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AGEING AND CHANGES IN PUBLIC SERVICE DELIVERY -- PRELIMINARY CONCLUSIONS

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EXECUTIVE SUMMARY

OECD countries have been successful in adding years to life; people are living longer and relatively healthier lives. However, one of the effects of this achievement is that population is ageing as the number of elderly people is growing and the proportion of younger generations is diminishing generating economic and social hardships. Indeed, demographic indicators show that the old-dependency ratio (65+ in % 15-64) will increase significantly from an average of 22.8 in 2000 to 51.2 by 2050 which is largely due to the combination of increasing life expectancy levels and decreasing mortality and fertility rates. This demographic phenomenon is creating pressures for governments to rethink the methods and mechanisms for the provision of public services in the most efficient, cost-effective and transparent manner. As a consequence, the delivery system, understood as the combination of pathways and actions undertaken to provide public services, needs to be adapted to the new demographic reality. The challenge for OECD countries is to guarantee the delivery of the appropriate services at the right time to people who need them no matter their age. This requires designing a flexible and adaptable delivery system that ensures high levels of efficiency, accountability and equity.

OECD countries are implementing actions to adapt the delivery system to the changing structural context that include the decentralisation of service provision. This implies the redefinition of responsibilities for service delivery across levels of government and the implementation of mechanisms to improve the distribution of financial and human resources among the different levels of government in order to ensure administrative capacity. The reason for this is that regional and local governments are typically in charge of the provision of basic public services like health and long-term care whose demand is expected to increase as a consequence of ageing. However, it is central government’s responsibility to ensure that regional and local governments have the capacity to perform their tasks. The creation of networks to reinforce co-operation across levels of government, a clear definition of tasks, and the adoption of a regional approach as an underpinning for regional and inter-municipal co-operation have been the cornerstone of reforms in this area.

The experience of OECD countries suggests that ensuring the provision of public services to an ageing population requires having a wider mix of providers and provision means. Thus, the involvement of private and voluntary organisations in service delivery has proved critical to diversify the range of providers and acquire additional capabilities for service delivery. The creation of multi-purpose venues and the use of arms’ length bodies have been the response to the dilemma of reducing the size and cost of bureaucracy, while at the same time increasing the coverage of public services. Meanwhile the implementation of market-type mechanisms such as public-private partnerships, vouchers and user chargers constitute a way of ensuring value for money and cost-containment in service delivery. Moreover, OECD countries are using ICTs as an asset to increase productivity, efficiency and the quality of services while reducing costs. Even more, ICTs are seen as a means for problem-solving and a mechanism to facilitate co-operation and co-ordination among the different stakeholders through the creation of online networks.

This report concludes that the organisation or adjustment of the public service delivery system is not solely determined by ageing. Democratic concerns to guarantee citizens’ participation in policy-making, the limited availability of resources to provide basic public services, and the need to increase productivity, efficiency, effectiveness and quality of public services also play a large role in setting priorities and
defining mechanisms for service provision. Moreover, this report found that in order to meet the demands of an ageing population in terms of public services governments need to have the ability to enhance co-ordination across levels of government and foster collaboration with private and voluntary organisations for the provision of services. The implementation of a *whole-of-government* approach is seen as a condition to reach integration in an otherwise fragmented environment. Finally, this report claims that the co-ordination and collaboration in service delivery for an ageing society needs to be underpinned by tackling ageism; making emphasis on prevention; maintaining older people’s independence, well-being and freedom to choose; perceiving ageing as an opportunity rather than as a challenge; and focusing on the entire population and not only on the elderly.
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INTRODUCTION

Societies in OECD countries are ageing as the proportion of older people increases and the number of young people diminishes. Although living longer is an achievement of science and technology developments and of public services, an ageing population is generating new problems for governments to provide public services. Basically, public service delivery systems are not designed to operate in a society with large cohorts of older people. This context is creating significant pressures on the ability of governments to maintain current levels of service in some areas and increase the level of productivity in others due to the new demands of an ageing population.

This report is the second part of the OECD research on ageing and the public sector. The first part was published under the title Ageing and the Public Service: human resource management challenges (OECD, 2007). This second report builds on the experience of eight OECD member countries to identify the current trends in reforming the public service delivery system to meet the challenges of an ageing population.

The eight case studies suggest that OECD countries are implementing a series of reform measures to adapt the public service delivery system to the context of an ageing population that consist of: (i) the redefinition of responsibilities for service delivery across levels of government, giving a more active role to regional and local governments in service provision; (ii) reallocating resources (financial and human) across levels of government to ensure the administrative capacity of local authorities to provide public services; (iii) the adoption of market type mechanisms intended to increase the participation of private agents in public service delivery; (iv) the use of communication and information technologies to facilitate service delivery, increase coverage and reduce costs; and, (v) the integration of the voluntary sector into the public service delivery strategy.

The first part of the report contains the main findings of the case studies analysis. Chapter one presents an overview of the demographic changes in OECD countries and their implications for public service delivery. In particular, it highlights the changing priorities and challenges for the delivery of public services as a consequence of ageing populations. Chapter two focuses on the institutional changes in multi-level governance that are being implemented by OECD countries to improve the delivery of public services. It discusses how OECD countries are distributing the responsibilities for service delivery across the different levels of government and the mechanisms they are adopting to reallocate staff and financial resources across levels of government to ensure that regional and local governments have enough administrative capacity to respond to the new demands for public services. Chapter three presents an overview of the organisational changes adopted by OECD countries aimed at contributing to a better co-ordination of efforts in service delivery with private and non-governmental service providers. It briefly discusses the policy approach and mechanisms commonly used by OECD countries to increase effectiveness in service delivery while at the same time controlling the bureaucratic burden. Moreover, it explores how the use of information and communication technologies is contributing to increase productivity gains in service delivery in the context of an ageing population. Chapter four analyses the role of the voluntary sector in service delivery and particularly its integration into the ageing strategy. Finally, chapter five presents the main policy lessons drawn from the analysis of the case studies. It examines the common features of the reforms to the delivery systems that may be the basis towards the establishment of
an ageing strategy. In addition, based on the experience of the ageing phenomenon, it analyses what the tendencies in policy-making are and the implications for the future of public management.

The second part of this report is integrated by the case studies of eight OECD member countries (Canada, Finland, Iceland, Italy, Japan, Korea, Mexico, and the United Kingdom) that are a revised version of the country reports submitted to the OECD secretariat. They all have the same structure followed in this report to maintain consistency. The country reports were prepared by the following officials:

- **Canada**: Mr Peter Hicks, Canada Public Service Agency; Ms Cecilia Muir, Vice-president, Canada Public Service Agency, Canada;
- **Iceland**: Ms Helga Jóhannesdóttir, Special Advisor, Ministry of Finance, Iceland;
- **Italy**: Mr Francesco Verbaro, Director of the Office Public Administration’s Personnel, Prime Minister’s Office, Department of Public Administration, Italy;
- **Japan**: Mr Bunzo Hirai, Chief Analyst of Human Resource Management, Ministry of Internal Affairs and Communications, Japan;
- **Korea**: Mr Giewook Richard Koo, Assistant Director, Ministry of Public Administration and Security, Korea;
- **Mexico**: Mr Rodrigo García Verdú, Deputy General Director for Financial Projects Evaluation, Ministry of Finance, Mexico;

The country reports for Finland and the United Kingdom were prepared by the OECD Secretariat. This report embodies the preliminary conclusions of the OECD Secretariat on the impact of ageing in public service delivery. A revised version is expected to be produced based on the comments and observations made during the discussions of the annual meeting of the Public Employment and Management Working Party in December 2008.
1. THE CHALLENGE OF AGEING POPULATIONS FOR PUBLIC SERVICE DELIVERY

The burgeoning proportion of older people in OECD countries is creating multigenerational societies. Population ageing is having deep implications in all social, economic, political and cultural spheres. Nowadays OECD countries face the challenge to adapt the public service delivery system to guarantee the adequate provision of services to a society with different priorities and needs. Therefore, the aim of this section is to present an overview of the demographic changes in OECD countries and their implications for public service delivery.

Ageing Populations in OECD Countries

Over the last decades, OECD countries’ population has experienced a deep demographic transition from a state of high births and death rates to one of low births and death rates. The result has been a change in the demographic structure of the population with the number and proportions of old people growing and the number and proportions of young people diminishing. Hence, population ageing may be understood as the process by which older individuals constitute a proportionally larger share of the total population over a period of time. Ageing refers not only to an increase in the proportion of the population aged 65 and over but to a decline in the number of children, youth, and working-age population (people between 15 – 64 years old). At least three factors may account for these changes: increases in life expectancy, low fertility rates, and decreasing death rates. Indeed, as Figure 1 shows, over the last decades, life expectancy has been growing in the eight OECD countries participating in this review, but this is a tendency in all OECD countries. Although in all countries life expectancy has increased, it has done so at different speed rates. For instance, in 1980 life expectancy in Mexico was 67.2 years in average and in Korea 65.9; however, in 2005 life expectancy was 75.5 and 78.5 respectively. Nowadays, life expectancy in Korea is comparable to the one in Finland and the United Kingdom.

Figure 1. Life expectancy in OECD countries

From 1980 to 2005

Source: Based on OECD DELSA database.

Ageing population is not an exclusive characteristic of OECD countries. Developed and developing countries are facing the same demographic phenomenon but at different tempo. Box 1 presents a statistical
snapshot of the demographic changes in world’s population’s composition. These demographic changes have been too recent and rapid to have been integrated in societies’ concept of life as a united whole, but this has been a progression of interrelated stages.

**Box 1. Statistical snapshot of world’s demographic changes**

- One out every ten persons is now 60 years or above; by 2050, one out of five will be 60 years or older.
- The older population itself is ageing. The oldest old (80 years or older) is the fastest growing segment of the older population. They currently make up 13% of the cohort over 60 years and will grow to 20% by 2050. The number of centenaries (aged 100 years or older) is projected to increase 14-fold from approximately 265 000 in 2005 to 3.7 million by 2050.
- The majority of older persons (55%) are women. Among the oldest old women constitute 64% of the population.
- Differences exist between regions as one out of five Europeans, but one out of twenty Africans, is 60 years or older.
- In some developed countries the proportion of older persons is already one in four. During the first half of the 21st century that proportion is expected to be one in two in some countries.
- As the tempo of ageing in developing countries is more rapid than in developed countries, developing countries will have less time than developed countries to adapt to the consequences of population ageing.
- Approximately half of the world’s older population live in urban areas. Thirty years ago the proportion was 40%.
- Twenty years have been added to the average lifespan in the second half of the 20th century, bringing global life expectancy to its current level of 66 years. However, large differences remain between countries. For instance, in the least developed countries, men reaching age 60 can expect only 15 more years of life and women 17 more, while in the more developed regions, life expectancy at age 60 is 19 years for men and 23 years for women.
- The impact of population ageing is increasingly evident in the old-age dependency ratio. Between 2005 and 2050, the old-age dependency ratio will almost double in more developed regions and almost tripled in less developed regions.
- Age structures of families are changing. The traditional pyramid of many youth and few elders is giving way to the inverse family pyramid of potentially one child, two parents, four grandparents and several great-grandparents. Two or more generations can be over age 60.


Low fertility rates have largely determined the changes in the age structure of population in the OECD area. As Figure 2 shows, in OECD countries one woman in reproductive age has 1.63 children in average. However, large differences remain among OECD countries. For instance, whereas Turkey and Mexico have the highest fertility rates (2.43 and 2.20 respectively), Czech Republic and Korea have the lowest fertility rates with 1.22 and 1.19 children per woman respectively.
As a consequence of low fertility rates, the total population in some OECD countries is expected to decrease. Such is the case in countries like Germany, Japan, Portugal and Slovak Republic (Table 1). In some others the total population is forecasted to continue at the same levels but with changes in the age pyramid.

Table 1. Total population forecast for OECD countries

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>19.2</td>
<td>28.1</td>
<td>Korea</td>
<td>47</td>
<td>44.3</td>
</tr>
<tr>
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<td>Luxembourg</td>
<td>0.4</td>
<td>0.6</td>
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<td>Belgium</td>
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<td>11</td>
<td>Mexico</td>
<td>98.9</td>
<td>140.2</td>
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<td>30.7</td>
<td>41.4</td>
<td>Netherlands</td>
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</tr>
<tr>
<td>Czech Republic</td>
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<td>9.5</td>
<td>New Zealand</td>
<td>3.3</td>
<td>5</td>
</tr>
<tr>
<td>Denmark</td>
<td>5.3</td>
<td>5.2</td>
<td>Norway</td>
<td>4.3</td>
<td>5.6</td>
</tr>
<tr>
<td>Finland</td>
<td>5.2</td>
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<td>Poland</td>
<td>38.3</td>
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</tr>
<tr>
<td>France</td>
<td>58.9</td>
<td>64</td>
<td>Portugal</td>
<td>10.2</td>
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</tr>
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<td>Germany</td>
<td>82.2</td>
<td>75.3</td>
<td>Slovak Republic</td>
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<td>Sweden</td>
<td>8.9</td>
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<td>Switzerland</td>
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<td>Italy</td>
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<td>52.9</td>
<td>United Kingdom</td>
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<td>69.2</td>
</tr>
<tr>
<td>Japan</td>
<td>126.9</td>
<td>100.6</td>
<td>United States</td>
<td>282.4</td>
<td>420.1</td>
</tr>
</tbody>
</table>

Source: Based on OECD DELSA database.

Indeed, as Figures 3 and 4 show, in the countries taking part in this review, the proportion of people aged 65 and over is expected to increase while the cohort of people under 15 years of age is forecasted to decrease. Although the cohort of working age people (15 – 64 years old) will continue to be the most numerous in the eight countries, they will face bigger challenges as the old-age dependency ratio will increase.
Figure 3. Distribution of total population by age group in 2000

Source: Based on OECD DELSA database.

Figure 4. Population estimates for 2050 by age group

Source: Based on OECD DELSA database.

Figure 5 shows that the old-age dependency ratio, that is the number of working age persons (15 – 64 years old) per older person (65 years or older) that is used as an indicator of the ‘dependency burden’ on potential workers, is expected to change dramatically over the coming decades as a consequence of population ageing. In 2000, the old-age dependency ratio in the OECD area was 22.8 and is forecasted to change to 51.2 by 2050. The dependency burden will be more dramatic for countries like Korea where the old-age dependency ratio will change from 11 to 68. Even countries with relative younger populations like Mexico and Turkey will experience considerable demographic changes as the old-age dependency ratio will change from 9 to 35 and 10 to 31 respectively.
An additional factor to consider is the geographical location of older people. As Figure 6 reveals the larger proportion of older people is located in urban areas where they have a relatively easier access to all kinds of health, social and long-term care services. Nonetheless, an important percentage of the elderly population is located in rural areas where access to basic public services is not always guaranteed. To reach people in remote rural areas governments are increasingly using information and communication technologies (ICTs), as this report will later discuss, but providing services to older people through ICTs requires having the appropriate infrastructure and training users on the new technological developments. This suggests that education will continue playing a crucial role in preparing the ground for providing and facilitating services to a rapidly ageing population.
Implications of Ageing for Public Service Delivery

Redefining priorities due to ageing

The ongoing demographic changes are leading governments to rethink the priorities in terms of public services to balance levels of offer and demand. Ageing societies with a large and growing proportion of elderly people need to find out ways to better provide public services to satisfy changing demands. In that sense, the redefinition of priorities is one of the first steps towards the readjustment of the public service delivery system, understood as the combination of pathways and actions undertaken to provide public services. The reports of OECD countries participating in this review suggest that the main priorities for public service provision may be summarised as follows:

- Increase the offer of basic public services (health, education, shelter, sanitation, security and transportation) to bridge the historical gaps related to public service delivery. According to the United Nations Programme on Ageing, population ageing means that health, long-term care, and social services will be in higher demand because old people, in general, require more health care services than younger generations. However, the aim is to reach all groups of society notwithstanding their age and geographical location. The demand for health services for the elderly is expected to increase as social security, welfare, long-term medical treatment and health guarantee are basic services for an ageing population. Even if old people tend to live healthier lives, the demand for services to treat degenerative diseases such as: outpatient care, hospices, organ transplantation, dementia, organ transplantation and home care visit programmes is
expected to increase. For example, as Figure 7 shows, in all countries participating in this study, total expenditure on health (public and private) has increased over the last 15 years.

Figure 7. Total expenditure on health in selected OECD countries


Source: Based on OECD StatLink database.

- Guarantee the administrative capacity of regional and local levels governments for the provision of public services supplying them with the necessary financial and human resources that would enable them to comply with their responsibilities.
- Build infrastructure for the provision of health and long-term care services to meet the expected increases in demand of these services due to ageing.
- Design mechanisms to support families in their role as care givers so as to maintain older people at home and reduce the burden for long-term care services which must focus on people who really need them. Flexible working conditions constitute an option explored by some OECD countries. Indeed, in most of the countries participating in this review there are concerns about the feasibility and adequacy of long-term care in place. The provision of long-term care at home is one of the most recurrent strategies used by countries (Canada, Finland, Iceland, Italy, Japan, Korea, and the UK) to alleviate the demand for institutionalised care for the elderly and as a way to maintain the family groups integrated. Governments are designing and establishing programmes aimed at facilitating the role of family members as care givers and making them more co-responsible for the well-being of the elderly.
- Increase the infrastructure of information and communication technologies for the provision of public services as a mechanism to obtain productivity gains and reduce costs. The use of information and communication technologies (ICTs) is having a larger role in long-term care mainly in areas such as disease prevention and treatments for degenerative diseases: Alzheimer, arthritis, diabetes, joint replacement, etc. However, there is little information regarding the

1. Although there is no information to suggest that these increases have been brought about by population ageing, the expected increments in the cohort of people aged 65 and over are likely to be a more determinant factor in the coming years.
number of people with these conditions in the medium and long-term; therefore, the use of ICT in health care for the elderly is to be determined, more likely, by today’s rates of frail population. It is worth noting that there are no forecasts or projections regarding the demand for public services for the medium and long-term in any of the countries that took part in this review.

- The establishment of conditions to encourage people to remain active either by delaying retirement what would relieve the burden to the pension system, or by participating in voluntary activities. This is because an active ageing is considered a way for older people to maintain their independence for longer and keeping themselves healthier.

- The creation of a culture of prevention. In this aspect the education system plays a key role as healthy ageing begins at an early age. Young people need to be trained and encouraged to live healthier life styles like avoid smoking, drinking and eating junk food and to motivate them to do exercise, following healthy diets and having their minds occupied in creative work. In the long-term prevention is expected to produce benefits such as the decrease in the number of physical and mental diseases associated with ageing. Therefore, the investment in educational, cultural, sport, and recreational infrastructure to which the whole population has access is considered a critical element of an ageing strategy.

Policy approaches to ageing

Ageing population is undoubtedly part of policy discussions in all OECD countries participating in this review, although at different extents. However, as the analysis of the eight case studies reveals, ageing is only one of the variables that determines policy priorities and reform strategies to enhance countries’ economic and social development. Nonetheless, the result of policy decisions is expected to be a system of service delivery more responsive to the needs of an ageing population. For instance, in Canada, Mexico and the United Kingdom increases in health care provision spending are largely due to policy decisions to improve the quality and coverage of health services for the whole population than as a result of a focus on ageing population discussions. Similarly, the creation of Service Canada to improve public service delivery was not directly linked to ageing.

Issues about the overall size and structure of the population do not have the same role in policy agendas across countries. In Canada and the UK for example, the size of the population is not as relevant in policy-making as in Finland and Japan. As a result, it is possible to distinguish two main approaches to provide public services to ageing societies. On the one hand, individual ageing strategies tend to focus more on policies that relate to older people addressing issues such as active ageing, ageism, retirement, income security, healthy ageing, etc. On the other, population ageing strategies focus on the policy implications of the changing age structure and size of the population, for instance, the social and economic effects of and older workforce. However, most of the countries analysed in this review present characteristics of both approaches.

Challenges for Public Service Delivery Generated by Ageing

Ageing population is creating pressures on governments to provide public services. Indeed, current public service delivery systems were designed to meet the demands of relative young societies where retired people, for instance, were not expected to live long retirement years. Moreover, it is not possible to distinguish a homogenous group of older people as there are senior citizens living healthier and independent lives and others who have very special social, health and physical needs. Hence, considering ageing as a backdrop, OECD countries have two main challenges in public service delivery. On the one hand, OECD countries have to make sure they provide the right services at the right time to the individuals who need them. This has always been the aim of any service delivery system but the fact that the demographic structure of the population is changing, it raises the necessity to conduct adjustments to the
system itself so that it can continue meeting its goals and increasing its coverage. On the other, OECD countries have to design a service delivery system that is flexible and adaptable to operate in an environment of continuous change in people’s demands. Even more, the delivery system has to assure that services are provided under high levels of efficiency, accountability and equity.

The challenge of providing public services in a context of an ageing population exacerbates the following variables that directly or indirectly impact the provision of public services to the whole population:

- Public service provision is taking place in a context of limited financial and human resources. Most of public services are financed by tax payers and most of the resources for financing public services depend on the ability of governments to raise funds and distribute financial resources according to priorities.
- OECD countries need to reinforce trust in public institutions. As the OECD (2000b) study reveals, OECD countries need to ensure that daily public service operations for business are reliable and that public resources are effectively, efficiently and properly used. Thus, it is important to reinforce communication channels between government and citizens to improve understanding and mutual trust levels.

**Box 2. Public trust in the Spanish health-care system**

Over the last decade Spanish population showed substantial dissatisfaction with the health care system. Policy-makers in Spain face a dilemma: the public wants more health spending to decrease wait times, but there is substantial resistance to increasing taxes as a means to finance improvements in the system’s capacity. Hence, health-care in Spain has undergone significant changes, including a decentralization of the system, an increase in spending and a change in the system is financed. As a result, there has been a substantial improvement in the public’s view about how well the Spanish health system operates. The proportion of people with negative feelings towards the health care system has decreased by half. An important finding is that health-care institutions and professionals are more trusted than other professional groups in the country. The public demonstrates a high level of trust in the publicly funded provision of health services at a time when there is a low level of trust in government in general.


- There is a high level of dependency on other actors outside the public domain for the provision of services (see for instance Richards and Smith, 2002). Non-profit organisations, the private sector, the different levels of government and individuals have an important role in the assuring the provision of public services to the whole population. Therefore, collaboration needs to be enhanced to have a co-ordinated provision of public services.
- There are pressures to ensure that public expenditure is cost-effective. This implies the creation of infrastructure to satisfy the demands for health and long-term care services while at the same time guaranteeing the supply of trained and qualified staff. To be cost-effective may also require the use of technology in service delivery to make up for the lack of staff but at the same time to reduce operating costs. The involvement of a wider variety of providers like purchasing services from the private sector to create economies of scale needs to be considered to increase cost-effectiveness.

The objective of reforms to the public service delivery system is to create long-term capacity for responding to ageing pressures in key sectors pursuing fiscal consolidation and reducing public debt
burdens. In order to do so, it is necessary to define strategic frameworks, including implementation structures and timetables, to implement reforms in a coherent way over time.
2. INSTITUTIONAL CHANGES IN MULTI-LEVEL GOVERNANCE FOR PUBLIC SERVICE DELIVERY

OECD countries are adapting their multi-level governance frameworks to improve public service delivery due, in part, to demographic changes. Increments in efficiency, improvements in co-ordination and reallocation of staff across sectors and levels of government, and a more transparent fair distribution of financial resources are just some of the goals OECD government are pursuing in their attempt to adjust the public service delivery system to an ageing context. If the term governance considers all actors beyond the ‘core executive’ that take part in policy-making, multi-level governance means the interaction of those actors at different locations: at supra-national, national, regional and local level. However, this review focuses on the interaction of the range of governmental organisations at national, regional and local governments involved in public service delivery. It should be noted that multi-level governance also covers the growing influence of international actors on domestic policy-making, but that aspect is beyond the scope of this review. Thus, the aim of this section is to provide an overview of the different institutional changes OECD countries are implementing to reform public service delivery.

