wound infection.
- a measure of patient satisfaction.

For each indicator, definitions are presented as drafts that are ultimately waiting for reliability and validity testing. It was been noted that nationally consistent data would probably not emerge before the end of 1998.

United States

In the United States, many private and public purchasers, including the Health Care Financing Administration (HCFA) through Medicare, are requiring participating plans to report their performance using the HEDIS indicator set as well as to be accredited by the National Committee on Quality Assurance (NCQA) or they will not choose the plan to cover their employees. The movement towards developing these performance indicators in the United States has been driven by the purchasers who have joined forces in establishing large coalitions to put pressure on the providers and health plans. In some cases, employers are linking compensation or contract payments to the achievement of performance targets based on these indicators (such as the Pacific Business Group on Health, a West Coast purchasing coalition based in San Francisco). Additionally, in the 1992 authorisation of Preventive Health and Health Services Block Grant program, Congress linked funding of states to their establishments of data systems and databases needed to monitor Healthy People 2000 objectives.

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.6 Outcomes measurement initiatives in selected OECD member countries

Australia:	Outcome measurement is used in assessing the quantity of and quality of services provided and health status gains achieved, through the development of clinical indicators.
Austria	Stepping up quality management and quality assurance within health care facilities, and introducing external control mechanisms to guarantee minimum standards.
Belgium	Some measures implemented over last decade in hospital sector. Now, survey of entire population's health underway.
Canada	Health Services Research Fund to support research on improving evidence-based decision-making in health care, treatment, and prevention
Denmark	Municipalities "make activity plans" to ensure health professionals are doing their jobs
Finland	Only in some restricted areas - i.e., dental care for kids, and experimental & R&D purposes
France	Procedure of accreditation evaluates health outcomes
Hungary	Outcomes measurement used in the field of home care
Ireland	Output indicators in use. In the context of the legislative requirement on health boards to prepare and adhere to an agreed annual service plan, a joint Department of Health and Children / health board group is refining a service plan format which will progressively incorporate outcome measures and performance indicators which will be used for monitoring and evaluation purposes by the Department and the health agencies.
Italy	Ministry of Health has provided new instruments for determining quality and rationalising expenditures. Contain diagnostic and therapeutic protocols which doctors must take into account when prescribing medicine. Launching a national observatory for the prices of locally consumed goods and services to support expenditure management.
Japan	No real policy, though hospital regulations exist
Korea	Demonstration program to evaluate hospital services 1995: Health Service Reform Committee.
Mexico	There are 71 outcome measures that allow a better evaluation about the efficiency of the policies, especially re: health status outcomes.
Netherlands	Significant work undertaken in the measurement and monitoring of population health status through its reports on the *Public Health Status and Forecast* every four years. However, no national policy objectives formally established.
Norway	Norwegian foundation for Health Services Research is developing indicators of hospital outcomes (e.g., patient satisfaction, hospital re-admissions, in-hospital mortality, health related quality of life outcomes).
Poland	Working to get information so can set up system.
Portugal	No systematic outcomes measures
Spain	Royal Decree 63/95 on regulation of health benefits under National Health System -- delineates benefits guaranteed to citizens by public system on basis of efficiency and rationality. Standing tools are in place to measure the quantity of services provided. There are also standing qualitative indices, as well as other tools implemented from time to time.
Sweden	No national model. Different models are tried in different parts of the country.
Switzerland	Federal Office of Social Insurance is collaborating with insurers, health-care providers, cantons and representatives of the scientific community in carrying out scientific studies of the implementation and effects of the health insurance legislation.
United Kingdom	Monitor performance in relation to Health of the Nation. Measures of health outcomes are being developed to compare and monitor the performance of health authorities.
United States	HEDIS measures; Foundation for Accountability (FAACT) has developed a system of outcome measures which would be primarily used by businesses, but is being examined by Medicare and Medicaid for their use.

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.7 Recent competition measures in selected OECD countries

Australia	Competition amongst health insurance organisations, medical providers, and amongst private hospitals and ambulatory care clinics currently exists. **1995 reform** allowed exemptions to the ban on gap insurance, and enabled health insurance funds to selectively negotiate contracts with hospitals, ambulatory care clinics and medical practitioners. This will enable insurers to offer more services through "preferred provider" arrangements, and thereby attract consumers. Consumers are encouraged to adopt private insurance by Government contribution towards the cost of premiums or through a tax rebate for those in middle and lower income brackets, and through a tax penalty for those in higher income brackets who rely on public coverage..
Austria	Competition amongst providers in that free choice of provider exists.
Belgium	Free choice of providers exists. Future competition not planned because of concerns over impact on access.
Canada	No explicit Federal measures. Some Provinces may encourage competition.
Czech Republic	Free choice of providers.
Denmark	Health care services financed by taxes. Patients may choose any hospital in the country.
France	No explicit policy. Free choice of providers.
Germany	Patients may choose amongst different health insurance funds, which encourages competition amongst the funds. **In the first stage of the three-stage reorganisation act**, patients given the right to terminate insurance relationships if the fund raises the contribution rate.
Greece	Some competition between public and private, but no explicit policy. Private not covered by social security.
Ireland	**1994 Health Insurance Act & 1996 regulations** opened Irish private health insurance market to competition. Health insurers must provide community-rated health insurance; an open enrolment period, and a minimum benefit package. In addition, they must participate in a risk equalisation scheme to sustain the community-rated system. Preparations are underway for the drafting of a White Paper on private health insurance which will set out fundamental policy objectives regarding the role of private health insurance in the overall health care system, the regulation of the private health insurance market, and the corporate structure and status of the Voluntary Health Insurance Board.
Italy	Recent **National health system reform** introduced partial separation between the roles of providers and recipients at USL (local Health Units) level. Elements of competition introduced through the drawing up of identical technical, functional and qualitative criteria for all providers; a standard, voluntary system of delivery for public and private providers alike; a system for paying providers based on pre-determined rates per benefit and linking financing to the volume and typology of benefits effectively delivered; and liberalisation of access for the insuree to accredited public and private providers.
Japan	Free choice of providers. Individuals assigned to health insurance funds based on profession. However, patients may choose supplemental insurance, which is governed by market forces. Ministry of Health and Welfare **considering** a measure to introduce more competition in the pharmaceutical market, to control the price of drugs.
Korea	**The reform proposal** by the Health Care Reform Committee introduced a competition measure among 145 funds by allowing each firm to select its own insurer ("fund). However, the government is enforcing a unified system integrating all funds (373) into a single fund. 1995 Health Service Reform Committee **implementing** an evaluation program of hospital services. This evaluation program increases competition by publishing quality reports on hospital services, which will provide customers a means of choosing amongst them.
Luxembourg	**1992 law** on health and maternity insurance encouraged new negotiating procedures between the insurance scheme and health care providers.
Mexico	**Considering** promotion of Managed Care to introduce competition. **Developing** a regulatory framework and plan to promoting managed care through social insurance.

Table 7.7 Recent competition measures in selected OECD countries (continued)

Netherlands	Dekker reforms would have introduced regulated competition amongst insurers, but this reform was never fully implemented. Nonetheless, the present health policies continue the shift in decision-making power from the government to the consumers, insurance agencies and providers of care. **Health Care act of 1996** allows consumers to change sickness funds once a year. Switches may increase as funds start charging different premiums. **As of 1994,** Sickness Funds Insurance (ZFW) may selectively contract with self-employed physicians. (No longer MUST contract with ALL physicians.) **As of 1992**, private health insurers and sickness funds allowed to negotiate lower fees than maximum payment rates.
Poland	**Implementing** a system of contracts with both public and private health services, which is expected to lead to an increase in quality. (Moving from "taxation" system with global budgeting to "insurance" system.)
Portugal	**January 1993 law** promoted competition between private and public sector by allowing for public services to be managed or provided by other organisations (public or private) under contract. Government provides incentive to move to private health insurance by subsidising premiums through the national Health Service. These insurers promote competition through selectively contracting.
Sweden	In some municipalities in Sweden, there has been an organisational split between providers and purchasers of care. This has led to limited competition among providers. Long term care: traditionally administered privately, and funded through municipalities
Switzerland	**New Health Insurance Act (LAMal, 1996) introduced** elements of competition between health-care providers -- by a ban on cartel-type arrangements-- and between health insurers through the introduction of a legal obligation to take out insurance, the right of patients to change schemes freely (libre passage intégral), and the statutory definition of the benefits covered. Coverage of benefits not available have been privatised, allowing competition on these benefits.
Turkey	Some competition among private providers. **Proposed** comp between health care providers; service providers. Introduction of separation between purchasers & providers.
United Kingdom	Private Sector insurance companies compete. Free choice of GP. From 1991-1997, hospitals were encouraged to compete under short-term contracts with "purchasers." 1997 reforms encouraged a more co-operative approach with longer-term agreements between hospitals and "commissioners".
United States	Ongoing anti-trust policies to prevent insurance monopolies, regulated by Department of Justice. **Recent (1997 OBRA)** expansion in the definition of managed care organisations allows more of these organisations to provide care under Medicare, leading to competition for the elderly market. More horizontal and vertical integration among providers is decreasing competition. Therefore, **Department of Justice is currently** relaxing anti-trust guidelines for providers, to allow them to collaborate on practice guidelines and improve utilisation patterns in local markets

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.8 Measures to improve quality of health care delivery

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
Australia:	• Commonwealth & State Health and Community Services ministers are working to clarify and improve the current allocation of roles and responsibilities, to remove current duplication and gaps and services and to focus service delivery more directly on meeting people's health needs, rather than on the current set of programmes and providers. Working on trials of co-ordinated care for those with complex health problems.	• Hospital Accreditation focuses on outcomes and continuous improvement using a quality management approach • Development and implementation of clinical practice guidelines, to reduce inappropriate variations in clinical practice • Cochrane Collaboration -- identification and promotion of best practice in health care delivery • Development of incident monitoring and adverse event detection, to provide clinicians with performance information and help them to ID areas of risk • Quality use of medicines, fostered in Australia through the Pharmaceutical Health and Rational use of Medicines (PHARM) committee.	• Fixing "Queuing" problem: Rating systems based on clinical urgency for admission & incentives to hospitals to reduce their waiting lists. • Participation of consumers in the planning, delivery and evaluation of health service, along with the use of patient charters in public and private health services.
Austria	• Creating a comprehensive and effective health planning & control mechanism at the Federal level	• Structural commission working in quality assurance area • Active member of International network of Health Promoting Hospitals, and last year, Austrian network of Health Promoting Hospitals established. Yearly meetings re: Health promotion & quality assurance projects. • Pilot projects in 3 hospitals each are designed to jointly develop and implement strategies for resolving specific hospital problems.	
Belgium	• Framework law on social security has set up numerous collaboration methodologies	• Developing permanent structures for evaluating the quality of health care both among professionals (by peer reviews) and among competent authorities • Conducting a better needs assessment through data sent into the Institut d'Assurance Maladie Invalidité (INAMI) • Carrying out a "systematic evaluation of health care" at central authority level & in the field, to maintain quality of care in the future.	• One medical file per patient for better co-ordination

Table 7.8 Measures to improve quality of health care delivery (continued)

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
Canada	• Health Services Research Fund to support research on improving evidence-based decision-making in health care, treatment, and prevention • Tax credit to reduce need of health care services through provision of informal care • Planning & implementing information technologies & systems to improve health system administration & service delivery	• Health Transition Fund: to support provincial & territorial pilot projects -- innovative approaches to modernising health care systems. • Canadian Council on Health Services Accreditation • Inventory of Quality Initiatives • Clinical Practice guidelines • Licensing and regulatory bodies	
Denmark		• New tools at central level for evaluation of health care have been introduced	• Enlargement of capacity for treatment/operations to diminish queues
Finland	• Nation-wide strategy to get care out of hospitals and into residential care settings.	• Efforts to get quality assurance part of daily activities in health services. • 1995; National guidelines in health and social services •	• Major Research & Demonstration project at beginning of 1997, to determine means of empowering clients, clarifying the role of care, specialised care & social services
France	• Created regional financing agencies for financing public and private hospitalisation. Meant to correct geographic inequalities.	• Hospitals given financial incentives to increase quality • ANAES -- Agence Nationale d'Accréditation et d'Evaluation en Santé -- Charged with putting an accreditation program for health care establishment s& develop evaluation criteria	
Germany	• **3rd step of the health reform on July 1, 1997**. Reform underlines responsibility of the self-government boards of physicians and health insurance funds as well as the insured persons in terms of financing and performance.	• Found that cost containment only worked for a short time, so proposing reform whereby self-government funds police uneconomic processes and wasteful spending. 1) Strengthening self-government boards of health insurance funds and performance providers 2) Improvement of the financial basis of the statutory health insurance funds 3) Strengthening of the financial responsibility of the individual health insurance funds and of the self-responsibility of insured persons.	

Table 7.8 Measures to improve quality of health care delivery (continued)

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
Greece	• Co-ordination of activities such as health technology diffusion, the development of health facilities, and the creation of the Primary Care Networks by the various public agencies is effected through the Council for Co-ordinated Action in Health Services, set up as an advisory body in the Health Ministry. Council formed by heads of major social security funds, the National Health Council, the National Medical Association, major labour unions, and the Directors General of Health and Social Security.	• Quality Control and Assessment promoted under a **recent law** through the creation of the **Institute for Research and Quality Control in Health Services.** This new agency shows that assessment and economic evaluation are delegated as a central role for the first time. New budgeting and allocating procedures, and the introduction of professional management in hospitals are designed to promote efficiency in hospital care provided by the public sector.	
Hungary	• Restrictions on hospital capacity; strengthening of primary care • Along with maintaining dominance of the public financing, pluralisation and privatisation of the services (non-profit organisations)	• Readjust financing system to the quantity and quality of performed services • Development programmes in the framework of an application system.	• Quality assurance, strengthening the enforceability of patient's rights

Ireland	• Two of the three goals of the Health Strategy are
	  • To focus prevention, treatment and care services more on measurable improvements in health status and quality of life
	  • To provide for more decision-making and accountability in management and organisational structures at regional levels, allied to better methods of performance management
	• The Health (Amendment) (No. 3) Act defined more clearly the remit of a health board, imposing on it an obligation in carrying out its functions to:
	  • secure the most beneficial, effective and efficient use of resources;
	  • co-operate with voluntary organisations providing services in its area;
	  • co-operate and co-ordinate its activities with other health boards, local authorities and public bodies, and
	  • give due consideration to the policies and objectives of Ministers and of the Government.
	• Health boards are now focusing more on "care groups" rather than on programmes and structures.
		• The Health (Amendment) (No. 3) Act requires health boards to prepare and adhere to a service plan agreed with the Minister for Health and Children in line with a given financial allocation.
		• As part of a series of expenditure reviews required by Government, evaluations of the areas of mental handicap, the elderly and some aspects of acute hospital services are currently being undertaken. Intention to review all expenditure programmes over the next few years.
		• Work ongoing to incorporate outcome measures and performance indicators into service plan formats. Some initiatives in relation to clinical audit.
		• Initiatives in place to reduce waiting times for particular surgical procedures.
			• The third goals of the Health Strategy is:
			  • to develop a greater awareness of the right of the consumer to a service which responds to his or her needs in an equitable and quality-driven manner and greater recognition of the key role of those who provide the services and the importance of enabling them to do so to their full potential.
			• A Plan for Women's Health was published by the minister in 1996 after an extensive consultation process with women. A National Council for Women's Health (one of the recommendations of the Plan) was established in 1997 and advisory committees on women's health are currently being established in each health board.
			• An increasing number of consumer surveys are being conducted by health boards on a range of health service issues.

Table 7.8 Measures to improve quality of health care delivery (continued)

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
Italy	• Structural reorganisation of the National Health Service in co-operation with the hospital network, and a re-prioritisation of hospital beds • Responsibilities of partners have been better defined to guarantee uniform levels of care.	• USLs and suppliers shall negotiate annual provisional activities and financing plans at local level. Public and private providers must also adopt a system for checking and reviewing quality.-- must take quality into account in contracting. • Introducing quality indicators in individual care and hospital care, measuring the quality of individual service of care provided. Implementing the Charter of Health Services in all public health structures.	
Japan	• At present, there are two separate sectors for health care services, the welfare and the medical, and it is planned to reorganise to form a new comprehensive system to allow the elderly in need of long-term care to receive necessary health, medical and welfare services in a comprehensive and integrated manner from varied concerned entities under the new long-term care insurance system. • Policies for high-quality health service delivery include: Functional sharing and functional linkage among medical institutions.; appropriate bed capacity based on planned health care services;	• Review of the demand-supply relationship of medical professions such as physicians, dentists and their quality improvement.	• Provision of health care information.
Korea		• Evaluation of hospital services being **implemented** to increase quality of hospital services and improve the degree of satisfaction of patients. • Several policies for helping private health service institutes which initiate and perform quality control movement voluntarily are developing along with research programmes for the establishment of the better evaluation method.	
Mexico	• "Reform of Health Sector 2000" calls for improving health care system by extending coverage, improving efficiency and raising the quality standards -- promote technological & scientific advances. • Efficiency of programming hospital attendance • Better use of infrastructure	• Stimulate training of personnel • Ministry of Auditing & Administrative Development and the Ministry of Health established Health Result Measurements in 1996 • Most States have implemented quality assurance program: • promotion of adequate use of clinical files	• improvement of patient/provider relationships • Decrease length of Stay • 1996: national commission of Medical Arbitrage (CONAMED) to resolve conflicts between providers and patients.
Netherlands	• Freedom of choice of insurers has been introduced.		

Table 7.8 Measures to improve quality of health care delivery (continued)

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
Norway		• Norwegian Board of health has technical responsibility for health care services. Regional medical officers oversee medical services to ensure high quality services.	• Other quality measures include: • authorisation needed for health care personnel • Waiting list guarantee based on priorities on general criteria ensures most of the patients hospital diagnostics/treatment within 6 months • System for patient complaints at every hospital
Poland	• Increasing the role of the territorial self-government in the field of health care. Delegation of tasks to territorial self-governments, in particular in the field of basic health care gives an opportunity of better adjustment of its activities to local needs, improvement of quality of provided services and more efficient management of granted resources	• Health care services contracting (privatisation of outpatient health services): Contracting of basic health care services in non-public institutions and private GPs. Organisation of services provision is transferred to the private sector, a tender is being held for public funds, services are provided at lowest possible price, private capital is mobilised into investment in health care sector • Medical services registration aiming mainly at introduction to the system of spent public resources control, providing information necessary for the health care system management, and forming the basis of settlements. • Giving public health care institutions autonomy in order to improve these institutions. • Register of Medical Services (RUM) contains information on treatments for all citizens.	• Restructuring of hospitals. Average length of stay has been shortened • Citizens given books registering medical services, containing tickets replacing prescriptions, orders concerning medical examinations, sending to hospitals, etc.
Portugal	• Alpha project which is an initiative from the Regional Health Administration of Lisbon and Traga aims to centralise health care on citizen through role of GP and: improve access to health care services; offer continuity and total access to services within the health care; to develop primary health care; to improve both internal co-ordination and with the outside sector; to improve satisfaction of consumers; to improve satisfaction of practitioners; improve quality and efficiency of health care; and improve the utilisation of the financial resources.		

Table 7.8 Measures to improve quality of health care delivery (continued)

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
Spain		• Internationally recommended performance rates and quality standards are being applied and each year objectives are set in terms of the improvement of such rates and standards over prior levels.	
Sweden	• day care surgery has increased dramatically during the last years • Move towards concentration, where some hospitals mainly carry out planned surgery while acute surgery is concentrated to a few hospitals in each county council. • Mergers between hospitals • More care is provided in one's own home -- Assistant nurses and nurses supported by general practitioners in primary health care and other specialists.	• All health care providers must, by law, have a quality assurance program. Swedish national Board of Health and Welfare has responsibility for following-up, evaluating, and controlling quality of care.	
Switzerland		• Federal Health Insurance Act provides that the government may introduce systematic and scientific controls so as to guarantee the quality and appropriateness of benefits provided under the compulsory insurance scheme.	
Turkey	• Decentralisation of Public Hospitals, and increased autonomy • Restructuring of central Ministry of Health and Decentralisation of Provincial Health Directorates • Decentralisation of decision-making to the provincial administrators has taken place.	• Health Information Systems: All provincial Ministry of Health organisations and the Central MoH will be connected through local and Wide Area Networks. • National Health Academy established through new legislation, for policy and strategy development in the health sector	• Increase the quality and efficiency of health services by introducing the Family Physicians System into primary care. Patient will have right to choose the family physician • Introducing the effective functioning of a referral system
United Kingdom	• Internal market is being replaced with more collaborative arrangements. The main commissioner of hospital care will be primary care groups led by GPs or nurses, serving typically a population of 100,000. They will be supervised by Health Administrators playing a strategic role, including planning capacity. • Greater partnership between health and social care providers and other agencies will also be encouraged throughout the NHS and, where appropriate, will be developed through "health action zones"	• Performance management is now to focus on effectiveness through monitoring 6 "domains of performance", including health services outcome and quality. Responsiveness and fairness will be given greater weight. • Developing. clinical practice guidelines for monitoring the quality of care in both health authorities and hospitals. • Health Commissioners (primary care groups) charged with securing high quality health care within budgets.	• A commitment to end waiting times for cancer surgery and to increase elective surgery admission

Table 7.8 Measures to improve quality of health care delivery (continued)

Country	Efficiency and Co-ordination of Care	Quality of Service Delivery and Accountability	Patient Satisfaction
United States	• Allowing private sector to accredit nursing homes, home health agencies, and clinical laboratories.	• Agency for Health Care Policy and Research fund Evidence-Based Practice Centres to develop clinical performance measures and other tools to improve the quality of health care services. • Quality "report card' measures through HEDIS so employees can evaluate their health plan choices and achieve value in their purchasing decisions. • Medicare and Medicaid have developed modifications of HEDIS, based on populations they serve. • JCAHO and the national League for Nursing have been upgrading measures used to accredit private facilities	• President has appointed a health care quality commission to report to the Secretaries of HHS and Labour regarding the development of a consumer "bill of rights" and appropriate ways to measure health care quality and to disseminate information about quality to consumers.