Reallocation of Responsibilities for Service Delivery across Levels of Government

Adjusting the public service delivery system to meet the challenges of an ageing population requires, invariably, determining the appropriate role of all levels of government in service delivery. Hence, improvements in the co-ordination across levels of government are paramount to increase efficiency and effectiveness and the range of options to the population as a whole and the elderly in particular. Typically, many services for the elderly are provided by regional and local governments such as: health care, long-term care, welfare, social and education services like in Canada, Finland and the United Kingdom. Central government is in charge of facilitating the means for local governments to manage and provide public services through information and best practices reflected in legislation and guidelines. For example, Table 2 shows the division of functions in the Swedish public sector where county councils and municipal authorities are in charge of the provision of services such as health and child and elderly care. Central governments, in general, facilitate
### Table 2. Division of functions in the Swedish public sector

<table>
<thead>
<tr>
<th>The Central Government Sector</th>
<th>County Councils</th>
<th>Municipalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implementation of national legislation</td>
<td>• Physical and mental health care</td>
<td>• Child care</td>
</tr>
<tr>
<td>• Foreign service</td>
<td>• Public dental service</td>
<td>• Care of the elderly</td>
</tr>
<tr>
<td>• Defence</td>
<td>• Regional communication</td>
<td>• Social support</td>
</tr>
<tr>
<td>• Police and courts</td>
<td></td>
<td>• Financial support</td>
</tr>
<tr>
<td>• Higher education and research</td>
<td></td>
<td>• Education (except universities)</td>
</tr>
<tr>
<td>• Motorways and long distance communication</td>
<td></td>
<td>• Local communication services</td>
</tr>
<tr>
<td>• Labour market and immigration</td>
<td></td>
<td>• Recreation and culture</td>
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<tr>
<td>• Social security</td>
<td></td>
<td>• Fire and rescue services</td>
</tr>
<tr>
<td>• National cultural institutions</td>
<td></td>
<td>• Water and sewage</td>
</tr>
</tbody>
</table>

Source: Swedish Agency for Government Employers

Local governments constitute then one of the main employers in OECD countries as the larger proportion of public servants works in the health and education sectors (Box 3). However, the analysis of the case studies shows that although reforms towards the decentralisation of public service provision are crucial to reinforce and improve the quality and coverage of the public services, ageing has not played a major role in the policy-making process, or at least it has not been the only factor to trigger reform processes in this area. Moreover, the influence of demographic changes in policy-making varies from country to country. For instance, in Canada, Korea, and the United Kingdom ageing, although present in policy discussions, is only one factor to define policy priorities and actions, whereas in Finland ageing has had a major role in triggering reform efforts. In Japan, demographic and economic factors have led to transfer responsibilities of public health nursing services from Health Departments to Welfare Departments as the later ones are the prime responsible for the implementation of programmes for care of the elderly. This fact is not surprising as in an era of governance the actors and terrains involved in policy-making are ever-increasing and it is not possible to isolate facts to bring about change as they all are interdependent and interact in a complex set of networks. These findings suggest that in OECD countries reforms to the public service delivery system are not usually tied to ageing issues. Thus, the distribution of responsibilities for service delivery obeys to factors of efficiency, effectiveness, customer focus, and to the increase of people’s participation in policy-making by bringing the decision making closer to the people affected by it.
Box 3. Sub-national levels of government as public service providers - an overview

**Canada:** Provinces and territories are responsible for the provision of most services such as education, health care and social assistance. Moreover, they also provide income support depending on the territory or provinces in question. Municipal governments are under provincial direction and often provide social and recreational services. Changes in public service delivery have not been dictated by demographic changes in Canada.

**Finland:** Local governments have the responsibility for providing two-thirds of basic services like education, social and health care, security and transport. Therefore, increases in demand for public services have to be borne by local governments. Finnish local and joint authorities employ 17% of the country’s workforce. Due to ageing, the promotion of health and education will have to be enhanced but municipal variations in the age structure produce an uneven distribution of services among municipalities. In order to enable the provision of basic public services, Finnish authorities consider of crucial importance reinforcing inter-municipal and sub-regional co-operation.

**Iceland:** Central government is responsible for the provision of secondary and upper education as well as for the administration and provision of health services. Local governments are in charge of the provision of basic social services like social and financial assistance in the form of welfare benefits, home assistance to the elderly and disable, child welfare, primary education, and cultural sports and leisure activities. Primary education services are by far the most important task of the municipalities as it represents 50% of the municipal budget.

**Italy:** Regional governments have legislative powers over health, welfare and employment services whereas local governments are responsible for delivering and/or funding social public services. Decentralisation of public service delivery grants more autonomy to local governments in service planning and local taxation. However, public services are highly fragmented and there are significant regional inequalities in the distribution of services, particularly between north and south of the country. Domiciliary assistance is the most widely spread service in the country used mainly by old and disable people.

**Japan:** Central government has the responsibility to design policies on work and income, health and welfare, learning and social participation and of establishing general principles to tackle the challenges posed by an ageing population. However, municipalities or prefectures are responsible for the provision of public health nursing services. These services include health guidance to families, health screening for children and adults, rehabilitation and support for frail elderly, identification of community health issues, among others. Public health nursing in Japan is an example of community-based care as nursing practitioners interact with people of all ages and types.

**Korea:** The provision of local services in Korea is the responsibility of local governments. The principle behind this allocation of responsibilities is that local governments have a closer relationship with citizens and are in a position to respond faster to the needs of the population. Central government has the role of acting as a facilitator and provider of the means for local governments to manage and provide public services.

**Mexico:** Over the last decades, Mexican authorities have implemented decentralisation policies in order to increase the coverage and quality of public services through the redistribution of responsibilities in terms of service delivery and the management of financial and human resources among the three orders of government. Local governments provide health and educational services but the federal government is also a provider of those services. Municipal governments have the role to act as improvers of local environment. Local and municipal governments, through the National System for the Integral Development of Families (DIF) provide welfare services to poor, disable and elderly people.

**United Kingdom:** Local governments are the main employer in the country as they are in charge of the provision of a large number of public services. Some of the services provided by local authorities are: education, leisure, social services, and care and support services to children, families and vulnerable adults. Particularly, local governments provide support for older people, adults with physical and learning disabilities or mental health needs and carers. Moreover, local governments also act as major supporters in school improvement. Other services provided by local governments are: transport, housing, improvement of local environment, and policing.

Source: Country case studies

Moreover, the case studies reflect three basic conditions for a more or less successful decentralisation process of service delivery. First, clear legal frameworks are the basis for facilitating the reallocation of staff and financial resources across levels of government. Allocation of responsibilities for service delivery
requires a well-defined institutional framework that specifies the roles and responsibilities of different levels of government. Reforms to the legal framework specifying concrete tasks, deadlines, and responsibilities of each level of government in service delivery are paramount to avoid misunderstandings regarding who is responsible and therefore accountable for the timely provision of public services. Indeed, in Italy, for example, misinterpretations in the legislation have hampered the transfer of staff to regional and local governments while in Korea the decentralisation process is based on a clear division of tasks between central and local governments for public service delivery.

Second, decentralisation of responsibility for service delivery to regional and local governments increases local autonomy but that should be accompanied of the faculty to legislate or decide on the most feasible way of providing public services. For instance, in Italy since regional authorities deliver and fund social public services, they have the possibility to legislate the way to deliver. In Finland, municipalities have the responsibility for the provision of a wide range of public services trying to comply with the standards set by the national government, but municipalities have the opportunity to opt for merging with other neighbouring municipalities or delivering services on their own. In Korea, recent amendments to the decentralisation strategy include measures to reinforce the legislative powers of regional assemblies regarding the management of financial and human resources.

Finally, decentralisation of service delivery requires of a whole-of-government approach to maintain coherence in an otherwise fragmented environment as OECD countries, in general, tend towards more regionally-based strategies to improve the quality and coverage of public services.

Reinforcing inter-governmental relations

One of the main concerns of OECD countries, as reflected in the case studies, is the establishment of mechanisms to reinforce inter-governmental relations to foster co-operation in delivering public services since the responsibility for their provision has been disseminated across the different levels of government. The level of policy co-ordination will determine the level of coherence of the strategy to make the public service delivery system more responsive to the needs of an ageing society. To a large extent, this co-ordination will be dictated by the political system adopted in each country. Indeed, the OECD study on Ageing and the Public Service concludes that the co-ordination of ageing policies may probably be more difficult in countries with a highly devolved (centralised countries) or completely autonomous (federal countries) systems. For example, the Canadian public sector is a political federation where central and provincial governments have sovereignty ensuring political independence and separation between levels of government. The case studies suggest some examples of the measures adopted by OECD counties to reinforce the interaction between the state actors at different levels of government.

Canada, Korea, and the United Kingdom have opted for the creation of networks to reinforce co-operation between levels of government with the inclusion of the wide variety of actors involved in service delivery. Moreover, networks are used as a way to improve levels of effectiveness in service delivery.

- In Canada, the planning and co-ordination of public service delivery is conducted by formal networks of ministers and officials from federal, provincial and territorial governments so as to increase coherence in policy-making and policy implementation for service delivery. These policy networks facilitate the definition of strategies for service delivery under a relatively more holistic approach in an area characterised by its complexity and diversity.
- In Korea, sub-national governments have organised associations integrated by majors, council chairs, governors and other local representatives to promote exchange of information and knowledge in area such as the management of the civil service. Local government within a given region also organise policy discussion groups to share ideas on inter-governmental human resource management.
In the United Kingdom, as part of the strategy to enhance community services, a cross-government group drives the broad health and well-being agenda with the involvement of key stakeholders from the National Coalition for Active Ageing. This includes networks of one-stop centres developed and controlled locally that provide services such as health, social care, housing, leisure and education. The provision of health and social services is made under a more local focus which emphasises the need for more join-up action to support service delivery.

Iceland, Korea and Mexico based the reinforcement of their inter-governmental relations on a clear definition of tasks and responsibilities that facilitates collaboration and co-ordination of service delivery. In addition this clear definition of tasks facilitates accountability.

- Iceland’s structure of government is of Nordic origin but does not have regional authorities. Hence, co-operation between the two administrative levels of government, the state and municipalities, is the cornerstone of the public service delivery system. Co-operation is based on a clear definition of tasks and responsibilities between levels of government complementing each other in the provision of public services to society.

- In Korea, the Special Decentralisation Act of 2008 defines concrete tasks, deadlines and mechanisms to enhance decentralisation. Moreover, in order to facilitate co-operation and co-ordination between levels of government in public service delivery, it establishes a clear distribution of tasks and responsibilities between central and sub-national governments, and a concrete timeline to amend the necessary laws to have a comprehensive handover of central government affairs to regional and local governments.

- Mexico has implemented a decentralisation process to increase the quality and coverage of public services through a redistribution of responsibilities for service delivery and the management of financial and human resources across levels of government. Although the decentralisation process is still ongoing, central government is creating the conditions for more freedom of management of resources at lower levels of government through the enactment of legislation like the National Agreements for the decentralisation of health and educational services.

Finland and Italy define their service delivery strategies under a more regional approach as inter-regional or inter-municipal co-operation is at the cornerstone of the planning of public services. Regional and local government have the option to join efforts to provide public services under a larger scale.

- Finland has implemented three mechanisms for service provision so as to solve the difficulties that municipalities are facing to provide public services. These mechanisms are based on a more regionally-based approach to reinforce inter-municipal and sub-regional co-operation. The ‘Joint Municipal Boards’ as a form of permanent collaboration of more than one municipality in some fields of operation like hospital districts. The ‘municipal mergers’ allow the formation of catchment areas for services and increase co-operation between municipalities. The ‘Kainuu regional government’, still in experimental phase, intends to transfer the power and responsibility from the municipality to a different administrative structure, the regional level of government, so as to improve service delivery, reduce municipal spending and foster co-operation at regional level.

- In southern Italy, the ‘Area Development Plan’ epitomises inter-comune planning based on a bottom-up approach to plan social and welfare services for the elderly through a local initiative rather than a specific statutory obligation. It incorporates private, public and non-profit organisations emphasising the need to integrate associations of the elderly into communal planning.
Overall, apart from Finland, there seems to be little linkage between the policies to decentralise public service provision and the strategies to face the challenges posed by an ageing population. Policy linkages between changes in multi-level governance and adjustments to the public service delivery systems are rarely made. Ageing population, although recognised as an imminent challenge for OECD countries, has not yet played a major role in policy-making regarding public service provision.

Changes in multi-level governance at least seem to obey to broader economic and political priorities to, on the one side, reinforce the mechanisms to increase productivity in the public sector, and on the other, to give a more active role in policy implementation to lower levels of government. Decentralisation of public services may be also used as a way to reinforce federalism like in the case of Mexico.

In general, changes in multi-level governance highlight the tendency to fragment the provision of public services to increase quality, efficiency and effectiveness but under holistic policies linked to a whole-of-government approach. Indeed, the case studies suggest that there is a tendency to give central/national governments the task of acting as co-ordinators and facilitators of the means for the provision of public services. Regional and local levels of government act as actual providers of services based on the resources received from the central government and their own revenues. This division of tasks portrays, at least in the public service delivery system, a ‘join-up’ or ‘holistic’ model with central control. But that central control is not complete because sub-national levels of government have the freedom to select the most appropriate way to deliver public services like the organisation of networks or municipal mergers.

**Ensuring Capacity for Service Delivery – the redistribution of resources**

Decentralising public service delivery to regional and local governments is not without its challenges. If sub-national levels of government are to have a more active role in service delivery, then central government is supposed to provide the means for them to comply with their new tasks and responsibilities. Overall, the case studies reveal that OECD countries need to address the issue of increasing or at least maintaining capacity throughout government and particularly at lowers levels of government to deliver services. This, according to the case studies, can only be done by reallocating staff and financial resources across levels of government and sectors most affected by increased demand due to ageing populations (health and long-term care). The problem OECD governments have is to find out the appropriate mechanisms to transfer resources to where they are most needed in a transparent and timely manner.

**Reallocation of staff across levels and sectors of government**

The OECD (2007) concluded that its member countries are facing difficulties to recruit skilled staff to face critical shortages generated as a result of ageing public services. The dilemma is to choose between encouraging people to work longer or hiring younger and probably cheaper staff while at the same time increasing or maintaining productivity levels without extra resources. The first option does not necessarily produce savings but may assure maintaining the necessary skills for the job; the second one may be a cheaper option but young staff may be qualified but not have the necessary experience and its getting to grips with the job may take some time. The problem is exacerbated by the fact that the public sector is not an attractive employer for younger and qualified generations. These are critical issues that countries have to address to maintain capacity.

Thus, in order to maintain capacity OECD governments are putting emphasis on reallocating available staff across levels of government and sectors but these changes are not always associated to ageing population. Indeed, the case studies show that, in almost all cases, reallocation of staff across levels of government would take place with or without changes in the age structure of the population. Decentralisation has been considered as a plausible alternative to increase effectiveness and efficiency in
service delivery and for that regional and local governments require to have the necessary capacity to deliver services. Due to the limitations to hire new staff and the difficulties to increase productivity governments need to reorganise the allocation of human resources. However, the way of reallocating staff varies from country to country depending on their human resource management system.

In Canada, for instance, every order of government is a different employer and when a function is shifted to another government, special negotiations are carried out to also shift appropriate staff to the new employer. In Korea, the fact that there are no significant differences in working conditions in the different levels of government generates an advantageous situation to encourage staff reallocation. Moreover, Korean central and sub-national governments hold policy discussion on the alternatives to improve human resource management across levels of government. One of the options implemented is the exchange programme between central and local governments as a way of strengthening manpower of local governments.

Compared to other countries, Finland seems to be the only country where ageing population has had a major role in the transfer of staff across sectors and levels of government. Ageing population poses to Finnish authorities the challenge of maintaining capacity in key sectors like education, health and long-term care. Since the delivery of these services has been devolved to local governments, Finland has adopted a whole-of-government approach to reorganise the workforce. For instance, since demand for basic education services is expected to decrease due to ageing, resources may be transferred to the health sector as the number of disable people is forecasted to increase.

Other countries favour the reallocation of staff based on sectoral needs as the responsibility to provide basic services has already been devolved to regional and local governments. For example, Japan has been forced to reduce the number of personnel to cut expenditure via natural attrition but to maintain capacity Japanese authorities intend to reallocate staff from sectors to be streamlined to sectors that need to be reinforced. However, reallocation of staff across levels of government is not yet considered; in fact, local governments have also been requested to reduce the level of staffing at the same ratio as the national government (5.7%). In Iceland, the workforce available in sectors with increased demand due to ageing population for example, has proved not to be enough; authorities intend to reallocate staff based on the principles of equal access, cost-effectiveness, solidarity and optimum quality. Staff reallocation will based on estimations of the manpower needs for the following 5-10 years period so as to guarantee the supply of knowledge and skills in sectors such as health.

In Italy, the reallocation of staff across sectors and levels of government has faced complications derived from misinterpretations of the regulatory framework regarding the extent of the autonomy of regional and local governments in the management of resources. The experience of Italy suggests that to transfer personnel from one level of government to another is necessary to have enough information on the profile and quantity of staff required by local governments as transfer cannot take place based on assumptions. Moreover, political motivations in Italy have led regional and local governments to request more staff than needed creating pressure for local finances as payroll increases.

In the United Kingdom local governments are the main employers in the public sector and there is no evidence that an ageing population is leading to reallocation of staff across sectors or levels of government. In fact, contrary to other countries participating in this review, in the United Kingdom, public sector employment in education, health and social work has increased in recent years. However, ageing is affecting public sector in general as public employees are comparatively older than the employees in the private sector. The proportion of employees aged over 50 has increased in the public sector of around 23%. Hence, the number of employees near retirement age increases while the supply of specialised staff in service delivery decreases as part of the demographic changes. The issue for British authorities is how to attract younger and qualified recruits to alleviate the shortages of staff as a result of retirement.
The reallocation of staff across levels of government or sectors is a complex issue for OECD countries. The case studies show that in order to reallocate staff is necessary to consider four basic aspects. First, it requires a clear vision of policy priorities based on the responsibilities allocated to lower levels of government in terms of service delivery and the sectors whose demand has increased or is expected to be so. Second, it is advisable to develop occupational projection systems based on calculations of supply and demand (like in Canada) not only at national level but at regional and local level as disparities in the distribution of personnel may not be even (like in Italy). Third, reallocating staff requires of flexibility in the management of human resources to facilitate staff mobility across levels of government. And four, similar working conditions between levels of government would indeed facilitate the reallocation of staff (like in Korea) but this may not be possible for all countries as this depends on their political system organisation and the level of autonomy of regional and local governments to organise their human resource management systems.

It is worth noting that, apart from Italy, no country mentioned numbers in terms of personnel to be reallocated, let alone due to ageing. This is probably because with the exception of Canada and Korea, no other country has made projections of staffing needs long in the future. Moreover, this is also a complicated issue technically and politically what makes difficult long-term planning.

**Reallocation of financial resources across levels of government**

In order to maintain capacity for service provision, enough financial resources to operate the public service delivery system are needed. The analysis of the case studies reveals that the transfer of responsibility to regional and local governments to deliver public services requires the assignment of a meaningful level of expenditure to sub-national governments with service autonomy so that they can respond to local needs. Similarly to the redistribution of staff, the reallocation of financial resources requires of a definition of priorities, assessment of the sectoral needs, and a multi-year allocation system. In that sense, OECD countries have defined mechanisms to transfer resources to lower levels of government but, like in the reallocation of staff, their design and implementation is not related to ageing issues. Moreover, changes to those mechanisms need to take into consideration more factors others than ageing.

In OECD countries, local governments have independent and multiple sources of revenue like local taxes or operating revenues (Finland and Iceland). In Canada, for instance, federal and provincial governments collect income taxes. However, the transfer mechanisms have been implemented in order to offset the costs local governments incur in providing health, educational and social services whether age-related or not.

In general terms, Finland, Iceland, Italy, Japan, Korea, Mexico and the United Kingdom reported that public expenditure in health, long-term care and even education has grown due to ageing population. However, in the Canadian experience, ageing population does not drive up health care costs but the increments in the demand of health care services by seniors rise up costs. For example, Figure 8 shows that over the last decade public expenditure on health as percentage of GDP has risen. Although the proportion of the increment varies from country to country, all of them have increased the amount of resources on health due, among other factors, to ageing.
Box 4. Transfer mechanisms of financial resources to lower levels of government

Canada has three transfer programmes of funds from the federal government to the provinces and territories: i) the equalisation system to smooth out the differences in revenue generating capacity across provinces; ii) Canada Health Transfer (CHT) to make up for the differences in the costs of providing health care services; and, iii) Canada Social Transfer (CST) that support provincial and territorial spending on post-secondary education, social assistance and social services.

In Finland, central government calculates grant transfers through distribution formulas so as to compensate regional disparities, either by equalising costs or equalising municipal income. This transfer accounts for less than one-fifth of all municipal revenues.

In Mexico, local (states) and municipal governments receive federal resources through three transfer mechanisms contemplated in the Federal Budget: i) ‘Ramo 28’ which refers to the federal participations to states and municipalities and represents the major source of income for local and municipal governments; ii) ‘Ramo 26’ which refers to transfer for social and productive development of poor regions; and, iii) ‘Ramo 33’ which refers to federal contributions to states and municipalities for the provision of services such as basic education, technological training, education of adults, support of health services, and public security.

In the United Kingdom, local governments provide a wide range of care and support services to children, families and vulnerable adults. The money local governments spend comes from central government transfers, business rates, and council tax. Council tax only accounts for 26% of all costs of the provision of public services.

Source: Country case studies

The analysis of the country case studies reveals some points worth considering while reallocating financial resources across levels of government. First, local governments need a certain room of discretion or flexibility to make their own expenditure allocation decisions depending on their own local priorities. Second, it is advisable to indicate the purpose of the transfer to enhance accountability, like in Canada, Mexico and the United Kingdom. Third, the determination of the amount of financial resources to be transferred needs to be done via legislation. Fourth, financing local governments through transfers may jeopardise their autonomy in decision-making as most of the time the resources transferred have a specific
purpose that may not respond to local needs. This fact may compromise the coverage and quality of public service delivery. Fifth, the mechanisms to transfer resources need to be clear and designed with the participation of local governments themselves. Finally, OECD countries are developing tools for measuring efficiency and assessing performance of public expenditure which are linked to budgetary decisions. For instance, in the United Kingdom, the Public Service Agreements (PSA) mark a transition from focusing on levels of investment to how effectively resources are being used and whether they are delivering the expected outcomes.

Moreover, in Korea and Mexico, local governments, in general, lack the ability to manage financial and human resources adequately what hinders the quality of the public services provided. This is explained by the long centralisation practices that until not long ago were common in those countries. Hence, as part of the decentralisation policy, provisions for the training of local officials are critical to provide them with the necessary skills to manage financial and human resources. There is no indication of the amount of financial resources, relative to the GDP, that are needed to meet the challenges of an ageing population in terms of public services. However, the majority of countries that took part in this review indicated that public expenditure in health, long-term care, education and social services is raising due to among other things, population ageing. The transfer of additional resources to those sectors seems to be imminent as demand for services and the proportion of senior citizens increases. Nonetheless, it is worth stressing that the quality and quantity of public services are not necessarily increased by raising the amount of funding.
3. ORGANISATIONAL CHANGES IN PUBLIC SERVICE DELIVERY

The aim of this section is to present an overview of the organisational changes for service delivery that, directly or indirectly, are expected to contribute to meet the challenges posed by an ageing population. OECD countries are adopting a series of measures to improve the public service delivery system that include the use of arm’s length bodies, the adoption of market-type mechanisms, and the use of information and communication technologies. These measures are intended to increase productivity, reduce costs, and improve the quality of service delivery.

What policy approach are countries adopting to increase effectiveness in public service delivery?

The analysis of the case studies reveals that policy-making and decision-making concerning public service delivery is based on a local focus. Community members are reported to have a more active role in the definition of priorities and the search for alternatives to re-organise the public service delivery system. In Iceland, the reorganisation of the health services was based on a community and home-base long-term care approach. In Japan, the general principles on ageing state that the central government has to promote the participation of local communities in service delivery; in addition, the public health nursing service is based on a community-oriented approach as interaction of service providers and people of all ages is enhanced. In the case of Mexico, the National Institute for Old People has a council of citizens integrated by elderly people in charge of providing opinions and proposals on ageing issues to the Directive Council and organises forums of discussion with the general public to frame a proposal of an ageing strategy. In the United Kingdom, the approach to reform health and social care services promotes bringing decision closer to communities which are going to be affected by the decisions made. As the UK Department of Health put it, the idea is to “… give people a stronger voice so that they are the major drivers of service improvement.” Nonetheless, it is unlikely that ageing has influenced this change in policy-making as this seems to be part of the process of evolution in politics with a larger involvement of citizens in policy discussions.

The introduction of organisational changes in public service delivery has been done under the framework of a whole-of-government approach (WG). This means that OECD countries aim to achieve better horizontal and vertical co-ordination in order to eliminate situations in which policies undermine each other by involving the different stakeholders that take part in service delivery. The decentralisation of public service delivery, the devolution of greater autonomy to frontline agencies and a more localised focus on policy-making have led OECD countries to look for increased co-ordination, and integration in the way they are meeting the challenges faced by the public service delivery system, for instance demographic changes. However, the case studies reveal that OECD countries have different approaches to WG. For instance, Iceland and Japan intend to achieve a better integration and co-ordination across sectors: health, work, education and living environment, giving each sector a defined task and responsibility. Mexico aims to improve horizontal co-ordination of ministries in the implementation of the national social policy (social development, education, labour, communication, and public health institutions) to provide an integrated response. Italy hopes for a better co-ordination in the activities of regional and local governments in the provision of public services. The inter-comune planning requires not only the co-ordination of public local bodies in service delivery but the incorporation of private and voluntary organisations in the provision of health and social services. The United Kingdom seeks a better joint-action between central departments, arm’s length bodies and local governments in the promotion of health and well-being in local communities.

2. www.dh.gov.uk
Hence, the experience of OECD countries suggests two points. The first one is that the success of reforms in the area of public service delivery, in particular to meet the challenges of an ageing population, requires better partnership and clear outcomes for services to help to focus on what an integrated response (whole-of-government) aims to achieve. The second raises the issue that the WG is only an umbrella concept that describes a group of responses to the group of increased fragmentation of the public sector and public services and a wish to increase integration (Christensen and Laegreid, 2007).

**Box 5. The Australian strategy to improve government service delivery**

In 2006 the Australian Ministry for Immigration and Citizenship published the Accessible Government Services for All report as a guiding framework that encourages all Australian government agencies to take a greater leadership role regarding diversity issues under a whole-of-government approach. The report incorporates the experience of over one hundred agencies, and contributions from state, territory and local governments, taking into account their ability to contribute both as separate portfolios and to whole-of-government responses to the challenges faced by a culturally diverse nation. The report underlines four principles and performance indicators that address key responsibilities of government. It aims to assist agencies to analyse their performance and better share good practice responses to challenges and opportunities.

- **Responsiveness** – Extent to which programmes and services are accessible, fair and responsive to the individual needs of clients.
- **Communication** – Open and effective channels of communication with all stakeholders.
- **Accountability** – Effective and transparent reporting and review mechanisms.
- **Leadership** – A whole of government approach to management of issues arising from Australia’s culturally and linguistically diverse society.


The adoption of a WG approach is not without problems. In OECD countries there are concerns about accountability issues linked to horizontal and vertical co-ordination between ministries and agencies and between central and local governments without violating their autonomy. Moreover, when different departments, agencies and authorities work together, and when public, private and even voluntary organisations co-operate in certain policy areas they may engage in competition and rivalry that may undermine co-operation. Furthermore, the costs and timing of the implementation of a reform based on the co-operation and integrated response of a number of public and private bodies may be high. Therefore, as the United Kingdom’s experience suggests, joint-action in public service delivery needs to be driven by a strong leadership to minimise the negative side-effects of a WG-based policy reform.

**How are countries increasing effectiveness in public service delivery while controlling bureaucratic burden?**

Increasing effectiveness in the provision of public services while, at the same time, reducing the size and cost of bureaucracy, has been one of the major challenges for OECD member countries. According to the case studies, OECD countries have adopted, at least, three measures to tackle this issue: i) multi-purpose provision venues; ii) the use of Arm’s Length Bodies (agencies, quangos, non-departmental bodies, etc); and iii) partnership between public bodies of different sectors.

**The multi-purpose provision venues**

The establishment of networks of ‘one-stop centres’ or ‘multi-purpose provision venues’ is one of the most recurrent strategies in the countries participating in this review to increase efficiency and
effectiveness. They constitute a single outlet for services provided jointly by different authorities. In most cases, these centres are developed, managed and controlled locally (Finland, Italy, Korea, and the United Kingdom). Moreover, these venues provide a holistic customer-oriented service and represent a solution to the problem of shortage of staff for the provision of certain services with the consequently financial savings in operation costs. The centres constitute an example of collaborative networks as they link several public institutions and in many cases private and voluntary organisations in providing social services and bringing closer provider and consumer. The target population of these centres varies from country to country. In some countries like in Italy, these centres are focused on providing information and social services to the elderly while in countries like Finland and the United Kingdom, the centres provide services to the whole population.

The creation, organisation and management of the ‘one-stop centres’ require a close co-ordination and joint work between the different public bodies participating in the scheme. Although the benefits of these centres are clear, there are still questions regarding the management of human and financial resources. For instance, it is not clear which authority is accountable for the services provided by these units, whether all parties collaborate with the same amount of financial resources. Mechanisms of co-ordination, evaluation and audit should be clear from the outset if increases in efficiency and effectiveness are to be achieved.

The use of Arm’s Length Bodies (ALBs)

Although ageing has not greatly influenced the creation of ALBs for public service delivery in OECD countries, they have represented an alternative to control the bureaucratic burden and fostering efficiency in service provision. The OECD (2005) concluded that the creation of ALBs is one of the most important organisational changes that have taken place within central government. One of the reasons for their existence is to make the public service delivery system more efficient and effective. ALBs are under ministerial responsibility with a certain degree of management autonomy and a separate financial administration. They undertake a wide range of functions from back office administrative functions to complex technical work. One of their aims is to support local services and improve standards of delivery. Since ALBs are sometimes associated with bureaucratic burden their number is kept to a necessary minimum or they are set up for a fixed term when it is needed.

According to the case studies, ALBs are mainly created when their functions need to be carried out at national level or when the nature of the functions can lead to the creation of economies of scale. However, the experience of OECD countries, for instance Canada and the United Kingdom, indicates that it is necessary to keep their number to a minimum to avoid bureaucratic burdens and to attain to be cost recovery wherever possible to reduce central government funding.

Compared with others, Canada and the United Kingdom appear to have a longer tradition in the use of ALBs in public service delivery. ALBs have been used extensively in the provision of health and social care services in the United Kingdom. Moreover, Canada, Japan, Korea, Mexico and the United Kingdom reported to have a special agency or public body in charge of individual ageing issues. These bodies promote healthy ageing, support research, agree discount for services for older people, establish or propose general principles concerning measures to face the challenges of an ageing society, and lead the discussions to delineate an ageing strategy.

How are countries ensuring value for money and cost-containment in public service delivery?

The use of market-type mechanisms has been seen as an alternative to reduce cost and increase value for money in public service delivery in a number of OECD countries. In spite of the fact that, as the OECD (2005a) concluded, the use of market-type mechanisms is increasing in OECD member countries, ageing does not seem to be the main lever in their adoption for reforming public service delivery. Although
market-type mechanisms are being used to provide services to the elderly like vouchers to access health services, their use seems to have been dictated by cost-containment, efficiency, value for money, economic reinforcement issues, and even to increase citizens’ choice.

### Table 3. Considerations to bear in mind in the implementation of market mechanisms

| Equity considerations | • Setting minimum standards (social/and/or geographical)  
| | • Must be complemented by robust evaluation and monitoring schemes  
| Measures targeting lagging social groups | • Targeted lower user fees  
| | • Means-tested income support  
| | • Vouchers and use-related funding  
| Measures targeting lagging regions | • Increasing the size of the market (merging municipalities, sub-central governments’ co-operation agreements)  
| | • Central government grants to sub-central governments  
| | • Equalisation policies  
| | • Regional and/or regional type differentiated standards  
| | • Searching for flexible contracts  
| | • Involving compliers in selecting the standards through participatory approaches  
| | • Recurrent revision of proxy measures used  
| | • Agreement of adequacy of non-compliance sanctions  
| | • Some countries have implemented incentive schemes  


Overall, the case studies suggest that market-type mechanisms are a wide spread instrument for service delivery among OECD countries and they can secure efficiency gains. The analysis of the case studies reveals that public-private partnerships, vouchers and user-chargers are the most common market-type mechanisms used in the OECD countries taking part in this review. However, the type of mechanism used depends on the political, financial and technical issues prevailing in each country.
Box 6. Market mechanisms used in service delivery in OECD countries

The experiences of OECD countries in the implementation of market mechanisms for the provision of public services may be grouped in four dimensions:

- **Private ownership and contracting.** This dimension deals with public-private ownership and different forms of contracting. Examples: tendering, out-sourcing, public-private partnerships.

- **User choice and competition.** This dimension deals with the regulatory environment for public service providers, the extent to which consumers are allowed to choose among providers and to what extent providers have access to the market. Examples: user choice, market access and competition among providers.

- **Price signals and funding.** This dimension deals with the principles of funding private service provision; the extent to which public funding reflects actual service utilisation and/or service performance. Examples: user charges and fees, vouchers and other related funding.

- **Monitoring devices.** Benchmarking and indicators systems.


The use of public-private partnerships (PPPs) in service delivery

The use of public-private partnerships (PPPs) is the most recurrent market-type mechanism for service delivery used in OECD countries. The reason may be that, as the experience of Finland and Korea shows, increasing spending in public service delivery to expand provision does not necessarily produce more outputs. Thus, in a context of scarce financial and human resources, the involvement of the private sector in service provision constitutes an alternative to mobilise resources for service delivery in OECD countries. PPPs are used when the criteria of efficiency, equity and accountability are likely to be met and clear value for money is ensured without sacrificing the terms and conditions of staff.

Box 7. Definition of public-private partnerships

The OECD defines a public-private partnership as an agreement between the government and one or more private partners (which may include the operators and the financers) according to which the private partners deliver the service in such a manner that the service delivery objectives of the government are aligned with the profit objectives of the private partners and where the effectiveness of the alignment depends on a sufficient transfer of risk to the private partners.

In Finland, private sector providers are encouraged to play a larger role in service delivery so that public spending can be focused on what is essential. The use of PPPs is seen as a way to increase efficiency, and reduce public spending freeing resources to meet other demands. The Finnish experience suggests that a wider mix of providers and means of service provision could lead to increases in efficiency. The main lesson derived from the Finnish experience is that market-type mechanisms in general and PPPs in particular, require the development of standards of delivery to ensure optimal provision of public services. In the United Kingdom, the creation of Partnerships UK (PUK), a PPP in itself, has helped to bridge the gap between public and private sectors to support the delivery of high quality public services. PUK promotes the development, procurement and implementation of PPPs where corporate responsibility with the public sector is central. The case studies reveal that the United Kingdom is by far the largest user of PPPs among OECD countries. At the other end of the spectrum, Mexico has a rather limited experience in the use of PPPs in public service provision. Although PPPs are one of the most common market-type mechanisms used by OECD countries, the extent of their use should not be exaggerated. The proportion of investment in countries like the United Kingdom in PPPs is still low compared with other traditional procurement practices.

The use of ‘vouchers’ in public service delivery

The extent of the use of vouchers is significant in some sectors in OECD countries. With the use of vouchers, the provision of public services is separated from its financing. The funding remains with the government in the form of a voucher, which is issued to individuals entitling them to exchange the vouchers for services at a range of suppliers. The use of vouchers has risen in OECD countries due to the fact that empower citizens to choose among public and private providers leading to efficiency gains due to competition, notably in terms of quality improvements. The OECD (2005a) found that providing publicly long-term care in private nursing homes and residential institutions typically takes the form of vouchers, either implicit vouchers paid directly to the institution or reimbursing the fees paid by residents in part or whole.

3. For an in-depth discussion on the use of public-private partnerships (PPPs) in OECD countries and the recommendations of the OECD for countries considering using them in service delivery see OECD (2008).
in whole. Some programmes also provide allowances for families of the elderly and disable to retain the role of caregivers, or for the elderly to employ personal attendance of their own. Finland, Korea and Mexico provide specific examples of the use of vouchers for the provision of public services to the elderly:

- In Finland, the government issued a law on the use of service vouchers for home services to help financing the cost of care services and give people the opportunity to choose among service providers. In addition, it approved the extension of the household deduction to cover work performed in the house of the parents of tax payers or the taxpayer’s spouse.

- In Korea, local governments provide social services through the use of vouchers. This has been a way of encouraging the private sector to participate in the provision of social services creating the conditions for fair competition and new markets. Vouchers are used to access services such as senior care, support for handicapped, and community services.

- In Mexico, the national government has adopted a form of indirect voucher. The National Institute for Old People has established agreements with public and private institutions to provide discounts of up to 50% to senior citizens affiliated to the institute in the acquisition of goods and provision of health, transportation and leisure services. The government of Mexico City has adopted the use of a smart card to guarantee to its senior citizens free access to food, medicine, and medical services. The smart card gives beneficiaries the possibility to choose among a range of registered providers and to decide what their priorities are.

The use of ‘user charges’ in service delivery

According to the case study analysis, the use of user charges as a market-type mechanism to finance services such as health care and social services is in decline. Indeed, only Finland reported to have been reviewing this mechanism as a way to finance public services as part of the Basic Services Programme. The idea behind user charges is to create a direct link between the benefits and costs of consuming public services and thus aim at removing excess demand for previously free services. Based on the Finnish experience it may be argued that user charges constitute a way of adjusting and alleviating public spending in public services but analysis of whether public funding should be available for all forms of public spending must be conducted. It is necessary to create the mechanisms to facilitate old-people to pay for extra services.

How are countries increasing productivity gains in the provision of public services in the context of an ageing population?

Communication and information technologies (ICTs) have been widely used in OECD countries to provide information and services to the population as a whole (OECD, 2003). E-government may be defined as “The use of information and communication technologies and particularly the Internet, as a tool to achieve better government”. (OECD, 2003: 23) The OECD (2003) study in the area concluded that ICTs is an integral part of how governments do business because they help to improve efficiency in government and enhance quality of service. Moreover, e-government supports more effective outcomes in key policy areas, the promotion of economic policy objectives, and the improvement of the overall trust relationship between government and public administrations. However, the case studies showed that the role of ageing as a triggering force to adopt ICTs for service delivery varies from country to country. For instance, although Canada has a wide range of on-line services, including a special web-site for seniors, it reported that ageing has not been and is unlikely to be a major factor in promoting e-government in coming decades. In Finland, on the other hand, ICTs constitute an asset in dealing with the challenges of an ageing population as they allow the provision of public services in rural and urban areas reducing the cost associated with geographical distance. In Japan, ICTs have brought about a process of cultural change while seeing the use of ICTs as an instrument for problem solving, making old people to recognize their
advantages and feel comfortable with their use. In Korea, there are no specific ICTs programmes for the elderly but Korean government has launched an integrated portal to provide information on social services to the whole population no matter their age.

The analysis of the case studies reveals that despite the variations in the impact of ageing in the design of e-government initiatives, there are some coincidences in the perception of ICTs in public service delivery:

- **ICTs are used as an instrument to provide information and services to the population regardless of their geographical location and age.** Indeed, the prime concern is to facilitate the access to basic public services and information to the whole population as all OECD countries have a wide range of on-line services regarding administrative procedures, health and education services, etc. However, ICTs have facilitated the provision of services to the elderly, particularly when they are located in remote areas or are not able to leave their homes. Nonetheless, this is only part of the general strategy to provide timely and adequate information and access to services to citizens.

- **The use of ICTs is an asset to increase productivity, efficiency, the quality of services, and to reduce costs.** In OECD countries, ICTs have helped governments to generate savings for taxpayers in the provision of public services on-line. Technology, in general, allows the delivery of services in a timely and economic manner with high quality standards. All these benefits offset the initial costs in the introduction of ICTs in service delivery in the long-term for both government and citizens. This is also due to the fact that e-government programmes encourage competition among providers leading to a reduction in prices, for instance broadband operators. Service providers, either public or private can access a wider market and thus must design strategies to compete not only with local but with external providers of services. Moreover productivity and efficiency gains are reflected in the fact that people have the possibility of accessing public services no matter their geographical location. That is the reason why countries like Finland, Japan and Korea are heavily investing on broadband strategies to increase internet access of the population.

- **On-line services are provided under a customer-oriented approach.** This has been a recurrent characteristic of on-line services in the countries participating in this review. On-line services are aimed at smoothing the path to access services or comply with administrative tasks like declaration of income, tax-paying, and the calculation of the retirement income. This approach intends to stimulate citizens of all ages to use on-line services convincing them that this is an easier, faster and cheaper way of satisfying their needs. Many of the portals constitute ‘one-stop shops’ to accelerate the access to public services and information.

- **National/central governments are encouraging local governments to use ICTs as a means for problem-solving.** Since the use of ICTs in service delivery has assisted in revitalizing national economies while opening markets and increasing competition, national/central governments are promoting their use in local governments as a way to stimulate local economies. Hence, national governments are keen to share the results of and their experience in the implementation of their national e-government strategies to encourage local authorities to use ICT models for problem-solving. This is particularly the case in Finland and Japan where local ICT strategies are being developed under the model, experience and standards of the national strategies.

- **ICTs are not only an instrument to provide public services but a mechanism to foster cooperation and co-ordination among the different stakeholders either public and/or private bodies.** The creation of on-line networks by which the different stakeholders are communicated and share information facilitates a joint and coherent approach in the planning and delivery of public services.
Box 8. The British Government Connect Programme

Government Connect is a pan-government funded programme led by the Department for Work and Pensions through partnership with communities and local government, the Department for Children, Schools and Families, and the local government community. Government Connect is a recognised, accredited and trusted secure government network for all local authorities in England and Wales. The network is called GCSx and it enables secure data sharing up to restricted level across government. The Government Connect network (Government Connect Secure Extranet – GCSx) is a key enabler in the drive to transform services, with particular focus on joined-up working, shared services, identity management and efficiency gains via solutions that provide secure communication capabilities.

The GCSx network enables local government to work more easily with other government departments and agencies that are already part of a ‘community trust’, for example the Government Secure Intranet for Central Government Departments, the Criminal Justice Extranet for the police and criminal justice and the network for the NHS. Local authorities will be able to join this community and will help deliver electronic services to the public.

Source: www.govconnect.gov.uk

The use of ICTs in public service delivery still has some challenges to meet, particularly when referring to deliver services to old people. Firstly, the issue of universal access to ICTs, in particular internet. Countries are investing in developing the infrastructure to allow every household to have a broadband connection. Schemes to finance the acquisition of equipment and the reduction of connection costs are paramount to bring everyone on board. Secondly, ICTs in service delivery need to overcome the resistance or fears towards technology and the unfamiliarity of the elderly in the use of ICTs. Not every member of old generations has the knowledge to operate computers let alone access to internet. Old people still need to meet the educational demands to stay informed of new technologies and systems. In many cases internet is seen as a work and communication instrument of young generations. Thus, governments need to implement programmes to change the attitude of old people towards ICTs and promote their use based on the comparative advantages they may bring to their daily lives. Thirdly, it is necessary to diversify and encourage the use of on-line services as in countries like Mexico people generally use internet for emailing and web-browsing and its use to access on-line public services is rather limited. Finally, despite the developments in tele-work, tele-education, and tele-medicine governments still need to reinforce the promotion of ICTs as an instrument to make working conditions more flexible and facilitate the provision of services. As Japan’s case study highlights, not many employers and corporations, either public or private, have a full understanding of the economic and social advantages of the use of ICTs in the lives of the individuals and of the organisations.

It is unclear the extent of the influence of ageing in promoting e-government policies and programmes, but what it is clear from the case studies is that ICTs are and will be a crucial instrument for the provision of services to the population in general regardless of their age.

4. THE INTEGRATION OF THE VOLUNTARY SECTOR INTO THE AGEING STRATEGY

The involvement of voluntary organisations in public service delivery has proved crucial in the provision of certain services to the population and in particular to the elderly. Therefore, this section aims at exploring the kind and extent of the involvement of these organisations in service provision and its incorporation in the strategy to meet the challenges of an ageing population.
The Role of Voluntary Organisations in Public Service Delivery

The ‘third’ or ‘voluntary’ sector has the potential of becoming government’s key partner in public service delivery. This is because the voluntary sector already participates in a number of areas that range from delivering services to constitute a channel of communication with citizens. Voluntary organisations reach communities and groups that government has difficulties to approach, mainly because they have high levels of public trust and confidence. However, as the British government (2006: 3) put it “The greater involvement of the third sector in delivery must not be about government abdicating its responsibility to fund public services. Instead, it is about ensuring that, in the right circumstances, the sector can deliver services where it is best placed to do so.”

The voluntary sector comprises a wide range of organisations such as charities, community groups, social enterprises, among others. However, its integration into the service delivery strategy and more precisely into an ageing strategy has had a mix response among OECD countries. While in some countries the voluntary sector plays an important role in the provision of services and its involvement has been recognised and supported by government, like in the United Kingdom; in others, the level of participation of voluntary organisations in public service delivery has been limited, for instance in Finland, Korea and Mexico.

The case studies reported two main tendencies regarding the voluntary sector in public service delivery. The first one refers to policies and programmes that have been implemented to strength the participation of voluntary organisations in the provision of public services to the wider community and to the elderly in particular. The second one depicts a strategy to encourage the participation of the elderly in voluntary work as part of active ageing policies over the whole-life course. Of course, characteristics of both tendencies can be found in some countries.

Finland, Italy, Japan and the United Kingdom epitomise the first tendency. In these countries the voluntary sector plays a key role in the provision of public services and its role as service provider is expected to be reinforced in the coming years due, in part, to population ageing. The involvement of the voluntary sector in service delivery ranges from drugs counselling to the provision of housing and health care. The key characteristic in these countries is that the voluntary sector has often led the way in developing more community-focused services in a wide range of areas. Local voluntary organisations are thought to have a better knowledge of local needs and have high levels of public trust and confidence.

- In Finland, the Seniorpolis Initiative in the municipality of Ristijärvi provides an example of how private and non-profit organisations may be involved in the provision of ageing-related public services. This is a unique local initiative that covers four main areas: housing solutions for old citizens; life-long learning through interactive and distant learning systems; care services emphasising self-help; and, relaxation services. Finnish authorities are looking to strength the role of informal carers to facilitate old people to remain at home for longer periods.

- In Italy, regional and local governments are in charge of public service provision but a network of voluntary organisations runs the ‘Estate Serena’ programme which focuses on maintaining elderly people’s independence and provides them with multi-functional services, integrating services already available in the area and ensuring continuity of services through resource planning. In the province of Salerno the “Area Development Plan” aims to integrate social and welfare services, institutional services, the local community, and public, private and non-profit organisations.

- Japan considers that the involvement of the voluntary sector in public service provision will increase as the baby boomers reach retirement age. Central and local governments intend to reinforce their working relationship with the voluntary sector to promote regional activities aimed
at satisfying the needs of services of the ageing population. Since voluntary organisations have an unstable workforce, central and local governments are expected to provide training for human resources, information and advice on how to stabilise workforce.

- Due to the large involvement of the voluntary sector in public service delivery, the government of the United Kingdom has created the Office for the Third Sector that aims to increase the involvement of this sector in public service delivery. For the British government the participation of the third sector is a crucial part of the strategy to build more cohesive, empowered and active communities. The government’s action plan for third sector involvement reveals four areas of engagement with the voluntary sector: commissioning, procurement, capacity improvement, and accountability.

The cases of Canada, Japan, and the United Kingdom exemplify the second tendency. In these countries the voluntary sector has been predominantly seen as a way to make older people remain active. In addition, governments seek to strength their role in service provision as they act as facilitators of governmental activities.

- In the Canadian experience ageing population has not been seen as a reason for a stronger or weaker role of the non-government community in public service delivery. Demographic changes have not been a major theme in the discussions on the role of the voluntary sector and its relationship with government. Instead, there has been more emphasis on the value of encouraging volunteering among seniors as part of a strategy of active ageing.

- In Japan, senior citizens are expected to join various regional activities and make use of their experience in nurturing children and caring elderly. This has the aim of establishing the conditions for a society with a spirit of co-operation and solidarity. However, the main challenge for Japanese authorities is to encourage senior citizens to act as volunteers as the level of interest remains low.

- In the United Kingdom, government’s plans for an active ageing strategy consider the involvement of the elderly in providing counselling to younger generations but mainly to other older people regarding similar frail conditions and the proper care it should be given. The government considers that the experience of the elderly who have already passed or are experiencing certain health problems may be useful for other people with similar problems.