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.9 Recent public health initiatives in Member countries

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Australia:	• National HIV/AIDS strategy; National Women's Health Policy Program; National Drug Strategy; National Mental Health Strategy; National Breast Screening Program; National Cervical Cancer Screening Program; National Cancer Control Initiative; National Diabetes Strategy. • Individual Public Health Measures: provides a framework for better co-ordination, integration, monitoring, review and reporting of all national public health strategies. • Department of health and family Services (DH&FS) is working closely with the Aboriginal and Torres Strait Islander Commission (ATSIC), community-controlled Aboriginal Health Services and their peak representative bodies as well as with State and Territory governments on several strategies to improve the health of indigenous people ($127 million) • National Health Priority Area process involving Commonwealth, State and Territory Governments. Providing a national approach to tackling five identified priority conditions: diabetes, cardiovascular disease, mental health, cancer and injury prevention. • National Public Health Partnership -- brings together the Commonwealth and State/Territory governments, the national health and Medical Research Council, and the Australian Institute of Health and Welfare to nationally co-ordinate action to improve and strengthen the public health effort and move towards an evidence-based approach to policy and practice	• The National Health Policy for Children and Young People -- to promote and maintain the health of children and young people • Immunise Australia -- The Seven Point Plan -- Seven initiatives to improve completed childhood immunisation rates.	
Austria	• "Health conscious" behaviour central health policy goal -- has gained prominence among GPs. • Specific Programmes & educational campaigns related to specific risk factors (smoking, addictions, or AIDS) are being targeted to specific environments -- kindergarten, school, and workplace, to reduce these risks.	• Mother & child health programme nationally; free check-ups for kids 6-18 years	• 12% total health spending preventive.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Belgium	• In Belgium, prevention takes place at the Communauté level. • In the French communauté, reorganising with a focus on prevention. Sets 5 year priorities for supervising & financing health education initiatives being developed • Re-examining maternal & prenatal care to make it more consistent • Developing a survey of the population's health. • Placing heavier restrictions on smoking & addiction -- by restricting advertising & cigarette taxes		
Canada	• Ongoing Public health promotion outlined in many documents, most recent being the (1994) Strategies for Population Health - Investing in the Health of Canadians, and Report on the Health of Canadians (1996). Strategies include: improving personal health practices; creating supportive environments in both living and working conditions; strengthening community action; developing public policies which take into account their health impacts; promoting public participation in decision-making; developing intersectoral action; developing structures and mechanisms to support evidence-based decision making; and supporting knowledge development through research. : (ongoing): Safer sexual behaviours, physical activity, healthy eating • Plans to renew and expand the Canadian Breast Cancer Initiate, Tobacco Demand Reduction Strategy. • National AIDS Strategy to be expanded an additional five years. • In 1997, release of the report of the National Forum on Health "Canada Health: Building on the Legacy." Recommends: a) preserving the health care system by doing things differently, b) transferring knowledge about health into action, and c) using better evidence to make decisions. • Federal cabinet approved a strategy to develop & test a population health approach at the Federal level. • Federal, provincial, & territorial government have worked together re: healthy child development, safety of the blood supply, surveillance & pharmaceuticals • Centres of excellence for women's health • Decreased tobacco use program	• Proposal for a National Children's agenda being developed by federal/provincial/territorial officials for the Ministerial Council on Social Policy Advisory Committee. This includes: 1. Community Action Program for Children -- (0-6 years) to deliver a continuum of integrated services to improve health and social development for at-risk children and their families 2. Community Mental Health/Child Development program (0-6 years)-- provides ongoing support to on-reserve First Nations & Inuit communities to develop community mental health programmes, with a strong child development component. 3. Strengthening Families -- To promote understanding and positive family communication through educational programmes and campaigns integrating such topics as early parenting skills, healthy growth and development, mental well being, prevention of injuries, and low birth weight 4. Parent Support Program. Inform and educate parents (of kids 0-18) and other primary caregivers on child development and to encourage the application of this knowledge in parenting 5. Parenting Skills Program • Prenatal nutrition initiative • Head Start program for aboriginal children; delivery of health services to same	• About 5% of total budget of total health expenditures. Responsibility of both the provincial & territorial governments, and the Federal government. • Can identify costs for individual programmes, but difficult to determine the full cost of preventive care and health promotion.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Czech Republic	• Emphasis on preventive programmes; public education concerning healthy ways of life.	• State-guaranteed regular prevention programme exists to promote health child development, including obligatory inoculation and educational programmes implemented in collaboration with the sectors of education and social care.	• Resources for implementation come from health insurance system, State budget (grants) and other sources. Individual companies and institutions fund too. Expenditures identified only in respect of health insurance, the State budget, and sources guaranteed by the State.
Denmark	• Free guidance on accident prevention, contraception, pregnancy & childbirth		
Finland	• 1986 Finnish Health for All strategy is underpinning of Finnish health policy, with a focus on equity, functional status of population, prevention, etc. • 1995: National Plan of Action for preventive social policy. Co-ordination between municipalities on this project. • **Main areas of preventive work:** health promotion, tobacco policy alcohol & drug policy, nutrition accident prevention, promotion of mental health & human relations, communicable diseases & occupational health. • Ministry of Social Affairs and Health has funded local-level projects to promote individual and community health cash benefits given to all women who undergo a medical examination before the 16th week of pregnancy	• Immunisations & health surveys carries out at school.	
France	• Ten goals were proposed in 1997. • In 1997, four themes were developed on the basis of these priorities: • Better prevention and health care for children, teenagers and young people; • Better cancer prevention, screening and care; • Fewer iatrogenic ailments and nosocomial infections; • Fewer intra- and interregional health inequalities. • These proposals are the subject of a government report to Parliament on health policy developments.		

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Germany		• Health insurance funds pay cost of regular examinations for timely detection of illness for all children up to 6 years of age. • 2nd reorganisation law will close gaps in preventive care in dental medicine for pregnant women and small children up to approx. 3 years of age. • In 3rd step of health reform, another screening exam for kids after age 11 added. Early screening for kids	
Greece	• General Directorship for Public Health created; • In 1994, Regionalisation of public health activities through the Regional Public Health Laboratories, supervised by the National Public Health Laboratory • national committee on Drug addiction set up two years ago, de-intoxication centre created for Methadone treatment.	• Created specialised Offices of School Health in each region	
Hungary	• Working to strengthen environmental health.	• Several public health and preventive programmes (the target group of which are mainly the young generations) has been given a high priority.	• Financed partly from regular health and education budget, but central government fund for preventive hygiene programmes.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Ireland	• Health Strategy -- Shaping a Healthier Future has three underlying principles: equity, quality of service, and accountability. Working to focus prevention, treatment and care services more on measurable improvements in health status and quality of life • National health Promotion Strategy published in 1995; a national Policy on Alcohol (1996); a Plan for Women's Health (1997); A National Cancer Strategy (1997); Cardiovascular Disease Strategy (1998) • Inter-Departmental National Drugs Strategy Team in place with co-ordinating teams at local level. • Work advanced to have the first phase of national breast cancer screening programme in place by end 1998; Cervical screening programme being piloted with the aim of introducing national programme in 2000. • Directors of Public Health appointed in health boards with responsibility for publishing regular reports on health status for their region; National Public health Report to be published soon • First version of Public Health Information System published in 1996 and second in 1997 with development ongoing; • National Disease Surveillance Unite to be established by the end of 1998 • Legislation in preparation for the establishment of a Food Safety Authority of Ireland • National Environmental health Action Plan to be completed by early 1999. • National Survey on Lifestyles recently commissioned.	• Department of Health retitled the Department of Health and Children. Minister of State at that Department has specific responsibility for children including a co-ordinating role in relation to the child care functions of other government departments such as Department of Education and Science and Department of Justice, Equality and Law Reform. • Improvements in the fostering service and additional accommodation and supports for out-of-home young people. • Strengthen reporting of child abuse • Health Education Initiatives aimed at children • 1996 implementation of a comprehensive Child Care Act, resulting in an improved legal framework for delivery of services to children. • National Priority Immunisation Programme has been agreed to	• Expenditure on community health and community protection programmes identified separately. Health promotion activities by health care workers not identified separately.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Italy	• **National Health Plan --** Oriented towards health promotion and disease prevention initiatives, targeting pathologies such as cardiac disease and malignant neoplasms, introducing evaluation systems and quality indicators. Specific projects to protect low income groups. Drew up strategies to deal with particular problems under progetti obbiettivo -- promotion of family planning, prevention and control of illnesses with genetic causes, the humanisation of health services with a view to caring for the psychological well-being of minors, better functioning emergency services, broad based and continuing care for chronic and disabling illnesses, and easier access to diagnostic and therapeutic services. • Promulgation of specifically targeted laws, (most recent cover smokers, heart transplant patient, the correct use of blood donations and disability) • Guidelines drawn up by expert committees (i.e., guidelines on cancer & combating AIDS) • Measures relating to user information , publicity and health education issues (e.g., food and self-medication) are also linked to health care.		• Can draw a distinction between expenditures allocated to preventive care and pertaining to a specific level of assistance, and expenditures pertaining to levels of assistance and relating to hospital care (i.e., acute care and long-stay, but can't determine expenditures on preventive care carried out in hospitals.
Japan	• Health services according to the Health and Medical Service Law for the Elderly • Addressing Second-Phase Measures for National Health Promotion	• Integrated health information management for children from babyhood through primary school age, to facilitate healthy child development • Public support offered for health check-up of women and infants and kids to help in early detection and treatment of abnormal conditions • Treat hepatitis B to prevent vertical transmission to infants.	• Health Service Bureau is responsible. for general health services, Health and Welfare Bureau for the Elderly, for elderly services; Children and Families Bureau (MCH), and Health Insurance Bureau. Expenditures for screening about 4.7% of national health expenditures.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Korea	• Control for High Risk Groups: Tuberculosis, leprosy, sexually transmitted diseases and AIDS, communicable disease, cancer, and mental disease • Control for Healthy People -- National Health Promotion Act: Focus on health education, improvements in nutrition, dental health, and health practice • Health Education: Production of health education materials, training of health workers, anti-smoking programmes, and parasitic disease control • Nutrition Improvement: National Nutrition survey, Advice on Nutrition, Lecture on Nutrition • Dental Health: Fluoridation program, education program • The Control for Frail People: Medical aid for disabled persons.	• Family Health: Maternal and Child Health and Family Planning Program	• national health Promotion Fund from parts of revenues from cigarette tax, the national medical insurance, budget of the Ministry of Health and Welfare, and cancer fund. • Can't identify curative and preventive.
Mexico	• PROGRESA programme focuses on promoting health, nutrition and education. (Started 9/1997). objective is to provide health care, education & nutritional supplements to kids 0-5 years. -- Breakfast at public schools; Legal aid to young children; Hoping to increase the public's health by expansion of coverage. • Reforma de Sector Salud 1995-2000. • Created an Under-secretary of Prevention & Disease Control		
Netherlands	• Have disease prevention & health promotion. Effective needle exchange program to decrease needle exchange amongst IV drug users. • Practice of controlling effects of drug use, rather than drugs themselves		
Norway	• In the Report on Public Health in Norway, (Chapter V), the following policies were listed: • 1995: Change in municipal health act to make it more effective in area of environmental health. Health authorities now have the authority to intervene if measures to control pollution are not handled in a way that satisfies health standards • health promotion is being emphasised in the current revision of the curricula for a number of relevant occupations. In 1996, proposal for the curriculum of an interdisciplinary continuing education programme in health promotion and disease prevention. • Working Environment act and the Directorate of Labour Inspection major force in preventing work-related accidents • Restrictions to protect people from passive tobacco smoke, with an emphasis on education and information. • Midwife services obligatory in municipalities since 1995	• Action Program of Children and Health 1995-99 has focus on objectives of health promotion and prevention, to stimulate co-operation amongst different disciplines • Guidance for Parents Program to strengthen role of parents as supporters of child's development. • Voluntary screening program for child development between 0-7 • Municipal Health Act legal basis for school health services. • National immunisation programmes. From 1997 onward, all lower secondary school students vaccinated against a particular type of meningitis	• Health promotion not specified separately in national budget. Many ministries involved in health promotion activities.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Poland	• National Health Programme just revised, (June 1996) with goals re: population status up to 2005. Supreme objective is the improvement of health status and related quality of life of the population by means of a life style change, creation of living and working environment which promote health conditions, limitation of differences in health status and health services access. Goals include: • Decrease of high mortality rate resulting from cardiovascular system diseases and atherosclerosis; decrease of mortality rate resulting from malignant neoplasms; decrease of infant mortality rate; decrease in frequency of injuries and intoxication occurrence and decrease of rate of mortality resulting from accident injuries and diseases; improvement of population psycho-social condition and decrease in mental aberrations frequency; decrease in frequency of diseases resulting from harmful conditions of life and work environment; significant decrease in frequency of certain infectious diseases occurrence; alleviation of disability effects, and dental condition improvement. • Programme revision took place in light a detailed analysis of activities being undertaken to implement, including: adjustment of activities to present living conditions, needs and health problems of the population; enlargement of a group of the national Health Programme participants and providers; Searching for more efficient forms of co-operation of the programme providers at different levels and principles of its monitoring and outcomes evaluation; taking into account new national and international experiences.	• Family Policy Program includes objectives such as: improvement of forms of care supplementing family care; improvement of alternative care of rejected children; guaranteeing children and youth access to higher education irrespective of financial conditions of the family; support for implementation of cultural function of the family; and improvement of a level of children and youth physical condition and culture.	• Overall health expenditures about 4.7% of GDP in 1994-95.
Portugal	• "Health in Portugal: A strategy for the turn of the century" has following dominant criteria: Dominant values of the country - recognition of the right to health care and the culture of solidarity; the improvement of the population state of health, producing “health gains” in detailed areas of priority action in terms of the health targets • Change focused on citizens -- better access to quality of health care; health management to promote a culture of solidarity in health administration & develop technical competencies; equity in access to health care, and quality of health care; mobilisation of required resources & effective utilisation; means of development and innovation, and the role of health performers -- dissemination of information amongst health care providers.	• 1993: National committee of Women and Child Health, has following objectives: • Definition of perinatal support hospitals and of perinatal differentiated support hospitals; satisfaction of the needs of human resources as well as the equipment of those hospitals; definition of the paediatric age up to 18 years old; guarantee of the health care continuity by the Health Units; and the application of a dental health programme in a considerable number of schools.	• Hospitals & Health Centres expenditures identified separately. “Other services” comprise 4.7% of budget.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Slovak Republic	• Developed a "Concept of the State Health Policy" identifies government tasks in area of primary prevention area, establishment of conditions for a high quality and generally accessible provision of health care; the implementation of National Health Support Program, implementation of health goals set in Conjunction with WHO initiatives: "Healthy towns, Healthy workplaces, Schools supporting Health. Recently created technical standard on drinking water. • Also, creating systematic measures of working conditions. Since 1994, activities in health promotion in place, including combating smoking and other addictions, healthy work, family planning, etc. Immunisation program in place.		• Protection of the health of the population cost 650 SK from the yearly health care budget.
Spain	• Health programmes formulated on a regular basis to maintain and improve public health levels. Such programmes address the special measures to be adopted both in preventive and curative medicine and in particular the efforts to be deployed to combat high risk agents like tobacco, AIDS or drug addiction.		• Can determine cost of education programmes, but not other programmes. E.g., same professionals who practice curative medicine also practice preventive measures, so not measurable.
Sweden	• A public health report is published every third year (latest May 1997) and presented to the Government for consideration and action. Parliamentary commission established to elaborate health targets. Will present in 2000. • At regional and local levels there are both political and technical bodies responsible for health promotion activities. • Swedish National Board of Health and Welfare responsible for Swedish Epidemiological Centre where health data is collected and analysed. • National Public Health Institute responsible for comprehensive health promoting activities with particular focus on alcohol, illegal drugs, tobacco and sexually transmitted diseases. • Special program carried out by NPHI to co-ordinate promotion of healthy child & youth development.		• Many agencies and authorities have health promotion responsibilities. Not specified separately

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
Switzerland	• As responsibility for public health lies with cantons mostly, the Federal state is only able to draft directives in areas where responsibility lies with the confederation. No body for the provision of health services and for planning for the country as a whole. But cantons are moving in the direction of adopting National Strategy of Health for All," as published by WHO. • Federal Government drawing up national strategies for promoting health and preventive care through Federal Office of Public Health in fields of AIDS, drugs, alcohol and tobacco, and the Swiss Foundation for Health Promotion in occupational health, young people's health, and cancer prevention.		• Cannot identify due to canton-Fed split
Turkey	• Refic Saydam national hygiene and Institute formed by new legislation. • Giving more priority to primary health care services through proposed health reform. • Increased tobacco taxes and improving immunisation rates.	• Extended: control of diarrhoea diseases program, control of acute upper respiratory infections program, promotion of mother breast feeding and baby friendly hospitals, iodine deficiency diseases program, • Extended immunisation program, phenelketenenuria screening program safe motherhood and neonatal care program	• General Directorate for Primary Care, General Directorate of Mother and Child Care and General Directorate of Curative Services of MoH have own budgets. "Other" expenditure category was 6.4% in 1995.
United Kingdom	• New Minister for Public Health, and new Public Health Policy • "Our Healthier Nation" policy to set quantifiable health outcome targets in four key areas: cancer, mental health, heart disease and stroke. • Major discussion papers on public health with a focus on health determinants and health inequalities. Supplemented by independent inquiry into causes of health inequalities and possible policy responses. • Focus on three settings for action: healthy schools; healthy workplaces; healthy neighbourhoods. • An independent food standards agency will also be established. • Government plans to introduce specific policies to reduce smoking, including a ban on advertising and sponsorship by tobacco companies.	• Handbook on Child and Adolescent Mental Health was jointly developed between the Department of Health, the Social Services Inspectorate and the Department for Education-- Echoed in the Children Services Planning Guidance and the Priorities and Planning Guidance for NHS. • Children Services Planning Guidance key mechanism to encourage better strategic planning and co-ordination between social services departments and others in the planning and publicising of services for children in need.	• Responsibilities for health promotion identified separately. Is the responsibility of numerous departments, including Department of the Environment and Transport, and the Health and Safety Executive.

Table 7.9 Recent public health initiatives in Member countries (continued)

Country	Population-based or cross-cutting Strategies	Strategies for children	Costs?
United States	• Healthy People 2000 set goals re: number of children immunised, span of healthy life, reducing health disparities among Americans, etc. • Centres for Disease Control and Prevention conduct programmes with States to improve the health of the population • Food and Drug Administration has a number of programmes to assure Americans won't be exposed to unsafe food or ineffective treatment and medical devices.	• Major initiatives to reduce infant mortality and increase immunisations rates. Ensuring access to health insurance for all children a priority. • Secretary of DHHS established a special National Youth Substance Abuse Prevention Initiative to educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco. • Early child development through the Head Start program • Increasing availability of good child care to support development of children from low-income families. • Expansion of Health Insurance to kids will help	• Each agency receives separate appropriations from Congress • Specific preventive coverage are being added to insurance policy coverage both public and private, such as immunisations, well-baby care, etc.

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.10 Recent equity policies in selected OECD Member countries

Australia:	• Expansion of primary health services to aborigines • Rural incentive programmes to ameliorate access to health care in rural and remote areas of country (1992)
Austria	• Encouraging burden relief measures for the most affected hospital sectors
Belgium	• Objectives of new social security law is to: • Extend right to improved health insurance interventions to other categories of entitlement holders • Broaden access to Health insurance scheme; make it more flexible • Adjust rules related to exemptions from taxation and social charges
Canada	• To reduce disparities in health between disadvantaged groups. Federal government implemented a pre-natal nutrition initiative for Aboriginal children and established centres of excellence for women's health,
Denmark	• To improve conditions of mentally ill, DDK 400 mill was allocated in 1997 to modernise psychiatric wards in the counties.
Finland	• Public Health Report outlined six strategy areas, the first of which is "promotion of equity in health"
France	• In 1997, one of the goals that will be presented to the Parliament in a Governmental report is to reduce inter-and extra-regional health inequalities
Germany	• Since 1/7/97, a standard co-payment limit of 2% of the annual gross income has been in force. Social protection of persons with chronic diseases was specially improved. For insured persons under permanent treatment for the same disease who have had to make co-payments to the protection limit for one year, the limit is reduced to 1% of gross income.
Greece	• Equity is a problem of geographic distribution of resources. A new program has been designed to provide emergency services to distant island communities.
Ireland	• 1994 Health Strategy has equity as one of three principles. Four Year Plan to implement the Strategy contains specific initiatives and targets to address the needs of the travelling community, the ill and dependent elderly, people with mental illness, and handicapped people. Recent allocations to the Health Boards have included additional funding for these key areas. • National Partnership agreement Partnership 2000 (negotiated between government and the Social Partners (representatives of employers, Trade Unions, farmers and voluntary / community groups) contains a number of health-related commitments aimed at reducing social exclusion
Italy	• Measures adopted in finance legislation (Law no. 662/96) are structural changes, designed to encourage synergy between the health and social sectors in safeguarding health and to broaden guaranteed access to exemptions on prescriptions for the poorest sections of the population. At the same time, the criteria for exempting health services users from payment of charges is being reviewed.. Aim is to weigh age criterion against earning capacity, plus weighting for poor and those suffering from illnesses with serious social repercussions.
Japan	• Ministry of Health and Welfare plans to gradually achieve, within the framework of comprehensive health care reforms sharing and closer linkages among medical institutions, the expansion of in-home health care activities, and the dissemination of the informed consent practice. • Efforts have been made to establish a new long-term care insurance system, which can be supported by the entire Japanese society: At present, there are two separate sectors for health care services, the welfare and the medical, and it is planned to reorganise to form a new comprehensive system to allow the elderly in need of long-term care to receive necessary health, medical and welfare services in a comprehensive and integrated manner from varied concerned entities under the new long-term care insurance system.
Korea	• Fostering medical institution in rural areas and expanding support for public medical institutions to address unbalanced distribution between urban and rural areas • Fostering and support for specialised hospitals for chronic disease • Expanding benefit coverage
Mexico	• Implementing following goals: • Extend coverage offered by the Social Security Institutions by creating mechanisms that allows people outside the labour force or inside formal economy to get coverage by SSI • Decentralisation of health services offered to the uninsured population in the States and promotion of efficiency in resource allocation • Extend coverage to the rural poor dispersed areas with no access to health care
Norway	• Better quality of care of patients suffering from psychiatric diseases is planned, both as a better structure of the care Organisation and as an increase of budgets • Health care services, both in primary and secondary health care systems, have been strengthened

Table 7.10 Recent equity policies in selected OECD Member countries (continued)

Poland	• "Health for all in 2000" has as a strategy to improve the population's psycho-social condition and decrease in frequency of mental aberrations
Portugal	• "Health in Portugal: a strategy for the turning of the century" has as a criteria: • the equity in the access to health care in health centres and in hospitals • Identifying the difficulties in the access, specially of those with a low income • Alpha Project experiment in the Regional Health Administration of Lisbon and Tarsus Valley "centralises health care on the citizen through the role of the GP," thereby improving quick access to the health care sector.
Spain	• A universalisation project for all citizens is currently under study, while measures are also being taken to fund such public care entirely with tax money
Switzerland	• New Health Insurance Act of 1996 created a compulsory insurance system, ensuring access to benefits under basic health insurance scheme. • The range of benefits covered by basic health insurance was expanded
Turkey	• Health Finance Reform: full coverage of the population without medical insurance by establishing a health financing institution • Service delivery reform: Introduction of Family Physicians Scheme and strengthening of Primary Health Services.
United Kingdom	• Major review of inequalities in health outcomes is currently underway. A key aim of new public health strategy is to improve health of worst off in society and to narrow the health gap.
United States	• Health Insurance Portability and Accountability Act increased rights of individuals to continue their health insurance while changing jobs. • New State Children's Health Insurance Program signed into law on 05/08/97. Total of $24 billion is allocated over FY 1998-2002 period to cover children either through Medicaid or other forms of insurance coverage.

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.11 Eligibility and coverage for health care in OECD Member countries

Country	Eligibility	Coverage
Australia	All residents entitled to free access to hospital care & subsidised medical care. Government subsidises pharmaceutical. care. Elderly & poor receive a "pensioners card," a "Health Care Card," or a "Commonwealth Seniors Card." Retain benefits after return to work. Private insurers cannot discriminate on the basis of age, health status, gender or sexuality in terms of the premiums they pay	HCCP: Community services & financial assistance to elderly. Everyone: Subsidised medical care; pharmaceuticals; free hospital. care. Some co-pays; mainly FFS. Free choice MD. Cardholders have minimal out-of-pocket expenses and cheaper drugs.
Austria	24 HI agencies. ASVG: most wage earners & salary earners. (80%) HI for civil servants; HI for farmers. People needing social protection & below a certain income exempted from many copays.	Each province must provide hospital facilities, nursing & medical treatment. ASVG: services w/o copays; low income patients don't pay for HI. HI for Civil: all services: 20% copay (waived for low income) Farmers: 20% copay; Self-employed: 20% copay; no pre pay.
Belgium	General health insurance scheme: Employees, civil servants, retired, handicapped & dependants (85% of pop) Scheme for self-employed: 15% of pop (Supplemental insurance avail) Centre Public d'Aide Sociale scheme covers poor, funded by local authorities.	Minor risk coverage: out-patient care; medicines, dental care. Major risk coverage: inpatient care; special technical services. General health insurance scheme & CPAS: Covers major and minor risks. Scheme for self-employed: Covers minor risks.
Canada	Provinces required by law to entitle 100% of residents for insured care. Provinces & territories give additional' coverage to people with limited income, disabled, and aged.	GPs as gatekeepers; refer to specialists. Basic benefit package required by law. Poor receive prescription drugs, dental & vision care, assistive equipment devices.
Czech Republic	18 insurance companies compete: GHIO (government owned) is default. Children, old age pensioners, people on maternity leave & social assistance, unemployed, convicts & soldiers make no contrib. for HC. (5.3% of pop).	Some issues of "cream skimming" since insurers get paid less for government subsidised insurance
Denmark	Choice of two schemes: Group 1, (96.4% of pop); Group 2	Group 1: Free GP, need referral for specialist. (Limited to one GP for a year.) Group 2: Free choice of GP; no referral necessary. Group 2 pays more. Outpatient drugs, dental services, physiotherapy are extra.
Finland	Every municipality must provide primary & specialised care for residents. Employers provide "occupational health" for employees. National Sickness insurance covers dental & drugs. Social welfare office will assist with user fees for lower income population	Primary care; hospital with referral. No choice of MD
France	Caisse national d'Assurance Maladie des Travailleurs Salariés (CNAMTS) covers 80% of insured & pensioners. 15 smaller funds cover self-employed & farmers. Fed government pays for health care for poor.	Ambulatory care, drugs, maternity care, dental care, medical goods and hospitalisation. Mutuelles cover ticket modérateur and some benefits. Sector 1 doctors charge negotiated fees & cost less. Sector 2 doctors charge their own fees & cost more.
Germany	85% of pop. covered by compulsory insurance. Kids up to 18 covered by the statutory health insurance without charge. -- (Must make over a certain amount to avoid it.) RVO fund (State insurance -- blue collar workers) =60% of pop; other = 28% (white collar). 10% private insurance Very low income exempt from copay through social assistance fund. **As of 1/7/97, Copays capped at 2% of income, catastrophic illness costs capped at 1% of income.**	Minimum benefit package required by law.
Greece	Three largest insurance funds: IKA: blue & white collar workers. OGA: rural population. (Funded by government through taxation.) TEVE: Small businesses. (All three: 80% of pop.) Governement (5%): Civil servants and military personnel. Indigent and unemployed covered by catastrophic insurance on a welfare basis. Copays capped at a specified percentage of income.	Various, according to scheme. All cover medical, hospital, pharmaceuticals. OGA, TEVE, don't cover dental. Most cover eye care.
Hungary	Those not covered by health insurance receive special coverage from government.	
Iceland	Health Centres provide PC; may be part of a hospital. People go to nearest health centre.	Health centres provide full range of Health services. User charges minimal. Specialist services provided, depending on Health centre. user fees for speciality care; emergent care. Fixed amount per year; lower for certain groups. Copays on drugs.