Remaining Challenges to Reinforce the Involvement of the Voluntary Sector in Service Delivery

Overall, the case studies reveal the necessity to strength the role of voluntary organisations in public service delivery, particularly regarding its incorporation into the ageing strategy to give coherence to their involvement in service delivery. OECD countries participating in this review consider voluntary organisations as key allies and facilitators for the provision of public services as they have a more local focus, know better local needs, have higher levels of trust and they act in areas where sometimes governments are not strong enough. Canada is the only country that reported a tendency towards favouring direct relations between the government and the citizens with less need for intermediaries. However, as the reports from Finland, Italy, Japan, Korea and the United Kingdom suggest, voluntary organisations are not intermediaries but partners in the provision of services. Moreover, it is fair to say that the involvement of the voluntary sector in public service delivery has not been largely dictated by population ageing but by the need to have a wider variety of mechanisms, expertise and skills to provide public services and cover areas where government’s presence has been limited. The analysis of the case studies indicates that to increase the participation of voluntary organisations in public service delivery countries need to:

- Set the conditions so that all kinds of voluntary organisations can bid for commissions from government to provide public services. That includes raising awareness among public...
commissioners of the opportunities of a larger participation of voluntary organisations in public service delivery.

- Reduce the regulatory burden so as to facilitate procurement and contracting processes.
- Establish clear mechanisms to support technically and financially voluntary organisations. This would make it easier for small local voluntary organisations to be involved in service delivery and for government to make use of their accumulated experience and knowledge on the needs of the localities.
- Provide assistance to voluntary organisations on how to manage their human resources so as to have a more stable workforce. An alternative to explore would be to encourage students to do internships at voluntary organisations providing them with financial support for the duration of their work.
- Establish the mechanisms to ensure the quality of the services provided by voluntary organisations. This may be done by defining performance frameworks between government and voluntary organisations so as to define minimum acceptable standards of quality in the services provided.
- Establish and reinforce accountability mechanisms so that voluntary organisations in charge of service provision with or without public sector's financial support can be held accountable for the quality of the services provided.
5. POLICY LESSONS FOR AN AGEING STRATEGY

The aim of this section is to highlight the main conclusions derived from the analysis of the case studies. It will underline the principal managerial and ageing issues that a reform agenda for service delivery should include in the context of an ageing population. Thus, this section will discuss the managerial elements commonly found in the strategies to reform the public service delivery system that may suggest new tendencies in policy-making. Then, it will briefly analyse how OECD countries are meeting the efficiency, accountability and equity requirements in service delivery. Finally, it will discuss the common elements included into the reform programmes of the public service delivery system to meet the demands generated by ageing.

Enhance Co-operation and Collaboration across Levels of Government and Sectors

The creation of collaborative networks for the provision of public services seems to be the trend in OECD countries (see for instance the cases of Canada, Finland, Italy, Korea, and the United Kingdom). Central governments are not the only players in service delivery but only one of the members of a network of public, private and voluntary organisations that interact towards a common objective. Networks are an intrinsic part of the notion of governance. Rhodes (1999:53) argues that “… governance refers to self-organizing, interorganizational networks.” Self-organizing means that networks are autonomous and self-governing. This idea raises the issue of the ability of central government to control the policy process. Government may not be the only actor in policy-making but has the role of avoiding fragmentation because of the generation of self-organizing networks. Therefore, as revealed in the case studies, in OECD countries policy-making, particularly on public service delivery, is being shaped under three main elements: collaboration, network building, and co-terminosity.

Building up collaboration among public and private service providers

According to the case studies, the challenges of an ageing population cannot be tackled within the fragmented public sector delivery systems. As it has been showed in this report, governments need to act in many fronts to be able to adapt the public service delivery system to an ageing context. Central governments cannot respond on their own to the challenges posed by demographic changes. Many times public services are delivered, as the case studies revealed, by different levels of government and therefore collaboration has emerged as a valuable tool to push reform programmes forward. Parker and Gallagher (2007: 14) argue that “Collaboration between organisations offers a way to weld different services and agencies into a more coherent problem-solving whole without tying them into rigid new structures. Collaboration between citizens and public institutions offers new ways to engage the public in keeping themselves healthy, or tackle anti-social behaviour, but it also allows people to opt out of the process if they so wish.”

OECD countries appear to have realised that collaboration presents a new approach to running local public services. The point is to have flexible public bodies that can quickly sense and adapt to changing contexts. The creation of forums for discussion where citizens and institutions interact to identify shared problems and find alternative solutions is paramount to increase collaboration. The case studies suggest that a more joint-up collaborative approach to public service delivery that opens a wide range of options to citizens is not only a way to increase co-responsibility in policy-making but to increase trust in public institutions. Moreover, the findings of this review suggest that OECD countries are going towards a more strategic thinking about reforming public service delivery that permits national, regional and local governments engage with civil society to work together.
Collaboration, apart from establishing the underpinnings of a more democratic policy-making, represents a window of opportunity to increase efficiency in service delivery, one of the most pressing concerns for OECD countries as reported in the case studies. Parker and Gallagher (2007) argue that local strategic partnerships can redesign local services around outcomes for citizens avoiding duplication of efforts under a customer-oriented approach.

However, one of the main challenges ahead for OECD governments is to design a system that encourages collaboration and better partnerships. In this system, central policies should be designed under a framework for collaboration with lower levels of government and strong co-ordination with private and non-governmental organisations. The case studies suggest at least four elements for that: i) committed leaders who are able to manage and work with actors from other levels of government and actors from the private and voluntary sectors; ii) the creation of opportunities for dialogue among stakeholders to enhance understanding and collaboration like the organisation of forums for policy-makers from different regions and levels of government; iii) the development of standards for service delivery that guide all actors to a common target reinforcing accountability; and iv) the development of common outputs and outcomes under a whole-of-government approach creating a shared vision to avoid fragmentation.

**Integrating networks of service delivery – disseminating power**

The complexity and diversity of policy arenas have led governments to interact with a wide array of actors from the private sector and civil society. This has generated a tendency in OECD countries to move from competition to collaboration in public service delivery under a more citizen-driven approach. For instance, as the case studies showed, information and communication technologies (ICTs) have created opportunities for sharing information and aligning service offerings across different providers. Consequently, OECD countries are increasingly using or integrating, formally or informally, networks of service providers oriented by a common goal, such as, the provision of services to the growing elderly population. The implications for policy-making in service delivery are that:

- A single institution is unable to meet the demands of a complex and changing society, therefore, a wider range of institutions and actors is important to design and implement public policies. As Stoker (2006: 47) argues, “[t]here is the need to give more recognition to the legitimacy of a wide range of stakeholders ... The fundamental idea is that for a decision to be legitimate or for a judgement to be made, it is necessary to have all the stakeholders involved.”

- The integration of networks for service delivery suggests that power is shared and not concentrated in one single actor or in a limited number of institutions.

- The importance of lower levels of government and the relevance of non-state actors in generating the capacity for policy delivery indicates that power is distributed horizontally and vertically. It is important to consider the extent to which the use of networks has dispersed power throughout the political system.

- Central government should then be able to exert control over the social, economic, and political system to avoid fragmentation but under the premise that its power and influence is just as important as the one of the rest of the members of the network.

- Improving channels of communication and building trust among the members of the network is critical for the success of the network. Members of the network should engage in building relationships and trust. This is linked to the requirement for listening to others and recognising the contributions other may make to reach the goals by which the network was created.

The movement in OECD countries towards collaborative networks of service delivery is a shift in networked governance where dialogue and exchange of information characterise policy-making and bottom-up approaches are used in decision-making. For the creation and success of networks in public
service delivery it appears that two main requirements must be met: i) a leadership with new managerial skills; and, ii) the engagement of civil society in policy-making.

The leadership requirement. The OECD (2001a) concluded that leadership is an important and crucial variable that leads to enhanced management capacity as well as organisational performance. Indeed, throughout the case studies it was evident that changes in the public service delivery required the active involvement of different actors located at different levels of government and in different sectors. To avoid fragmentation a strong and committed leadership with a new mind-set and managerial skills appear to be decisive if the changes were going to take place. Hence, derived from the experience of member countries dealing with ageing issues in public service delivery, it may be argued that this new leadership requires having the ability to generate and manage knowledge. This knowledge generation leads to innovate and this has been paramount in the, to a certain extent, positive response to the different initiatives to prove services to a growing older population. Moreover, innovation is needed to design mechanisms for service delivery across levels of government. Just as importantly, communication skills are a key feature of the leadership required to bring about change as interaction with wide diversity of actors and interests is needed.

Citizens’ involvement in policy-making. In an increasing number of OECD countries citizens have an active participation in decision-making and policy-making (OECD, 2001b). Certainly, in most of the countries participating in this study there is a cultural shift as public acquiescence is not enough but the active endorsement of citizens is expected as most of them stressed the need to give people a say in the definition of policy priorities. The problem here, however, is to engage people in policy-making in ways that go beyond the ballot box. ICTs provide an alternative to generate flexible, attractive and not too time-consuming ways of participation. In consequence, effective channels of communication are essential to know people’s levels of satisfaction with the existing services but to establish a dialogue with citizens about their priorities in terms of public services and how they can be best delivered. Such participation is essential in ensuring efficiency gains in service delivery. Different to other policy approaches, in OECD countries there is an increasingly common view that politics matter. If people are to co-operate and participate in policy-making, politics is then vital to encourage them. Furthermore, politics is being seen as a useful instrument to change people’s minds and preferences creating the conditions for better partnership.

Enhancing co-terminosity – common boundaries

The analysis of the case studies suggests that the development of a public service delivery system responsive to the needs of communities, problem solving in partnership is a burgeoning practice in OECD countries. Thus, co-terminosity, it appears, is a critical factor in policy-making that facilitates joint-working and underpins local democracy. The basic idea is that the more closely aligned are the respective partners’ boundaries, the more effectively the partners can combine in providing public services. This implies that co-terminosity should be understood beyond its traditional definition as the sharing of the same geographical boundaries between two or more organisations to include operating on a 1:1 basis. For instance, the provision of health care services implies a stakeholder community that often transcends any specific locality. As a result, co-terminosity should focus on the formation of communities of practice that act across governments and that are not hierarchical but more networked.

Co-terminosity is then a useful mechanism in helping public and private organisations to work together as they would focus and deal with the same population. For local authorities, co-terminosity represents the opportunity to match the strength and influence of other key service providers in the area, facilitating community planning, the share of common services, the development of a single entrance point for local contact points and shared service centres; and the creation of a common purpose. In theory, co-terminosity should also increase efficiency and effectiveness in service provision improving performance and avoiding duplication of activities but no evidence was gathered in the case studies to confirm this
point. The implications of co-terminosity in service delivery still need to be fully assessed based on more evidence and discussion among member countries. Issues such as who should lead the efforts in service delivery operating on a 1:1 basis remain unclear.

**Meeting Efficiency, Accountability and Equity Requirements in Service Delivery**

Overall, the provision of public services is guided by three core managerial questions: efficiency, accountability and equity. Every system of service delivery is expected to fulfil the expectation in these aspects as public services remain largely funded through taxation and therefore are subject to democratic monitoring. Efficiency makes reference to a continuous check that activity fits purpose valued by public. Accountability denotes rendering an account for action or inaction accepting formal responsibility for what has been done. Equity means developing individual capacity so that rights and responsibilities are realised. This last element is linked to democratic principles of the construction of dialogue with the widest possible number of individuals on a number of issues that directly affect them. Whether focused on ageing issues or not, every case study provided a hint on the way countries are acting to meet efficiency, accountability and equity demands. Table 4 presents an overview of how some OECD countries are responding to those requirements in service delivery.

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<tr>
<th>Effeciency</th>
<th>Accountability</th>
<th>Equity</th>
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<tbody>
<tr>
<td><strong>Canada</strong></td>
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<tr>
<td>Formal networks of federal, provincial and territorial ministries and officials aimed at planning and co-ordinating public service delivery.</td>
<td>Municipal governments are under provincial direction in the provision of public services.</td>
<td>Implementation of three instruments to transfer funds from the federal government to provincial and territorial governments to ensure capacity to comply with their responsibilities in service delivery. Service Canada aims at helping all citizens to access a wide range of public services.</td>
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<tr>
<td>The 'points of service' created through Service Canada have made possible to produce financial savings in service delivery.</td>
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<td><strong>Finland</strong></td>
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<tr>
<td>Enhancement of inter-municipal and sub-regional co-operation to provide public services in a larger scale. Creation of municipal mergers and Joint Municipal Boards.</td>
<td>Central government defines the standards by which public services must be delivered. Municipal governments have to comply with those standards.</td>
<td>Municipal governments receive grants from central government to level-up the capacity of the different municipalities to provide services so that all citizens have access to the same level of services around the country.</td>
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<td>Adoption of a whole-of-government approach in the planning of public services provision.</td>
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<tr>
<td>Country</td>
<td>Action Plan Considerations</td>
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<tr>
<td>Iceland</td>
<td>Establishment of the Action Plan 2010 that describes the main priorities of the health strategy, the objectives and the methods to meet them. Revision of legislation to ensure a distribution of responsibilities on service delivery across levels of governments.</td>
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<tr>
<td>Italy</td>
<td>Establishment of planning agreements to coordinate the provision of public services between local authorities and private and voluntary organisations. Creation of a network of public and private networks for the provision of services. Creation of networks of multi-functional services for the elderly available in one area.</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>Central government defines general principles to guide the formulation of measure to face ageing. Emphasis the development of local ICT networks to solve local challenges regarding service delivery. ICT expected to increase efficiency and productivity.</td>
<td></td>
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<tr>
<td>Korea</td>
<td>Enhance decentralisation of public service provision to increase efficiency. Adoption of an integrated policy approach for the provision of public services in the context of an ageing population.</td>
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<tr>
<td>Mexico</td>
<td>Enhance decentralisation of public service provision to increase efficiency. Improving budgetary practices to increase efficiency in the management of resources for service delivery.</td>
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<tr>
<td>United</td>
<td>Adoption of market-type Establishment of public service Adoptions of mechanisms to ...</td>
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</table>
Kingdom mechanisms for the provision of public services (public-private partnerships). Placing horizontal coordination across ministries and arm’s length bodies, and joint-up service provision across levels of government to increase efficiency and effectiveness in service delivery. 

agreements to ensure value for money to ensure that outcomes are delivered in return for resources. The Adoption of comprehensive performance assessments to monitor the standards of service delivery awarding ratings of performance to councils.

increase people’s choice and participation in service delivery by bringing decision-making closer to communities. Adoption of measures to tackle inequalities and improve access to community services.

Source: Country case studies

Table 4 reveals some common mechanism adopted by OECD countries to comply with the efficiency, accountability and equity demands in service delivery. In general, efficiency is met by collaboration of the different actors involved in service delivery that interact through networks. Improvements in the use of resources, for example redistribution according to priorities and the use of performance agreements are also expected to raise efficiency levels. As for accountability, it may be argued that the establishment of networks itself brings about control over the system making every player accountable for their performance. Moreover, the adoption of standards, although they may also be regarded as a mechanism for efficiency, is an instrument of control to push service providers towards the same goals complying with minimum quality requirements. In relation to equity, Table 4 suggests that OECD countries are opting for a more community focus where citizens have more opportunities to participate in the different stages of the policy process. Bringing the decision on what the main priorities are and the best way to satisfy them closer to citizens has been a common practice in the countries that took part in this review.

It might be argued that to distinguish between efficiency, accountability and equity mechanisms is problematic as one mechanism may serve different purposes. Nevertheless, the message from the case studies is that for a public service delivery system to beresponsive to the changing needs of the population is not enough to be flexible and adaptable but that is necessary to provide alternatives to meet the basic requirements of efficiency, accountability and equity as public services are largely funded by citizens.

Underpinnings of an Ageing Strategy in Public Service Delivery

The analysis of the case studies leads to conclude that in OECD countries the organisation or adjustment of the public service delivery system is not solely determined by ageing. Overall, the spirit of the reforms has been to increase productivity, efficiency, and quality of public services provided to the population regardless of their age. However, although the impact of ageing in policy discussions and policy decisions varies from country to country, all have acknowledged the ongoing changes in the demographic structure of the population. The analysis of the case studies reveals some common characteristics of the reform initiatives implemented by OECD countries that constitute the underpinnings of the reforms towards the establishment of an ageing strategy in service delivery:

- **Tackling ageism.** Countries are redefining the concept of ageing so as to eliminate stigmas, stereotypes and policies which actively discriminate against senior citizens. For example, mandatory retirement has, in many cases, limited the active participation of seniors in the economic and social life of their communities. Strategies to assess competency throughout life are being assessed in order to move from aged-based criteria to competency evaluation with sound evidence. The principle is that the elderly represent the values and culture of the community and therefore they constitute valuable members of society.
• **Emphasis on prevention.** OECD countries are implementing policies and programmes aimed at creating a culture of prevention as part of their strategies to regenerate and build sustainable communities. The reason is that most of the illnesses that affect old people are avoidable like: diabetes, and osteoporosis. Prevention is expected to reduce the risk of diseases and the risk of other age-related problems, and in consequence the burden on the health, social and long-term care sectors should decrease.

• **Maintaining old people’s independence and well-being.** Overcoming ageism and adopting a culture of prevention are intended to set the basis for keeping old people at home for as long as possible reducing the demand for long-term care services. Moreover, policies are now based on the fact that old people are living most of their senior years in good health and therefore they do not need support for activities of daily life. Long-term care services are being reserved for people who really need them, regardless of their age. Hence, policies focus on securing financial, social and health conditions of people throughout their lifespan.

• **Maintaining people’s freedom to choose.** This characteristic of reforms has two meanings. Firstly, it refers to giving the elderly the possibility to choose between different providers of services either from the public or private sector. As the case studies reveal, OECD countries are adopting policies and programmes to encourage the participation of a wider mix of providers of public services to increase not only efficiency and quality but to give people the opportunity to select the provider that most satisfies their needs. Secondly, the reading of the case studies made implicit or explicit that the elderly should be given the opportunity to decide what their priorities are. Older people are commonly believed to have the same priorities for instance access to health services. However, as most of them are living healthier lives their priorities are others like education to keep up with the latest developments in ICT to access a wider selection of public services. Moreover, this also means giving people the possibility to decide where to live and even when to retire.

• **Strengthening the role of informal carers - families as care givers.** Maintaining old people at home requires families to have a more active role in long-term care. Hence, supporting family members in charge of looking after senior relatives is a key part of OECD countries’ strategies to reduce the demand of long-term care services and, above all, to foster the role and participation of seniors within the nuclear family and community. This implies a cultural shift as in many countries old people tend to be seen as a burden. Thus, flexible working policies and a wider mix of day care services for old people may reduce the difficulties for families looking after their elderly relatives.

• **Perceiving ageing as an opportunity rather than as a challenge.** The fact that people are living longer is being considered as an achievement of social, health and educational policies implemented by governments. A long and healthy life is an opportunity to increase and preserve the experience of seniors for community and family life. Thus, the challenge is not ageing itself, but to ensure that longer life means more years of health and well-being.

• **An ageing strategy is not focused solely on old people but on the entire population.** An ageing population does not mean that the priority, at least for public service delivery, is senior citizens. The policies and programmes implemented by OECD countries aim at providing public services of high quality to all citizens regardless of their age. However, what an ageing strategy seeks to address are the drawbacks of the public service delivery systems as they were not designed to meet the demands of a population where senior members constitute one of the most numerous groups of the population. As the Canadian Special Senate Committee on Aging Second Interim Report (2008: 4) put it “… aging is a life-long process, and … some of the options to improve health and well-being among seniors need to be implemented throughout each stage of life, and not only in senior years.”
• **Considering ageing as only one of the factors that influence social and economic development.** Ageing, as it was evident in all case studies, is not a separate matter from other economic, social and cultural issues such as economic stability, social integration, poverty, etc. As a consequence, one of the main lessons derived from the case studies is that discussions on ageing and its implications in public service delivery cannot take place in isolation from other policy areas equally relevant for the provision of public services such as: managerial improvements, autonomy of local levels of government, cultural backgrounds, among others.

However, changes to the public service delivery system have been driven by a number of factors such as the need to increase productivity, efficiency, effectiveness and quality in service provision for economic social and political reasons. In some countries, like in Finland and Japan, the ageing phenomenon has been a more determinant factor in triggering reforms, but in others like in Canada, Mexico and the United Kingdom, its impact in fostering policy change has been rather limited. Thus, although reform actions may not be directly linked to demographic changes, they are expected to have some effect in adjusting the public service delivery system to the context of an ageing population.

It is necessary to develop a new thinking to view ageing as a lifelong and society-wide phenomenon so as to adjust social, economic, and administrative structures to adjust them to the demographic changes where young cohort diminish and old ones rise. All members of society need to recognise the advantages of a multigenerational society and its contributions to world development.

**The Way Forward – the challenge for public service delivery**

There is no doubt that OECD countries are immersed in a transition process, not only demographic but also managerial. Adapting the public service delivery system to the needs of an ageing population is a challenge for all countries. As it was showed in this report, ageing is an ongoing process that is changing people’s priorities and is forcing governments to react in consequence. However, as it was also discussed, ageing is only one variable of many factors that interact in a complex set of policy networks that aim at providing public services to the whole population. The challenge is then not to adapt the delivery system to the conditions set by individual variables but to the design of public service system that is adaptable, flexible and community learning-based able to respond to the problems posed by several inter-connected variables. The lesson to draw from the case studies is that the delivery system will not work unless it is adjusted on a continuous basis. Managers have an important role to play as it seems that they are no longer focused on whether procedures have been followed or whether the goals have been achieved, but whether they are meeting people’s demands. Continuous evaluation and learning-based on evidence are crucial to undertake the necessary changes.

The use of collaborative networks seems to be an option in the creation of a more flexible and adaptable public service delivery system. However, there are still some questions to be answered: how is it possible for government at different levels to collaborate politically while introducing innovations in service delivery? How to ensure accountability of all actors involved in the delivery of public services? What is the correct balance between the role of the central government in service delivery and the one of local authorities? If most of the factors that trigger reforms have cultural linkages, how to that change will take place?
6. AGEING AND PUBLIC SERVICE DELIVERY IN CANADA

Demographic Trends and Projections

Like in many other industrialised countries, the Canadian population is ageing. By 2015, for the first time in its history, Canada will have more people aged over 65 than people under age 15. This is the result of both the ageing of the Baby Boom generation defined as the population group born between 1947 and 1966 and a longer life expectancy (Figure 10). Indeed, Canadians have one of the highest life expectancies in the world. On average, a 65 year old man in Canada can expect to live another 17.4 years and a 65 year old woman an additional 20.8 years. In 2000, the old age dependency ratio (65+ in %20-64) was 20 and by 2050 it is expected to be 45. In the same period, the total population will grow from 30.7 million inhabitants in 2000 to 41.4 million in 2050. The majority of older people live about 13 of those years after age 65 in good health. According to the Canadian Institute of Aging, ageing will be one of the most significant forces shaping Canadian society over the next 20 to 30 years.

**Figure 10. Life expectancy at birth in Canada**

From 1980 to 2003

![Life expectancy graph](image)

*Source: Based on OECD StatLink database.*

The median age in the country has risen from 26.2 years in 1971 to 38.8 years in 2006. In 1971, the percentage of the Canadian population aged over 65 was 7.9% and that figure rose to 13.1% in 2006. Nevertheless, the ageing of the population has not been even throughout the country. There is a growing east-west divide in which the populations of the five most eastern provinces are, in general terms, older and ageing more quickly than the populations of the western provinces and the three territories.
Moreover, the proportion of seniors in each province varies considerably. While senior citizens account for 10.4% of the population in Alberta, they account for 14.6% in Saskatchewan. Birth rates and inter-provincial migration are the two main factors that explain the disparities in the proportion of senior citizens across the provinces and territories. The general trend of inter-provincial migration is of young people moving from poorer provinces to those with better economic opportunities. Students and working-age people (20-39 years old) account for half of all migration in recent years. Provinces such as Ontario, Alberta and British Columbia have been the recipients of this migration flows coming mainly from the Atlantic Provinces, Quebec, Saskatchewan and Manitoba.