Table 7.11 Eligibility and coverage for health care in OECD Member countries (continued)

Country	Eligibility	Coverage
Ireland	Category I: Adults & their dependants who can't afford GP services without hardship (35% in 1997). -- Means tested. Category II & III (collapsed); all others. People qualify for Category I for a period of time after taking up employment. Only community-rated private health insurance may be sold, so the same premium is charged for a given level of cover regardless of age, sex, or health status. Persons paying pay-related social insurance receive assistance towards the cost of dental treatment.	Category I: Full range of health services free of charge. Category II: All services as above; mostly with minimal copays. Must pay full cost of GPs, dental care.
Italy	All residents. Universal coverage. Guaranteed access to health care in emergency in all clinics & hospitals. People below a certain income an/or meeting certain age criteria exempt from contributions.	Comprehensive, free choice of MD, even emergency room. 50% copay on prescriptions. Waiting lists for non-urgent hospital procedures.
Japan	EHI = employees; NHI = self-employed, retired, etc. Recipients of public assistance receive publicly funded medical aid, funded 3/4 by National Government and 1/4 by locals. Other than that, there is an individual system of health care for the elderly. For those 70 and older (65-69 if bedridden), are covered under a separate system, that is funded by beneficiary patients, contributions from the health insurance organisations and the public funds (provided from the national, prefectural and municipal governments)	Outpatient, inpatient drugs. Small copays. Overseas medical expenses. Fee-for-service with uniform fee schedule.
Korea	96.3% of the population covered by compulsory ins; 3.7% of the poor population selected through a means test administered by the government medicaid program, in which there are two types of benefits. One is free of charge, the other requires a 20% co-payment by patients for treatment. Government loans are also provided to medicaid patients which are funded 80% at the federal level; 20% local level.)	Not much variation in coverage. Mainly in-kind benefits. Duration of health care coverage: 270 days per year (no limit for the disabled and elderly). Expensive high tech procedures, special diets, bed fees for spacious rooms, and ad hoc service fees by specialists chosen by patient are excluded. Deductibles and co-payment for outpatient care from 20-50%.
Luxembourg	Depends on profession. Those entitled to RMG have their health insurance payment deducted from their RMG.	GP treatment, specialist, dental, drugs, etc.
Mexico	Workers are covered under compulsory insurance. (IMSS is scheme for workers, ISSSTE is scheme for civil servants, PEMEX is scheme for oil workers, or private insurance.) Those without health insurance are covered by the ministry of health, or the IMSS Solidaridad, both financed by Federal government. Those without insurance can "buy into" this system, or go to network of free clinics.	All insurance companies have at least a basic benefits package.
Netherlands	All may choose any insurers. Insurers required to offer a basic health plan. Minimum coinsurance of 200 Dutch Guilders per year on hospital services; may be means tested for poor and elderly. Poor and elderly covered under sickness insurance plan for health insurance.	Basic health insurance package covering both health and social services; more depending on the insurer.
New Zealand	Access to regional service providers. Lower health care charges for low income.	Heavy subsidies for "core health services." (e.g., mental health; immunisations). Some flat rate charges for drugs; Free inpatient care. User copays & user charges on outpatient. services. Poor and "high users" get "community services card" access to subsidised HC.
Norway	Health Services financed through compulsory membership in national Insurance Scheme. (Covers entire population). Social assistance is meant to be paid towards fees and medical expenses. Copays are low for outpatient care.	Individual gets expenditures refunded at fixed price (coverage of health expenses; not health services). Inpatient hospital care free. Fixed out of pocket expenses per year. Reimburse for "blue" drugs (necessary drugs -- funded at generic price). Voluntary free screening for kids 0-7 at mother & child health stations
Poland	Free health care & subsidised drugs for majority of population. People may apply for social assistance to cover medical costs. financed from State or local budgets.	Comprehensive care in theory offered by ZOZs, who refer people to specialists & secondary care. Variety of services & dental available. However, much regional variation.

Table 7.11 Eligibility and coverage for health care in OECD Member countries (continued)

Country	Eligibility	Coverage
Portugal	All are eligible; some have private insurance (Do civil servants & bank employees still have same scheme?) Flat rate user fees not applied to vulnerable groups.	Must choose provider within residential health centre. Under private insurance, free choice of provider means a higher premium. Referral to specialist for specialises services; nursing services. Means-tested copays.
Slovak Republic	State pays insurance contribution to health insurance companies for registered unemployed citizens not getting income support. Slovak government pays insurance premiums on behalf of civil servants, children, and retirees.	
Spain	Compulsory insurance makes INSALUD biggest insurer. Public employees may choose private insurance. Poor are covered under INSALUD subject to a means test. This is financed through taxes.	Comprehensive - GP, specialist, pharmaceutical (40% copay), hospital care, and dental extractions. INSALUD members see GPs at health centres. GPs are gatekeepers. Private insurance less restrictive but rare
Sweden	A system of health centres linked with hospitals within regions. Patients are seen at health centres or at hospitals. Ceiling on copays to avoid financial hardships. In some county councils, health care free for kids.	Comprehensive. Small fees for public health facilities, prescribed (generic) drugs, and visits to private doctors. Low amount of preventive care.
Switzerland	Patients may choose any insurance provider. Flat rate premium payments. Federal grants subsidise premiums for poor through annual grants to cantons. Cantons must also add subsidies to these premiums themselves.	Minimum guaranteed benefit package with yearly fixed deductibles. some drugs reimbursed. by all insurers. Near free hospital care; copays & deductibles for GP care. 10% copays phased in for both. Those on supplementary benefits qualify for reimbursement of MD, dentist, & pharmacy charges.
Turkey	SSK - social security organisation for private sector employees, blue collar workers. Bag-Kur - Insurance Scheme for self-employed. GERF - pension fund for Civil Servants; active Civil Servants covered by their organisations. "Green Card" for citizens with no capacity to pay for health services. Private health insurers. Free health services provided to elderly with no relatives & in need. Health insurance premiums paid by low income groups are adjusted according to their income.	Universal coverage is at the implementation stage with basic health package which includes primary and secondary health care services with copayments for drugs. Major draft laws have been made ready to submit to Parliament. Some variation in coverage depending on scheme (coverage of the population: 44.1% (for employees), 16.8% (for the self-employed), 16% (national civil servants), 1.5% (beneficiaries of social funds), etc: available hospitals are also different among the schemes): to the GERF pays only a certain amount of the cost of the hearing aids and wheelchairs whereas the Social Insurance Institution for the workers pays the full cost of these supplies.
United Kingdom	Whole population. Less choice of providers in rural areas. Private medical care available for those who wish to pay. Employers may provide private insurance (treated as taxable income) Also a private nursing home sector. Those on IS, income-based JS, FC, and DWA are exempt from prescription charges, receive free dental treatment, & vouchers for eye tests & glasses.	People can choose GPs, who act as gatekeepers. Flat rate low prescription charges. No charges for in or outpatient care. Private medical care on a fee-for-service basis. Residential & domiciliry care financed at local level.
United States	Medicare: people over 65; certain people with disabilities. Medicaid: poor who are **also** aged, blind, disabled, pregnant, or parents of dependent children. States determine eligibility, based on Fed. guidelines. KidCare: uninsured children above State MA eligibility. Access to care for others through public emergency rooms and Federally Qualified Health Centres.	Varies from State to state and program to program. Most States have broad coverage guidelines.

Sources:

1. OECD (1992b) *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries*, Health Policy Studies No 2, Paris.
2. OECD (1994d) *The Reform of Health Care: A Comparative Analysis of Seventeen OECD Countries*, Health Policy Studies No 5, Paris.
3. OECD (1995) *Economic Survey: Mexico*
4. Filer, Randall K; Veprek, Jaromír, Výborná, Olga; et al. (1995), "Health Care Reform in the Czech Republic" *The Czech Republic and Economic*
5. World Bank (1992), *Poland Health System Reform: Meeting the Challenge.* Human Resources Sector Operations Division.
6. World Bank (1995a), "Issues in Health Care Delivery: The Case of Korea." *An International Assessment of Health Care Financing: Lessons from Developing Countries*
7. World Bank (1996) *Health Care Systems in Transition: Czech Republic* Regional Office for Europe, Copenhagen.
8. World Bank (1995b) *Hungary: Structural Reforms for Sustainable Growth. A World Bank Country Report.*
9. World Bank (1994b) *Slovakia: Restructuring for Recovery. A World Bank Country Report*
10. Caring World questionnaires

Box C: Australia's healthy seniors initiative

In Australia, the Federal Government has committed $1.5 million funding over three years for the Healthy Seniors Initiative, to fund projects encouraging good health and well-being for older people. The Initiative will encourage innovative approaches to promoting, protecting and maintaining the health of older people by providing grants to projects which facilitate best practice and a sustainable infrastructure to achieve good health and well-being for older Australians.

One of the main objectives is to improve the opportunities for all older Australians to participate in activities which promote their good health and well-being. This will include projects targeted at removing the barriers which prevent some older Australians from participating in physical, recreational and community activity. Main themes are to:

- acknowledge the value, diversity and contribution of older Australians to our society;
- build partnerships between government, communities, and individuals/families to meet the needs and aspirations of Australians as they age; and
- look at ways to enhance the responsiveness of programmes and services in meeting the needs of older Australians.

The Healthy Seniors Initiative is one of the ways in which the Federal Government is targeting efforts to improve health protection , prevention and promotion for older people. The Initiative forms part of a national approach to maintaining the ongoing good health of older Australians.

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 7.12 Characteristics of health care systems--systems of provision for the elderly in selected Member countries

Country	Special provision for the elderly	Burden of distribution between elderly and young.
Australia:	Only place where elderly come into play is in funding for hospitals. Public hospital agreements under Medicare is indexed in accordance with population growth. The population is weighted by age and sex to account for different levels of hospital utilisation by different age/sex groups. The heaviest weightings are for males aged 75 and over, females aged 75 and over, males aged 65-75 and females aged 65-74 respectively. Females aged 15-49 have a heavier weighting than males because are of childbearing age.	Burden is shared by young to the extent that income redistribution by taxation occurs
Austria	No special provision.	Redistributive in that contribution is related to income
Belgium	No special provision. Copayments on health charges are paid by entire population, but are divided into categories based on financial resources.	
Canada	All residents are eligible for health care. Supplemental health services such as drugs and extended health care services (e.g., long term care and home care) provided by provinces and territories to targeted groups generally available on an ability-to-pay basis. Means testing and copays may be charged. Funding is a mixture of public and private sources.	
Czech Republic	All are covered under social insurance	
Denmark	No special provisions implemented.	
Finland	No special financing system for the elderly. Client fees and tax treatment same for all groups.	
Germany	Age, sex, and health risk of insured are no relevance to the amount of insurance contribution.	
Greece	Elderly contribute only to the extent that they pay taxes out of which the system is financed.	The current generation's contributions pay for the needs of the retirees. This is a serious problem as the ratio of workers to pensioners is declining. (Now at 2,4:1)
Hungary	No special provision in basic health care.	Health care services financed by insurance scheme are funded by the working population.
Ireland	All are entitled to services depending on their means.	Since Ireland health care system is funded mainly through taxation, the dependency ratio becomes important when there's an increased demand for services. However, age dependency ratio and economic dependency ratio are looking better. Ratio is expected to fall through 2006, then rise again, but it will still be lower than it has been previously.
Italy	No specific differentiation (Referral) regarding financing for the elderly, but experiments undertaken to weight the per capita share of national funds to the Regions , taking into account the age of the resident population in each of the Regions and needs indicators in the health sector.	Assuming an annual income of under 40 million lire, employees pay contributions of 1%, self-employed workers 6.6% and retirees 0.9% (with an 18 million lire disregard.) On an annual income of 40-150 million lire, employees pay 0.8%, self-employed workers 4.6% and retirees 0.4%.
Japan	There is an individual system of health care for the elderly. For those 70 and older (65-69 if bedridden), are covered under a separate system, that is funded by partial cost sharing by beneficiary patients, contributions from the health insurance organizations and the public funds (provided from the national, prefectural and municipal governments).	Tough to break out what proportion is funded by working rather than by elderly
Korea	Insurance duration is unlimited for the elderly over 65 years of age Reduced deductible at clinic for the elderly over 65 years of age	Risk-diversification among funds for the medical cost accrued from patients over 65 years of age.

Table 7.12 Characteristics of health care systems--systems of provision for the elderly

Country	Special provision for the elderly	Burden of distribution between elderly and young.
Mexico	Same benefits as rest of population. Uninsured get health care from Ministry of Health services, elderly entitled to pensions receive through social security, which is funded by working people	
Norway	No special funding for elderly, though user fees may vary depending on municipality.	
Poland	No special funding for elderly	
Portugal	Covered by Ministry of Health, but no specific "elderly" budget.	
Spain	Financed almost entirely by national tax funds, small part with fees paid by workers. The elderly do not contribute to health costs except to the extent that they are required to pay taxes which are used, among many other things, to finance health services.	
Switzerland	Funds for the aged are composed primarily of the old-age and survivors' insurance (AVS), along with occupational pensions (second pillar). These benefits are used to pay for health care costs that are not covered by health insurance. If the benefits offered are not sufficient to cover a beneficiary's individual needs, they have the right to and supplementary AVS benefits(means-tested benefits). These supplementary benefits are mostly used to cover the direct costs of care. When these benefits reach a certain ceiling, the person may have the right to complementary benefits through certain communes and cantons. Cantons and communes contribute to overall funding through funding for hospitals, old people's homes and home-care services.	Both health insurance and the old-age and survivors' (AVS) schemes contain elements of inter-generational mutual support. In health insurance, for example, the transfer from working population to retirees rose to 20% of total expenditures in 1994. 6.7% of the population use up 27.7% of all health service expenditures.
Turkey	Health care for elderly members of social insurance schemes financed by that scheme. Uninsured elderly are insured through three different arrangements: "Law on Granting Salaries for those Turkish Citizens Over the Age of 65 Who Are in Need, Having No Relatives and Weak and Unhealthy #2022, free health services provided. "Law on Social Services and Protection for Children #2828 and "Law on Social assistance and Solidarity #3294." In addition, the Green Card services covers health expenditures	Elderly in social insurance schemes do not pay health insurance premiums, so working members bear their costs
United Kingdom	All citizens contribute to the NHS through general taxation	Burden distributed through general tax burden

Table 7.12 Characteristics of health care systems--systems of provision for the elderly

Country	Special provision for the elderly	Burden of distribution between elderly and young.
United States	Health care for those 65 and older is primarily provided through Medicare program. Part A is mandatory hospital insurance, financed through mandatory payroll deductions. Employees and Employers: 1.45% each of payroll. Self-employed, 2.9%. Goes into a trust fund. Part B is supplementary hospital insurance, financed by beneficiaries (25% of funds) and government. Health care for elderly also financed through Private "Medigap Insurance" (supplemental coverage,) and State Medicaid programmes (13% of elderly), which pays for Part B premiums and cost-sharing requirements for both Part A and B for poor elderly.	About 47% of the health care costs for the elderly covered by Medicare. The rest are paid through Medicaid and private contributions (out-of-pocket costs, nursing home costs, MediGap insurance premiums). As Medicare is financed by working population, a concern that the working age population will be unable to support the elderly as time goes by.

Sources:

1. OECD (1992b) *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries,* Health Policy Studies No 2, Paris.
(Belgium, France, Germany, Ireland, Netherlands, Spain, United Kingdom)
2. OECD (1994d) *The Reform of Health Care: A Comparative Analysis of Seventeen OECD Countries,* Health Policy Studies No 5, Paris.
(Australia, Austria, Canada, Denmark, Finland, Greece, Iceland, Italy, Japan, Luxembourg, New Zealand, Norway, Portugal, Sweden, Switzerland, Turkey, United States)
3. OECD (1995) *Economic Survey: Mexico*
4. Filer, Randall K; Veprek, Jaromír, Výborná, Olga; et al. (1995), "Health Care Reform in the Czech Republic" *The Czech Republic and Economic Transition in Eastern Europe.* Svejnar, Jan, Ed. London, Academic Press, pp. 395-426
5. World Bank (1992), *Poland Health System Reform: Meeting the Challenge.* Human Resources Sector Operations Division.
6. World Bank (1995a), "Issues in Health Care Delivery: The Case of Korea." *An International Assessment of Health Care Financing: Lessons from Developing Countries.*
7. World Bank (1996) *Health Care Systems in Transition: Czech Republic* Regional Office for Europe, Copenhagen.
8. World Bank (1995b) *Hungary: Structural Reforms for Sustainable Growth. A World Bank Country Report.*
9. World Bank (1994b) *Slovakia: Restructuring for Recovery. A World Bank Country Report*
10. Caring World questionnaires

Table 8.1 Policy concerns in terms of long-term care

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Australia	Yes	Yes (Inefficient, outdated and inflexi-ble funding structures)	Yes	Yes	• Sustainability and targeting of services • Promoting infrastructure investment • Co-ordination of programmes • Means-testing and extension of needs-based planning mechanisms to community-based care	• Need-based planning → equitable distribution of services • Controlled access based on assessed need for care → making services available to those who are really in need • Government subsidies ensure access regardless of capacity to pay
Austria				Yes (ensuring autonomy and consumer choice by the long-term care benefit system)	• Establishment of the federal system of long-term care benefit Principles of the long-term care system (example) • Covers all types of physical, mental, sensorial or psychological disabilities • Seven-gradation system for different approaches to individual needs • The tax-free benefit irrespective of the beneficiaries income or age.	• Only part of the long-term care cost is subsidised by the federal budget, though the rest of the cost, to be paid out-of-pocket by the beneficiary, are supplemented by income-tested benefits.
Belgium	Yes				• Extending institutional cover for long-term health care by converting acute hospital beds into beds in nursing (and rest) homes. • Domiciliary care for people who no longer have any autonomy has also changed considerably in different ways in different Regions.	• Social welfare, including health care, is a right enjoyed by anyone (including the elderly) who is legally permitted to living. • The services are provided to the poor by local authorities, each of which has a Public Social Assistance Centre.

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/com munity care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Canada	Yes	Yes	Yes	Yes	• Determining the appropriate mix of public/ private financing • Access to a more integrated system • Attending to formal and informal care provider issues • Developing health information systems and integration of institution- and community based health services	• The elderly have confidence in the availability of long-term care services. • Waiting lists may exist; however, health status is considered in setting the priority.
Czech Republic					• The present system is essentially satisfactory.	• The capacity of social care institutions providing long-term care services is lower than the demand; there are waiting period for placement.
Denmark				Yes (consumer choice)	• Improved management of the general care scheme and more transparent allocation of funds → consumer choice and satisfaction • Some municipalities now restructure the implementation of the general care scheme and are introducing contracts with private companies to provide care for the elderly.	• Long-term care is one of the branches under the Social Assistance Act available to all the residents in the municipality. There are not plans to modify this principle
Finland	Yes	Yes		Yes (training personnel, client-oriented service provision)	• Increase and diversification of non-institutional services • Payment policy to support outpatient care (funds are available through many channels) • Use of aids and technology • Shift in the balance of the elderly care also demands staff training, esp. in gerontology and rehabilitation.	• The municipalities are responsible for organising the services for all people living permanently in the municipality. The client fees are income-related in long-term care.
France	Yes				• In the National Health Conference established in 1996, providing community care for the frail elderly who choose this option has been raised as one of the public health priorities.	

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Germany	Yes	Yes	Yes	Yes	• Where appropriate, the person in need of long-term care ceases at least partially to be dependent on social assistance due to the Long-term Care Insurance.	• Elderly people can finance long-term care services from their own income and the (property-independent) benefits from long-term care insurance, or social assistance finances it in case the benefit amount is not sufficient.
Greece	Yes (Open Care Centres , Home help programs to be developed further.)	Yes (high administra-tive cost in many institutions)	Yes (in en-couraging voluntary organisa-tions and families to be more active)	Yes (in encouraging community care)	• Increase of demand for institutional care → emphasis on regulating private initiatives and improving state-run institutions. • Reduction of current very large number of institutions through mergers to contain costs and raise quality	• Open care widely regarded as success. Quality of institutional care leaves much to be desired. • Gradual shift in emphasis from cash benefits to benefits in kind.
Hungary	Yes				• The role of the hospitals in services for elderly to be partly shifted to home care and institutional social care	• Fees for long-term care are adjusted to the income of the elderly, or made free of charge. (In those cases, the family members may be required to bear the cost or the fee may be charged to the legacy.)
Ireland	Yes	Yes	Yes	Yes	• Ensuring that they have access to best possible medical and long-term care when remaining in home is no longer possible • Strengthening the capacity of community, hospitals and residential services in order to support ill and dependent old people • The growth of older people, particularly those over 75 years old, add significance to the problem. • Every general hospital should have access to geriatric department. • It is to be ensured that the Nursing Home Legislation meets the areas of greatest need in relation to support of elderly people.	

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Italy	Yes	Yes	Yes	Yes	• Population ageing → more attention on health policies for the elderly. • Improved access by integration of services and specific analysis of the both of needs expressed at local level and existing supply. • Access to rehabilitation and long-stay beds in hospitals	• There is a geographical difference in providing care, thus posing problems for families. • Quantity of services is not satisfactory, as well as quality (in particular, that of private for-profit services). Expanding public supply for both institutional and home care services is important.
Japan	Yes	Yes	Yes	Yes	• Rapid increase in the number of the elderly in need of long-term care or are in frail condition • Prolonged period of care provision • Ageing and weakening capacity of family members who take care of the elderly • Integration of health services and social services for the elderly (esp. though establishment of public long-term care insurance scheme, whose related law passed the Diet in December 1997) • Development of infrastructure with the "New Gold Plan"	• Municipalities are committed to the systematic improvement of necessary infrastructure, for in-home care and institutional care • Local Health and Welfare Plan for the Elderly, established in each municipality and prefecture by 1993, supported by the New Gold Plan (national global plan for developing infrastructure for long-term care).
Korea					• How to respond to the increasing long-term care demand (quantitative aspect) is the current main policy concern.	• Quantity of the services are insufficient: many unmet needs of long-term care services.
Luxembourg	Yes	Yes			• Ageing → increase of the number of the elderly who needs long-term care * The issue is distinctive with those who are 65 or over • 2% of the total population needs long-term care, 80% of which are the elderly. • "Dependence insurance" (implemented in January 1998)	• Shortage of accommodation units for elderly dependent people (waiting lists, continued hospitalisation for medical reasons, seeking accommodation to foreign nations, etc.), though the level is considerably better than many countries. • Also, under the situation that home care is promoted, the shortage could be considered less of the problems.
Mexico					• Strengthening the financial resources of the elderly when they retire (→ pension reforms)	• Only those elderly eligible for pension are confident that their social security institutes will give this kind of care to them.

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Norway	Yes		Yes (to provide respite services to family caregivers)		• How to keep up with the needs of the increasing number of old people, especially the people of 80 years and older. * Respite care is considered to be a crucial measure to support family caregivers and enable the elderly to live in their home as long as possible. (Regularity and predictability of respite care is pursued as a goal.) • Expanding and improving care services for the elderly is planned by the Government's Plan of Action for the Elderly which was approved by the National Assembly in May 1997.	• There are significant differences between municipalities when it comes to capacity in long-term care. The Government's Plan of Action for the Elderly 1998-2001 has introduced a national level for coverage of long-term care and a plan for how to reach it countrywide.
Poland					• Access to institutional care (Since 1990, institutional care for the elderly has began to be build from the beginning.) • Social Assistance → to help individuals and families to overcome difficulties which can not be solved by their own capacity, to activate the beneficiary and encourage them to be integrated in the society.	• Development of institutional care by social assistance is insufficient. • Private service providers exit, but they are not available to low-income families due to their high prices.
Portugal	Yes	Yes	Yes	Yes	• Problem of financing heavy needs from "abedded elderly persons," etc., caused by progress of population/individual ageing, decrease of family capacity to attend the elderly, etc. • Improving life quality of persons, their social and community reintegration, personal improvements, etc.	

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Slovak Republic						• The social care services are provided without paying the costs or a full or partial payment of costs (determined based on the amount of the payment, the income and family and property relations of the citizen from whom the payment is required) For certain social care services, it is not possible to require the payment. • When the beneficiary entitles to the care services, it is an obligation of the state administration or relevant bodies to provide such care.
Spain	Yes			Yes	• Decentralisation • National Gerontological Plan, drawn up by the central government in order to develop a policy to cope with population ageing and to develop community care (along with institutional care) and adequacy of care, among other measures.	• The public assistance network has considerably expanded in recent years, ranging from institutional care to community care. • However, the services have not yet reached the level prescribed by the Plan, because there is still fairly long waiting periods.
Sweden		Yes (Organising and financing the care)		Yes (ensuring autonomy, security, privacy and consumer choice)	• Ädel Reform: shift of responsibilities to municipalities → clear lines of accountability and organisational structure	• Everyone who needs assistance is equally entitled to it, though a charge is made which is often related to the income of the individual. • Opinions may sometimes differ on the extent of the services. In that case, the individual is entitled to appeal the decision in the county administrative court.

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
Switzerland		Yes	Yes	Yes	Future goals: • Disability insurance: to keep its first role as an insurer and not to resolve social or health problems • Supplementary benefits: to make sure that the cantons fix a reasonable price framework for taking on the responsibility of those in institutions. • Supplementary benefits: to re-examine the consideration of the private means of the insured so they are not tempted to transfer assets • Assure that taxes favourably treat those insured who have already contributed a large number of resources	• The elderly have a confidence in the availability of long-term care services. • Health insurance: the effects of the readjustment of depedent care policies (in terms of insurance benefits and the cost of care) will be examined.
Turkey						• Only curative services are provided to the insured elderly when they have some kind of diseases. (Preventative and curative health services are covered by proposed health reforms.)
United Kingdom		Yes		Yes (Long-term Care Charter to define the standard of services)	• Affordability of long-term care is discussed in the Health Select Committee Inquiry. • Following the recent election, the new government intends to look in detail at the funding of long-term care for the elderly. (* Royal Commission on the Funding of Long-term Care for Elderly People was set up in December 1997)	• The elderly have a confidence in the availability of long-term care services.

Table 8.1 Policy concerns in terms of long-term care (continued)

Country	Develop-ment of home/ community care	Cost/ funding of long-term care	Support of informal care	Quality/ appropriate-ness of care	Others	General self-assessment of current long-term care policies
United States	Yes	Yes (High out-of pocket cost of services → private insurance becoming a concern)	Yes	Yes	• Access to and utilisation of services (over as well as underutilisation of services) • Public financing is told to be biased toward nursing home care • However, the Medicare home health benefit constitutes the major exception to the prevailing pattern of modest annual growth rates in expenditures for publicly-funded long-term care services and its increase has become a focal point of concern.	• Access to formal home and community-based services and long-term care services are considered problematic. • Although virtually all states make some public funding for home and community based care, such coverage is not necessarily provided as an "entitlement" and there exists waiting lists for the services. • Based on the 1989 National Long-Term Care Survey, about 2/3 of the elderly with functional disability living in the community rely exclusively on informal care. For the rest of 1/3, average weekly use is about 16 hours.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.2 Roles and responsibilities of the actors in the field of long-term care

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Australia	• Funding and purchasing of community care (shared with the State governments) • Funding and regulations for residential care	State governments • Funding and purchasing of community care (shared with the Commonwealth government), with some states also provide care. • Providing a small number of residential care services Local governments • Providing both residential and community care in some states (Funding roles are limited).	• Providing for the majority of subsidised community care. • About 2/3 of residential care places	• Providing for about half of nursing home places • Small proportion of hostels for the aged • A small but significant amount of community care (though the most part is not subsidised)	• Provides a small amount of residential care, mainly at the lower end of dependency, in board house type arrangements. • Under the new arrangements, the providers of the new services will have to be incorporated.	• No family members are legally required to provide care. • 75% of total community care are provided by family members and there is a community expectations for that.
Austria	• Long-term care benefit law is under the charge of the federal government.	Länder authorities • In case there are no relatives who has legal responsibility to care the elderly, the Länder is responsible for granting social service benefits. • If the income of the patient is not sufficient to pay the cost for the social services, the Länder may provide supplementary benefit. • Based on the agreement with federal government, the Länder authorities must, within three years, specify their needs in long-term care and develop plans to be implemented by 2010.			• About 80-85% of the long-term care benefit claimants receive home-based care by family members, neighbours, etc.	• Legal responsibility: spouse, children, or parents • About 80-85% of the long-term care benefit claimants receive home-based care by family members, neighbours, etc. (* 10% for nursing homes, 5-10% for exclusively social services)
Belgium	• Issues norms relating to institutions and care providers • The Department of Social Affairs manages the various aspects of social security	• The regions are responsible for the accreditation and harmonisation of institutions. • The communities have competence in respect of primary prevention and health education. • Public Social Assistance Centres are responsible for taking care of people who are economically dependent; they may provide institutional care as well as community care.	• Co-ordinated domiciliary care services • Many self-help associations (for specific diseases) which provides information services and act in the interest of the patients.	• In most cases, private insurance companies which covers the portion beyond the coverage of the compulsory insurance.	• Services by privately recruited providers are often nursing or other non-reimbursable ones.	• Legal responsibility to individuals who are deprived of capacity for psychiatric reasons: (1) spouses (2) children (3) more distant relatives, and so on. • The above order also applies to the scheme of guardianship. • Care voluntarily provided by family members often concentrates on the areas not covered by the health insurance.

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Canada	• Financial transfers • Federal legislation such as the Canada Health Act • Direct service delivery to aboriginal people, for example. • Health protection and regulatory process • Contributions to health information and health research nationally.	Provincial governments • Overall policy development, planning, financing, monitoring, and setting standards for delivery of health care • regulations for private residential care facilities. Municipalities • Greater responsibilities for health care delivery • In some provinces, municipalities have been given authority in terms of funding, setting standards, etc.	Primarily the delivery of services	Primarily the delivery of services	The delivery of services: regulated or unregulated by professional standards	• The federal *Criminal Code* provides a legal duty to provide" the necessaries of life" (esp. on married persons to their spouses) * In terms of the children and more distant relatives, the responsibility becomes less clear. • About 80% of the community care is provided by informal care givers. • There is a clear trend of considering family as primary care givers, backed up by public/private providers.
Czech Republic	• Provision of help services (care services in the home) * The share of the State as direct provider is gradually shrinking. • Provision of institutional care	• Provision of help services (are services in the home) * Along with the shrinking share of the state as direct provider, the role of local government is increasing. • Provision of institutional care	* Along with the shrinking share of the state as direct provider, the role of non-governmental organisations is increasing.			• The basis for the provision of social care is the family. (Where social assistance can not be provided by family, the necessary assistance is provided by the State, the community or the district authority.) • With some exceptions, the State authority may require financial participation from persons who are responsible for the dependent persons (spouse, children, etc.)
Denmark	• Due to the very decentralised administration, only few details are provided at national level. • Central government agencies do not exist apartfromthe social appeals board.	Municipalities • In charge of the long- term care scheme (Total number: 275) • If the person with legal responsibility to care is unable to do so, the responsibility is shifted to the municipality. * Even when contracted private companies provide services, the responsibility of the services is on the municipality in terms of taking decisions on entitlement to benefits,	• The municipalities may contract non-profit organisations to run nursing homes, etc., though the municipality keeps the overall responsibility for the services.	• Carries out long term care in some municipalities under the guidelines laid down by the municipality council. (In line with the restructuring of the scheme.)	• The role is considered to be minimal.	• Under the provisions of the Social Assistance Act, a person is responsible for providing for himself/herself, the spouse and any children younger than 18 years of age.

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Finland	• General guidelines for both non-institutional and institutional care • Council of State: approves a plan on municipal social welfare and health care services prepared by the Ministry of Social Affairs and Health • Studies and develops services for the elderly in co-operation with the Ministry and municipalities.	Local government • Monitoring and development of services in co-operation with municipalities. Local municipality • Local municipalities have legal responsibility for organising the necessary services. • According to the Constitution Act of Finland, everyone who is unable to procure the security required for a dignified life shall have the right to necessary subsistence and care. The public authorities shall secure, in the way stipulated in the law, for everyone adequate social welfare and health services and promote the health of the population.	• Supplement of municipalities • Many social welfare and health care organisations manly provides supportive and community services. • Their role in organising serves is also important.	• Municipalities buy some services relating to old people's homes, service housing as well as home services and auxiliary services from private enterprises.	• At the moment of marginal importance	• Family members have not legal responsibilities, though they have major importance. • It has been estimated that about two thirds of the volume of care is help provided by family members and other type of informal care. • The spouse's income is taken into account when defining the charge for care only in non-institutional care.
France	• The central government alone has the powers to set the legal framework for social policy in general. • The *Direction de l'Action Sociale* prepares and where appropriate manages or jointly handles policy relating to the elderly, among other things.	• The département, which is the second level of the local government, has become a significant actor , having powers under ordinary law relating to social assistance for the elderly and other service recipients.				

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Germany	• Long-term Care Insurance Act • No responsibilities in the context of home or institutional care itself.	Länder • Construction of infrastructure, etc. Local government • Responsibilities for the person who is in need of long-term care but is not ensuring care for himself/ herself , and would fall into a state of neglect if left alone. • Social assistance scheme: for the cost not covered by long-term care insurance. • Also responsible for constructing infrastructure Long-term Care Insurance Funds • They bear the costs and are responsible for the provision of care to their members.	• As owners of nursing homes contracted by the long-term care funds, non-profit organisations traditionally are the most important service provider in nursing care.	• May also enter into contracts with the long-term care funds and render nursing services provided that they meet the statutory requirements.	• Individuals can not enter into contract with long-term care funds for providing in-kind benefit, but this is rather left to discretion of the funds. • The person in need of care can individually hire carepersons, claiming cash benefits from the funds.	• There is no legally enforceable obligation of family members to provide nursing services; however, family members are still playing the major role in providing nursing care. (80% of the persons in need of long-term care have applied for the cash benefit.) • In exceptional cases, the social assistance scheme may bear the cost for hiring individual carepersons. • The property and income of the spouse as well as the children may be drawn upon for financing professional care if the own means of the person affected and the benefit of the long-term care insurance are not sufficient.
Greece	• Legislation and financing for home care services • Has been an option for direct provision and/or funding of the services when the family members are incapable of them.	• Implementation of services • Decentralisation→ shift of the role of care and funding borne by the state to municipal and prefectural bodies. • Open Care Centres are established and non-institutional care and home services are provided by it.	• Pioneered in this field • maintaining a crucial role in the state initiatives. • Welfare institutions have been an option for direct provision and/or funding of the services when the family members are incapable of them.			The family members in effect carry the major responsibility for the frail elderly.
Hungary		Role: 1st * In terms of the legal duty, it comes as 4th, after the more distant relatives.	Role: 2nd	Role: 4th	Role: 5th	Role: 3rd (They receive governmental support) * Legal duty: (1) spouse (if possible) (2) children (3) more distant relatives

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Ireland	• The Health (Nursing Homes) Act of 1990 specifies ensuring standard of services, etc.	• The health boards provides institutional care. (About 17,000 people are in the health board long-stay institutions) • Community care services, such as home help, meals on wheels, etc., are also provided by the health boards, though they are not statutory entitlements.	• Voluntary groups are involved in community care services, both in philanthropic capacity and as employees of the health boards	• It is estimated that the number of this kind of companies would be very small. • Private for profit nursing homes tend to be owened by individuals	A small number	• Family members are not legally required to provide care for their elderly parents.
Italy	• Drawing up guidelines for home care and for how it should be function. • The Department of Social Affairs has recently set up for co-ordinating linkage activities involving state administration and other providers actively engaged in work for the elderly	• The Regional and Local Health Units: for organising the care and for managing related finance	Supply of services (The presence of non-profit agencies is very slight in this area, although there are self-help and volunteer groups staffed by elderly people who take care of elderly in need.)	Supply of services		• Family members are required a more committed role in the care for the elderly. • There is a legal obligation on spouses and children, including children-in-law. • In practice, the responsibility is on (1) spouse (2) children (usually female) (3) daughters-in-law. • Female kin is more readily called upon and expected to care.
Japan	• Funding and regulations • No direct provision of the services	Prefectures • Local Health and Welfare Plan for the Elderly • Subsidies for home care , day care centres, etc. Municipalities • Local Health and Welfare Plan for the Elderly • A prime responsibility to properly take necessary steps to take care of the frail elderly. • Involved in direct provision of services to some extent; the degree is high in case of day-care services. • Manages nursing home, residential homes at a low-cost with subsidies from the central/local governments	• Majority of the services are provided by non-profit organi-sations, especially institutional care services which do not charge fees and visiting nurse services.	• More than half of the fee-charging homes for the elderly are managed by private for-profit companies.		• Legal duty → 1) spouses (2) (grand) children, (grand) parents and siblings (3) More distant relatives (up to third degree of distance) might be legally required, too. • There is no concrete data available on the degree of involvement of the family members.

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Korea	• Financial support for construction of institutions or hospitals for the elderly • Outlining the general goals of the care services, providing guidelines for service agencies. • Subsidies for home care, day care centres, nursing homes for the elderly with dementia, etc.	• Subsidies for home care, day care centres, nursing homes for the elderly with dementia, etc.	• None	• Only recently entered the field of constructing retirement communities for the elderly		• The most of the physical care for the elderly have been provided by family caregivers. • The proposed legislation includes a provision to grant the heads of the institutions the right to ask the patient's children to pay for the fees.
Luxembourg	• Issuing accreditation and the care-and-help contracts which all providers use as the basis for carrying out their jobs • Social assistance to pensioners living in an institution and can not pay board and lodging costs.		• Domiciliary care providers	• Domiciliary care providers	• Informal helpers	• Informal helpers
Mexico	• Regulation and funding * Related agencies: IMSS, ISSSTE, DIF, INSEN (Their roles are different according to whether the recipient is covered by social security or not, among other things.)		• Private providers (for-profit or non-profit) are preferred when institutional care is chosen.			• Legal Duty: (1) Spouse; (2) children • Because of the family structure and loss in real income, the family members play an important role in cost and care given to the elderly.

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Norway	• Interpret laws, and issue rules and guidelines • Follow-up on action plans • Allocate earmarked grants • Initiate and/or finance research and develop projects	Local government • Supervise municipalities in effectuating government policy • Process complaints from customers regarding sufficiency of municipal services • Quality checking of health institutions • Allocate governmental grants for special purposes • Co-ordinates statistics and other reports from municipalities to government agencies Counties • Responsible for specialist health services, hospital services and rehabilitation services. Municipalities • Primary legal responsibility for arranging and financing community based as well as institution based assistance. (Note: distinction of the above three has not been made clear in the response.)	• Almost non-existent for home care services, but owns and runs about 15% of long-term care institutions	• Non-existent for home-nursing or personal assistance services • Some companies do home cleaning services, etc. • As to institutional care, the first nursing home by private company was built in 1997.	• Some of the personal assistants are recruited through a co-operation of the consumers.	• There is no obligation apart from regular parental care for children under the age of 18. • Important role in voluntary care. • Municipalities offer respite care, and establish care plan to make the public service predictable and fitting into a whole for the consumer and family care givers.
Poland	• Running special agencies • Organising and financing social assistance homes, etc., with over-local reach • Introducing a compulsory standard, or organising professional inspection	Legal responsibility • When the assistance is not provided by families, local municipalities are responsible for the care as specified in the relevant legislation. Responsibilities of gminas (administration district) -- providing shelter, nursing services covering spending for health services, etc. (as their own responsibility) -- granting and paying various benefit, providing special nursing services, etc. (as delegated responsibility from state (financed by the state budget))	• Complement to and support of the state activities in the field of meal services, material help, medical help, etc. • The number of non-governmental organisations in this field is estimated as 6,500.			Legal responsibility (1) spouse, children (2) more distant relatives

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Portugal	Legal Responsibility: The Central Administration Services (3) * Direct appeals to the Central Administration Services is increasing,		The main responsibility for the home care, and establishment , fall under the Private Institutions of Social Solidarity subsidised by the Social Security.			Legal Responsibility: spouse (1) children (2)
Slovak Republic	• Provide the assistance to the elderly within the social care • Pays costs for social care benefits and services at socially dependent citizens	• Municipalities: to provide the assistance to the elderly within the social care (The contents of services: cash benefits, benefits in kind, educational and advisory service, etc.)	• Social services may also be provided by other legal and physical entities. The relevant state bodies and municipalities may provide contributions to cover costs for these services to legal and physical entities providing social services.			Legal responsibility: spouse, parents, children • The above family members might be required to reimburse the cost for care by the state.
Spain		• The governments of the Autonomous Communities and local authorities share most of the roles in planning, control, funding and supply of social services and, to a lesser extent, health services.	• Private initiatives through companies or associations is increasingly expanding the supply of services.			• The Civil Code refers to the "alimony duty" between relatives. (1) spouse (2) descendants (3) ascendants • 83% of informal caregivers is women, three-quarters of whom are married.
Sweden	• Contributes to the municipalities' financing through general government grants.	<u>Municipalities/social services</u> • Responsibility for supplying and financing the care needs of the elderly.	• Purely non-profit organisations do not exist.	• Runs some types of accommodation for the elderly, the home help service, etc., but the care is financed by public system.	• This category of providers is rare.	• There is no obligation by law for grown-up children to take care of their parents. • Can be employed by the municipality to perform certain care tasks • Municipalities provide respite care and other supports for family carers.

Table 8.2 roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
Switzerland		• Social assistance is a responsibility of the canton or commune. Because of its subsidiary character, it intervenes after the branches of social insurance (e.g. old-age, health))	Old-age and survivors insurance (AVS) subsidises private institutions recognised as in the public interest which give advice to the elderly as well as providing home help and home care.			• In determining social assistance, grants, the level of income and the assets of finally members can be taken into account. • When one of the separated/divorced couples can not obtain the maintenance allowance to which he/she has a right, he/she can apply to an office providing cash advances and a maintenance recovery service. • The legal obligation (by virtue of the Civil Code) by spouses to care for their young children, those in schooling as well as ascendants or descendants is, in practice, very subsidiary and rarely invoked.
Turkey	• The social security system covers long-term care. • Supervision of the whole system (The State Planning Organisation and the Ministry of Health) • An agency for health service development will be established in the proposed health reform and will support the Ministry.	• Provincial health directorates make contracts with providers of services. • In the ongoing process of health reform, there will be decentralisation of administration to provincial health directorates. • Municipal rest homes	• The Social Service and Child Protection Institution (SHÇEK) provides long-term care services. • Non-profit associations	• They are also included in the system. • Private hospitals • Private rest homes		

Table 8.2 Roles and responsibilities of the actors in the field of long-term care (continued)

Country	Central government	Local governments	non-profit organisations	private for-profit companies	individual privately recruited care providers	Family members (legally required to provide care/voluntary providing care)
United Kingdom	• The Department of Social Security provides social security benefits, and has some residual responsibilities of financing residential care. • Health care in general is provided by NHS and is mostly free at the point of use, being funded by central government.	• Local Authorities are the prime commissioners of care. They can also operate as providers. • The local municipality is responsible for arranging social care and may require the individual (and on occasion, his or her spouse) to pay for this.	Providers of care	Providers of care	Individuals are free to directly hire their own carers and by-pass the public system.	• There is no such obligations imposed on family members. • However, care provided by informal carers (family, friends, and neighbours) makes a significant contributions to long-term care. The number of informal carers has increased by about 15% since 1985.
United States	• Legislation of Medicare, Medicaid • Funding the Medicare and Medicaid programmes	State governments • Funding for Medicaid * Responsibilities for implementation of health care and social policy, including those for the elderly.		Private long-term care insurance is prevalent.		• Only persons who has legally appointed as guardian has a clearly defined legal right and responsibility to make arrangements for the long-term care of the person when he/she has become incompetent. • Only spouses are legally required to make financial contributions toward nursing home care or other long-term care services, though they are legally protected by measures such as "spousal impoverishment" protections legislation, etc. • Many states continue to retain on the books what are, typically, rather vaguely worded and not readily enforceable "family responsibility" statutes.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.3 Ensuring access to long-term care from financial perspectives

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
Australia	Residential care • Subsidised by the Commonwealth Government (also indirectly by several forms of income support for the elderly) Community care • Commonwealth: 60% State : 35% Local : 5% Financial assistance for carers • by Commonwealth government	• Care Payment (for carers who are below a certain income and asset level) • Domiciliary Nursing Care Benefit (for carers of people who would otherwise need nursing home care) • Child Disability Allowance (for carers of children) • Additional resources for needs assessment and information resources for carers	• No explicit policy for private insurance, though reform of user charges may bring incentives for it.
Austria	• The long-term care benefit is funded directly out of the federal budget. • The rest of the cost for long-term care has to be paid out-of-pocket by the beneficiary, though there is an income-tested supplementary benefit.	• The majority of care providers are elderly women who are entitled to widow's pensions derived from their husbands' pensions. Also, persons having given up their job for taking care of somebody may take out a voluntary insurance.	• No explicit policy for private long-term care insurance, though such an additional insurance would be tax deductible.
Belgium	• Funded by social insurance scheme. • Institute of Illness and Disability Insurance (INAMI) has the task of administering health care insurance as well as various benefits. • For the poor people, entitlement to social assistance and health care is guaranteed by local authority and Public Social Assistance Centres.		• Supplementary services may be covered by private insurers, but the insurance of this type focuses more on acute care rather than long-term care.
Canada	• About 50% of long-term care facilities are privately owned. Some of them are subsidised by the province/ territory. • Trend of "regionalisation," or shifting authority of allocating budgets from province to regional authorities. • Some federal funding for long-term care, as specified in the Canada Health Act. Present arrangement is "block funding" including other fields such as education, no specific amount allocated to long-term care.	• No national policies in this area • Home maker and nursing services are typically included in the government-sponsored home care programmes. • Alternate approaches, such as paying families to provide care, are rarely available. • Tax relief for a certain family care givers was introduced in the 1996 Budget, but its coverage is small. 1998 Federal Budget introduced new tax credit for caregivers providing in-home care for relatives.	

Table 8.3 : Ensuring access to long-term care from financial perspectives (continued)

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
Czech Republic	• Long-term care is financed from the budget of communities, towns and district authorities which, in turn, receive a lump sum subsidy from the State budget. • Specific policies for long-term care insurance has not been envisaged yet, but it is envisaged that a benefit in cash (a voucher) will be provided to the citizens eligible for social assistance for the purchase of the service needed.	• State subsidy is available to families providing care.	
Denmark	• The long-term care scheme is financed by the municipalities.	• A person who takes care of the elderly relatives are entitled to residence-based social security benefits (e.g. health care and pension credits due to the residence). • Cash benefits can only be provided for those providing care for a dying relatives at home. • The amount of benefit is assessed according to the normal income from work of the caregiver, up to a certain ceiling. A new special benefit will be introduced from 1998 based on the provisions applicable under the sickness cash benefit scheme.	• There are no such policies or plans.
Finland	1995 Local authorities: about 50% State subsidies : about 30% Clients : about 20% (The proportion for the client varies. 20% is for the costs in old people's home and about 12% in home services for the elderly.) * Sickness insurance, which covers (in the case of the elderly, in particular) medicine and travel expenses, doctors' fees in the private sector as well as medical examination and care fees, is financed by the employers (35%) and the insured (65%).	• 10,300 carers receive "informal care allowance" in 1995. • The Social Welfare Act also recommends that informal care givers should take free time on monthly basis, and pilot programmes are taking place in collaboration of the state and municipalities, where such care givers can receive service vouchers to purchase services from other providers. This program is funded by the Finnish Slot Machine Association. There is now discussion for making the program a statutory one.	• No explicit policies in this regard.