International migration represents 61% of the overall population growth. According to Statistics Canada, without migration the Canadian population would be growing much more slowly. For instance, in 2000 the natural increase was 3.6 per 1,000, with births exceeding deaths by 109,200. "This continues a downward trend that began in the early 1990s and is bound to continue because of the ageing of the population" (Statistics Canada, 2001: 9). It is expected that inter-provincial migration, falling birth rates, declining fertility rates and differences in population age structure will widen across provinces and territories in the future. Hence, Statistics Canada forecasts that by 2031 senior citizens will represent 23.4% of the overall population.

The Canadian Policy Approach to Ageing

These demographic trends and projections have made ageing one of the most relevant topics of policy discussion and analysis in Canada. There is hardly a policy study that does not refer to ageing issues. Indeed, a Special Committee of the Senate of Canada on Aging is currently investigating a wide-ranging number of topics dealing with policy responses to ageing and has issued two interim reports which contain its main policy conclusions and findings. The latest report covers several topics such as the question of how different age structures in different parts of the country might affect the fiscal capacity of the federal
and the provincial/territorial orders of government in Canada to deliver services. The Committee is about to launch a final consultative phase in the area.

Since living longer is indeed an achievement, not a problem, the focus of policy discussions in Canada tends to be about exploring future possibilities in the relatively underdeveloped area of policies for seniors, trying to fill an increasingly important gap in welfare state programming. Social policies in mature welfare states have tended to concentrate on the young (education), on people in the middle years (social welfare and employment policies), on people who are sick or disabled (health care), and on pensions for older people that were designed on the assumption that durations of retirement were relatively short. People are spending a growing period of their lives as seniors, typically with little (or changing) attachments to the main institutions of society: withdrawal from the labour market, changing family attachments, and typically a reduced attachment to community organization and volunteering (at least in the middle and later older years). For Canada, and probably for many other OECD countries, the question is how to respond to this new reality.

Hence, policy discussion on ageing, as reflected in the second interim report of the Senate Committee, tend to focus more on policies that relate to older people, in other words, to individual ageing. It discusses issues such as active ageing, ageism, retirement and income security, healthy ageing and regional distribution of health costs associated with senior citizens. In other countries participating in this review like Finland and the United Kingdom, the focus is predominantly on the policy implications of the changing age structure and size of the population or what it is called population ageing. They focus on the fiscal consequences of an ageing population and the social and economic implications of an older workforce.

However, the Senate Committee’s report underlines that ‘…aging is a life-long process, and that some of the options to improve health and well-being among seniors need to be implemented throughout each stage of life, and not only in the senior years’ (Special Senate Committee on Aging, Second Interim Report, 2008: 4). Moreover, the report acknowledges the important role of individuals, non-profit organisations, the private sector, and the various levels of government in ensuring that senior citizens have a wide range of choices in terms of public services such as housing and pensions. It must be pointed out that many of the programmes and services for older people are delivered by provincial and territorial governments and that the role of the federal government as a facilitator in the exchange of information and best practices across jurisdictions needs to be reinforced.

In Canada, particular attention has been paid to the appropriate role of policy in support of care-giving for older people, both institutional care and in family care-giving at home. This has forced policy analysts to recognise the little knowledge and information available about the role of the family in social relations compared with the role of the labour market. There have been consequential efforts to draw on other social science disciplines in addition to economics, to look to new sources of data and new analytic techniques, and to take life-course perspectives that complement the traditional point-in-time economic analyses.

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Box 9. Overcoming Ageism

In its second interim report, the Special Senate Committee on Aging emphasises that healthy ageing and active ageing are instrumental to the well-being of senior citizens. However, it points out that one of the key barriers to overcome in facilitating active ageing is ageism. It considers that ageist stereotypes and prejudices unnecessarily limit the intrinsic value to society which older people bring. Negative assumptions that society has about ageing have been used to limit the active participation of seniors in life, for example, one case is mandatory retirement.

Hence, the Committee considers necessary to reframe the concept of ageing and move away from policies which actively discriminates against seniors. This is because chronological age has provided an expedient proxy to competency. It stresses that it is imperative to come up with strategies to assess competency throughout life, and not just in the senior years. It highlights three options for tackling ageism: i) the launch of a national strategy to combat ageist stigma and discrimination through, for instance, public education campaigns; ii) the promotion of the development of alternatives to chronological age as indicators of competency; and, iii) the promotion of research on competency to move from age-based criteria to competency evaluation with sound evidence.

Source: Special Senate Committee on Aging (2008), Second Interim Report. Issues and Options for an Aging Population

The Impact of Population Ageing in Public Service Delivery

The volume changes brought about by population ageing have not been a major factor in analysis of service delivery in Canada. In services that are concentrated in certain age groups, an effect on the supply and demand of service-providers or in the fiscal capacity of different orders of government that provide those services might be expected. Planning in most service delivery areas does take account of demographic trends. However, for the most part, population ageing has not been considered to be sufficiently important either as a way of organizing service delivery agendas or as dominant theme in analysis of service delivery policies.

For example, educational services are an area where population ageing is likely to result in relatively smaller volumes, other things equal. However, in the Canadian experience, other changes in population characteristics loom at least as large as the changing size of the source population. Immigration growth from countries where neither English nor French are the main language has placed challenges on the education system that are at least as large as changes in the total size of number of children of elementary or secondary school age. There are other pressures on the education system that could compensate, at least in part, for the relative decline in the size of source populations. Extending elementary schooling to younger age groups, building a nation-wide early and learning childcare system, and reducing secondary-school dropouts could, at least in principle, more than offset the declines in the source population. The effects of these other sources of change could have much deeper effects on educational service delivery than would population ageing.

At the other end of the age spectrum, health and long-term care services, where a rise in demand would be expected as a result of population ageing, issues about the adequacy of these services have already been a matter of concern for a long time in Canada. There have long been questions about the rather small role being played by geriatric medical practitioners and by geriatric training. This is because older people make up disproportionate number of medical clients while most doctors are more completely trained to deal with needs of the young and middle aged. According to the Canadian experience and studies in these areas⁵, population ageing per se is not the main driver in the volume or cost of health care services.

It is primarily a technologically-driven trend reflecting the increasing costs of the medical care that is used by older people. There is no doubt, however, that policy discussions on population ageing have focussed attention on the issue of health care, its costs and effectiveness.

In the long-term care area Canada has followed a pattern of de-institutionalization of care-giving that is familiar in many OECD countries. Concerns about the adequacy of care-giving in place have certainly been given higher priority in recent years as a consequence of the projected growth of the number of older people in the population. However, in the Canadian experience, it is doubtful if the analysis of ageing populations has helped to better understand what the appropriate policy action will be. The reason is that technology and medical knowledge plays such a large role in long-term care and is almost certain to have large, but unknowable effects, in areas such Alzheimer’s, arthritis, diabetes and joint replacement. The reality is that very little is known about what the volumes of people with different conditions will be 25 years from now. Given this inevitable uncertainty, policies are almost certainly to be guided by trying to provide better care for today’s frail population.

The Implications of Ageing in Policy Priorities and Social Demands

Canada faces a greater growth in its older population over the coming decades than do many other OECD countries. However, ageing creates fewer policy problems in Canada because of the relatively good shape of its retirement income policies, both fiscally and in terms of meeting their anti-poverty and income maintenance objectives. Moreover, labour markets in Canada are already quite flexible compared with many other countries, and the barriers to working longer have been relatively low.

The possibility of an eventual shrinking of population size, and the consequent possibility of having to rely much more heavily on immigration in order to maintain population size has been a more recent policy concern in some OECD countries. However, issues about overall population size do not play a large role in policy agendas in Canada, at least at the national level. Besides, immigration levels are already high by international standards.

A decade or more ago, when population ageing became a dominant theme in many policy agendas, considerable attention was placed on the role of ageing on health and long-term care. At that time, there was a worry that people were living longer, but that this extension of life was, to a large extent, spent in poor health and disability. The concerns were both social (was increasing longevity as desirable as it seemed from a quality of life perspective?) and fiscal (the spiralling costs of health and care). Since that time, analysis has showed that early fears were exaggerated because a good deal of extended life is spent in good health, and that many chronic conditions are concentrated in the years before death, no matter at which age death occurred. Newer evidence also found that population ageing, while important, was not the major driver of the costs of the health care system.

Nevertheless, in Canada at least, analysis of the policy effects of ageing population still place most attention in areas of health and long-term care, including implications for service delivery in these areas. It is important to stress that these are “new” in the sense that they have increased the priority attached to finding solutions. They are not new in the sense of the content of the policies. The nature of the services that are delivered are not likely much different than those that would have existed in the absence of the baby boom bulge. Moreover, studies and planning in sectors such as health, long-term care, work forces, voluntary sector, etc., invariable take into account the effects of ageing, both population ageing and individual ageing. However, this does not translate into any broader age-based vision of service delivery because ageing is only one variable taken into consideration in policy discussions and policy-making.

As for changes in public service demands, it is rare in Canada to find forecasts or projections in any area of public policy that go out several decades into the future. Public pension projections are the main
exception, where existing programs are carefully examined in terms of their future balance between benefits and contributions. The area of pensions will experience a growth in the numbers of pension beneficiaries (although income transfers such as pensions are not always treated as service programs). In Canada, both orders of government share responsibility for the contributory public pension (the Canada Pension Plan and the Québec Pension Plan.) A flat-rate pension and a pension targeted to low incomes are in federal jurisdiction. Public pension financing has already been made sustainable in light of population ageing. Much study, debate and policy action has taken place in the area of health care, again involving both orders of government. However, health care pressures do not flow primarily from ageing, although it is certainly a factor.

There is less clarity about the age-generated demand for services in other areas. However, most experts expect that there will be increases in health and long-term care services, areas within provincial/territorial jurisdiction, but with a federal financing responsibility through fiscal transfers.

Financial Challenges on Public Service Delivery due to Ageing

Canadian studies tend to reach two conclusions about the public costs associated with population ageing, which is the dominant fiscal driver. On the one hand, many studies conclude that population ageing will increase overall costs to government, but usually by amounts that are modest when compared with some other countries. The particular answers depend greatly on the nature of the model in question and the assumptions made in areas such as retirement ages. In general, the more sophisticated models seem to show smaller financial costs, as they take account of more factors.

On the other hand, other studies show that there should be little overall fiscal impact on government, or even gains. For instance, Denton and Spencer (1999) concluded that if one looked at all categories of government spending and adjusted the data by the size of the age groups to which the programs were addressed (e.g., pensions for older groups and education for younger groups) then age-related spending in the coming decades would grow, but would never reach the levels of 1950s and 60s. That is, the total fiscal effects look dramatically different from that in studies that examine health or pensions in isolation, or that use only old-age dependency rate analysis (instead of total dependency rate analysis). However, the need to make large adjustments within the total spending envelope is large in both sorts of studies. This analysis refers to the total public costs of ageing, not to service delivery per se. The actual delivery costs would almost certainly be moderate overall, but could nevertheless loom large in specific areas, such as provision of home (or institutional) care to frail elderly people, particularly when the baby boomers reach old age in around 25 years from now.

Furthermore, due to the expected increases in the demand for financial resources in the pension area, Canadian authorities managed to obtain the needed resources by increasing contributions rates to the contributory plans in order to build a larger reserve which is being invested in the market and this new rate is considered to be sustainable decades into the future. In many other areas, most effort has been devoted to reducing costs and increasing efficiency. In most areas as well, expenditures are financed from general revenues that are not earmarked for specific services. Here Canada has been a leader in reducing overall fiscal burden through eliminating deficits and reducing debt. For example, the government of Canada has a long-term economic plan called Advantage Canada with the goal of eliminating the total government net debt in less than a generation, by 2021. In 2006–07, the government spent 14.4 cents of every revenue dollar on interest on the public debt, down from the peak of 37.6 cents in 1990–91. It is expected that success in meeting broader debt reduction goals will leave Canada well situated to deal with a variety of new pressures, including those relating to ageing.

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Box 10. Advantage Canada - building a strong economy for Canadians

In 2006, the Canadian Ministry of Finance released the initiative Advantage Canada: building a strong economy for Canadians whose objective is to eliminate Canada’s total government net debt in less than a generation and further reduce taxes for all Canadians. This is a long-term plan that is expected to create the right conditions and opportunities for families and business to succeed. Advantage Canada seeks to gain a global competitive advantage in five key areas:

- **Tax Advantage**: reducing taxes for all Canadians and establishing the lowest tax rate on new business investment in the G7.
- **Fiscal Advantage**: eliminating Canada’s total government net debt in less than a generation.
- **Entrepreneurial Advantage**: reducing unnecessary regulation and red tape and increasing competition in the Canadian marketplace.
- **Knowledge Advantage**: creating the best-educated, most-skilled and most flexible workforce in the world.
- **Infrastructure Advantage**: building modern infrastructure.

Source: www.fin.gc.ca

Staffing Challenges on Public Service Delivery

Several years ago, the Canadian government created an agency called Service Canada aimed to improve the delivery of government services and help citizens to access a wide range of government services and benefits through more than 595 points of service located across the country, call centres and the internet.7 Service Canada immediately placed high priority on developing a “service delivery profession” within its organization. This included setting up a comprehensive Service Delivery Career Development Program; instituting a Service Canada College, a service delivery training curriculum and a certification programme. The Service Canada College aims to become the national learning centre for all service delivery professionals within Service Canada through the provision of high-quality courses and programmes with a uniform curriculum across the country and the formal recognition of the role of service providers as a profession and a career in the federal public service.

The recent experience with Service Canada suggests there will be radical changes in the service delivery function, including in training, recruitment and in accountability to those who are served. It is less clear what the implications will be on the size and cost of staff. However, to date, Canadian authorities claim that it has been possible to make gains in service provision while producing financial savings.

Nonetheless, in Canada, population ageing is not a big factor in manpower planning for public service provision. Canadian authorities consider that the changes referred to by the creation of Service Canada would have taken place regardless of the age structure of the population. This is because the essence of good service delivery lies in tailoring services to the needs of individual citizens, regardless of their age, gender, ethnicity or language. Hence, the provision and quality of public services should not be greatly affected by the volume changes associated with factors such as population ageing.

Similarly the number of staff positions does not play a major role in the long run in most public institutions in Canada. In most cases, there is much flexibility in creating positions, provided that substantive case has been for undertaking the activity. It will certainly take longer to create position

7. For reference see www.servicecanada.gc.ca
descriptions that reflect current views about the duties and pay levels associated with a new service delivery function. However, these issues can be worked out over time, if there is agreement on the substance of what is required. There may be more difficult staffing issues in some agencies, particularly the ones that provide services to older people with chronic conditions.

Consequently, in the case of Canada, and probably in many other countries, there are no definitive forecasts on the staffing needs to satisfy the demands for public service provision. What there have been are many simple “what if” forecasts in many areas of service provision. For example, how many family care-givers would be needed in 2025 if existing approaches to home care remain the same and if the percentage of older people requiring home care remained the same as it is today? However, in the Canadian experience, that kind of forecast is not very useful for planning. Since, for instance, the health care field is greatly influenced by a rapidly changing technology; it is not possible to expect the existing arrangements to remain unchanged for decades.

Service Canada epitomises the fact that it may not be necessary to increase staff to maintain or increase productivity in public service delivery. According to the Canadian experience, staffs may grow or decline for many reasons, but changing technologies are particularly important, for example, the dramatic fall in the numbers of stenographers and data entry operators. For Canadian authorities the provision of internal services within government is an area where technology, over some a number years, might allow for staff reductions and higher productivity. Although changes in service demands associated with population ageing would be another reason for changes in staff size, the experience of the Canadian Nurses Association suggests that caution is needed in this respect as:

Advances in technology and diagnostic tools, and the emerging shift to health promotion and disease prevention will address the present shortage of health professionals, including registered nurses and physicians. These developments will help offset the shortfall in the health workforce and improve the current system of costly and fragmented health-care delivery (Canadian Nurses Association, Vision for Change).8

Moreover, Canadian authorities expect shortages of staff in the areas of health and long-term care. Here it is important to note that the issues relate not only to volume but also to the mix of training and expertise within a profession. As Byron Spencer, a witness before the Senate Committee on Aging, pointed out, the training provided to medical professionals does not align well with the fact that older people make up a large and growing proportion of all recipients. This is due, in part, to a lack of system-wide planning within the health care system.

Canada has one of the most sophisticated occupational projection systems in the world, based on calculations of both supply and demand. It shows that, taking the economy as a whole, there is a reasonably good balance between the supply and demand for labour overall, and in many occupations. However, there are shortages in some geographic areas (especially in the western part of the country) and in some occupations including in the health services area. Nonetheless, these occupational projections cannot forecast accurately far into the future – certainly no longer than 10 years and often for a much shorter period than that. Moreover, they do not take account of whole new ways of doing business such as outlined by the report of the Nurses Association.

Because the effects of population ageing are often many years in the future, it is therefore difficult to project the future effects of ageing on the labour market for particular services. Therefore, according to the Canadian experience, for the long term, the best strategy would be to emphasise core, generic skills that

can be readily adapted to tomorrow’s unforeseeable needs, plus adjusting professional training to take account of the already existing age-structure and age-related needs of its clientele.

**Institutional Changes to Adjust the Public Service Delivery System**

**Reallocation of Responsibilities across Levels of Government**

There have been few institutional changes related specifically to ageing and service delivery in Canada. The creation of Service Canada was an important milestone in government service delivery at the national level of the government, but it was not directly linked to ageing. Similarly a Minister of State for Seniors has been established along with a National Seniors Council. However, the mandate is not limited to service delivery.

The Canadian government has a range of services in the areas of health protection and promotion, in supporting an active role of seniors in the community, some employment services (although many have been devolved to the provinces and territories) and has many income transfer programs and tax-based supports (unemployment insurance, old age security, student aid, etc). The provinces and territories are responsible for most services (education, health care, social assistance, etc) and also provide income supports, depending on the provinces or territory in question. Municipal governments are under provincial direction and often provide a wide range of services including social services and recreational services.

There have been some legal changes to the responsibilities across levels of government in relation to the provision of public services but ageing has not played a major role. However, there are important, formal networks of federal, provincial, territorial ministers and officials that deal with the planning and co-ordination of public service delivery.

**Reallocation of Staff across Levels of Government**

The different orders of government are entirely separate employers. When a function is shifted to another government such as the case with many employment programs, special negotiations have been undertaken to also shift appropriate staff to the new employer. However, it is unlikely that these shifts have been associated with an ageing population.

**Reallocation of Financial Resources across Levels of Government**

There are mechanisms to reallocate financial resources across levels of government, but these are not currently related to ageing. All orders of government have independent, multiple sources of revenue and have much flexibility in the amount of revenues they raise, whether to cover age-related expenditure changes or for any other reason. For example, both federal and provincial governments collect income taxes. In addition, there are three programs that transfer funds from the federal government to the provinces and territories: equalization, the Canada Health Transfer and the Canada Social Transfer.

The Senate Committee on Aging heard witnesses that advocated incorporating age-based expenditures into these transfers since the age structure of the population varies widely across the country, as does expenditure, particularly health care expenditures. However, the Committee points out in its report that it is not the ageing of the population that is driving up health care costs but rather the fact that demand for health care services by seniors is increasing. For example, the rise in per capita health care expenditures by seniors accounts for about two thirds of the change in national health expenditures over the past 30 years.

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**Box 11. Canada’s system of transfer payments**

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Canada has three instruments to transfer funds from the federal government to provincial and territorial governments:

**Equalization**: equalization is a federal formula-based transfer programme that helps to smooth out the differences in revenue-generating capacity across provinces. This programme is governed by the principle that provinces should have access to sufficient revenues so as to be able to provide a reasonably comparable level of services at a reasonable comparable level of taxation. It provides annual cash payments to those provincial governments that have a relatively weak ability to generate revenues using the tax based at their disposal.

**Canada Health Transfer (CHT)**: the CHT is an unconditional transfer from the federal government to the provinces and territories intended to help offset the cost of providing health care services. It consists of an annual cash payment and the nominal value (to each province) of a one-time transfer of tax room from the federal government to the provinces. The value of the tax room grows in line with the personal and corporate tax base, while the value of the cash component is determined in multi-year funding commitments.

**Canada Social Transfer (CST)**: the CST is a block transfer in support of provincial and territorial government spending on post-secondary education, social assistance, and social services. In 2007 the federal government announced that it would move the CST towards an equal-per-capita distribution of CHT and CST. Many programmes supported by the CST are intended for younger Canadians. Hence, it is not pertinent to the expenditure needs associated with an ageing population.


The Senate Committee reviewed various options for making age adjustments in the various federal transfers. For instance, by incorporating age-based expenditure needs into one or more of Canada’s existing major transfer payment programmes or by creating a separate and distinct transfer to address that specific policy change. However, the Committee has noted that including such adjustments in the Canada Social Transfer could offset to some extent the effect of introducing similar adjustment in the Canada Health Transfer. The Canada Social Transfer is related to programs that are more associated with younger population, while the Health Transfer is more linked to older populations. The Committee has described the problems associated with each option and is not making any recommendation at the moment as it considers that many factors other than ageing must be taken into account before defining changes to transfer arrangements. Rather, it is presenting these options as a basis for further discussion in the next phase of its work, along with a long list of other possible changes that could be explored.

**Organisational Changes to Adapt Public Service Delivery to an Ageing Context**

In the Canadian experience, population ageing, taken by itself, is not seen as a major challenge for public service delivery. Similarly, individual ageing perspectives run the risk of promoting ageist policies that treat people in otherwise similar situations in different ways based on their age. Hence, in Canada, organisational changes to improve the provision of public services have not been dictated by ageing.

Unlike other OECD countries, no major linkage appears to have been made in the public debate in Canada between market mechanisms and population ageing. The retirement of boomers does not appear to have strengthened, or weakened, calls for greater use of market mechanisms. However, as in many other countries, there are a range of views in Canada on the role of market-type mechanisms as instruments of public policy. There are also trends in thinking about these topics, with perhaps less interest in moving further towards market-type mechanisms than there was a decade or so ago.

In the same way, Canada’s experience in using arm’s length bodies in public service delivery has not been greatly influenced by ageing. Perhaps the closest connection might be the establishment of the Institute of Aging, one of thirteen institutes that comprise the Canadian Institutes of Health Research (Box 12). Population ageing and service delivery may have played a factor in its creation and its mandate, as one of its research themes is health services and policy related to older Canadians. However, its research mandate primarily deals with issues arising out of individual ageing.
Communication and Information Technologies (ICTs) in service delivery have been widely used in Canada. Service Canada has a full range of on-line services, including a special web-site for seniors. For instance, senior citizens can apply for employment insurance benefits; submit their employment insurance report; view or update their personal information for the Canada Pension Plan (CPP) and/or Old Age Security (OAS); calculate their retirement income; and obtain information on how to advertise their job skills. Service Canada has designed the ideal one-stop service experience for each of its main channels of service delivery, including internet based services. Moreover, it has established service standards and has enhanced the integrity of its programmes, achieving significant savings for taxpayers.

The changes in service delivery that have begun in Service Canada are expected to result in much better service to citizens, with far-reaching consequences for social well-being, including increased trust in government. These changes are only beginning to be felt. For example, newer real-time computing technologies and new analytic tools will greatly increase the quality of information that can be provided directly to citizens – with knowledge products replacing many current (and much more costly) service products. According to the Canadian experience, none of this seems to have much to do with ageing, however. The goal is to be responsive to the needs of all citizens, regardless of age.

In terms of access, computer use has become part of everyday life for many Canadians. Between 1990 and 2003, the share of households with a personal computer increased from 16% to 67%. Internet penetration followed suit, with the share of households accessing the Internet from home more than tripling between 1997 and 2003, rising from 16.0% to 54.5%. The share of senior-led households with home Internet access increased from 3.4% to 22.7% and access among households headed by someone aged 55 to 64 increased more than four-fold. Access has been growing steadily since then. While an age-based digital divide still exists, it will almost certainly fall rapidly in coming years, especially as the new technology becomes even simpler and more intuitive to use. Age is unlikely to be a major factor in access to e-government in coming decades.

Involvement of the Voluntary Sector in Public Service Delivery

According to Statistics Canada, in 2003 there were an estimated of 161 000 voluntary and non-profit organizations in the country. More than half of these are run entirely by the contributions of their members, in time and money. There is much diversity in size, function and source of funding, for example,
non-profits can include hospitals with large paid staffs. They drew on some 2 billion hours of volunteer time (the equivalent of about 1 million full-time jobs). Canadians have taken out 139 million memberships in these organizations, an average of 4 per person. The primary areas of activities are sports and recreation (21% of all organizations); religion (19%); social services (12%); grant-making, fund raising etc (10%); arts and culture (9%); and development and housing (8%). Some 11% of all voluntary organizations serve elderly people, but many of the remaining organizations have older people among the people they help.

According to a 2004 Statistics Canada survey of the population almost 12 million Canadians (45% of the population aged 15 and over) volunteered in the year before the survey. They were most likely to volunteer for sports and leisure, social services, education and research, and religion. Volunteering is highest among youth, those with higher income and education, those with children at home and those who are active religiously. The rate of volunteering declines by age, and is lowest among those aged 65 and over (although older people who do volunteer tend to donate considerably more time). Relatively few people donate a lot of hours. Average hours donated was highest among seniors, those with low incomes, and those who are active religiously. These results do not include the very considerable amount of time that people spend in providing care to family members and neighbours.

In Canada, it is not clear whether the participation of voluntary organisations is likely to increase due to ageing. Originally many services were provided by voluntary organisations. In recent decades, with the growth of the welfare state, Canadian governments have supported non-governmental organisations in the delivery of services. For example, at the federal level, these bodies were used extensively for delivering training and employment programming to unemployed people and in the provision of some community services to seniors.

However, these relations have had a cyclical aspect, stronger at certain periods and weaker at others. Currently, the relationships are not as fully used as in the past. A key reason for this is that the much employment programming has been devolved to the provinces and territories and is no longer delivered by the government of Canada. As well, there has been a tendency towards favouring direct relations between the government and the citizens with less need for intermediaries such as non-governmental bodies. For example, devices such as refundable tax credits have been more fully used in recent years by the government of Canada than have service interventions.

More generally, there has been much recent soul-searching about the role of the voluntary, non-governmental sector in Canada and its relationship with the government. However, population ageing has not been a major theme in these discussions. It is not seen as a reason for a stronger or a weaker role for the non-governmental community, at least at the level of the federal government of Canada. Moreover, there is no clear evidence of any major new plans to specifically stimulate and support the voluntary sector to provide public services to meet the demands of an ageing population, although some may exist in some parts of the country and some sectors.

The Senate Committee has identified a number of options for strengthening the voluntary sector more generally, but their emphasis has been more on the value of encouraging volunteering among seniors as part of a strategy of active ageing. Moreover, the Committee notes that, in the Canadian experience, support to volunteering is best thought of as part of a strategy of active ageing over the whole life-course, encouraging volunteering well before people become seniors. Therefore, volunteering should be seen through a life-course lens, not an ageing lens.

Conclusions

Although Canadian population is ageing fast, ageing has not been a major driver in the re-organisation of the public service delivery system. Ageing has been only one of the several factors or elements considered in policy discussions. However, initiatives such as Service Canada and the creation of the Institute of Aging, in one way or another, contribute to respond to the new reality that ageing will generate in the short-term. This is probably because, as the Canadian experience shows, policy solutions or alternatives to deal with the requirements of an ageing population are not always, and probably they do not have to be, tied to age. Even more, the Canadian case reveals that policy-makers and academics are still a long way from understanding how a mature social policy will deal with individual ageing.

The discussions on ageing in Canada focus on individual ageing as exemplified by the Senate Committee’s Second Interim Report. Although no recommendation has been made so far for policy reforms, the report is valuable in the sense that it explores different options in an otherwise undeveloped area. Recommendations, policies or programmes derived from these discussions may fill an important gap in the welfare state programming, as stated by Canadian authorities, but policies based on individual ageing need to be integrated into a whole-of-government approach. Although focusing on the special needs of the elderly is sensible, reform initiatives aimed at dealing with the challenges posed by ageing should take into account the rest of the population. The Senate Committee put it as ‘… aging is a life-long process, and … some of the options to improve health and well-being among seniors need to be implemented throughout each stage of life, and not only in the senior years’ (Special Senate Committee on Aging, Second Interim Report, 2008: 4).

The Canadian experience and discussions reveal at least three points. First, that population ageing is changing service delivery volumes, but its effects should not be seen in isolation from other potentially far more important elements such as technology developments. Hence, it is necessary to be aware of its limitations as an analytical framework to analyse changes in service delivery. Second, there are no evidence-driven discussions on how, why and to what extent policies can or should affect the course of people’s lives in the search for greater life-course flexibility. Finally, an individual ageing perspective might make more sense on the surface. However, the new life-course perspectives which are taking over from older age-based approaches suggest that it might be better to tie policies directly to an individual’s needs and functions regardless of age.
7. AGEING AND PUBLIC SERVICE DELIVERY IN FINLAND

Contextualising Service Delivery in an Ageing Population

The Extent of the Ageing Challenge

Finland has one of the world’s fastest ageing populations and the population growth has slowed down. In 2000, Finland had a population of 5.2 million inhabitants and it is expected that by 2050 the population will be 5.3 million. At the end of 2007, the Finnish population was 5 300 484 of which 16.9% were children aged 0 to 14 and 16.5% were over 65 years of age. Life expectancy in Finland rose by a year every decade during the 20th century (Figure 12). This achievement has been facilitated by improvements in working, housing and living conditions such as: high educational levels, financial welfare of the population, nutrition, clean water, disease prevention and progress in medical and healthcare.

![Figure 12. Life expectancy at birth in Finland](source: Based on OECD StatLink database)

The rise in life expectancy and the decline of the birth rate are the two main triggering structural factors that have cause a rapid ageing. The consequences are that the Finnish population, like that of many industrialised societies, will grow older and the growth will slow down (Table 5). For instance, for the period 2004-2005, the Finnish population grew at a rate of only 0.2% and during 2007 the population grew in 167 municipalities and shrunk in 242. Finnish authorities estimate that by 2030, the proportion of persons aged over 65 in the population will rise from the present 16% to 26%, an increase of 80%, and then remain almost unchanged for almost the next decade. That means that in 2030 one Finn in four will be 65 or over. Respectively, the share of persons aged under 15 will diminish from the present 17% to 15.5% by 2040. By the same year, the proportion of working age people will contract from the present 66.5% to 57.5%. By 2034, the demographic dependency ratio, that is the number of children and elderly people per one hundred persons of working age, will go up from the present 50 to 74.6.

11 According to Statistics Finland’s data on population changes, 58 729 children were born in Finland in 2007, 111 less than in 2006. www.stat.fi
Table 5. Population by age in Finland

1980 - 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Aged 0 - 14</th>
<th>Aged 15-64</th>
<th>Aged 65 -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1980</td>
<td>4 787 778</td>
<td>20.2</td>
<td>67.8</td>
<td>12.1</td>
</tr>
<tr>
<td>1985</td>
<td>4 910 664</td>
<td>19.4</td>
<td>68.0</td>
<td>12.6</td>
</tr>
<tr>
<td>1990</td>
<td>4 998 478</td>
<td>19.3</td>
<td>67.2</td>
<td>13.5</td>
</tr>
<tr>
<td>1995</td>
<td>5 116 826</td>
<td>19.0</td>
<td>66.7</td>
<td>14.3</td>
</tr>
<tr>
<td>2000</td>
<td>5 181 115</td>
<td>18.1</td>
<td>66.9</td>
<td>15.0</td>
</tr>
<tr>
<td>2005</td>
<td>5 255 580</td>
<td>17.3</td>
<td>66.7</td>
<td>16.0</td>
</tr>
<tr>
<td>2006</td>
<td>5 276 955</td>
<td>17.1</td>
<td>66.5</td>
<td>16.5</td>
</tr>
<tr>
<td>2007</td>
<td>5 300 484</td>
<td>16.9</td>
<td>66.6</td>
<td>16.5</td>
</tr>
</tbody>
</table>


Figure 13. Population estimates for Finland by age and gender groups

![Population estimates for Finland by age and gender groups](image)

Source: Based on OECD DELSA database.

Finland is a unitary and decentralised welfare state. The benefits and services provided by the social security system are universal entitlements. This means that people can receive benefits and services even if they are not employed or married to an employed person or do not have special insurance coverage. The Finnish social welfare system is comprised of social insurance (pensions and benefits in the form of daily allowances and private and public institutions are responsible for their provision) and services (social and healthcare services provided by local authorities). However, the demographic changes are jeopardising the welfare system as they are impacting public finances compromising the provision and standards of public services.
Public services constitute a triggering force for development as they have the potential to attract investment and an economically active population. Nevertheless, an ageing population implies a shift in the demand of certain public services; for instance, an increase in the demand of healthcare services and a decrease in the demand of educational services. Indeed, as the age structure of Finland’s population changes, the priorities of government policies and peoples’ demands for public services are shifting towards health and social care. The Finnish government has based its strategy to face the challenges of an ageing population on structural forecasts and a continuing evolution of public service delivery. The OECD projects that in Finland, between 2010 and 2020 the expenditure in education, health and social care will increase around 40%, of which expenditure in education will tend to decrease but not significantly enough to compensate for the increase in the others.

One of the biggest challenges that Finland faces is to safeguard and finance current levels of service provision. Institutional restructuring and reallocations of public expenditures between levels of government and sectors have already started in response to new public service demands. The increment in the number of older people will inevitably lead to an increased need for services. Moreover, the problem is exacerbated by the reduction in the workforce available, the changes in its age profile and dated professional training. Due to the fact that a growing number of employees are retiring, the labour market is losing experienced expertise as younger generations trained in new skills necessary for the economic development is diminishing. It is estimated that the annual demand for new workers will exceed supply by approximately 10 thousand workers in the early 2010s.

Changing Demands and Priorities due to Ageing

Talking about public service delivery in Finland is talking about local governments. There are over 400 local authorities in Finland which produce two-thirds of basic services such as education, healthcare, social care, culture and technical infrastructure (Box 13). The rest is produced by the national government, private sector and non-governmental organisations. 75% of total public employees work in local government. Moreover, local governments account for 30% of total public spending. Finnish municipalities, particularly in rural areas, currently face a number of challenges to provide public services with the minimum standards established by the national government. For instance, i) the unbalance between local influence on services and the national goal of ensuring equity; ii) the disparity between the responsibilities of municipalities to provide public services and their financial capacity to meet their obligations; iii) the need to comply with minimum standards for the provision of basic services imposed by the central government to tackle regional disparities and the necessity to cope with the administration’s effort to cut spending; iv) the lack of critical mass for provision of services, difficulties to access remote settlements and the shifts in demands due to ageing, which result in an increment in the costs of services.

Box 13. Public services provided by local authorities in Finland

In Finland, local authorities are responsible for providing welfare services for their residents under the basis of high quality and universal entitlements.

12 However, services have less productivity growth than industrial production.
13 This figure is based on the Finnish report Finland for people of all ages – government report on the future: demographic trends, population policy, and preparation for changes in the age structure; Prime Minister’s Office 34/2004.
Local authorities:
- Run the country’s comprehensive and upper secondary schools, vocational institutions and polytechnics.
- Provide adult education, art classes, cultural and recreational services, and run libraries.
- Provide child day-care, welfare for the aged and the disabled, and a wide range of other social services.
- Provide preventive and primary care, specialist medical care and dental care.
- Promote healthy living environment.
- Supervise land use and construction in their area.
- Are responsible for water and energy supply, waste management, street and road maintenance and environmental protection.
- Seek to promote commerce and employment in their area.

Source: www.kunnat.net

Moreover, local governments will face the shortage of specialised staff particularly for healthcare services as, for instance, there are already a number of vacant doctors’ posts in rural areas. In Finland over 75% of total public employees work in local government what represents one fifth of the whole country’s workforce. Skilled labour needs will grow in some areas, creating requirements that cannot be filled by personnel hired for general administrative tasks. This situation presents Finland with two contrasting scenarios. On the one hand, there is pressure for less public employment for efficiency reasons and for reduction in demand. On the other, there are higher pressing needs for specialised public employees which cannot be easily covered by the reduced demand in education.

Education, for example, is the sector that has seen a reduction in the level of demand in recent years. According to Finnish authorities the number of comprehensive schools was down by 130 between 2006 and 2007 (Table 6). At the end of 2007, there were 880 active providers of education and 4 443 educational institutions in which 1.9 million students pursued their studies. The number of education providers was 19 and that of educational institutions 167 lower than in 2006. Of the providers of education, 54% were municipalities or joint municipal boards, 7% were central government units and 37% private. Moreover, according to the Statistics Finland’s data, in 2007 there were 3 067 active comprehensive schools which had 547 500 pupils. Special education schools at the comprehensive school level numbered 159 and they had 8 300 pupils. A total of 121 comprehensive schools or comprehensive school level special education schools were closed down or merged with another educational institution. Of these, 24 were educational institutions with under 20 pupils, 65 had between 20 and 49 pupils while 32 had at least 50 pupils. This reduction in demand of educational services obeys, to a large extent, to demographic changes and that means that although education remains central for the development of the country, the organisation of the education sector and its focus have to change to meet new priorities.
Table 6. Variations in demand for educational services in Finland

Data for 2007

<table>
<thead>
<tr>
<th>Type of educational institution</th>
<th>Number of institutions</th>
<th>Change from previous year</th>
<th>Number of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive schools</td>
<td>3 067</td>
<td>-113</td>
<td>547 500</td>
</tr>
<tr>
<td>Comprehensive school level special education schools</td>
<td>159</td>
<td>-17</td>
<td>8 300</td>
</tr>
<tr>
<td>Upper secondary general schools</td>
<td>406</td>
<td>-12</td>
<td>122 600</td>
</tr>
<tr>
<td>Comprehensive and upper secondary general level schools</td>
<td>37</td>
<td>0</td>
<td>24 400</td>
</tr>
<tr>
<td>Vocational institutes</td>
<td>161</td>
<td>-12</td>
<td>164 900</td>
</tr>
<tr>
<td>Special needs vocational institutes</td>
<td>12</td>
<td>-1</td>
<td>4 900</td>
</tr>
<tr>
<td>Special vocational institutes</td>
<td>37</td>
<td>-1</td>
<td>28 900</td>
</tr>
<tr>
<td>Vocational adult education centres</td>
<td>32</td>
<td>-2</td>
<td>42 700</td>
</tr>
<tr>
<td>Fire, police and security service institutes</td>
<td>2</td>
<td>0</td>
<td>1 400</td>
</tr>
<tr>
<td>Military vocational institutes</td>
<td>15</td>
<td>0</td>
<td>…</td>
</tr>
<tr>
<td>Polytechnics</td>
<td>30</td>
<td>-1</td>
<td>143 300</td>
</tr>
<tr>
<td>Universities</td>
<td>20</td>
<td>0</td>
<td>176 300</td>
</tr>
<tr>
<td>Military academies</td>
<td>1</td>
<td>0</td>
<td>…</td>
</tr>
<tr>
<td>Music schools and colleges</td>
<td>89</td>
<td>-2</td>
<td>62 600</td>
</tr>
<tr>
<td>Sports institutes</td>
<td>14</td>
<td>0</td>
<td>1 600</td>
</tr>
<tr>
<td>Folk high schools</td>
<td>89</td>
<td>1</td>
<td>14 500</td>
</tr>
<tr>
<td>Adult education centres</td>
<td>234</td>
<td>-6</td>
<td>506 900</td>
</tr>
<tr>
<td>Study circle centres</td>
<td>11</td>
<td>0</td>
<td>53 800</td>
</tr>
<tr>
<td>Summer universities</td>
<td>20</td>
<td>0</td>
<td>32 500</td>
</tr>
<tr>
<td>Other educational institutions</td>
<td>7</td>
<td>-1</td>
<td>600</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4 443</strong></td>
<td><strong>-167</strong></td>
<td><strong>1 937 700</strong></td>
</tr>
</tbody>
</table>

Source: Statistics Finland, www.stat.fi

Finnish authorities will have to make larger investments in health and functional ability as well as in education ensuring the welfare of children and youths. The health of the younger generations is part of the strategy for facing the challenges of an ageing population in Finland. This is based on the principle that an ageing population policy should address demographic developments or, in other words, changes in the relative size of age groups. An ageing population does not only mean an increase in the number of people aged 65 or over but a decline in the number of children, youth and working-age people. Hence for Finnish authorities the ageing challenge relates less to the growing number of older people than to the diminishing numbers of children and people of working-age. Thus, investing in educational, cultural, sport and recreational activities is at the cornerstone of the ageing policy as they are not only for the young generations but also for the elderly.

The ageing population presents Finland with a number of challenges in the short and medium term. The increase in demand of services will represent a fiscal burden as

Between now and 2025, merely meeting the demographically determined additional service demand would imply an increase in public sector employment by about 6%. However, with the population of working age expected to decline by about 11% over the same period, and in the absence of any improvement in the aggregate employment rate, the share of the business sector in total employment would fall from 74 to below 70% (OECD, 2005, p.11).
The shortages of skilled and specialised staff for the delivery of certain services, for instance healthcare and child protection will create a challenge for all municipalities in Finland, particularly in rural areas, to meet the demand complying with the national standards determined by the national government. In addition, the dominance of public employment poses the risk of crowding out private sector as it dominates heavily the economic structure. Rural areas, in particular, largely depend on public finances which impacts the economic activity. Moreover, in Finland, the healthcare, social care and education sectors represent more than 80% of municipal employment. The search for efficiency and the reduction of operating costs may produce unemployment if those workers, mainly women, cannot be absorbed by the private sector, leading them to migrate to other areas exacerbating the uneven age and gender distribution of the population.

Table 7. Effect of population factors on the demand of basic services

(Index 2005 = 100)

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>Expenditure, million €</th>
<th>Changes % in year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Services</td>
<td>5,368</td>
<td>100</td>
</tr>
<tr>
<td>Preschool education</td>
<td>65</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive school</td>
<td>3,134</td>
<td>100</td>
</tr>
<tr>
<td>Upper secondary school</td>
<td>528</td>
<td>100</td>
</tr>
<tr>
<td>Vocational education</td>
<td>1,136</td>
<td>100</td>
</tr>
<tr>
<td>Polytechnic</td>
<td>505</td>
<td>100</td>
</tr>
<tr>
<td>Health Services</td>
<td>5,914</td>
<td>100</td>
</tr>
<tr>
<td>Specialised hospital care</td>
<td>3,853</td>
<td>100</td>
</tr>
<tr>
<td>Health centres</td>
<td>2,061</td>
<td>100</td>
</tr>
<tr>
<td>Social Services</td>
<td>4,051</td>
<td>100</td>
</tr>
<tr>
<td>Day-care for children</td>
<td>1,928</td>
<td>100</td>
</tr>
<tr>
<td>Institutional elderly care</td>
<td>723</td>
<td>100</td>
</tr>
<tr>
<td>Home care</td>
<td>541</td>
<td>100</td>
</tr>
<tr>
<td>Service accommodation</td>
<td>859</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance, www.vm.fi

Institutional Changes in Multi-level Governance to Adjust Service Delivery to an Ageing Context

The Responsibility for Public Service Provision

As it was stated above, in Finland, local governments have the responsibility for providing two-thirds of basic services like education, social and healthcare, security and transport services (Table 7). Hence, any increase in the demand of public services will have to be borne by local governments whose financial position is deteriorating. Public service employment comprises public administration (which accounted for 13% to 17% of public service labour force in 2004, depending on the type of area), education (between 20% and 23%), healthcare (between 44% and 50%) and other municipal services (between 13% and 16%).
Table 8. The regulation of responsibilities of Finnish municipalities

<table>
<thead>
<tr>
<th>Type of regulation of the task</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary tasks within the frames of the local self-government</td>
<td>Infrastructure (partly regulated), leisure services, industrial policy</td>
</tr>
<tr>
<td>Nationally regulated tasks with considerable local discretion in</td>
<td>Care for the elderly, cultural services, libraries, fire and rescue</td>
</tr>
<tr>
<td>the implementation</td>
<td>services, environmental services</td>
</tr>
<tr>
<td>Strictly regulated tasks with national (and professional standards)</td>
<td>Healthcare, primary and secondary education, day care for children</td>
</tr>
<tr>
<td>and subjective right to services</td>
<td></td>
</tr>
</tbody>
</table>

Source: Sandberg, S. (2004), Local government in Finland, Institute for Comparative Nordic Politics and Administration, p.10

In general terms, Finnish local and joint authorities employ 430 000 persons, which is about 17% of the country’s workforce. Public services account to close to 30% of employment. Women account for the vast majority of the municipal workforce as only two out of ten employees are men. The average age of municipal employees’ is 45 years what means that over the next few years, local governments will need to recruit a lot of new personnel as one-third of all personnel retire by the end of this decade. It is expected that the healthcare and social services sectors will be the most affected by the shortage of personnel if it is considered that about four-fifths of municipal employees work in healthcare, education and social services (Table 9).

Table 9. Municipal employees in various branches 2002.

<table>
<thead>
<tr>
<th>Branch</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare</td>
<td>29.2%</td>
</tr>
<tr>
<td>Social services</td>
<td>27.0%</td>
</tr>
<tr>
<td>Education and culture</td>
<td>26.9%</td>
</tr>
<tr>
<td>Town planning and public works</td>
<td>4.9%</td>
</tr>
<tr>
<td>Municipal enterprises</td>
<td>4.4%</td>
</tr>
<tr>
<td>General administration</td>
<td>3.4%</td>
</tr>
<tr>
<td>Real estate</td>
<td>2.1%</td>
</tr>
<tr>
<td>Public order and safety</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Source: Association of Finnish Local Authorities www.kunnat.net

Finnish authorities consider that the expected growth in the demand for certain services will require more attention to be paid to the promotion of health and education of the different age groups of society. Due to municipal variations in the age structure, the need for services will be unevenly distributed among municipalities jeopardising their availability. For example, in net emigration regions where the majority of people are older, the demand for care and nursing services will increase and, at the same time, the economy will slow down; hence, finding care personnel will become increasingly difficult because of a diminishing working-age population. In many areas, it will be harder to provide all citizens with the same standard of welfare services. The challenge lies in the fact that whereas the size of the working-age population will diminish by 300 thousand workers by 2030, more staff will be needed in care and nursing services.

Local authorities are finding increasingly difficult to finance public service provision because the service structures of municipalities are not suited to face increases in service demands. Hence, whereas a number of municipalities have been forced to raise their tax rates, some others have been receiving...
discretionary funds from central government to finance public service delivery. Adaptation of the service structures to the context of an ageing population will require, among other measures, the reallocation of the workforce and the availability of new staff. For instance, services for children and youths will be reduced but in a way that does not threaten the quality and standards of services provided to them like educational and recreational services. Moreover, the ongoing demographic changes will produce an increase in government funding through the calculated system for central government transfers to local governments.

The difficulties that municipalities are facing to provide public services mainly related to funding and staffing shortages have led Finnish authorities to rethink the transfer of some responsibilities for public service delivery to a different level of government under a more regionally-based approach to build-up on the minimum scale required for their provision. Three mechanisms for service provision have been implemented in Finland:

- **Joint Municipal Boards** were introduced in 1993 as a form of inter-municipal co-operation. A Joint Municipal Board is a form of permanent collaboration of more than one municipality in some fields of operation. They are set up under an agreement or charter between the local authorities concerned which has to be approved by their councils. Municipalities are encouraged to voluntarily come together to pool resources for the provision of services or municipal co-operation, buying services from other municipalities or providers. Currently, there are around 230 joint authorities in Finland. The most prominent joint authorities include regional councils, hospital districts, and districts for care of the disable. Joint municipal boards have favoured the creation of hospital districts and specialised care districts and education districts. Three-quarters of all joint authority expenditure goes to healthcare services.

- **Municipal mergers** were introduced in 2006 aiming at strengthening services and municipal structures. They allow the formation of larger catchment areas for services and increase co-operation between municipalities. Municipal mergers are intended to improve the manner in which services are produced and organised; to overhaul local government financing and the system of central government transfer to local government, and to review the manner in which tasks are divided between central and local government. The aim is to improve productivity, reduce local expenditure and create a sound basis for steering the services organised by municipalities. In recent years, only a few municipal mergers have taken place, in 1997 there were 452 local authorities and in 2008 that number declined to 415. From 2009 the number of municipalities is expected to decrease from 415 to 348 due to municipal mergers. In total, there are 99 municipalities included in these mergers.