Table 8.3 Ensuring access to long-term care from financial perspectives (continued)

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
Germany	• The main responsibility for long-term care benefits: -- Long-term Care Funds (social security) -- Local municipalities (social assistance) • Along with the introduction of the public insurance for long-term care, there is a substantial decrease of the expenditure for social assistance (DM 17.47 billion in 1995 to DM 13.7 billion in 1996).	• Existing social insurance schemes are available when some insurance contingencies happen in the course of caring the elderly relatives (and also children). • To promote willingness to provide home care, social protection of carepersons (defined as those who looks after a person in need of long-term care at least 14 hours a week in the latter person's home but not in the form of gainful employment) is being improved. -- Contributions from long-term care insurance to statutory pension insurance for those who can not work more than 30 hours per week because of the care provision -- Statutory accident insurance for carepersons (from Apr. 1995), the cost of which is borne by local municipalities -- Up to 2,800 DM per annum may be granted for a replacement of the care-giving persons who are temporarily unable to continue care-giving.	• The existing compulsory private long-term care insurance covers about 10% of the resident population, who are not covered by the statutory health insurance system. The schemes are totally funded by contributions.
Greece	• Personal savings and resources are primarily used for long-term care. • In case that the elderly can not pay for the services, they are made free or subsidised based on the arrangement among the state and service providers. • Social insurance has no major involvement. Public institutions mostly funded by the government.	• So far, the relatives are reimbursed for taking care of their kin only in exceptional cases.	• Private insurance companies are usually for-profit, financed by charges paid for by clients and their families. Subsidies apply in exceptional cases.
Hungary	• Social insurance-based part (home care) and a bigger social assistance-based part are separated. • The local authorities mostly provide the care.	• Family members caring for the elderly relatives are entitled to "care fee" which makes them eligible for social insurance. • The Act of Social Assistance envisages the payment of a fee for caring.	• Legal regulations make private long-term insurance schemes possible with tax concessions.
Ireland	• The health boards, with funding provided by central government, finance long-term care and it is estimated that the cost of such care is in the region of £Ir 170 million each year. • Patients have to make a contribution based on their income.	• Family members who care for an elderly relative may be entitled, with means-test, to a Carer's Allowance which is paid by the Department of Social, Community and Family Affairs. The scheme is currently under review.	• No plans in this regard. It is left to private health insurers.
Italy	• The National Health Service currently makes long-term care available to the elderly by providing them with accommodations in residential nursing homes.	• Financial aid and workplace-level assistance are being considered to family members taking care of the elderly (or other non-autonomous people) • Financial assistance in the form of the attendance allowance is available to the non-autonomous people themselves, the cost of which is borne by the Ministry of the Interior.	• Under discussion

Table 8.3 Ensuring access to long-term care from financial perspectives (continued)

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
Japan	Present system • Operation cost: (1) user fees based on the income for the recipient (2) 50% (state) and 25% (prefecture and municipality) of the rest of the cost * There are other variations in the cost sharing in some other cases such as construction costs. The new long-term care insurance system • The cost of long-term care is funded by the general taxation (50%, state: prefecture: municipality = 2:1: 1) and contributions (50%: they are collected from adults of age 40 or over)	• No social benefit particularly for family members who take care of the frail elderly, though there are schemes of tax concession s for them. • Legislation in 1995 enables workers to take leaves of up to consecutive three months for the purpose of caring frail family members.	• The new legislation also allows effective utilisation of commercial insurance to satisfy broad and varied needs.
Korea	• No funding system for long-term care. The majority of the elderly have to pay the whole cost out of their pockets. • No special financial scheme for long-term care, other than the health insurance which partially covers long-term care. • The extension of the social insurance is one of the growing concerns.	• For public officials, special allowances are provided if they are living with their parents.	
Luxembourg	• The financing of "Dependence Insurance" -- State (45%) -- Contributions for dependence insurance, imposed on employment and replacement incomes (managed by the General Social Security Office) -- Contributions for dependence insurance, imposed on estate revenues (managed by the Direct Contributions Administration)	• Cash benefits take a role of enabling the recipient to seek help from close friends and relatives. • The dependence insurance scheme also has to assume complete responsibility for pension insurance contributions calculated on the basis of the monthly minimum salary.	• No explicit policies in this regard.
Mexico	• Relevant institutions of the federal government: IMSS, ISSSTE, DIF, INSEN (Their roles are different according to whether the recipient is covered by social security or not, among other things.)	• The family members caring the frail elderly are not entitled to social benefits.	

Table 8.3 Ensuring access to long-term care from financial perspectives (continued)

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
Netherlands	• The General Act on Exceptional Medical Expenses (AWBZ) covers long-term care such as institutional/home care, as well as out-patient psychiatric care, appliances and prostheses, and other items not covered by compulsory or private health insurance. • The scheme is funded by income-related contributions, general taxation and other social insurance contributions.	• Family members could receive benefit if the elderly relative is awarded cash benefit. • The eligibility is assessed by a committee for admittance to nursing homes, with the amount of benefit based on hours needed for care per week.	
Norway	• The municipality finances long-term care from local taxes and block grants from the State. • Specialist health care services, hospital services, and rehabilitation services are financed by the National Insurance Scheme and the county.	• Family members providing care to the elderly relatives are entitled to social security benefits as all residents are. Such care often qualifies for higher pensions than for non-active without such care record. • The person in need of long-term care may also be entitled to an assistance allowance in order to be able to pay for the services. • All municipalities are required to offer "care salary" to relatives who take on extensive care obligations.	• No explicit policies in this regard
Poland	• Social Insurance Fund (for employee and other workers) is financed by contributions paid by employers, with subsidy from the state budget for possible deficits. • The social insurance for individual farmers is financed contributions from the enrolees and complementary donation from the state budget. • The social insurance for the army, the police, etc., is financed fully from the state budget. • The health services are funded largely by the state budget. Very small percentage is funded by each gmina. • Social services are funded by the state budget and by each gmina.	• Family members taking care of the elderly relatives are entitled to certain benefits (cash benefits as well as benefits in kind) from the social assistance institutions if they fulfil certain requirements. • The institutions of social assistance also provides nursing services for the family that takes a long-term care of its relative. This type of services can also be provided against payment.	• Various forms of commercial insurance are emerging and developing, though they are not currently regarded as a real alternative to state long-term care assistance (for less wealthy social groups) because of some problems such as high contributions.
Portugal	• Long-term care is financed by the Social Security and the National Health Services within their respective areas of expertise.	• If the person is a pensioner, he himself confers the right to a flat-rate complementary benefit -- Allowance for Assistance by a Third Person -- to be yearly updated.	• No explicit policies in this regard

Table 8.3 Ensuring access to long-term care from financial perspectives (continued)

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
Slovak Republic	• The state basically covers cost of social services for socially dependent citizens (sometimes totally, and in other cases for part of the cost). The rest is funded by user charges.	• Social services may also be provided by other legal and physical entities. The relevant state bodies and municipalities may provide contributions to cover costs for these services to legal and physical entities providing social services.	• Under current situation, no establishment of a special insurance system for the case of immobility is supposed at the present time.
Spain	• A large share of public long-term care services are currently financed by the Autonomous Communities, but this responsibility is shared with local authorities (in the field of specific health services, and especially social services by the provincial General Councils and municipalities of more than 20,000 inhabitants.	• Depending on the circumstances of the retiree and the relative caring for that person, the latter can receive the Social Security pension after the former person has died (reversal of pensions in favour of relatives).	• There are no explicit policies for the time being. In the medium term, however, this type of insurance may well be encouraged.
Sweden	• Care of the elderly is financed by local government taxation (64%), state general transfer (15%) and sales, rents (10%). • Individual also pays a sum which on average covers 9% of the actual costs.	• Relatives can be employed by the municipality to perform certain care tasks. • In addition, each municipality is able to determine the financial remuneration to the family carer. • The governmental remuneration system is "Cash Benefit for Closely Related Persons," which is provided from the social insurance system for a total of 60 days in the event of a relative falling seriously ill. • The right to take leave of absence is also given to the carers.	• Private management of long-term care has increased during the 1990s, though financing and contents of services are decided by municipalities. • Private provision increase competition, make the public sector cost-conscious, and improve quality of care for the elderly.
Switzerland	Five pillars of the system for funding: (1) Compulsory health insurance (2) Disability allowances under the Old-age and Survivors' Insurance Scheme (AVS) and the Disability Insurance Scheme (AI) (3) Disability allowances under AVS/AI and occupational pensions (4) Supplementary AVS and AI benefits (5) Cantonal/communal benefits as social assistance * (1)-(4) are run on insurance basis, but (5) are financed directly by public funds.	• The period of caring for relatives as unpaid work are taken into account in calculating pension income from AVS. Supplementary AVS/AI benefits may also be used to reimburse the family members for caromg fpr for dependant persons (minimum of three months). • Some cantons also provides allowance to these carers. • There is also a system of respite-care in day-care centres or short-stay hostels.	• No explicit policies in this regard.
Turkey	• Funded by the sickness insurance scheme	• The family members are not entitled to social benefit just because they are looking after the elderly relatives. • Parents who are taken care of by those who are insured by the sickness insurance or by those who are receiving the pension or indemnity from the employees scheme receive health care services by the sickness insurance.	

Table 8.3 Ensuring access to long-term care from financial perspectives (continued)

Country	Funding for Long-term Care	For families taking care of the frail elderly	Policies on private insurance for long-term care
United Kingdom	• Responsibility for long term care was recently transferred from the Department of Social Security to Local Authorities, with some transitional arrangements. • Local Authorities receive finance from central government for the provision of long-term care. They can increase the expenditure by their discretion. • Health commissioners pay for some long-term care which has substantial nursing input, if this is the most appropriate way to meet health needs.	• Carers are eligible for social security benefits on the same grounds as other citizens. • There are also a number of benefits with eligibility criteria designed for the frail or disabled, e.g. Attendance Allowance and one for people who care for the frail and disabled (Invalid Care Allowance).	• No explicit policies in this regard.
United States	• Medicaid: Primary source of public funding for nursing home care and for less medically-oriented home and community-based care services. • The program is financed and managed by the federal government (on average 50% of total expenditure) and the states, with some contributions from counties in some states. • In terms of nursing home care, Medicaid accounts for 77% of related public expenditure. The rest is funded by Medicare, Veteran's Administration, and some special state appropriations. • In terms of home and community-based care, about 60% is publicly funded by Medicare and 25% by Medicaid. Funding for the rest are provided under the aegis of the Older Americans Act, by the Social Service Block Grant, etc.		• The Health Insurance Portability and Accountability Act (HIPAA) provides incentives for the purchase of long-term care insurance in the form of tax-concessions • Recent opinion surveys indicate that people are becoming more aware of limitations on public financing, so private schemes might be an option. Majority of the respondents made a favourable answer for employer-sponsored plans, flexible benefit plane, etc.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.4 Qualitative aspects of services and policy responses

Country	Autonomy	Privacy	Consumer Choice
Australia	• Particularly in the context of people remaining in their own homes	• Key quality assurance standard for both residential and community care	• Paramount consideration in community care • Integral part of the guidelines for Aged Care Assessment Teams, when referring people to appropriate services • Maximising choice by enabling people to remain in their own home for as long as possible
Belgium	• Deinstitutionalisation policies aim to ensure maximum autonomy and enable dependent people to live in familiar surroundings.	• Depending on a professional vow taken by all health workers.	• The freedom to choose health care providers is one of the basic principles.
Canada	• More prominent as policy goals in long term care policy • National initiatives such as Canada's Seniors' Strategy, the National Framework on Ageing, etc. • Part of emphasis in shift to community-based care, home care	• Primarily in the context of the development of health information systems and introducing "smart" cards for health insurance • Related to setting more restrictive criteria for means testing, etc.	• Fundamental principle for required care • System restructuring to increase choices for care settings
Czech Republic		• At present, emphasis is placed on the provision of social care in people's homes with a view of safeguarding privacy to old people. Services are being developed with the intention of not interfering too much in the living styles of old people.	
Denmark	• Major policy goal in respect to housing and other social activities. • Participation of the elderly to the public administration related to themselves -- *Complaints boards* for care benefits and *Senior Citizens Councils* (municipality) -- *Senior Citizens Forum* (national)		• Major policy goal in the present restructuring of the long-term care scheme.

Table 8.4 Qualitative aspects of services and policy responses (continued)

Country	Autonomy	Privacy	Consumer Choice
Finland	• One of the basic principles for the elderly care, which requires development of living environment and social support such as the followings: -- Living at hoe as long as possible -- Sufficient services to support autonomy -- Safeguarding universal and adequate pension -- Utilisation of aid devices and new technology	• One of the basic principles for the elderly care, which requires the followings: -- Living at hoe as long as possible -- Sufficient services to support autonomy -- Safeguarding universal and adequate pension -- Utilisation of aid devices and new technology • Institutional services have been developed so that they are homelike, for example, single rooms, as well as abolition of strict timetables and routines in some old people's homes.	• One of the basic principles for the elderly care. • Diversified services are available, such as day care, private home and auxiliary services, etc. • Private services are rather expensive and restricts demand, though private health services are supported by the sickness insurance system.
Germany	• The benefit of the long-term care insurance is designed to enable the person in need of long-term care to lead the most independent life possible despite their care requirements.	• Under the long-term care insurance, home care has priority over institutional care.	• Persons in need of long-term care may choose between benefits in-kind by professional services or cash benefits if they ensure care themselves (usually by family caregivers)
Greece	• Yes (in line with the process related to increasing demand for institutional care: the quality of institutional care to be more closely monitored.) • Open care centres and the home help pilot programmes aim to promote autonomy and privacy.		
Hungary	• By promoting non-profit organisations and tax concessions for the operations.		• By involving non-governmental organisations in the service provision, as the same position as the state
Ireland	• Enabling the elderly to maintain independence at home is one of the main principles of overall policy.	• Facilitating privacy is an aspect of policy but much progress remains to be made.	• Range of services available e.g. home support, day care, public and private longstay care.
Italy	• Regaining autonomy is one of the objectives: by responding individual needs with integrating social and health care services.		
Japan	• One of the rationales of the new long-term care insurance scheme as well as of the Gold Plan, the national plan for developing infrastructure for long-term care services • Development of in-home care services such as the 24-hour continuous mobile home help services	• Education for home helpers emphasises "ensuring privacy" as one of the primary concerns. • Ensuring privacy is also incorporated in the quality control process for institutional care.	• For the sake of diversified and flexible long-term care services, private services are actively used in addition to public ones. • New legislation for long-term care insurance enables the elderly to enjoy varied services more freely than before. It also enables private organisations to enter the field of in-home care services.

Table 8.4 Qualitative aspects of services and policy responses (continued)

Country	Autonomy	Privacy	Consumer Choice
Luxembourg	• "Dependence Insurance" looks at prioritising of education in dealing with dependence to preserve the person's autonomy and prevent premature dependence. Related activities of the Assessment and Guidance Unit will be funded by health insurance. • Efforts are also being made within the scheme of dependence insurance to enable the elderly to live in their own home as long as possible.	• The assessment of the degree of dependence will not be given to the person concerned, and will only handed over if he/she so requests.	• The dependent person can freely choose the care providers . • It is predicted that the growing demand will cause the increase of supply and broadened range of supply.
Netherlands	• It is a policy issue how to translate the value of "autonomy" into nursing homes or retirement home settings. • Developing practice guidelines to encourage self-regulation by the elderly themselves	• The number of people in the room is an issue in institutional care.	• Free choice of general practitioners and institutions (though there is a waiting list in some institutions) • Cash benefit is provided to enable the elderly to purchase services for themselves.
Norway	• Primary goal to help people in need of long-term care in home care settings. • Improve and expand home services of different kinds. • National Government's earmarked investment subsidies for "care flats" • The State House Bank grants loan to finance the cost other than national subsidies and rent-loans to the residents. • From 1994, the national government has offered subsidies to services on 24-hour basis. • Other reforms: "care salaries" for the relatives, or measures for the non-elderly people with disabilities.	• The Government's Plan of Action for the Elderly has focused on the need for privacy also for residents in nursing homes. • Financing for single rooms instead of multiple person rooms, leading to the legal right of the residents to select a single room. • In remodelling facilities, it is also a policy to give bathrooms to every resident's room.	• Legal obligation of municipalities to deliver services at a time and in a way that is preferred by the consumer. • As to institutional care, the consumer can choose the type of the rooms.
Poland	• Social Assistance scheme should, as much as possible, lead to the activation of the beneficiary. • The basic condition for granting institutional assistance is the collaboration of the individual who receives this assistance.		
Portugal	• Promoting conditions leading to autonomy and well being of the elderly by encouraging them to participate in the resolution of their own problems is one of the objectives.		

Table 8.4 Qualitative aspects of services and policy responses (continued)

Country	Autonomy	Privacy	Consumer Choice
Spain	• One of the main objectives of the National Gerontological Plan, achieved through access to adequate housing support, home help, technical aids, etc.	• Constitutional Law ensures the right of all citizens to enjoy privacy.	• Constitutional Law includes the principle of defending all citizens as consumers.
Sweden	• The goals for the Ädel Reform (1992) were set forth as autonomy, security, privacy and consumer choice. • Amendment to the Social Services Act (1998) included the section stating that the Social Welfare Committee shall work to give the elderly the opportunity to live independently and safely, with respect being shown to their independence and privacy. • Freedom of choice or greater choice is also are important political objective.		
Turkey		The Constitution guarantees that all the citizens have the right to privacy.	SSK (Social Insurance Institution) communicates to employers about the names and addresses of doctors to be utilised by the beneficiaries and the members of their family. The beneficiaries and the members of their family are free to choose one of these doctors.
United Kingdom	e.g. The Community Care (Direct Payments) Act 1996 allows local authorities to give people control over the purchase of the services they need.	e.g. Wherever practical and sensible, care is provided in the individual own homes.	e.g. Needs assessment takes into account the preference of users and guidance expects that uses and carers must be involved in the formulating of care planning.
United States	• The main current concerns about quality focus directly on issues of autonomy, privacy and consumer choice. • "Assisted living" is widely viewed as a promising residential long-term care option, which claims to promote greater independence and autonomy, privacy and more choice for residents than have traditionally been available in nursing homes. • However, there is also a concern about the quality of the assisted living facilities and need for appropriate supervision of them; states continue to have the primary responsibility for developing standards and monitoring care provided in the assisted-living facilities (though the methods vary among the states.		

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.5 Private providers/insurers of long-term care, in selected countries

Country	
Canada	In some provinces, trend towards contracting with private sector by public institutional and community long-term-care sectors has led to competition in this market.
Finland	Municipalities may contract with private service providers.
Greece	Private providers attract better-off patients. Quality standards in the private sector to be monitored more closely.
Hungary	"Tendering" process by local authorities to choose health services.
Ireland	Private nursing homes compete for patients, some of whose places may be fully or partially funded by the State.
Italy	Recent National health system reform introduced partial separation between the roles of providers and recipients at USL (local Health Units) level. Elements of competition introduced through the drawing up of identical technical, functional and qualitative criteria for all providers; a standard, voluntary system of delivery for public and private providers alike; a system for paying providers based on pre-determined rates per benefit and linking financing to the volume and typology of benefits effectively delivered; and liberalisation of access for the insuree to accredited public and private providers.
Japan	• Local municipalities are encouraged to assign some in-home welfare services to other providers such as private corporations. • The new legislation for the long term care insurance system applies equal regulations to both non-profit and for-profit providers who wish to enter into in-home care services activities. This will make it easier for for-profit providers to enter the market and encourage competition by giving consumers a broader choice.
Mexico	Private providers compete to attract wealthy patients.
Netherlands	Dekker reforms would have introduced regulated competition amongst insurers, but this reform was never fully implemented. Nonetheless, the present health policies continue the shift in decision-making power from the government to the consumers, insurance agencies and providers of care. Health Care act of 1996 allows consumers to change sickness funds once a year. Switches may increase as funds start charging different premiums. As of 1994, Sickness Funds Insurance (ZFW) may selectively contract with self-employed physicians. (No longer MUST contract with ALL physicians.) As of 1992, private health insurers and sickness funds allowed to negotiate lower fees than maximum payment rates.
Norway	Some competition exists among humanitarian and market-type organisations, who contract with the municipality.
Spain	A growing number of non-profit and for-profit providers has led to a greater variety of services available at a low price.
Sweden	Traditionally administered privately, and funded through municipalities
Turkey	Private hospitals provide long-term care, which is paid by the patients or social security institutions when there is a contract. Private rest homes provide long-term care, which is paid by the related parties. The homes have to accommodate low-income people with the cost paid according to their capacities.
United Kingdom	Independent not-for-profit and for-profit providers of care compete with each other and with public providers. Specific actions have been taken in the past to encourage competition from independent providers.
United States	Mostly private and competitive. Medicare contracts with all providers meeting certain criteria. State policy differs on the extent of competition between Medicaid providers.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.6 Integration and tailoring of services

Country	Integration of the Services	Tailoring of the Services
Australia	Between Health and Social Services • Health services handle the medical and acute care needs of the elderly, though long-term care services include nursing homes, hostels and community care services. • There is considerable interaction between the two (e.g.: 65% of nursing home admissions are from hospitals). • There are some boundary problems regarding post acute care and co-ordinating medical care and social care in the community settings. • Commonwealth and State Governments are working together to improve continuity between the sectors. Others • Streamlining through better co-ordination of Commonwealth and State Government programmes, merging two residential care programmes (nursing homes and hostels) into one funding structure, structural reform of support for family carers	• Need based arrangements (have been for residential care, extending for community care) • Pilot programmes to test more flexible ways to deliver care (e.g. respite care, care linked to housing, nursing home level care in the community) • The Government has sought to balance between residential and community care. • The services are assessed by nationally-established standards. The Agency Care Standard Agency takes the role of monitoring residential services from 1998, with the accreditation of the institutions which will be required from 2000.
Austria	Between Health and Social Services • Visiting nurse services are covered by the public health insurance scheme and are strictly separated from long-term care. • Health care services involved in long-term care is of a purely curative nature, though long-term care itself has to be provided permanently and is not the result of an acute illness.	• The federal government is fully aware that the long-term care benefit alone can not be sufficient address the needs for long-term care. • Quality of social services are also one key element and there has been an agreement between the government and the Länder in term of the joint measures for persons in need of long-term care.
Belgium	Between Health and Social Services • Health services mainly involved in long-term care are: Nursing Rest Homes (specialising in the treatment of certain chronic diseases), hospital geriatric and convalescence services, and in co-ordinated domiciliary services. • Boundary problems can arise to those who are covered by CPAS (Public Social Assistance Centre), who are obliged to go to providers accredited by the CPAS without their own choice.	• Through the gradual extension of a quality assurance excise to all health services and, in certain cases, by linking finance to performance.

Table 8.6 Integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
Canada	Between Health and Social Services • Long-term care is usually categorised as health care, rather than social services in actual administration of provincial/territorial governments. • Integrated service delivery approaches tend to reduce the boundary issues between the health and social services components. • Funding from the federal government to provincial/territorial governments does not distinguish between health and social services, but there is a certain criteria for health that the provincial/territorial governments have to fulfil for full transfer. Others • Single point of entry offices to assist people with information and placement services • Integration of long-term care and home care placement services	• Single point of entry offices to assist people with information and placement services • Integration of long-term care and home care placement services
Czech Republic	Between Health and Social Services • Health services are essential in the provision of long-term care, in particular institutional care. • Boundary problems between health and social care are dealt with by the ministries concerned.	• The services are available in the place of permanent residence of the beneficiaries.
Denmark	Between Health and Social Services • The health services provide medical treatment in case of illness and required aftercare at home. • Boundary problems may occur in case of rehabilitation. Those cases are resolved by agreements between the municipality (responsible for the long term care) and the regional authorities (responsible for health services).	• Grants to a number of municipalities for carious projects which will improve the management of the long term care scheme. • In addition, funding is provided for municipalities to build better social housing for the elderly citizens.
Finland	Between Health and Social Services • The professionally specialised system of social welfare and health services has been criticised for not considering the client as a complete person but only from the point of view of different illnesses and problems. • Boundary problems exist between primary and specialised health care, as well as health care and social services. • Attempts to promote co-operation in social welfare and health care: merging of the section in the municipalities in charge of home-help services and home nursing functions, combination of the field of social welfare and health care in basic education for professionals, such as practical nurses. Others • Emphasis should be placed on primary health care for the long-term care settings; specialised health care should be confined to the situation where special expert knowledge is required.	• It is provided in social welfare and health care legislation that a detailed care and service plan be made for every long-term client in non-institutional care. • With a just grading of care and diversified services their quality can be promoted with reasonable expense.

Table 8.6 Integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
France	Between Health and Social Services, and Other Services • Consistency between health and social welfare policy and policy in other sectors was strengthened by the 1996 reforms which introduced a parliamentary debate on the annual Act on Social Security Funding.	
Germany	Between Health and Social Services • Public Health Services (e.g. epidemics control) have not importance related to long-term care. • Health services are provided in line with the benefit regulations of the health insurance scheme. • Long-term care insurance funds can enter into service contracts and remuneration agreements with the providers of home and institutional care services. • Social care is an obligation of assistance for the aged, rather than covered by independent health or long-term care insurance system.	• The Long-term Care Insurance Act stipulates that all nursing institutions that meet certain quality requirements are entitled to a service contract with a long-term care funds. • There is a considerable increase of nursing care providers, though the demand is not yet fully covered with some regional difference.
Greece	Between Health and Social Services • Health services are stipulated in all institutional care depending on need. • Boundary problems exist between a chronic illness and handicaps, between long term and final care. • Public hospitals keep elderly patients longer than medically justified. Lack of social services facilities (or information about them) to blame.	• Recent legislation provided stricter operational conditions, such as periodic evaluation of a social counsellor.
Hungary	Between Health and Social Services • Increasing co-operation between the health care sector and the social service sectors. • The two sectors are difficult to be separated in care of home care services. • There is a difference of funding methods (fee-for-service (health services) and capitation (social services)) which might cause tensions between the sectors.	• Targeted subsidy may be claimed to the central government for the purposed of tailoring services to the needs of the elderly.
Ireland	Between Health and Social Services • Both services fall within the responsibility of the same Department (Health and Children) and so integration is at a reasonably high level.	• Health Boards must by law prepare annual service plans to be approved by the Minister for Health and Children.
Italy	Between Health and Social Services • Health care is funded by National Health Fund, while social care is not. • Integration of health and social care, degree of responsibilities, etc., have caused disputes between the associations operating in the sector on behalf of the disabled and the long-term sick.	