- **Kainuu regional government.** This is a regional administrative experiment which began in 2005 and is planned to last until the end of 2012. Since there are only two official levels of government in Finland, the national government and the municipal government, the aim of this project is to transfer the power and responsibility from the municipality to a different administrative structure, the regional government level, to improve the provision of services and reduce municipal spending through co-operation at regional level. The Kainuu regional government is currently a joint body of 9 municipalities with 3 350 employees and an annual budget of EUR 240 million for what special legislation was enacted. This regional authority has the responsibility of providing education, social and healthcare services, regional development and regional land use planning.

### Table 10. Patterns of service production in Finnish municipalities

<table>
<thead>
<tr>
<th>Mostly in-house, some utilization of private producers</th>
<th>In-house or joint-municipal authority/other co-operative</th>
<th>Mostly joint municipal authority</th>
</tr>
</thead>
</table>

67
As Table 10 reveals, Finnish municipalities on their own provide basic services while more specialized services are being delivered by joint municipal authorities. Only urban municipalities like Helsinki because of its size in terms of inhabitants and economic development are able to provide specialised services but for rural or smaller municipalities joint action seems to be the best alternative to meet the demands of services to the population. Nevertheless, Table 11 shows that Finnish local governments are taking on new responsibilities regarding public services increasing the need for extra staffing and financial resources.

Table 11. Allocation of new responsibilities in Finnish local governments

<table>
<thead>
<tr>
<th>New responsibilities</th>
<th>Extended right to day care for children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regionalized functions</td>
<td>Fire and rescue services</td>
</tr>
<tr>
<td>Functions transferred to local state authorities</td>
<td>A number of minor authority functions within the social sector</td>
</tr>
</tbody>
</table>

In order to safeguard service infrastructure and service provision, Finnish authorities consider that it is of crucial importance reinforcing inter-municipal and sub-regional cooperation. This would enable the provision of basic public services in much larger operational entities than the current municipalities. In Finland, despite of having financially efficient municipalities, a large number of them are already too small to provide public services. Hence, the Finnish government is trying to enforce inter-municipal cooperation and rationalisation. For instance, in 2005 there were 432 municipalities and approximately 250 joint municipal boards and other municipal cooperation boards. The 2005 budget included an allocation of EUR 54.4 million for supporting increased cooperation between municipalities and projects to improve operational efficiency. Cooperation models vary according to local circumstances and the services involved, what means that there are different solutions for the same needs depending on the region.

An ageing population represents for Finland a challenge in terms of maintaining capacity in key sectors, but also an opportunity to reorganise the workforce around the new needs and priorities. Education and health are expected to be the services more affected by the demographic changes and since they have been devolved to local government authorities, a whole-of-government approach will be needed to reorganise the workforce and the reallocation of responsibilities and financial resources. The fact that the demand for basic education services will decrease, as shown in Table 2, it will allow government to transfer resources to the health sector as the number of disable people, for instance, is expected to increase.
Additional institutional plans to restructure municipal powers and create sub-regional entities with public service delivery capacities may amount to a comprehensive reorganisation of Finnish public service delivery. In that sense, in April 2005 the Finnish government issued a review of the structure of municipalities and the state administration preparing for a larger reform. The basic principles of this reform project are ‘…that the size and population base of municipalities must be sufficiently large to ensure professional service provision, and in particular specialised health care should be provided by larger units. To improve cost effectiveness, it is also envisaged to involve a wider variety of providers including incorporation of current public entities and more purchase of service from private sector entities in order to benefit from economies of scale’ (OECD, 2005: 20). However, budgetary constraints may lead local authorities to look for further resources, even while inputs are decreasing. Maintaining public workforce capacity is then a priority for Finnish authorities.

**Restructuring municipalities to improve service delivery**

Finland is a highly decentralised country. The constitution grants local and municipal authorities extensive autonomy, including the right to determine the tax rate on personal income and manage their funds. However, the fragmentation and autonomy of Finnish municipalities has made difficult to implement programmes to improve productivity. Hence, in 2005 Finnish authorities started a Project to Restructure Municipalities and Services in order to: i) improve productivity in the municipal sector; ii) slow the recent pace of growth in local government expenditure; and iii) improve the co-ordination of services organised by municipalities. The project intends to encourage economies of scale by forcing small municipalities to form either a merger or a partnership area with neighbouring municipalities. This is done by setting a minimum population size for the provision of different services (for instance, 20,000 for primary health care and social services). At the moment only a quarter of health centres are located in municipalities with a population of more than 20,000. Exceptions are made for municipalities that are in an archipelago environment, for municipalities that cover very large distances, or in order to safeguard language and cultural rights.

Financial incentives (merger grants) of EUR 2.0 to EUR 18.54 million are offered to municipalities that merge between 2008 and 2013, with the incentives more generous for mergers in the earlier years and supplementary grants for mergers of more than two municipalities. However, if the total cost of merger grants exceeds EUR 200 million in the years 2008-2011 then central government transfers to local government will be reduced proportionately. In this case all municipalities that do not merge could face a cut in transfers from the central government. Larger municipalities are also required to draw up plans on how to improve co-operation with neighbouring municipalities.

There have been, however, some negative experiences regarding mergers as they do not reduce expenditure. Moreover, raising productivity in the Finnish context requires municipal government focusing more on core services and encourage private sector to play a larger role in the provision of non-core services, at least in municipalities where there is sufficient population to ensure competition. Central government should then concentrate in setting the framework conditions in which municipalities can operate ensuring that local authorities have the capacity and administrative systems to pursue more efficient public service delivery.

**The Fiscal Challenge Posed by Ageing**

Ageing is posing pressures over public spending as the need for investment grows and the tax revenue decreases. Indeed, the OECD considers that in Finland public spending is likely to continue growing especially due to ageing. The problem for local governments is to provide public services under national standards with personal and property taxes as the main sources of revenue. Municipalities account for almost 40% of total government expenditure and the ageing challenge will continue to put increasing
pressures on certain components of municipal expenditure like health care and old-age care. Finnish local governments have three main sources of revenues: i) municipal taxes, ii) grants from the central government, and iii) operating revenue (Box 14).

**Box 14. Sources of revenue for Finnish local governments**

**Municipal taxes.** They account for almost half of municipalities’ revenue which highly depends on taxes, particularly income tax (41% in average). They are the most flexible source of income because they are not limited by central government thresholds. Other taxes are the real estate tax and a share of corporate tax.

**Grants from the central government.** For some municipalities, the taxable population base has decreased due to low population density, out-migration and an ageing population. However, these municipalities are expected to provide at least the same level of services than the most prosperous settlements. In order to level-up the capacity of the different municipalities to provide services, the central government calculates grant transfers through distribution formulas that compensate regional disparities, either by equalising costs or equalising municipal income. Local authorities are able to allocate their resources for various purposes as long as they comply with national standards for public service delivery. Central government transfers account for less than one-fifth of all municipal revenues.

**Operating revenue.** It is conformed of sales of goods and services which on average account for 28% of municipal income while expenses account for, on average, 26% of municipal expenses. Since public services are not meant to be a for-profit activity, operating revenue does not greatly contribute as a source of revenue, but merely accounts for the costs. However, for rural areas this is not always the case as the cost of provision surpasses the municipalities’ revenue. Most of the customer charges are collected for services such as water supply, waste disposal, power supply and public transport.

Source: Based on OECD (2008) and www.kunnat.net.

Ensuring the sustainability of public finances while maintaining the essential parts of the welfare society is highly conditioned by: i) raising the effectiveness of public spending, ii) reforming the financing of municipalities to improve the control of spending and limit future rises in municipal income taxation, and iii) rebalancing the mix between public and private provision and funding of services. These objectives are of crucial importance considering the dramatic changes in the age structure of the Finnish population in the short and medium term. However, ageing and changes in the demand for services reveals the necessity to ameliorate public finances as over the last seven years the ratio of taxes and compulsory social security contributions collected by general government to gross domestic product (GDP) has shown a constant decline. For instance, in 2007 the tax ratio was 43.1% relative to the GDP, a 0.4% lower than in 2006 (Table 12). Although the percentage of tax revenue for local governments has remained relatively constant during the last four years, its percentage compared to the GDP is lower than in 2000.

<table>
<thead>
<tr>
<th>Table 12. Taxes and compulsory social security contributions by receiving sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>- Income and property tax</td>
</tr>
<tr>
<td>- Value-added tax</td>
</tr>
<tr>
<td>Municipalities</td>
</tr>
<tr>
<td>Social security funds</td>
</tr>
<tr>
<td>European Union</td>
</tr>
</tbody>
</table>

14 Based on the OECD (2005) report on *Ageing, welfare services and municipalities in Finland*.
This demographic change generates financial pressures as the provision of health and long-term care services will require additional human and financial resources. This is because the demand for services will increase, and then the provision of services will require structural reforms and improvements in cost-effectiveness. The Finnish system of equalisation, that compensates municipalities whose income revenues are below average, has revealed the necessity of finding alternative ways of providing services like cooperation between municipal authorities and the involvement of private sector in public service delivery.

The financial surplus of the Finnish government has shrunk from a peak of 7% of GDP in 2000 to 1.9% in 2004, with this surplus more than accounted for by the social security and pensions funds. The OECD concluded that Finland is relatively well prepared for ageing by having partly pre-funded the future pension liabilities for the earnings-related pension with substantial assets held by the pension funds. However, due to a rapid ageing, ‘... the current fiscal policy is not sustainable in the sense that the current generosity of pension and transfer incomes and spending on public services cannot be maintained at the current levels without raising taxes in the future’(OECD, 2005: 11).

Moreover, the population of working age is expected to decline by about 11% within the next 20 years making the share of the business sector in total employment fall from 74 to below 70%. The problem is exacerbated by the fact that public sector retirement will double in less than a decade and to meet the demands for public services public sector employment should increase in all types of municipalities (rural heartland municipalities, RHM; sparsely populated rural municipalities, SPRMs; and urban municipalities, UMs). The most important increases are expected in health and welfare services. ‘Currently, replacing those who retire from the public sector requires the equivalent of one in five of the young entering the labour market … [but] if the current expansion of public employment were to continue in addition to ageing-related service spending, the equivalent of three out of every five persons entering the labour market would have to enter the public sector’ (OECD, 2005: 12). Hence, the OECD concluded that substantial improvement in public sector productivity is probably the only option for the longer term to meet the growing demands for public services. For instance, the combined total productivity of education, health and social work of local government fell by 0.6% in 2006 (Figure 14). Finnish authorities consider that this decline is due to stronger growth in total input volume than in output volume. Between 2001 and 2006 local government total productivity has declined by a total of slightly under 5%. Similarly, the productivity of central government agencies and institutions deteriorated in 2007 as total productivity fell by 1.9% compared to its 2006 level. Consequently, in order to ensure fiscal sustainability and be able to have further tax cuts three policy directions are deemed necessary: a) raise efficiency in public services; b) reform the financing of municipalities; and, c) reconsider the priorities of public spending.
One of the challenges created by ageing is then the financing of public services. The growing number of older people is leading to an increase in the need for services, for instance, services for disable people. Indeed, in 2004 the number of people aged 55 or over who had problems performing basic functions was around 250 thousand; by 2015 that figure is expected to be 290 - 340 thousand people.\textsuperscript{16} As Table 13 shows, health public expenditure has slightly risen during the last decade passing from 75.6% of total public expenditure to 77.8%. This fact reveals that two-thirds of public expenditure goes to health related services and the proportion of that figure may increase due to ageing. However, increases in financial resources are not enough to tackle the ageing challenges, as these data reveal, productivity has been declining despite increases in investment. With the likely reduction in revenue and increasing spending pressures in public services, local governments will face greater challenges to guarantee the availability of resources. For instance, although the number of practicing physicians has had an increase over the last decade, a growing number of people aged 65 or more will demand more specialised healthcare staff and to be in conditions to meet the new demands, local authorities will have to invest more in health training and employment in the context of limited financial and human resources.

\begin{table}[h]
\centering
\begin{tabular}{|l|cc|cc|cc|cc|cc|cc|cc|}
\hline
\hline
\textbf{Total expenditure on health} & \% of GDP & & & & & & & & & & & & & \\
\textbf{Public expenditure on health} & \% of total expenditure & & & & & & & & & & & & & \\
\textbf{Health expenditure} & Per capita USD PPP & & & & & & & & & & & & & \\
\textbf{Pharmaceutical expenditure} & \% of total expenditure & & & & & & & & & & & & & \\
\textbf{Acute care beds} & Per 1 000 population & & & & & & & & & & & & & \\
\textbf{Practising physicians} & Per 1 000 population & & & & & & & & & & & & & \\
\textbf{MRIs} & & & & & & & & & & & & & \\
\textbf{Scanner units} & & & & & & & & & & & & & \\
\textbf{Per million population} & & & & & & & & & & & & & \\
\hline
\end{tabular}
\caption{Health spending and resources in OECD countries}
\end{table}

\textsuperscript{16} Based on the Finnish report\textit{ Finland for people of all ages – government report on the future: demographic trends, population policy, and preparation for changes in the age structure}; Prime Minister’s Office 34/2004.
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Canada</td>
<td>9.0</td>
<td>9.1</td>
<td>7.1</td>
<td>7.0</td>
<td>2.05</td>
<td>3.32</td>
<td>13.8</td>
<td>17.7</td>
<td>4.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Denmark</td>
<td>8.1</td>
<td>9.1</td>
<td>8.2</td>
<td>8.1</td>
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<td>3.10</td>
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<td>8.9</td>
<td>4.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Finland</td>
<td>7.5</td>
<td>7.5</td>
<td>7.5</td>
<td>7.5</td>
<td>1.42</td>
<td>2.33</td>
<td>14.1</td>
<td>16.3</td>
<td>4.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Iceland</td>
<td>8.2</td>
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<td>8.3</td>
<td>8.2</td>
<td>1.85</td>
<td>3.44</td>
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<td>13.3</td>
<td>4.3</td>
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</tr>
<tr>
<td>Italy</td>
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<td>8.5</td>
<td>7.0</td>
<td>7.6</td>
<td>1.56</td>
<td>2.53</td>
<td>20.7</td>
<td>20.1</td>
<td>6.2</td>
<td>3.3</td>
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<tr>
<td>Japan</td>
<td>6.9</td>
<td>8.0</td>
<td>8.3</td>
<td>8.1</td>
<td>1.54</td>
<td>2.35</td>
<td>22.3</td>
<td>19.0</td>
<td>12.3</td>
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<tr>
<td>Korea</td>
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<td>35.7</td>
<td>53.0</td>
<td>531</td>
<td>1.31</td>
<td>33.5</td>
<td>27.3</td>
<td>2.7</td>
<td>6.5</td>
</tr>
<tr>
<td>Mexico</td>
<td>5.6</td>
<td>6.4</td>
<td>42.1</td>
<td>45.5</td>
<td>388</td>
<td>679</td>
<td>N</td>
<td>21.3</td>
<td>1.0</td>
<td>1.0</td>
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<td>Netherlands</td>
<td>8.3</td>
<td>9.2</td>
<td>7.1</td>
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<td>3.08</td>
<td>11.0</td>
<td>11.5</td>
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<td>Norway</td>
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<td>9.1</td>
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<td>83.6</td>
<td>1.89</td>
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<td>9.0</td>
<td>9.1</td>
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<td>3.0</td>
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<td>86.6</td>
<td>84.6</td>
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<td>2.72</td>
<td>15.3</td>
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<td>3.1</td>
<td>1.6</td>
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<td>USA</td>
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<td>15.3</td>
<td>45.3</td>
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<td>6.40</td>
<td>8.9</td>
<td>12.4</td>
<td>3.7</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Notes:
The figures are indicative and should be interpreted with care. Some data belong to previous or later years depending on the information provided by member countries. See http://dx.doi.org/10.1787/OIF2007en2 for further details.


Organisational Changes to Improve Public Service Delivery

Finland faces a number of challenges to meet the demands of public services of a decreasing and ageing population in a context of financial constraints and specialised workforce shortages. The participation of the private and voluntary or ‘third’ sectors in the provision of public services is crucial to increase the offer and quality of services available to citizens. Market mechanisms represent an alternative to public service delivery, but their use in regional and local levels of government in Finland remains limited. The private sector is having a more active participation in the provision of some social services, such as waste collection, but its role as a provider of more politically sensitive services such as nursing homes and childcare services is rather restricted. In rural areas, for instance, the Village Associations and Local Action Groups have been key actors in service delivery. The participation of civil society constitutes a source of information about local needs and viable alternatives of responding to new demands.

Alternatives to Face the Ageing Challenge

Finland has developed innovative approaches for the provision of public services. They do not only contribute to the delivery of services in remote and rural areas but they also contribute to tackling the challenges posed by an ageing population. The strategies for service delivery may be classified in three main areas: a) multi-purpose provision venues; b) mobile services; and, c) the use of Information and Communication Technologies (ICTs).

Citizens Services Offices: multi-purpose provision venues

Since 1993, Finland has implemented a form of co-operation called Citizen Service Offices (CSOs) or, in other words, multi-service points. There are about 207 CSOs with different ranges of service provision which may go from handing out forms to a full service point. These multi-purpose venues not only allow the provision of services (whether public, private, non-for profit, or mixed) to be provided from a single outlet under a holistic customer service, but they may constitute a solution to the problem of shortage of staff for the provision of certain basic services as workforce diminish due to ageing.
The objective of the CSOs system is to offer a single outlet for services that are suited to be managed jointly by different authorities, for instance municipal, district court, tax and work administration, National Pension Institute, among others. The aim is to ensure a customer-oriented service and efficient utilisation of information technology, a sufficient and high quality service network, increase the productivity of the local service network and reduce the cost.

**Mobile services**

Sparsely populated rural areas, decrease in population and workforce, and high costs are some of the reasons why an important number of services, private and public, have been closed. For instance, at the end of 2006 there were 4,610 educational institutions throughout Finland, 228 less than in 2005. As the network of services diminishes, it is necessary to either bring people to the services (transportation services) or bring services to the people (mobile services).

In sparsely populated areas the reduction of public transport has led to an increase in the use of private car or taxi services. Both alternatives become hardly effective in the context of an ageing population as the elderly may not always be in conditions for driving and the use of taxis may become a highly expensive way to access other public services. Therefore, the provision of public and private services through mobile service units may be a viable alternative for an ageing context. Some of the mobile services provided in Finland are: mobile shops, mobile libraries, mobile gyms, a voting bus, or nurses visiting their patients at their home in several municipalities. However, some mobile services have been through rationalisation due to the declining population and cuts in public budgets.

**The use of Information and Communication Technologies**

Information and Communication Technologies (ICTs), particularly broadband, constitute an asset in dealing with the challenges of an ageing population. They do not only facilitate the access to information but also the provision of public services in both urban and rural areas. Moreover, ICTs contribute to reduce the costs associated with geographical distances, allow scale economies without proximity, and improve the quality of services. Some of the areas where Finland has achieved positive results are:

- **Tele-education.** The coverage of fixed external connections in comprehensive schools rose from 54% to 90% between 2000 and 2005, and in upper secondary schools from 97% to 100% in the same period.

- **Health sector.** ICTs have allowed access in rural areas to specialised services which could not be provided otherwise. Finnish authorities have implemented a tele-medicine project whose aim is to establish availability of broadband services to hospitals particularly considering imaging. Archiving and remote viewing of digital X-rays is the most bandwidth-intensive telecommunications application used in hospitals. These services have also been linked to the more extensive introduction of electronic patient data systems and further to the reorganisation of basic and specialist medical care.

In order to deal with the deficiencies of the decentralised broadband strategies and the existence of different technological standards, the Finnish government adopted a National Broadband Strategy whose principles are: a) competition ensures low prices; 2) public aid targeted only areas of lagging business interest; and 3) regional planning. Through this strategy, all provinces were to prepare a regional broadband strategy with local municipalities in close co-operation with the National Broadband Task Force. The Ministry of Transport and Communications reported that the aims of the broadband strategy have been achieved. For instance, 1 million subscriptions to broadband were expected by the end of 2005, but by January 2007 there were already 1.5 million subscriptions. Broadband services through a fixed network were available to 96.1% of the population by January 2007. Currently, access to fixed network
broadband services is possible for more than 96% of Finnish households and over half of all of them have already acquired a broadband connection. Prices were dropped by about 45% which means that the competitive environment has served to stabilize retail prices at an appropriate level. The availability of broadband has been possible due to the efforts of telecom operators, municipalities and regional councils. These results position Finland in third place of European leaders in the number of subscriptions and broadband services.

**Encouraging Private Funding to Meet Public Service Demands: the use of market mechanisms**

As part of the Basic Services Programme, Finnish authorities are reviewing user charges for health care and social services as the share of municipal health and social service operating costs being financed by user charges has declined. The OECD (2005: 31) found that such decline ‘…has been clearest for basic and specialised health care and institutional care for older persons, together representing three quarters of municipal spending on health and social service, whereas the share of user charges has grown for dental care and home help for older persons.’ To adjust public spending to the ageing context, the OECD (2005) concluded that Finnish authorities should analyse whether public funding should be available for all forms of care services. Moreover, the way users are charged for ageing-related services could be re-shaped so as to facilitate users to pay for extra services themselves, for instance the introduction of vouchers to pay for health care services or a subsidy determined *inter alia* by the intensity of the need. These instruments, however, will require amendments to the legislation trying to make compatible national and local regulations.

Efficiency and prioritisation are key elements of any strategy to adapt public service delivery to the context of an ageing population. Whereas raising efficiency in public funded services requires strong commitment, prioritisation needs to focus on what is really essential to safeguard welfare. In the case of Finland, the continuous spending in public funded services and the deficit in municipalities provide a clear sign that efficiency and prioritisation still need to be reinforced. This context demands a deeper co-operation between municipalities and between municipalities and civil society.

Moreover, there has been a decline in productivity in delivering public welfare services provided by municipalities, particularly in education and social services. Public service delivery in Finland requires a wider variety of mechanisms, other than just cost containment, to ensure value for money. In recent years, Finnish authorities have increased spending in public service delivery aimed at expanding its provision. However, the extra resources are not paying off in terms of more output or better outcomes. The OECD (2005) observes that to improve outcomes, any spending increases have to be tightly targeted based on available evidence of where it can produce improved outcomes. In order to raise productivity, the Finnish government launched a broad programme aiming at administrative simplifications, better use of IT and increased exposure to competition.

Based on the Finnish experience, the OECD (2005) considers that a strategy to increase productivity should include the following five elements:

- Realise the productivity potential in administrative functions via increased IT usage which will free resources for other services.
- Ensure better control and prioritisation in the ongoing expansion of service spending.
- Increase the use of benchmarking.
- Change the way funding is allocated among service providers to improve incentives to be more efficient.
- Increase the use of contracting out.
Box 15. Facing the ageing challenge - a managing change perspective

In recent years, Finland has been implementing reform initiatives to tackle the challenges posed by an ageing population. For instance, the regionalisation and productivity programmes have been crucial to organise the public sector and adapt it to a new context. The regionalisation programme aims at relocating state functions to other areas in the country by 2015 which implies moving 10% approximately of all state functions outside the capital area. Separate service centres have been created in regional areas according to the new services required by the population and the needs of the public service. Existing personnel have been asked to move to the service centres to continue working. Nevertheless, government cannot force civil servants to change residence. This fact has created problems concerning human resource management and a leadership gap on a wider scale.

The productivity programme has the purpose of reforming state functions to a shape that in practice requires fewer personnel as the reduction of skilled staff is expected to worsen. The programme was launched with the basic idea that ministries and agencies would prepare themselves for the upcoming change in staffing. However, the programme has in some quarters been seen as a head count reduction initiative, creating the need for a renewed sense of change management and leadership.

As a response to the problems presented in the implementation of the regionalisation and productivity programmes, in December 2006 the Ministerial Committee for Economic Policy established the change management programme called Finwin – towards a new leadership. Its aim is to bring about a shared understanding and vision concerning the future challenges and the way to manage them. In other words, Finwin intended to facilitate the implementation of change through the dissemination of information and the exchange of positive and negative lessons on reform programmes in different areas and levels of government. The programme is directed to top civil servants and employee representatives. It started in June 2007 and finished in May 2008 with a turnout of 1 200 participants approximately.