Table 8.6 integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
Japan	Between Health and Social Services • The functions to be shared by medical services are to be designed to assist the service recipients to live an autonomous life. • Medical services are to be established putting emphasis on daily life guidance and the maintenance and recovery of mental and physical functions which will help contribute to the autonomous life of the elderly. • It is difficult to set a clear boundary between the health and social services, though the purpose of the former lies in properly treating the affected mental or physical functions and the latter in offering personal care. Therefore, the Co-ordination Teams for the Services for the Elderly which are to be established in all the municipalities (which co-ordinates the whole long-term care services tailored to the elderly receiving services) is composed of health, medical and welfare professionals. • The newly established long-term care insurance scheme takes the role of integrating health and social services for the elderly by setting up a specific fund for long-term care which included both services.	• Each municipality has the Co-ordination Team For the Services for the Elderly, consisting of health care, welfare and medical care professionals. This team is to offer appropriate services tailored to individual needs. • "In-home Care Support Centre," which works for the elderly in need of long-term care through individual guidance and liaison to the necessary public services. It is aimed that 10,000 centres be established by 2000. • Each prefecture is to establish "The Committee on In-home Welfare Services Assessment" from 1996 for the purpose of further improving in-home welfare services. • The new legislation on long-term care insurance stipulates that service recipients can request for making "care plans," which is tailored to their individual needs.
Korea	Between Health and Social Services • Because long-term care services are recently provided, the integration of health and social care is not a major issue yet. • However, professionals agree that a close linkage must be established between the health-medical field and the social welfare field for the high quality provision of long-term care services.	
Mexico	Between Health and Social Services • Health care is provided by the Federal government during the individual's lifetime. • Two institutions, DIF and INSEN, provide other comprehensive services including health care assistance.	No Measures
Netherlands	Between Health and Social Services • The General Act on Exceptional Medical Expenses (AWBZ) covers long-term care such as institutional/home care, as well as out-patient psychiatric care or other services not covered by compulsory or private health insurance.	

Table 8.6 integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
Norway	Between Health and Social Services • Generally, boundary problems are not an issue of much concern nor attention. • In most municipalities, community care and institutional care has been integrated in one unit consisting of both health and social care services. A new profession "Care Worker" has practical expertise in both health and social care. • The "old-age homes" often accommodates residents who requires long-term care to the same extent as those in nursing homes, thus causing problems of responsibility for health care and its quality control. Others • Administration for community services and institutional services in most municipalities is made into one unit → quality and cost-effectiveness of services	• The Ministry of Health and Social Affairs has in 1997 issued rules and guidelines for quality of services. • Decentralisation of decision making and responsibility for services. • Administration for community services and institutional services in most municipality is one unit. This integration of services has been done to secure quality (local knowledge) as well as cost-effectiveness and flexible use of total resources).
Poland	Between Health and Social Services • The both sectors (health and social services) are necessary for solving the problems of long-term care. • Institutional corporations are needed in terms of the health benefit entitlements other services in the field of social assistance. • Appropriate legislation ensures medical care, nursing care and rehabilitation to the persons living in homes run by the social assistance scheme.	• Educational programmes for the employees in the social assistance institutions has been enhanced, as well as the future employees. • Modernisation work is going on in order to enhance the standard of institutions. • The standard of the services has been ensured by the Act on Social Assistance.
Portugal	Between Health and Social Services • Health services are, in principle, entirely responsible to ensure the necessary health care regardless of service providers or of the place of services. • However, practically there is a problem in allocating funds between health care services and social services. • In the Integrated Home Care settings, the measures are implemented through pluridisciplinary actions and care rendered at home, supported by various fields of professionals.	
Slovak Republic		• Improving the professional performance of the employees through examinations of their professional capacity. • Legal conditions were established in providing social services by other non-governmental organisations.

Table 8.6 Integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
Spain	Between Health and Social Services • Health care is guaranteed to the entire population as long as there is a need of it, including in the settings of long-term care. Health care services aim at improving the quality of life of persons suffering from long-term conditions in home care or institutional care settings (objectives in the National Gerontological Plan) • Hospitals rather often take the role of non-health facilities, because of the lack of appropriate care facilities or other resources for people with conditions which should originally be treated in non-health care facilities or taken care of by family members. Another reason is that there is a lack of precise delimitation of these people's needs for medical care and social care. There is a project to define clear boundaries between the two services and allocate the resource for health care to those who are really in need of that. • As one of the objectives of the National Gerontological Plan, achieving the integration and co-ordination of health services and social services at sectoral level is being sought, by agreements between health and social sector administrations. These agreements have already had a tangible impact on the provision of care to users.	• Each level of the governments (Autonomous Communities and local authorities) is particularly responsible for assessing the level of availability and the quality of services to the public.
Sweden	Between Health and Social Services • Municipalities are responsible for health and medical care in both institutional/home care settings. • Boundary problems still exits after Ädel reform, and improved co-operation and co-ordination are needed between the two sectors. At the local level, district nurses and needs assessors are to cooperate in joint planning for care provision, in the area of rehabilitation, etc.	

Table 8.6 Integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
Switzerland	Between Health and Social Services • Boundary problems are not strictly relevant. When long-term care is necessary, the compulsory health insurance scheme pays for benefits provided by a doctor, a hospital or by social assistance or home-care services. Others • The new Health Insurance Act places no time limit of benefit provision by the compulsory health insurance scheme.	Health Care • Professional monitoring for ensuring good quality of care • Federal legislation on health insurance stipulated high quality of care through measures such as preventative care and requires an evaluation of the effect of the law; particularly its effect on quality. • Quality of health care is equally a priority at the cantonal level and institutions providing home care services. Others • The social assistance and home care service network (SPITEX) • Old-age and survivors scheme (AVS) grants to support staffing and organisational cost of approved institutions. • AVS modifies its subsidies following an increase in cost. The Federal Office of Social Insurance negotiates benefit agreements to ensure proper allocation of funds.
Turkey	Between Health and Social Services • Health care will be guaranteed to the entire population as long as there is a need of it, including in the settings of long-term care. Others • The role of long term care is not significant in Turkey. • There is not any specific programs for long term care. • The recent reform in the schemes for employees and the self-employed has enabled all the enrolees to receive health services without limitation of period. Home care can be provided when necessary.	• Private insurers provide services and reimburse the costs of the rest homes and special departments in private hospitals.
United Kingdom	Between Health and Social Services • Health care services are involved in each client assessment, which always take place on discharge from hospitals and will include a hospital social worker. Community Health Services are also provided. Others • Community mental health teams: multidisciplinary, with one “key worker” to co-ordinate delivery. • The National Health Service provides beds and services for geriatrics, mental illness, etc., whose role is diminishing and attempt is being made to clarify the eligibility for the NHS.	• Each individual receives their own assessment and services are provided on the basis of that assessment within financial constraints.

Table 8.6 Integration and tailoring of services (continued)

Country	Integration of the Services	Tailoring of the Services
United States	Between Health and Social Services • Medicaid has been accepting "social care" (covering non-professional home attendants, etc.) for its coverage, than Medicare, though such measures are provided at state option and therefore varies across states. • The Medicare home health benefit was expected to provide mainly professional, medically-oriented home care, though the trend of rising proportion of home health aids against the health professionals have raised the concerns that the benefit is no longer appropriately focused in the provision of short-term, medically oriented, skilled care. • Uncertainty and lack of consensus about appropriate standards for staffing and other aspects of care provision --- Concerns that the "social care" emphasis can lead to assisted living residents receiving less medical and nursing care than they require. Others • A number of states hope to develop models of managed care which co-ordinates the provision of acute and long-term care services.	• Growing interest in providing residential care alternatives to traditional nursing homes • Experiments with "consumer-directed" modality of care e.g. "Cash and Counselling" project in four states, which offers cash payments in lieu of services arranged by professionals and provided through home care agencies. * This "consumer-directed" modality of care was initially advocated by for younger physically disabled people, though it is now supported by the advocates for the elderly, too.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.7 Duty/authority of deciding eligibility and contents of services

Australia	• Aged Care Assessment Teams (ACATs): multi-disciplinary professional teams funded by the Commonwealth and State Governments. • ACATs are responsible for assessing the peoples' care needs and referring them to the most appropriate services, including residential care services which require referral by ACATs in admission.
Austria	• It is up to the beneficiary to decide what help or type of accommodation he/she needs. • In case of children, mentally and psychiatrically ill, their legal representatives (parents, in most cases), or, if applicable, the guardian responsible for organising the necessary care.
Belgium	• The loss of ability is assessed for determining the eligibility.
Canada	• Following self-referral or referral by a family member, nurse, or physician, a multidimensional assessment of needs and available informal support is completed (usually by nurses, but other professionals such as social workers may also do it.) • Treatment goals and a care plan (including the placement plan) are developed. • Single entry system to help co-ordinate access to a range of services. • Funding is being slightly shifted from hospitals/physicians to community care sectors.
Czech Republic	• The decision concerning the provision of care (shelter) is made by the community or the district authority.
Denmark	• The municipalities are responsible for providing long term care and social housing for the elderly.
Finland	• In municipalities, there usually is a multi-professional team (where social welfare and health care personnel is usually represented) which takes care of the monitoring together with the client and his/her close relatives. • Social workers are encouraged to co-operate with local housing authorities regarding the allocation of council housing, service housing procurement and housing repairs to meet the needs of the elderly.
Germany	• In general, the persons in need of long-term care decide themselves upon the type of nursing services. • For example, when a person in need of long-term care chooses institutional care, the Medical Service of the health insurance examines its necessity, depending on the severity of the need. The criteria also may include the willingness of potential carepersons to assume nursing care, family situation, and other personal circumstances.
Greece	• Ministry of Health and Welfare decides on guidelines, which are implemented by municipalities operating through social workers.
Hungary	• Local authorities will do the assessment.
Ireland	• Assessment of need is made by health boards.
Italy	• There are plans to set up multi-disciplinary Geriatric Assessment Units in all geriatric hospitals and in Local Health Units nationally; they will have the task of determining care needs and co-ordinating the integration of health and social services in an intervention plan that can also he implemented in the home.

Table 8.7 Duty/authority of deciding eligibility and contents of services(continued)

Japan	• Municipalities are responsible for deciding in-home/institutional services for the elderly needing long-term care.
Korea	• The system for long-term care is in early stage, and the decision for the contents of the services are personal decision in most of the cases. • For the elderly under the public assistance programmes, welfare workers in the service providing agencies decides the services based on the socio-economic or physical status of the recipients.
Luxembourg	• Under dependence insurance, the Assessment and Guidance Unit conducts a multi-disciplinary analysis for the person's dependence, drawing up of an individually tailored care-plan together with the kind of help that may be required, and a proposal in favour of domiciliary care or admission to a long-stay institution.
Mexico	• In case that the person is suffering bad conditions, the State can decide to send him/her to a public institution. • The related agencies (DIF (public, for those who are without social security coverage) and National Institute of the Elderly) are to provide attention to the population suffering bad conditions.
Netherlands	• Local authorities have responsibilities for setting up assessment committee, for the services such as home care, home nursing, or admittance to nursing homes.
Norway	• The municipality has the primary responsibility. • The decision is usually taken by an area manager (or an area team) of community and nursing home services.
Poland	• Consent of the person is need of long-term care or his/her plenipotentiary is needed in the placement of the person to institutional care, or they themselves apply for the institutional care, when the nursing services can not be provided in the place of residence. • When their consent is not obtained, appropriate institutions (the centre or home run by the social assistance) inform the guardianship court of the prosecutor.
Slovak Republic	• Decision is based on the application for the services by the applicant. • In case of the services provided by organisations or individuals, the contents of services are decided with reference to the contracts between the provider and citizen.
Spain	• Legally, the final decision is taken by the person concerned, except in the event of a judicial measure in replacement of his/her wishes. After evaluating the person's needs, in order to direct the person towards the most suitable services, the diagnosis and decision can be made by a multidisciplinary team consisting of social workers, etc.
Sweden	• An administrator in the municipality (home help officer, needs assessor, care manager) takes a role in the needs assessment, though this is often for a limited geographical district. • The municipality has often determined political guidelines for the care of the elderly, and the Social Welfare Committee or equivalent has delegated the authority to decide on an individual case to that person.

Table 8.7 Duty/authority of deciding eligibility and contents of services(continued)

Switzerland	• When it is not unambiguously clear whether a decision of this type is determined by the person's health status, it is usually taken together with the family doctor and representatives of home-care services and institutions that might have a part to play. (A study in Geneva has identified a sharp deference of perception between the person affected and health professional as to the role that various actors take in steps leading up to institutionalised care.)
Turkey	• A specialised individual physician or a committee of the physicians are responsible for the assessment.
United Kingdom	• The final decision on social care provision rests with local government. • Individuals who may need social care are assessed, and this assessment considers the views of the client, carers and relevant health and social care professions.
United States	• There is no universal requirement or system for long-term care services assessment and care planning. • Acute hospital stay → long-term care services: arrangement by hospital discharge planner • Medicare home health service: physician's certification (with the need of re-certification in every 60 days) and care plan usually determined by registered nurses in the certified home health care agencies. • Medicaid: pre-admission screening (by a nurse, social worker or nurse/social worker team) for admission to nursing homes, and in many states for develop care plans for home and community-based services.

Source: Responses to the OECD Caring World synthesis questionnaire.

Table 8.8 Cost containment measures and preventative approaches

Country	Strict Eligibility Criteria/Needs Assessment	Limit of supply/benefits	User charges/ copayments	Shifting responsibility of care	Other cost containment measures	Preventative approaches by Health Insurance
Australia	• Control of demand through gatekeeping by Aged Care Assessment Teams	Yes (For community care, budgetary limits on supply eligibility guidelines (but not strict).)	Yes (but well below the actual cost)		• Government control of the allocation of funds to promote geographical equity and to ensure funding for specially needed groups • Means-testing of Government subsidies, extension of need-based planning, more equitable distribution of resources across the care continuum, containing outlays growth	• Regulation of health insurance funds (by the Commonwealth Government) are flexible to allow benefits for a range of preventative services (e.g. breast screening clinics, preventative dentistry programmes, etc.) • Substantial public funding for public health programmes through the Commonwealth and State Governments.
Austria	Yes (more strict suspension of long-term care benefit for those who are hospitalised)	Yes(•Reduced amount of benefit for a certain category of beneficiaries • Stopped valorisation of long-term care benefit for 1997, 1998 and 1999.)			• The goal to keep the expenditure for long-term care in 1996 and 1997 down to the level of 1995.	• The public health insurance scheme covers annual health check-ups especially for young people.
Belgium	Yes		Yes (depending on his/her resources and the type of service provided)			• The coverage of health insurance scheme appears rather *ad hoc*, and the items covered focuses almost exclusively on curative care.
Canada	Yes	Yes	Yes (but medically required care remains fully covered)	Yes (hospital (insured) → community (not insured))	• Measures for universally insured health care services could also reduce costs for long-term care as well. • Private contracting-out for services by the public institutional and community long term care sectors. • Substitute for lower-skill providers → Tendency to use the least skilled provider where possible to provide care. (→ quality of care being questioned?)	• Ensuring medically necessary physician and hospital care could be regarded as preventative in that required care need to be not delayed. • Some preventative services are insured, such as physical examination every two years, some health education (under physician counselling to the patient.) • Preventative services are also covered by public health programmes (breast screening, etc.).
Czech Republic	Yes	Yes (definition of social need, minimum living standard)	Yes			• The statutory state health insurance covers both preventative and curative health care.

Table 8.8 Cost containment measures and preventative approaches (continued)

Country	Strict Eligibility Criteria/Needs Assessment	Limit of supply/benefits	User charges/ copayments	Shifting responsibility of care	Other cost containment measures	Preventative approaches by Health Insurance
Denmark					• Municipalities are responsible for controlling the expenditure at local level. (The Social Assistance Act does not specify guidelines for those measures --- as long as minimum standard is observed, each municipality can take its own measures.)	• The health care scheme covers both categories of health care.
Finland	Yes (targeted, though criterion is not the client's income or property but the needs for services.)		Yes	Yes (changing the balance between different forms of care, esp. emphasis on community care)	• Development of municipal accounting system→easier cost monitoring	• Municipal health centres are also responsible for the preventative health care for the elderly, mainly consisting of disease screening • It is considered that preventative works, such as guidance relating to physical exercise, should be developed.
Germany	Yes	Yes			• Legal limit on nursing home and domestic care charges (note: no clear indication of this measure to cost-containment policy)	• Health insurance (Note: it is not government-managed in Germany) covers preventative care as well as curative care.
Greece				Yes (option for home care)		• State insurance and social insurance covers all primary and hospital care.
Hungary				• The role of the hospitals in services for elderly to be partly shifted to home care and institutional social care		• The health insurance scheme also covers preventative health care.
Ireland	Yes (to health board long-stay care, as well as nursing home subvention paid to dependent people in private and voluntary nursing homes.)	Yes	Yes			• Government managed health insurance does not cover preventative health care.

Table 8.8 Cost containment measures and preventative approaches (continued)

Country	Strict Eligibility Criteria/Needs Assessment	Limit of supply/benefits	User charges/ copayments	Shifting responsibility of care	Other cost containment measures	Preventative approaches by Health Insurance
Italy	Yes	Yes		• Increasing pressure on family/kin for caregiving • Ongoing debate on the respective roles of health and social assistance services.	• Families and institutional and private care and health structures will be called on to integrate the two sectors (social care and health care)and determine services that match the overall needs of people. • Reform of the care sector will enable social and health care to make more impact.	
Japan	Yes		Yes		New public long-term care insurance • Insurance benefit shall be awarded only after the assessment of the necessity for long-term care; the amount of benefit is also according to the result of the assessment. • User fees of the 10% of total cost, as well as the cost for the meals in case of institutional care	• There is a concept that the health insurance is to provide benefits to some contingencies that occur over one's control, so activities made on one's discretion can not be justifiably covered by the scheme. • However, with increasing importance of preventative care and health promotion along with the prevalence of lifestyle-related diseases, the insurers are beginning to be actively involved in health check-up, health consultation or other services.
Korea					• The entire population is covered by health insurance or medical assistance schemes. • Since 1996 the limit of the period for reimbursable treatment has been extended. • High out-of-pocket payment for health care (20-55%) have imposed financial burdens on patients, especially the elderly and the poor.	• Generally speaking, health insurance coverage is more focused on curative health care rather than preventative care.
Luxembourg	Yes (Strict Requirements. Also, any decision for the duration of provided help is decided based on the opinion of the Assessment and Guidance Unit.)	Yes (limit for the hour of providing professional care (24.5 hours a week for home care, 31.5 a week for institutional care.)				• Health insurance only covers curative care.
Mexico					• Cost-containment measures for health care system will also address those of long-term care.	• Pensioners are entitled to all types of health services in their social security institutes.

Table 8.8 Cost Containment Measures and Preventative Approaches (continued)

Country	Strict Eligibility Criteria/Needs Assessment	Limit of supply/benefits	User charges/ copayments	Shifting responsibility of care	Other cost containment measures	Preventative approaches by Health Insurance
Netherlands				Yes (shift of services from nursing homes to home and community based services)		• The Sickness Funds Insurance (ZFW) covers also preventative care.
Norway	Yes (allocation of services is partly based on professional evaluation of need.)	Yes (allocation of services is partly based on availability of resources in the local community.)	Yes (most municipalities charge, within certain limits set forth by the Government. The amount is often on an income-based scale.)	Yes (Decentralisation of the responsibility of care)	• Integration of services aim at cost-effectiveness as one of the goals.	• The municipalities and the National Insurance Scheme share the responsibility for preventative and curative health care. Co-payments by patients is the rule.
Poland	Yes (an eligibility requirement has been changed from the number of family members to equivalency scale according to the needs in various categories of families.		Yes		• The cost-containment measures have largely been conducted within the overall social assistance programmes, not limit to those for the elderly.	
Portugal				Yes (Promoting home support at all costs and encouraging solidarity from neighbours and voluntary personnel)		• The National Health Service is essentially free of charge (except for medications) though here are situations in the field of long-term treatments not clearly typified in terms of costs.
Spain					• Each level of governments employs its own financial and procedural decisions. • It is generally noted that strict eligibility criteria is not very compatible to the status quo where there is still inadequate development of services (in terms of quantitative aspects).	• Access to public health assistance is open to all and the emphasis is on the promotion of health and prevention of diseases.

Table 8.8 Cost Containment Measures and Preventative Approaches (continued)

Country	Strict Eligibility Criteria/Needs Assessment	Limit of supply/benefits	User charges/ copayments	Shifting responsibility of care	Other cost containment measures	Preventative approaches by Health Insurance
Sweden	Yes		Yes		• The municipalities are testing various ways of limiting costs and increasing financing.	Not applicable
Switzerland					• Cost containment measures are taken as those for health care as a whole, some parts of which will affect long-term care specifically. • There are some instances in terms of home care where some cantons withdraw funding they had previously given to health care providers. This increases the cost borne by health insurance (beneficiaries are required to be covered by the health insurance)	• Compulsory insurance for health care covers both the cost of certain examinations designed to detect illnesses in time, and preventative measures to assist insurees. • Insurers and cantons are co-managing an institution in charge of stimulating, co-ordinating and evaluating measures aimed at promoting health and preventing diseases.
Turkey					No measures taken or planned	• The health insurance scheme also covers preventative health care. • Vaccination campaigns • Maternity and child health services in health centres
United Kingdom	Yes	Yes	Yes		• Overall, there are different regimes for different types of care. A Royal Commission will be examining these issues.	• The NHS provides preventative and public health services as well as curative services.
United States	Yes • Some states do the measures such as the following: -- the strictest possible means-testing requirements -- modifying assessment and care planning procedures to tighten up functional disability criteria, etc.	Yes -- setting global expenditure limit on Medicaid financed home and community-based services.) -- Freezing or limiting cost increases in rates paid to providers of service				• Yes. The scope of coverage is not decided based on the distinction between curative and preventative aspects of the services.

Source: Responses to the OECD Caring World synthesis questionnaire

Table 9.1 Housing assistance for low-income people in OECD countries

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Australia	Yes	Separate rent assistance for pensioners and beneficiaries in private rented housing (A$1.6 billion/year)	Renters only	For private tenants, up to 75% of rent over specified thresholds
	Arrangements vary slightly across States and Territories	Commonwealth-State Housing Agreement provides grants for provision of public and community housing, housing assistance to special needs groups and other services such as rent, bond and mortgage relief (A$1.5 billion/year)		Public sector tenants pay 20-25% of their incomes in rent
		Other subsidies for home buyers	Owner-occupiers	
Austria	Yes, but varies by province	Payment as addition to social assistance	Usually renters only. To prevent homelessness authorities can take over mortgage payments	Varies according to province. Can meet full costs or fixed amounts.
		Funding of public housing stock, provision of alternative housing for aged people.		
		Interest-free loans	Owner-occupiers	
Belgium	Only on a local discretionary basis	Social assistance payments (RMG) are meant to cover housing costs. No generalised housing benefit system.	At discretion of local welfare centre	
		Subsidies mainly in “bricks and mortar”		
Canada	Yes, from Federal and provincial governments	Shelter costs included in assistance payments, up to maximum levels set by province.	Both private renters and owner-occupiers, but some provinces require reimbursement of increased equity	Actual housing costs up to provincial maximum
		Social housing tenants pay rents according to their incomes.		
Czech Republic	Yes	Housing assistance for low-income earners	Both renters and owner-occupiers	Amount of supplement varies according to housing costs, net income, number of people in the household
		Construction of public housing		

Table 9.1 Housing assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Denmark	Yes	Housing benefit for pensioners (5.863 million DDK)	Renters, owner-occupiers, those in co-operative homes	Housing subsidies calculated on basis of total household income, rent amount (up to max limit) and accommodation size..
		Rent support for non-pensioners (1.972 million DDK)	Renters	Pensioners required to meet lower proportion of costs. Rent support average payment approximately 1/4 total rent, paid to around half of all tenants.
		Public support for dwelling construction, urban renewal and housing repair (5.866 million DDK)		
Finland	Yes	General housing allowance for low-income families (consumer housing subsidies) with unreasonably high housing costs	Renters and owner-occupiers in working-age population	Income and wealth tested, depends upon housing expenses, size of household, location and size of apartment. Household liable for basic deductible amount.
		Separate housing allowance schemes, as part of each social security benefit	Renters and owner-occupiers	Up to 80% of housing costs covered. Social assistance recipients can receive help with remaining 20%.
		Pensioners' housing allowance for the elderly or other pensioners with above average housing costs.		Depends on income, housing costs and location of apartment
		Housing supplement for students, as part of student financial aid scheme.	Live alone in rented accommodation in right-of-occupancy accommodation or student dormitory	
		Conscripts' housing assistance as part of conscripts' allowance scheme.		
		State-subsidised housing loans (ARAVA loans), partial State subsidies of housing loans from financial institutions, State subsidised rental and owner-occupied apartments, new interest subsidy loans for housing companies, tax deductibility of mortgage interest payments	Mainly owner-occupiers	All seek to reduce housing tenure costs
France	Yes	Separate housing benefit scheme	Both renters and owner- occupiers	Generally only part of costs met, depending on household composition and size

Table 9.1 Housing assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Germany	Yes	Housing allowance for low-income earners, up to maximum housing cost limits.	Both renters and owner occupiers	Income-tested, also depends upon size of household, rent or housing expenses. Recipients of social assistance or war victims' welfare benefits can get a lump-sum housing allowance
		Social housing: Building loans and assistance towards housing construction and repair/ restoration with accommodation to be available for low-income persons and those who find it difficult to get suitable market accommodations (e.g. large families, lone-parent families, disabled people)	Both renters and owner-occupiers	Rent subject to rent controls. Increased tendency towards "agreed assistance"
Greece	Yes	Workers Housing Organisation (OEK) assists country's workers and pensioners with housing through: • loans for purchase, building or renovating a house	Both renters and owner-occupiers	
		• offering finished houses for sale/rent • offering interest rate subsidies to those with bank loans • rent allowances to certain beneficiaries (elderly over 60 years, young couples, low-income families with more than 3 children, unemployed)		
Hungary	Yes	Financial support for purchasing or building new housing for families with children. Assistance with housing expenditures	Owner-occupiers	

Table 9.1 Housing assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Iceland	Yes	Housing policy tends to favour owner-occupation. Means-tested loans are available for up to 90% of costs Financial Assistance includes component for rent, but since January 1995 local authorities have the power to operate separate housing allowance schemes	Both renters and owner-occupiers	For home buyers, interest rate for loans set according to income, household size and family type. For renters on social assistance, only about a third of average rents likely to be met within Financial Assistance
Ireland	Yes	<u>Social Housing:</u> • Local authorities provide housing to people in need of housing • Loans to voluntary housing bodies to help them house – elderly, handicapped, homeless people (Capital Assistance Scheme -- non-repayable cash-limited loan) – low-income families (Rental Subsidy Scheme -- repayable loans and ongoing subsidies)	Public renters	Rents related to ability to pay Rents related to ability to pay
		<u>Private Sector Housing Assistance:</u> • Supplementary Welfare Allowance Scheme to persons not in full-time employment, with mortgage assistance or rent assistance • Mortgage interest tax relief, with special concessions for first-home buyers in initial 5 years • Income tax relief on rent paid • Various grants, tax incentives to promote housing ownership, rental accommodation • Sale of local authority houses to tenants at discounted prices	Both renters and owner occupiers Owner occupiers Renters Renters and owner occupiers	Assistance is calculated taking account of individual circumstances. 80% of interest from mortgage loan Income tax relief allowances are £Ir500 for a single person, £Ir1000 for married couple Tenants receive a discount from market value equal to £Ir 3,000 plus 3% of the market value for each year of tenancy (up to limit of 30%)

Table 9.1 Housing Assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Italy	Yes	Tax allowances for first-home buyers (lower registration tax, higher tax deductions on loans) • New provision from December 1997 to provide a partial tax rebate on expenses of renovating an apartment Financial support for young couples or people with young children who buy a house (needs to be approved by the Italian Senate as a t end March 1998)	Owner-occupiers	
		Social housing for people on low incomes	Public rental	
		Financial incentives for those providing low rent accommodation for young couples or people with young children (needs to be approved by the Italian Senate as at end March 1998)	Renters	
	Some regions	Rent assistance for those in financial difficulties, reductions in Council Tax for first home or homes for rent, means-tested assistance for young couples and families with children to buy/refurbish home	Renters and owner occupiers	
Japan	Yes	Housing Aid	Renters and owner-occupiers	Can cover housing deposits, rent and necessary repair costs, up to locally determined maxima
		Public housing for low-income people	Public rental	Provides low-rent housing
Korea	Yes	Public housing project provided 190,000 permanent-rent apartments. Public housing covers 58,000 public assistance beneficiaries (42% of total beneficiaries). Rent-loan scheme, provides very low interest loan to poor people	Renters	

Table 9.1 Housing Assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Luxembourg	Yes	Rent allowances payable as part of Revenu Minimum Garanti	Renters only	Difference between gross rent and 10% of RMG payment to household , up to specified maximum
		Housing assistance for low-income people to purchase housing through grants, and subsidies/interest rebates on mortgage loans	Owner-occupiers	
		Inexpensive Housing Fund to promote construction of inexpensive housing for sale or rent	Owner-occupiers and rental	
	Some regions`	National Society for Cheap Housing and small municipalities also have programmes for building reasonably priced housing		
Mexico	Yes	National Popular Housing Fund provides financing for construction materials and new house purchase, with high priority to those with incomes below 2.5 times minimum wage	Owner-occupiers	
		Direct subsidies for beneficiaries buying homes		
		Mortgage subsidies for low-income people		Credit adjusted to mortgage repayment capacity
		Agreement between government and main producers of raw materials for discounts on building products of between 3-62%		
Netherlands	Yes	Social assistance payments meant to cover housing, but separate housing benefit available to meet particularly high costs. Administered separately from social assistance. Where costs exceed specified ceiling, temporary supplement available through social assistance and recipient supposed to seek cheaper dwelling	Renters and owner-occupiers in flats or houses (single room tenants not covered)	Costs met above specified level and below set limit.

Table 9.1 Housing Assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
New Zealand	Yes	Accommodation Supplement, available for low-income people on benefit or in employment	Renters, boarders and owner-occupiers	Supplement meets 65% of costs over threshold (25% of base benefit rate for renters and 30% for home owners), up to specified regional limits
		Public housing, owned/managed by Housing New Zealand	Public rental	Accommodation rented at market rates
Norway	Yes	Housing loans regardless of conventional credit worthiness tests	Owner-occupiers	
		Housing allowance for those with particular needs		
	Some regions	Complement housing allowance with supplementary assistance		
		Promotion of low-cost dwellings for purchase		
		Student housing, public institutions for the elderly, small public housing sector.		
Poland	Yes	Housing benefits for low-income people	Renters	Tax-free assistance is means-tested, adjusted in line with housing costs in the region and household size.
		Support for building houses with low rent for low-income families through National Housing Fund and Social Building Societies		
		New system of saving for houses and mortgage interest credits	Owner occupiers	

Table 9.1 Housing Assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Portugal	Yes	Means-tested housing allowance administered by Ministry of Public Works. Recipients must have suffered 30% reduction in monthly income or have income at level of the non-contributory social pension.	Renters only	Fixed amounts, limited to 12 months duration
		Special Reallocation Programme (PER) to remove sheds in metropolitan Lisbon and Oporto, replaced by new constructions. Families may also purchase their accommodation.	Renters and owner occupiers	Home purchase financed 50% from municipalities, 50% from government-subsidised low-interest loans from financial institutions.
Spain	No general scheme			
Sweden	Yes	Housing allowance to families with children, comprising two parts: – special allowance for children living at home, varies according to number of children in the family – contribution towards the cost of housing where the applicant lives/is registered		Special allowance is flat rate between 600Kr with for one-child up to 1,800Kr for 5+ children. Housing allowance pays 75% costs above threshold to limit, them 50% up to maximum limit. Housing allowance means tested for both families and young people; lone parents have income threshold of a couple. Allowance reduced at rate of 20% for families, 33 1/3% for young people.
		Housing allowance to young people between age of 18-29, without children		
		Social assistance recipients can have housing paid as supplement to assistance standard if "reasonable"	Renters and owner-occupiers	For assistance recipients, full costs met if reasonable. Interest payments only on mortgages
		Pensioners can also receive income-related municipal housing supplement.		

Table 9.1 Housing Assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
Switzerland	Yes	Supplementary AVS and AI benefits and social assistance can take account of housing costs. (In some regions, may also be supplementary benefits)	Renters and owner-occupiers	Discretionary
		LCAP aims to: 1) make housing at moderate rents available to those on low incomes. 2) make favourable treatment on acquiring ownership of apartments and family houses (this may involve underwriting by the Confederation, repayable advances, loans or contributions). LCAP particularly encourages construction of housing for the elderly, disabled and young people in training. The federal government, on the other hand, subsidises construction of housing for apprentices and students, as well as stabilisation of housing in mountainous regions. Those measures are also taken by cantons and certain communes.	Both renters and owner occupiers	Reduces housing costs
Turkey	Yes	National civil servants and employees with certain collective labour agreements can receive housing allowances. When necessary, the cost of housing rents for civil servants can be paid out of the budget and public housing can be provided to them with favourable conditions. In addition, national civil servants working for 10 years or more can request loans from the Social Housing Fund with special conditions.		

Table 9.1 Housing Assistance for low-income people in OECD countries (continued)

Country	Help available?	Form of housing assistance	Tenures covered	Extent of housing costs covered
United Kingdom	Yes	Housing Benefit scheme open to all tenants. Administered by local authorities. Rules of eligibility, entitlement and means test aligned with Income Support (except for double capital limit). Means tested benefit available to tenants with low incomes, irrespective of whether in work or without work. Form of cash or rebates.	Private and public tenants	Income Support recipients can have full rent met if reasonable. For those with incomes above this level, maximum benefit is reduced by 65p for each £1 of extra income
		Owner-occupiers can receive help with mortgage interest payments as supplement to Income Support (but not Family Credit)	Owner-occupiers	Mortgage interest only, subject to maximum level of mortgage. If claimant under 60 years, only 50% of interest met for first 16 weeks.
		Provision of capital and revenue subsidies to local authorities and registered social landlords (RSLs) to provide social housing	Renters only	Sub-market rental rates
United States	No national housing assistance -- geographically uneven	Section 8 Tenant-based Assistance provides vouchers or certificates used to subsidise rental costs in private sector (1.4m households in 1995)	Renters only	
		Section 8 Project-based Assistance provides government contracts with owners of rental units to provide assistance to low-income households Public Housing Assistance provides rental housing to low income individual in accommodation owned and operated by local public housing agency (2.5m households in project-based and public housing 1995)		Difference between market rent and 30% tenant's adjusted income
		Low-Income Energy Assistance Program (LIHEAP) permits states to provide assistance to low-income households with heating, air conditioning and weatherproofing of homes		

Sources: Eardley et al (1996) *Social Assistance in OECD Countries: Synthesis Report* ,
Responses to OECD Caring World Synthesis questionnaire

Table 9.2 Governmental responsibility for housing policy across the OECD

Country	Programme (if applicable)	Who sets the overall framework	Funding responsibility	Who sets detailed programme rules	Administration and delivery of programme
Australia	Rent assistance Commonwealth/State Housing Agreement	National Government National/state agreement	National 2/3 national 1/3 states, territories	National National legislation, some state/territory flexibility	National through Centrelink States/territories
Austria		National	National, provided to Länder	Länder	Länder funds municipalities and building funds
Belgium		...	...	...	...
Canada		...	...	...	...
Czech Republic	Housing assistance	National	National	...	Local bodies which pay other social assistance
	Public housing	...	Shared by National government and communities	...	Communities
Denmark	Housing subsidies	National	National/municipal levels responsible for share of subsidy costs according to established rules. Municipal councils cover administration costs	National	Municipal Council
	Public housing	National	National	...	...
Finland	Direct housing allowances	National	National	National	National Social Insurance Institution local offices, with some co-operation from municipalities
	Housing loans/subsidies	...	...	...	...
Germany	Social housing	National	Some national support to states	States	Local and district authorities
	Housing allowance	State consent to national legislation	Shared equally by national and states	National/state	Local housing allowance offices generally, social assistance offices for social assistance and war victims beneficiaries
Greece		National (OEK)	National	National	National

Table 9.2 Governmental responsibility for housing policy across the OECD (continued)

Hungary	House building	National	National	National	...
	Housing assistance	...	...	...	Municipalities
Ireland	Social housing	National	National	National	Local authorities
	Private sector assistance	National	National	National	National
	except sale of local authority houses to tenants,	...	...	National	Local authorities
	shared ownership	...	...	National	Local authorities
Italy	Social housing	National	...	...	Local regions
	Tax allowances for first home buyers	National	National	National	...
	Rent assistance, reductions in Council Tax	Local (selected ones only)	...	Local regions	Local regions
Japan	Housing aid	...	...	Local government sets maximum payment limits	...
	Public housing	National	National and local governments	National and local governments	Prefectures and municipalities
Korea	Public housing project (1989-95)	National	...	...	140,000 units constructed/administered by national govt, 50,000 by local community
	Rent-loan scheme	National	...	...	...
Luxembourg	Rent allowances in RMG	...	...	...	Paid with RMG by ...
	Housing assistance	National	...	...	...
	Inexpensive Housing Fund	National	...	...	Independent state body
Mexico	Recent agreement to transfer responsibility to state government				
Netherlands	Housing benefit	National	...	...	...
New Zealand	Accommodation supplement	National	National	National	National, through local offices of Income Support, the national benefits delivery agency
	Public housing	Managed by state-owned business, Housing New Zealand			

Table 9.2 Governmental responsibility for housing policy across the OECD (continued)

Norway	Housing grants, loans Housing allowance	National National	National National	National National	National Housing Bank Local government receives applications, does initial casework then passes to National Housing Bank who assesses rate and makes payment.
Poland	Housing benefit Support for social house constructional	National National	National contribution to the Gminas National	National National	Payment is the responsibility of Gminas National Housing Fund
Portugal	Special Reallocation Programme	National	National 50% Municipalities 50%	...	No central administration involvement. Agreements and participation of municipalities, cooperatives and two housing agencies.
Sweden	Housing allowance	National	National	Swedish National Social Insurance Board (responsible for supervising, monitoring, evaluating)	Local Social Insurance Offices
Switzerland	Supplementing AVS, AI benefits Social assistance (housing costs) Subsidy to construction of rental housing Encouragement of acquiring ownership	National Local (certain cantons) National + Local (certain cantons and communes)	National and Local (via insurance) Cantons/communes National Local National	Federal Cantons/communes National Local National	Cantons Cantons/communes National/cantons Local National/cantons
Turkey	Housing loans (by the Central Bank Housing Fund)	Central administration Local administrations	Social Housing Fund Private banks	National/Local	Central administration Directly to individuals or co-operatives
United Kingdom	Housing benefit Social housing	National National	National ...	National Local authorities, Registered Social Landlords (RSLs)	Local authorities in Great Britain, Northern Ireland Housing Executive Local authorities, private sector, voluntary sector

Source: Responses to OECD Caring World Synthesis Questionnaire

Table 9.3 Reform of housing assistance, selected OECD countries

	Changes to:			Policy trends; switch between housing measures	Switch in administrative arrangements
Country	**Public/social housing**	**Construction support, private housing**	**Housing allowances**		
Australia	Focus on options for improving efficiency and effectiveness, through better targeting, reform of rent setting, tenure and management of waiting lists		Increased rates of assistance over last 10 years	Developing principles for long-term policy, to be considered by Housing Ministers in 1998	
Denmark				Political interest in switching away from construction but has not been implemented.	
Finland		Relative importance of tax relief on mortgage interest declined over recent years. New support since 1996, with state-subsided loans, interest subsidies for individuals and building companies, help for young first home buyers		Government reducing its housing measures. Direct support through housing allowances will be increased and decline in interest subsidy to construction companies	
Germany	Assistance available from States tended to increasingly be means tested to react to changes In income of recipients	Housing Reform Bill in July 1997 initiated reforms in housing construction support	Currently considering whether to continue with separate lump-sum housing allowance for social assistance and war victims' benefit recipients, or merge it with the housing allowance.	With new reforms, central principle will be needs-based assistance for households in new dwellings and existing stock.	
Greece				Small interest free or subsidised loans main form of housing assistance until early 1990s, then increase in number of rent allowance recipients from 3,900 in 1990 to 40,000 expected in 1997	

Table 9.3 Reform of housing assistance, selected OECD countries (continued)

	Changes to:			Policy trends; switch between housing measures	Switch in administrative arrangements
Country	**Public/social housing**	**Construction support, private housing**	**Housing allowances**		
Ireland	Expansion of social housing output, role of voluntary housing sector, together with policies relating to social housing management and reduction of social segregation in housing		In recent years, supplementary welfare assistance rent and mortgage supplementation has increased sharply	1991 "Plan for Social Housing" expanded social housing and introduced a range of new responses. The measures introduced under the 1991 Plan were reviewed and updated in 1995 and again in 1997.	
Korea	Large public housing project to construct 190,000 permanent-rent dwellings for low-income households between 1989 and 1995, providing around 1% of total housing units in Korea.		Rent loan scheme introduced in 1990 to be replaced by rent subsidy programme to be enacted in new living protection law for the poor.		
Mexico		Several programmes introduced for building of new houses and buying/renovating existing buildings, such as National Popular Housing Fund (FONHAPO) credit to low-income families, agreements for reduction in price of construction materials.			Agreement signed to transfer housing responsibilities to the state level of government, in the context of broader decentralisation process.
New Zealand	Public housing now managed by a state-owned business, Housing New Zealand, which rents accommodation at market rents		New accommodation supplement	Accommodation supplement replaced a mixed cash assistance for private sector accommodation and subsided rents for the public sector housing, in 1993.	
Norway		Promotion of low-cost dwellings still important but gradual reduction of direct subsidies promoting housing supply	Policy to calculate market-based rents and then give rent subsidy for those on low incomes	Movement away from general housing assistance to means-tested assistance	

Table 9.3 Reform of housing assistance, selected OECD countries (continued)

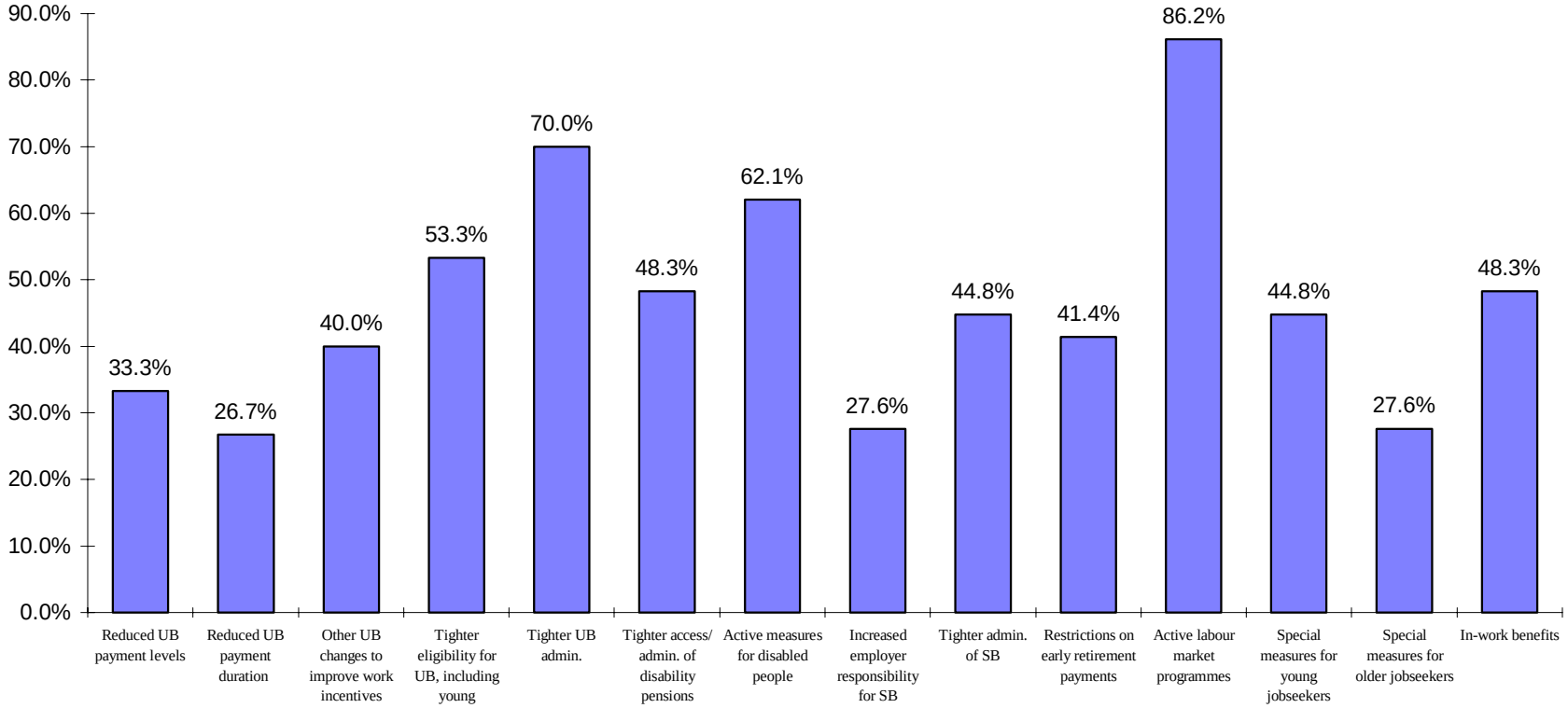
	Changes to:			Policy trends; switch between housing measures	Switch in administrative arrangements
Country	**Public/social housing**	**Construction support, private housing**	**Housing allowances**		
Poland		New system encouraging saving for housing purposes, interest rate subsidies, assistance to construct accommodation for low-income households in October 1995 Direct support for building own property planned after year 2000	Housing benefits became more focussed on low income families from July 1994		Increased role of Gminas in establishing local housing policy, since new rent setting arrangement in 1994.
Portugal		Special Reallocation Programme (PER), introduced 1993, to replace sheds in metropolitan areas of Lisbon and Oporto. From 1996, families could purchase own home in PER.		Transfer of emphasis from central administration housing promotion to financing of housing programmes developed by the municipalities. Housing policy being co-ordinated with social integration measures.	
Sweden					From 1 January 1994, state bears full cost of housing allowance and responsibility for administration given to local social insurance offices.
Switzerland		Volume of assistance for acquisition of ownership has declined since 1995 because of developments in broader housing market, such as low demand, falling property prices and surplus supply in some areas.		Federal law has traditionally preferred to focus on housing supply rather than income to assist low income households. However, management of limited resources benefits from the benefits of social assistance (cantons/communes) or of insurance (supplementary benefit of AVS/AI)	

Table 9.3 Reform of housing assistance, selected OECD countries (continued)

	Changes to:			Policy trends; switch between housing measures	Switch in administrative arrangements
Country	**Public/social housing**	**Construction support, private housing**	**Housing allowances**		
Turkey	A feasibility study being prepared for 10,000 housing units in South Eastern Anatolia	Housing loans with favourable conditions to low-income people (from July 1, 1998) The Social Housing Administration is planning the infrastructure. Central/local administrations provide land for housing at low prices.		Long tradition of minimal direct public intervention abandoned in 1980s. Intervention only temporarily successful and fiscally unsustainable. Looking to develop new strategy emphasising facilitating role of government.	
United Kingdom	Raising rent levels in local authority sector has now stabilised. Considering how to best constrain increases in rent in Registered Social Landlord sector			In recent years, Government has shifted the balance of expenditure from subsidy on rents to subsidies directed at those on low income.	
United States				Recent trends in housing assistance are towards certificates and vouchers rather than housing supply measures. However, in 1995 had 1.4 m households receiving vouchers or certificates and 2.5m households in public or project based housing.	

Source: Responses to OECD Caring World Synthesis Questionnaire

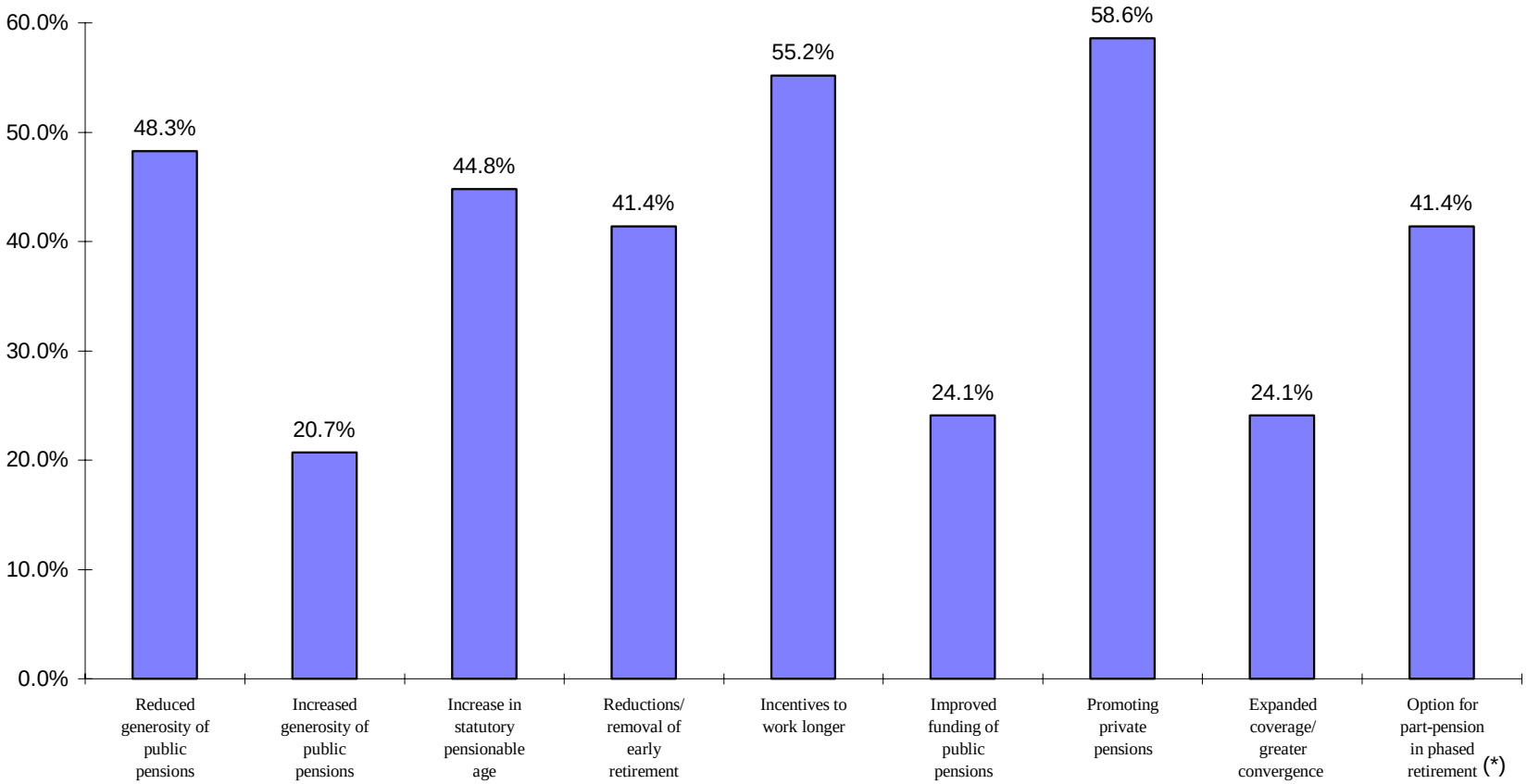
Chart 5.1: Countries taking policy action for people of working age, as a proportion of countries reviewed



1. UB is Unemployment Benefit; SB is Sickness Benefit
2. For changes in unemployment benefit arrangements, the proportions are from a maximum of countries (of 30). For other aspects, the maximum number of countries is 29 as Iceland did not respond to the Caring World questionnaire.

Sources: Country responses to Caring World questionnaire; OECD (1994b) *OECD Jobs Study: Evidence and Explanations Part II* ; OECD (1997c) *Implementing the OECD Jobs Strategy: Member Countries' Experience* ; OECD (1996-98) *OECD Economic Surveys* , various countries, various years.

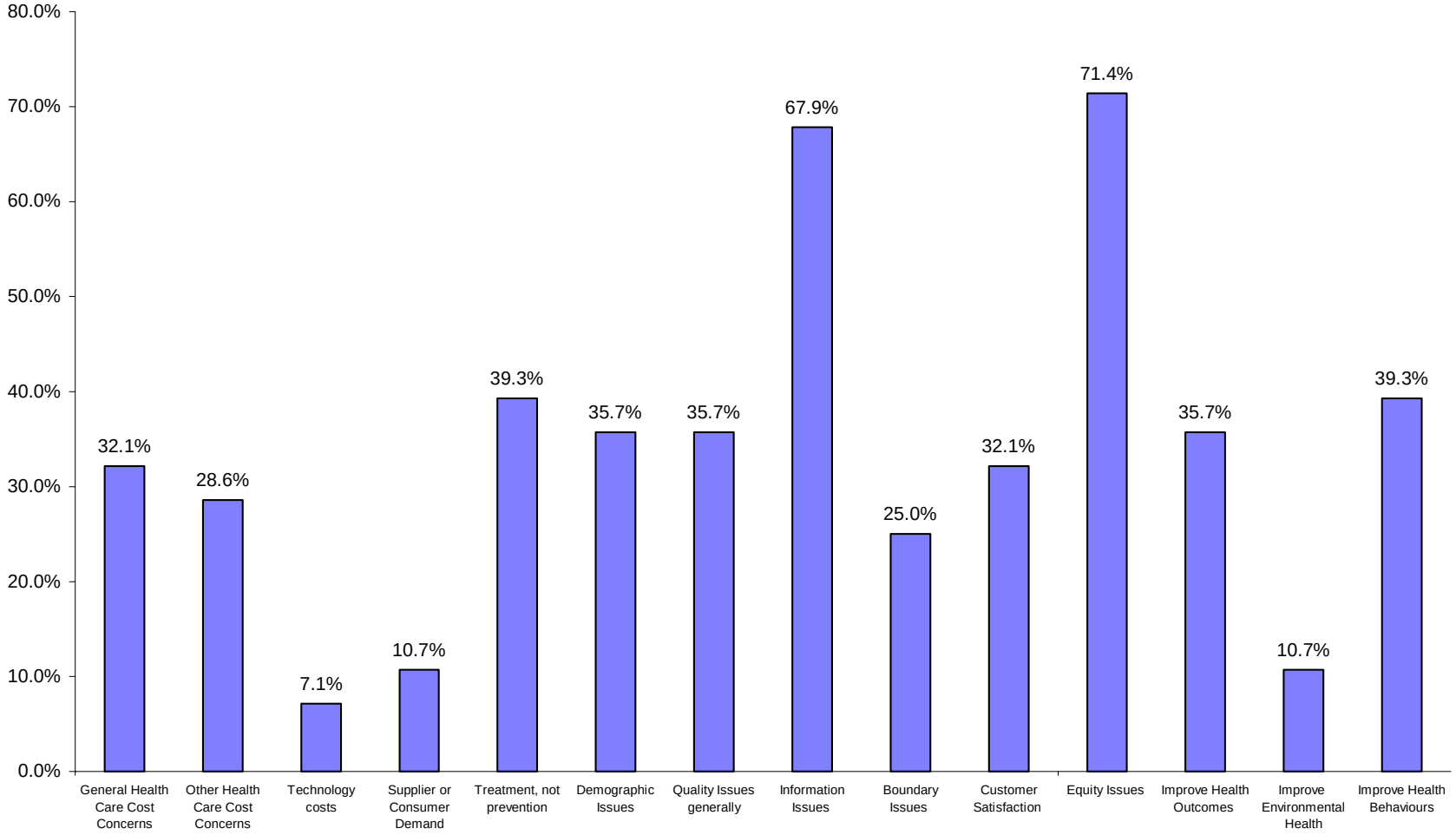
Chart 6.1: Countries taking policy action in retirement incomes, as a proportion of countries surveyed



Note: Excludes policies "still under consideration"

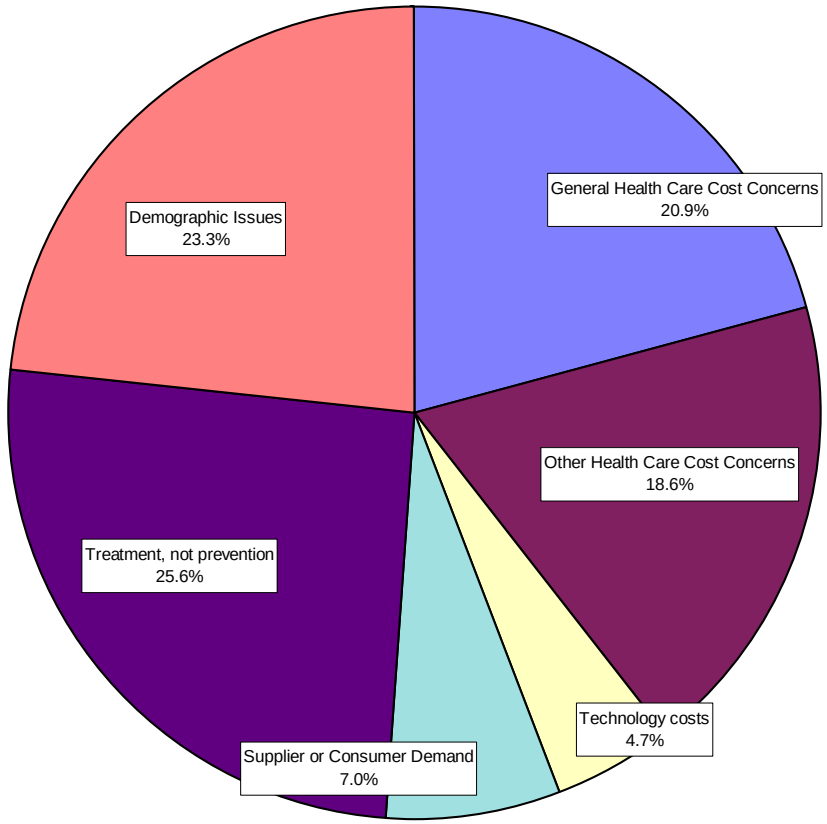
(*) Includes Italy which is moving to restrict this policy and Sweden which has plans to remove it.

Chart 7.1: Breakdown of health policy concerns by issue area, as a proportion of countries experiencing concerns



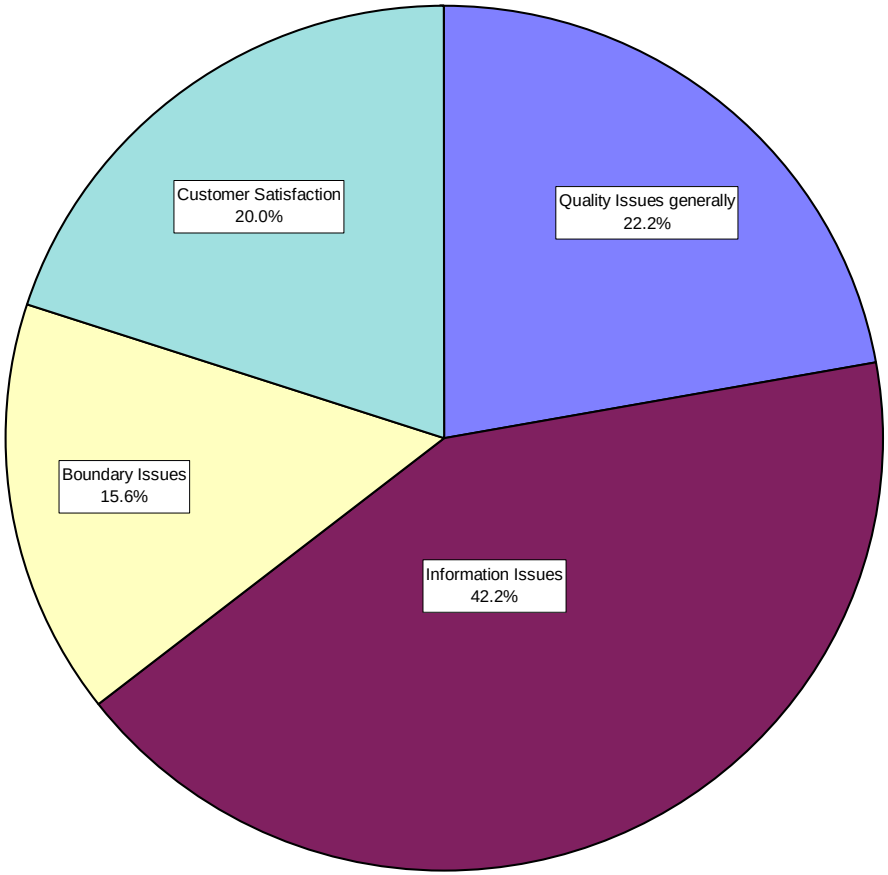
Methodology: The results presented in the above chart correspond to Question III.A.1 of the Caring World synthesis questionnaire, which asked an open-ended question: "what are current policy concerns relating to health policy and what are the recent and planned public policy responses to these questions?" The number of countries expressing concern about a specific issue were divided by the total number of countries (28) responding. The next few charts provide more detailed information about definitions.

Chart 7.2: Breakdown of country concerns about health care costs



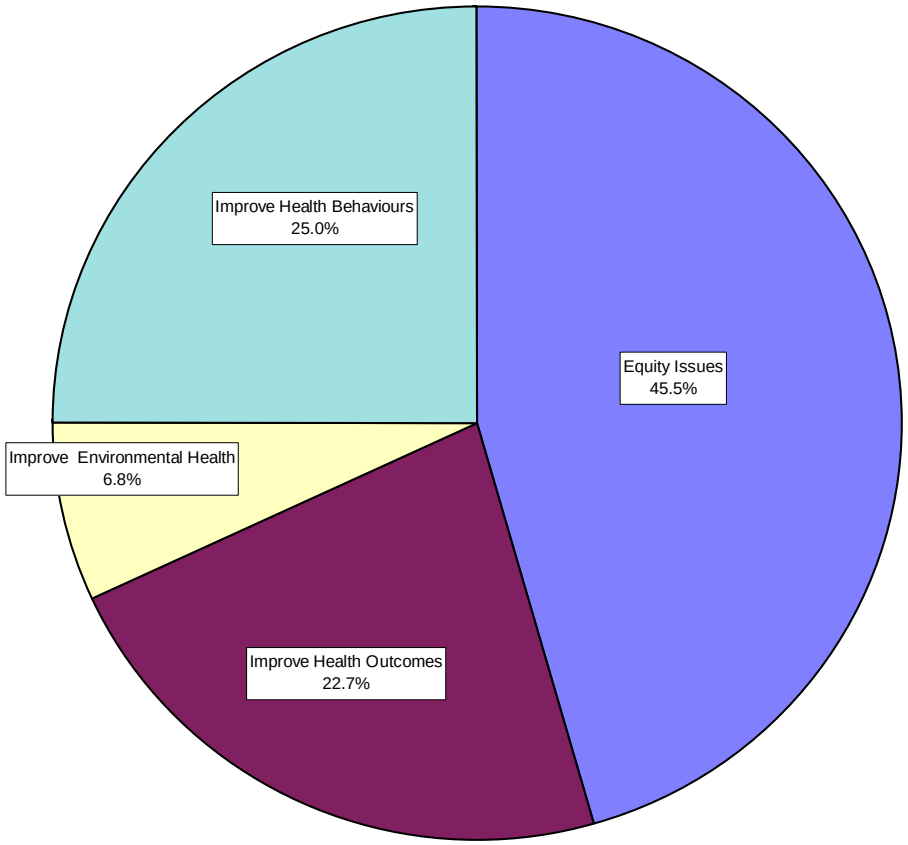
Note: This breaks down concerns by topic area. That is, of the 25 countries that expressed concern about cost and financing issues, this is the percentage breakdown**. Country concerns were classified as follows**:
General Concerns with Health Care Costs: Issue of health care costs in general, without specifics.
Supplier and Consumer Demand: Concerns about excess consumer demand, oversupply of services, or insufficient consumer accountability.
Technology costs: Concerns about insufficient evaluation measures or poor return on investment in technology.
Demographic issues: Issues about ageing populations or a lack of revenue due to a decrease in the number of people paying for the system.
Treatment, rather than Prevention: Concerns about providers being overly focused on a treatment (or curative) paradigm rather than a prevention-oriented paradigm.
Costs -- other: Issues, such as fraud, that did not fit neatly into other categories.

Chart 7.3: Breakdown of country concerns about quality in health care delivery



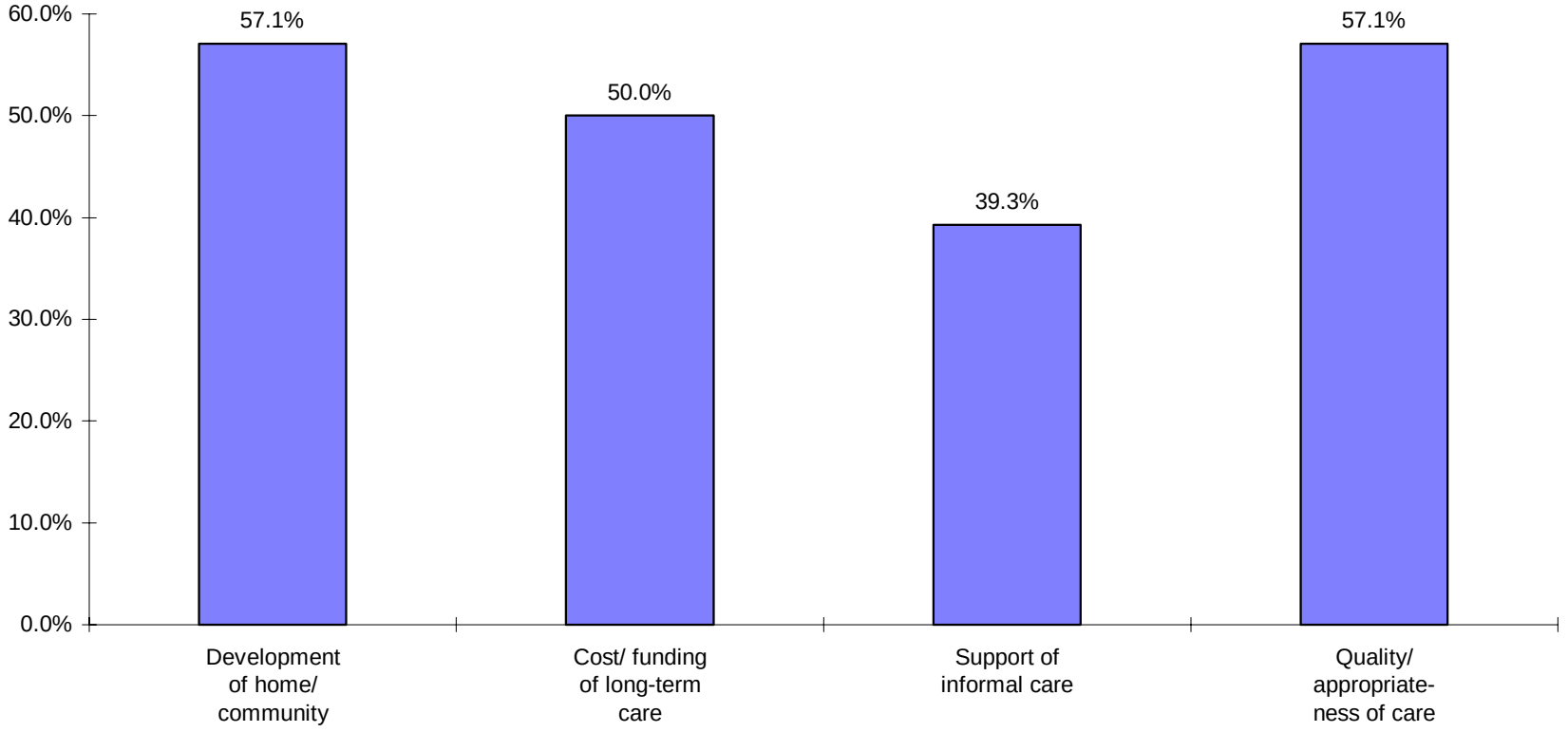
Note: This breaks down concerns by topic area. That is, of the 23 countries that expressed concern in this area, this is the percentage breakdown. **Country concerns were classified as follows**:
Quality Concerns -- Generally: Concerns about the quality of health care systems without further specificity.
Efficiency and information issues: Inefficiency, duplication of services, and lack of information and data systems.
Boundary issues Merging departments, shifting responsibility for certain programs from one area of government to another, or developing cross-cutting social programs may lead to concerns about efficient distribution of resources and turf battles over responsibilities.
Customer Satisfaction: Includes *causes* of customers dissatisfaction such as queuing for services or waiting lists for treatment, and *symptoms* of customer dissatisfaction, such as people leaving the public system for private insurance indicates dissatisfaction with the public system. Also included: concern over provider dissatisfaction.

Chart 7.4: Breakdown of country concerns about public health



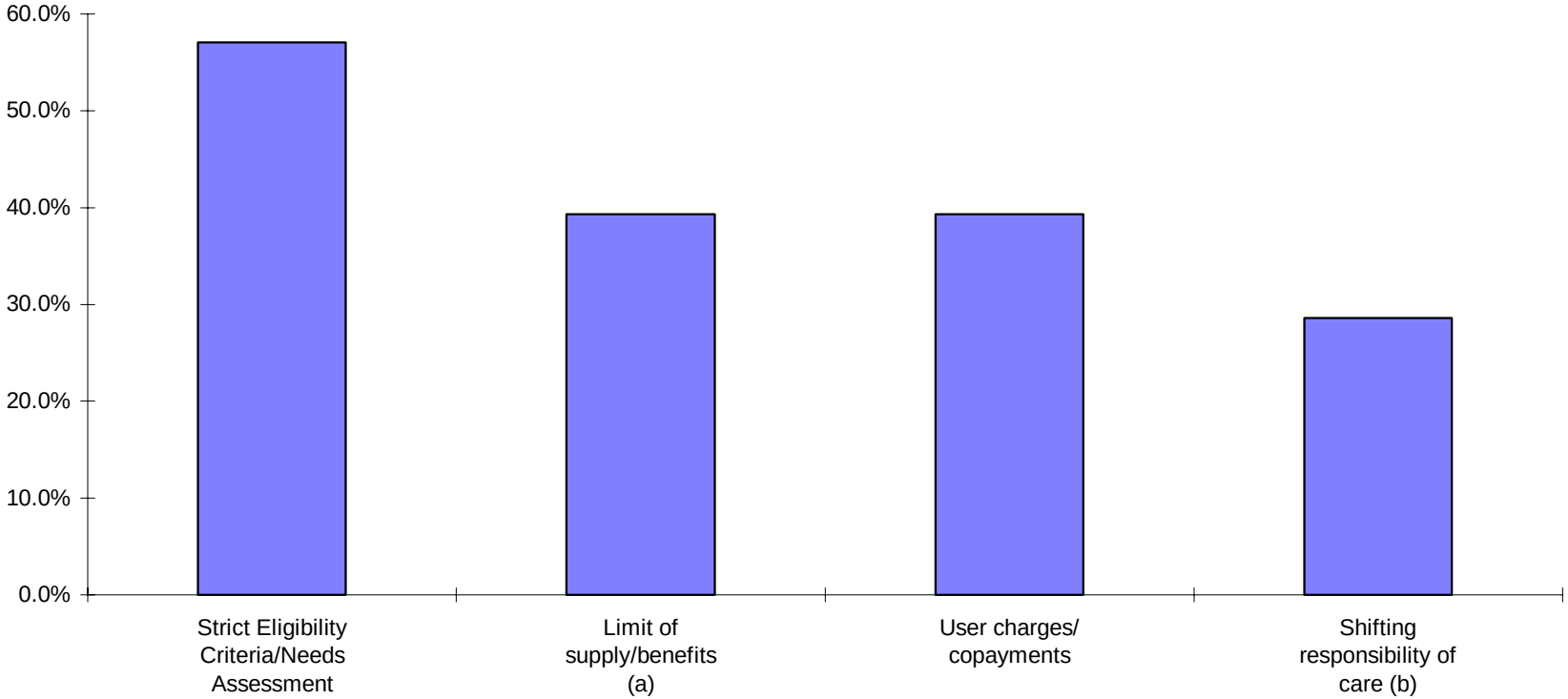
Note: This breaks down concerns by topic area. That is, of the 24 countries that expressed concern about public health issues, this is the percentage breakdown. **Country concerns were classified as follows**:
Health Outcomes: Issues such as emerging infectious diseases, increased prevalence of chronic diseases, infant mortality rates, and life expectancy. This was also the 'other" category for the purposes of classification.
Improving Environmental Health: Issue relevant to the newer OECD member countries. These countries are still struggling to improve their drinking water and environmental health.
Improving Health Behaviours: Issues such as smoking, decreasing transmission of sexually transmitted diseases, and encouraging a healthy lifestyle. While all of these programs would likely improve health outcomes, countries tended to list their goals about this policy area separately.
Equity: Concerns about expanding coverage for their population, guaranteeing access for those with limited income, or disparity of health outcomes between populations.

Chart 8.1: Policy concerns in terms of long-term care, as a proportion of countries surveyed



Note: This shows the proportion of countries that indicated the above policy concerns in their long-term care systems, according to the national responses to the Caring World synthesis questionnaire. (The total number of respondents is 28 countries.)

Chart 8.2: Cost-containment measures (long-term care) taken by countries, as a proportion of countries surveyed



Note: This shows the proportion of countries that implemented the above cost-containment measures in their long-term care systems, according to the national responses to the Caring World synthesis questionnaire. (The total number of respondents is 28 countries.)
(a) Includes limit of hours for service, limit of funding or other resources, etc. Setting the basic minimum of services in general is also included.
(b) Includes decreasing insured benefits, hospital care to community care, etc. Decentralisation of administration is also included.