The message Finwin tried to pass through was that all efforts should point to a common aim. It concentrated particularly on training top managers on managing change and provided them with the necessary communication and leadership skills to face a changing environment under a common vision. Despite the initial resistance to the programme from some members of the civil service, Finwin facilitated horizontal dialogue as senior managers from different ministries and agencies had the opportunity to discuss a common vision on the future and share experiences and fears regarding the challenges ahead. One of the legacies of the programme is that it created a guiding coalition to restructure and implement the strategy to face the challenges of an ageing population.


The use of market type mechanisms such as Public-Private Partnerships (PPPs) constitutes an alternative for Finnish authorities to mobilise human and financial resources for public service delivery. The provision of postal services and school transport in rural areas are examples of standards and a regulated environment for PPPs. For instance, since school buses would prove inefficient in some remote rural areas, some municipalities pay taxi pick-up services to drive children to schools. This helps maintaining taxis as a viable business for other purposes as they allow commuting to municipal centres to access other services. However, market type mechanisms require the development of standards of delivery so as to ensure the optimal provision of public services.

Moreover, limited companies, co-operative societies and foundations are able to co-operate with joint authorities in order to create a stronger investment base for a wider range of projects. If a local authority is a major shareholder in a company, or exercises dominant influence in a community, the said company or community, together with the local authority, make up a municipal corporation. The regulations on municipal corporations establish the policies of the participating companies and communities and they are accountable to the local authority. For instance, local authorities have established joint waste management companies, enterprise service companies and even travel bureaux.

The Involvement of Private and Voluntary Sectors in Service Delivery

The participation of the private sector and, above all, the voluntary sector in public service delivery is a way of providing services in places where there is not enough demands to hold a market. Ageing is creating strong pressures over public spending making it necessary to rethink priorities and determine what it is essential for safeguarding welfare. Changes in the age structure of the population will affect the
number of people willing to take part in volunteering work. Indeed, the Finnish age related policies base their success in finding new forms of cooperation between central and local authorities, voluntary organisations, individual volunteers and private companies.

Due to the fact that service demand from the elderly will grow beyond today’s levels in the short-term, the OECD (2005) considers that private service providers should play a larger role in service delivery so that public spending can be focused on what it is essential. This would avoid the risk of expanding demand for less-vital services driving-up public spending simply because such services are produced in the public sector today. Hence, increasing efficiency in public service provision could lead to a reduction in public spending freeing resources to meet future demands generated by an ageing population. One aspect that may prove crucial for the Finnish strategy to adapt the system of public service delivery to an ageing context is the development of an alternative private service supply stimulating, at the same time, the creation of jobs in the service sector.

The scope of action of non-profit institutions and private firms in public service delivery is large. They have an important role in providing institutional placement for children and youth, adapted housing for the elderly and disabled, helping substance abusers and providing work rehabilitation. However, the level of participation of non-profit institutions and private firms in institutional care and home help for the elderly and disabled and in day care for children remains limited. Moving towards a wider mix of providers and means of service provision could raise efficiency. For instance, since the elderly need assistance with activities of daily living (ADLs), in 2004 the Finnish government issued a law on the use of service vouchers for home services to help financing the cost of care services and give people the opportunity to choose among service providers. Moreover, the government approved the extension of the household deduction to cover work performed in the house of the parents of the taxpayer or the taxpayer’s spouse.

An example of how private and non-profit organisations may be involved in the provision of ageing-related public services is the Seniorpolis Initiative in the municipality of Ristijärvi. This initiative is seen as a way of coping with the shortage of specialised labour in rural areas of the country. The Seniorpolis expertise centre develops business operations that promote well-being and lifestyle opportunities for senior citizens. Seniorpolis, in co-operation with universities, research institutes and technical high schools promotes know-how, technology, product development and business concepts within different senior citizens services providing a large variety of services and products. The approach of the initiative is seeing ageing as an opportunity for value added and not as a problem.

**Box 16. An innovative Finnish approach to service delivery - Seniorpolis**

**Seniorpolis is:**
- A network that collects, promotes co-operation, combines and integrates activities and operations involving senior citizens.
- A project that co-ordinates and develops project implementation and procedure.
- A senior citizens’ village: Ristijärvi has been selected as a pilot area where specialized private housing and lifestyle services for senior citizens will be developed on a business basis.
- A prototype-workshop that guides product development, innovations, applications and an application testing environment.
- A brand for marketing and launching the concept.
- A franchising-concept to develop and maintain business activities and product/service packages.
- A centre of expertise: One amongst several research, development, education and business centres in the
region of Kainuu (others include Measurepolis, Woodpolis and Snowpolis).

- A corporate and holding company; Seniorpolis Oy (Ltd) manages the Seniorpolis concept, develops Seniorpolis business logic, participates in risk financing, marketing and business development and owns the Seniorpolis licensing and property rights.


The Seniorpolis Initiative combines four main areas to develop a uniform and extensive service selection to meet the requirements of senior citizens: 1) housing solutions for senior citizens through detailed research of good housing conditions and the building of development and renovation schemes; 2) life-long learning through interactive and distant learning systems for senior citizens; 3) development of care services with particular interest in the self-help sector and preventive care through the development of digital service solutions; and, 4) relaxation services through sports, cultural, entertainment, multimedia and tourism services and events.

Furthermore, as an alternative to diversify public service provision, wider its coverage and meet the rising demands, Finnish authorities are looking to strengthen the role of informal carers since it is possible to live at home up to a more advanced age. The goal is to ensure that informal carers are able to maintain their working ability and have the possibility of taking days off. Hence, the participation of non-governmental organisations and joint work with municipal authorities is paramount to provide temporary care services. Local authorities have the challenge of diversifying public service provision and finding new methods to provide social welfare and healthcare based on the new demands of society and workforce trends. Technology will have a key role in the provision of public services and promoting independent living for the elderly and disable people. In this respect, social welfare and health care service system will require making use of the latest technological developments to increase the quality of services provided and make them more cost-effective. The establishment of operational unit networks is expected to facilitate cooperation among units through the construction of electronic client data systems and the implementation of standard national definitions. Moreover, the operational units will guarantee the supply of emergency services, mainly in depopulating areas. The use of the new technologies will permit to deliver services such as: real-time monitoring mechanisms, tele-medicine, video-based training, among others.

In Finland, village committees have taken a lot of public responsibilities concerning the provision of social, educational and health services. It is government’s task to monitor how private and non-for profit organisations are providing public services, who has access to them and what the outcomes of their activities are. This is because, according to the OECD (2008), equity considerations and the regulation of contracts should be borne in the implementation of market type mechanisms in the provision of public services.

Conclusions

Finland has adopted an ambitious ageing strategy that reforms organisational and institutional aspects of the service delivery system such as the reallocation of responsibilities across levels of government, the creation of joint municipal boards, multi-purpose provision venues, mobile services, the use of ICTs, and strengthening the participation of the private and voluntary sectors in service delivery. The aim is to maintain the standards and levels of provision, increase productivity levels, create jobs that respond to the new demands of population and guarantee the access of the whole population to public services.

The Finnish ageing strategy adopts a holistic approach to restructure the entire public service system. Based on structural forecasts, Finnish authorities have designed a proactive ageing strategy whose ultimate goal is to preserve the comprehensive and egalitarian structure of the Finnish welfare state model.
However, this does not necessarily mean an exclusive participation of local authorities in service provision but creating the conditions to facilitate the participation of private and voluntary organisations in service delivery. Hence, the Finnish government is conducting structural reforms to create the necessary conditions to meet the demands in terms of public services posed by an ageing population. The purpose is to generate a new culture where ageing is not seen as a problem but as a window of opportunity. Ageing, from this point of view, does not only refer to the increase in the number of elderly people but to a decline in the number of children, youths and working-age people and to changes in the age groups of the population. Hence, ageing means changes in the population age structure what generates new priorities and creates pressures for changing the focus of the Finnish welfare system. Indeed, healthcare, social services and specialised education are the services most affected by the demographic changes but since population, particularly retired people, is relatively healthier and fitter, better educated and live longer in an independent way, their needs for services are different to the needs of the elderly some decades ago as they, for instance, require more leisure activities. The Seniorpolis initiative epitomises a way of how to respond to this new trend.

Despite the efforts of Finnish authorities in adapting public service delivery to an ageing context, there are some lessons and challenges that may be highlighted so far. Firstly, the Finnish experience proves that an increase in investment does not necessarily lead to an increase in productivity. Financial and human resources for public service provision are in short supply, hence the key challenge for Finland is to set priorities, reorganise its workforce, redefine responsibilities, reallocate resources and look for further alternatives for service delivery. An increment in productivity has been acknowledged as a crucial aspect to meet the demands for public services. The use of ICT, enhance competition, administrative simplification and contracting out go in that direction. And secondly, the Finnish case reveals that to transform service delivery it is necessary a whole-of-government approach as substantial improvements in inter and intra-governmental relations are needed as underpinnings of the ageing strategy. National government organises the allocation of responsibilities, resources and sets standards of provision while local governments operate and have to deliver public services with the resources provided.
8. AGEING AND PUBLIC SERVICE DELIVERY IN ICELAND

Demographic Trends and Projections

Iceland has been experiencing considerable demographic changes in recent years. It is estimated that from the mid 1990s until 2010 the overall population will grow by around 11%. In 2008 Iceland’s population was around 313 000 inhabitants and it is expected to be around 430 000 in 2050. At the same time, the age structure of the population is changing as the number of people aged 65 and over is forecasted to increase by 23% and particularly the cohort of 85 years and over is estimated to increase by 45%. In 2000, the old age dependency ratio (65+ in %20-64) was 20 and by 2050 it is forecasted to be 40. Two factors that may have triggered these changes are the quality of the health care services considered among the best services in the world and, in consequence, the continuous increase in the life expectancy of the population over the last two decades (Figure 15). The average life expectancy in 1980 was 76 years and in 2005 it was 81 years. Moreover, Icelanders are not only living longer but are spending more of their senior life in relative good health.

Figure 15. Life expectancy at birth in Iceland

Source: Based on OECD StatLink database.
At the beginning of 2008 the population aged 70 years and over constituted approximately 8.47% of the population; in the next 10 years this cohort is expected to represent 9.65% of the total population in Iceland. According to Statistics Iceland, a professionally-independent institution under the aegis of the Prime Minister in charge of the official statistics, it is estimated that in 2050 the cohort of 70 years and over will represent 16% of the total population. Even more, as Figure 17 shows, the cohort of 65 years and over will be more numerous than the cohort of less than 14 years. The cohort aged under 5 years of age is expected to decrease from 8.3% to 7.5% of the total population whereas the cohort between 6 and 16 years old will decrease from 15.6% to 14.1% by 2050.
Although the Icelandic population is ageing, this is not a short-term challenge as the effects of ageing will be more evident in the long-term, based on the trends showed in Figures 17 and 18. However, since senior citizens are already experiencing shortages in the availability of public services, this is probably the time to start planning adjustments to the public service delivery system so as to prepare the ground for the imminent ageing challenges ahead.
Changing Priorities for Service Delivery

As a consequence of the demographic changes, the public service delivery system, both the health care and the social sector, are facing pressures to satisfy the needs of the population. Although the employees at nursing homes and hospitals are qualified, the supply of staff will not bee enough to satisfy the future demand. Ageing is creating some challenges for Icelandic government in terms of service delivery.

Some reports mention the lack of room in nursing homes to accommodate all the elderly population in need. According to the Icelandic National Audit Office the supply of nursing home places varies from 60 to 118 places per one thousand inhabitants depending on the region in the country. Approximately 50% of nursing home rooms are single occupancy rooms and 29% have a separate bathroom. Even the size of the rooms varies from 8 to 26 square meters.

Hence, the priority for government has been to develop facilities for the elderly addressing the imbalance supply of facilities in different parts of the country. From 2001 to 2006 beds and places increased by 7.2%. The changes consisted in an increased number of places in nursing homes and decreased number of places in retirement homes. Day care places supply increased by 34% from the year 2001 to the year 2006. Nonetheless, pressures in public services are not only from the demand side, the financing of the services to pay for extra staffing at nursing homes and health centres, and state pension benefits is generating concerns in government. Moreover, ageing also creates difficulties in the educational sector for the need to train more health care professionals.

Institutional Changes in the Public Service Delivery System

Reallocation of responsibilities in health service delivery across levels of government

Iceland has two administrative levels of government: the State (central government) and the municipalities (local government). The Icelandic governmental system builds on the separation of the judicial, legislative and executive powers. The structure of local government in Iceland is of Nordic origin and in many fundamental ways similar to the present structure in the Nordic countries. However, contrary to other Nordic countries, in Iceland there are no regional authorities.

The central government is not only responsible for the provision of secondary and upper education but also, through the Ministry of Health, is responsible for both the overall and day to day administration and provisions of health affairs. The country is divided into health care regions, each with their own primary health care centres, some of which are run jointly with state rune hospitals. Under the aegis of the Ministry of Health the primary health care centres have the responsibility of general treatment and care including preventive services and general medical treatment. Preventive services comprise child health care, maternity care, school health care, immunization, family planning, among others. Home nursing care is one of the responsibilities of the health centres, whereas home help services are part of the municipal social service system. However, it is expected that services like home nursing now provided by health centres will be integrated into the range of services provided by municipalities.

Local governments are in charge of the provision of basic social services which include social and financial assistance in the form of welfare benefits, home assistance to the disable and elderly, child welfare, primary education, culture, sports and recreation, leisure activities for young and old people, among others. The provision of primary education is by far the most important task of the municipalities in Iceland. On average, 50% of municipal budget is used to provide primary education (40% - 50% depending on the size of the municipality). As Figure 19 reveals, municipalities use a minimal percentage of their resources in the provision of health services, which are mainly the responsibility of central
government. This is partly explained by the fact that local governments delivering services that have direct or indirect effects in old people’s life such as home help assistance, transportation service and occupational services that take place in special centres for senior citizens.

**Figure 19. Local government expenditure in the provision of health, education and social protection**

Percentage of GDP

Source: Based on Statistics Iceland, www.hagstofa.is

**Reallocation of financial and human resources for health services**

The health service in Iceland is primarily financed and run by central government. Financing is mainly based on taxes (85%) and fees for services (15%). “A number of nursing homes and old people’s homes are run as independent institutions by local governments and voluntary organisations. They are partly financed by user charges but the major part of financing is provided by the government either through the national pension scheme, as is the case for old people’s homes, or through the health insurance scheme, as is the case for nursing homes.” 17

The workforce available in the health sector has proved not to be enough to satisfy the current demands for health services. This situation creates pressures in terms of financing, staffing and training. There is no evidence to suggest that government will receive extra revenues for financing additional staff to cover the demands of the population in terms of health services, therefore, Icelandic governments need to reallocate both human and financial resources available based on a definition of priorities. In that sense, the central government aims at making the health service financing sustainable and improving the allocation of resources based on the European principles of equal access, cost-effectiveness, solidarity, and optimum quality. Hence, for 2010 central government intend to make the level of expenditure develop for health care services at no less than the annual growth of national income. This is of prime importance because as Table 14 shows, Iceland is primarily financing health care services through public funds which is the characteristic of welfare policy in Nordic countries.

17 Health Statistics in the Nordic Countries 2005, page 27.
Table 14. Health care expenditure in Nordic countries

(Million KR/EUR) 2005

<table>
<thead>
<tr>
<th></th>
<th>Denmark (1)</th>
<th>Greenland</th>
<th>Finland (2)</th>
<th>Iceland</th>
<th>Norway</th>
<th>Sweden (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DKK</td>
<td>DKK</td>
<td>EUR</td>
<td>ISK</td>
<td>NOK</td>
<td>SEK</td>
</tr>
<tr>
<td>Public financing</td>
<td>104 678</td>
<td>897</td>
<td>9 217</td>
<td>79 497</td>
<td>147 123</td>
<td>198 274</td>
</tr>
<tr>
<td>Private financing</td>
<td>20 302</td>
<td>4</td>
<td>2 636</td>
<td>16 827</td>
<td>28 908</td>
<td>35 176</td>
</tr>
<tr>
<td>Total health care expenditure</td>
<td>124 980</td>
<td>901</td>
<td>11 845</td>
<td>96 325</td>
<td>176 031</td>
<td>233 450</td>
</tr>
</tbody>
</table>

(1) Preliminary estimates for 2004
(2) Finnish figures include Aland


Moreover, Iceland’s government is allocating about 7.99% of the GDP to finance health services. The expenditure in health care services has presented some fluctuations reaching its highest point in 2003 (8.48% of GDP) and then a continuous reduction to be just under 8% in 2007. Although public expenditure in health is still higher than for education and social services, Iceland’s government is beginning to invest more in education and social protection.

Figure 20. Iceland’s total expenditure in health, education and social protection

From 1998 to 2007

1. No information on total expenditure in social protection for 2007.

Source: Based on Statistics Iceland, www.hagstofa.is

The promotion and protection of health requires professionals in health and other sectors not only on good supply but also with the appropriate knowledge and skills. In order to reach that goal, Icelandic government intends to make estimations of the manpower needs annually for a period of 5-10 years.
Indeed, the access to study for health care related professions has to take into account the manpower needs of the health care services, and the health care curriculum needs to take into consideration the health needs of the population and the government’s plan to reform the health service system. Table 15 shows a distribution of health personnel in different areas of health care. It is worth noting that although, in general terms, there has been an increase in the number of health personnel, the growth of the population makes it difficult to catch up with the needs of staffing in the health sector.

Table 15. Iceland’s health personnel

From 1998 to 2006

<table>
<thead>
<tr>
<th></th>
<th>Number of inhabitants per employee</th>
<th></th>
<th>By number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>1 017 1 001 1 002 1 019 1 076</td>
<td></td>
<td>271 283 288 287 286</td>
</tr>
<tr>
<td>Nurses</td>
<td>125 127 123 116 120</td>
<td></td>
<td>2 205 2 237 2 342 2 525 2 567</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1 188 1 232 1 057 1 019 986</td>
<td></td>
<td>232 230 273 287 312</td>
</tr>
<tr>
<td>Physicians and surgeons</td>
<td>303 293 280 277 275</td>
<td></td>
<td>909 968 1 029 1 056 1 120</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>828 700 -- 679 724</td>
<td></td>
<td>333 405 -- 431 425</td>
</tr>
<tr>
<td>Social workers</td>
<td>3 535 2 673 2 345 -- --</td>
<td></td>
<td>78 106 123 -- --</td>
</tr>
</tbody>
</table>

Source: Based on Statistics Iceland, www.hagstofa.is

Enhancing the management of health services

In order to improve the effectiveness of health care services, the central government has adopted an integrated approach to manage the health sector. The operation of the health care system is becoming increasingly based on teamwork and continuity of service so as to have a more community-oriented primary health care. Moreover, working procedures in health care services outside as well as inside institutions are being synchronised. Furthermore, the management of the health services is progressively more oriented towards health outcomes. Health care institutions are developing tools for measuring efficiency based on accepted databases to evaluate their work. They are establishing a formal quality development procedure and every institution is following its own plans in quality issues. Iceland’s target is that by 2010 over 90% of patients should be satisfied with the health care services they receive. There is no evidence to suggest that these measures have been taken purely on the basis of an ageing population. The improvements in the management of health services seem to be more the product of the necessity to make a better use of resources and upgrade the quality and availability of services to people regardless of their age.

Reorganising the Health Service System

Adopting a community and home-based long-term care approach

In 1998, as part of the strategy to improve the health services, the central government adopted a health plan to the year 2010. It describes the main priority projects on health, defines the objectives and establishes the methods to reach them. This plan considers health services to senior citizens as one of the main priorities of the overall health strategy.

The Ministry of Social Affairs adopted an action plan in the summer 2008 according to service for the elderly. The action plan establishes that elderly will get individual services so they can remain at home for as long as possible, quality standards will be set for the service which will be supplied by a highly qualified
staff, and that residential measures for the elderly will be increased. One of the aims of the action plan is to make that by no later than 2012 the provision of all services for the elderly be the responsibility of the local governments. The aim is to keep the elderly at home for as long as possible while provide them access to retirement or nursing homes as the need arises. The success of this programme depends on the training of nurses and the development of reliable software used to manage information concerning the programme.

There are then two variables that may be of use for assessing the changes to the public service delivery system:

- *How relevant is the service to the needs of the target population?* The changes in the public service system must guarantee that the services provided cover the needs of an ageing population (i.e. health, long-term care, social services).
- *How much does it cost?* This refers to how much governments have to pay for public service delivery. The financing of the services should be based on the idea that there are less people contributing to finance pensions and public services costs, as the cohort in retirement will tend to be bigger than the cohort of younger age.

Icelandic authorities consider that with the appropriate services and support more people would be able to stay longer at home and therefore reducing the level of demand. Hence, the strategy aims at improving the physical and mental abilities of senior citizens so as to enable them to remain at home for as long as possible. Consequently, the waiting time for nursing home vacancies would be reduced from 267 days in Reykjavik in 1997 to no longer than 90 days in 2010. Box 17 shows the main objectives and methods described in the plan regarding services to senior citizens.

**Box 17. Health services to old adults**

**Main objectives**

- Reduced waiting time for people in great need for a place in nursing home to maximum of 90 days.
- Over 75% of people 80 years and older should be in so good health that they can with an appropriate support live in their own home.
- Reduce prevalence of breaking coxal and back bones by 25%.
- Over 50% of people 65 years and older should have at least 20 healthy teeth in a bite.

**Methods**

- Health-promoting actions and increased physiotherapy and occupational therapy for senior citizens.
- Strengthen and increase cooperation and coordination of home help, health centre home services, hospital senior citizen services, and nursing and retirement homes for elderly persons, with special emphasis on team work.
- Coordinated evaluation of the needs of senior citizens and of the quality of service at every level will be utilised as a means of further developing treatment.
- Increase the availability of day care, health centre home services, in which the emphasis should be on round-the-clock, 7 day service and short term hospitalisation.
- Good access to hospital services for senior citizens and other extra-institutional treatment options.
- Draft clinical directions for senior citizen service teams pertaining to the specialised care of senior citizens.
- Strive to create equilibrium between supply and demand for nursing home vacancies.
- Draft clinical instructions for health care services for middle-aged and younger senior citizens who would
contribute to their improved health, for instance with regard to osteoporosis.

- Strengthen dental health care for adults and senior citizens.

Source: The Icelandic National Health Plan to the year 2010, Ministry of Health and Social Security.

Although the central government does not base the national health plan primarily on demographic changes, the health strategy aims at creating a culture of prevention by promoting and protecting people’s health during their entire lifespan and, in consequence, preparing the ground for the ageing challenge ahead. This marks a coincidence with Canada’s, Finland’s and the UK’s strategies for ageing, that a healthy ageing begins from an early age and therefore and ageing policy should consider all groups of society and the provision of high quality public health and educational services to every member of society regardless of their age. The adoption of a preventive approach may be then considered a way of diminishing the impact of ageing in the public service delivery system. Iceland intends to make the necessary adjustments in the health system so as to maintain and even improve the level and quality of services by adopting not only a culture of prevention but also an individual ageing approach in focusing on improving the health services provided to the elderly. Although ageing is a long-term challenge for Iceland, the shortages of staff in nursing homes and the long waiting times to be allocated a place in a house for elderly people reveal the weaknesses of the health service and its lack of capacity to satisfy current levels of demand. This situation needs to be addressed if the country is to be prepared for the imminent growth in the cohort of people aged 65 and over.

**Opting for a multi-sectoral tactic**

Iceland’s central government authorities have adopted a series of measures to ensure the participation of different sectors in pursuing the objectives of the national health plan. In that sense, legislation is being revised so as to ensure that by 2010 every sector of society bears responsibility in health care matters. Moreover, systematic environmental evaluation is being performed on the possible effects of every major industrial development project, work project and social action on the health of the public. Projects in the field of education, information and research are increasingly aimed to promote awareness among all individuals, regardless of their age, of their collective responsibilities in health matters.

The educational sector, for instance, has to ensure that by 2010 at least 95% of schoolchildren receive systematic education and training in health promotion. It is also expected that, by the same time, at least 50% of cities, towns and other communities in the country define and set targets in the field of health promotion; and at least 20% of large and medium-sized companies have committed themselves to encourage health promotion among their staff.

Although these measures have not been defined based on an ageing population context, indirectly they may have an impact in preparing the ground for the imminent challenges posed by the demographic trends by changing people’s culture and attitudes towards a healthy living. In that sense, the effects of ageing over the demand for health services may be diminished as more people aged over 65, at that time, is likely to be in good health for longer time and play a more active social role. It seems that Iceland is well positioned to face the problems created by an ageing population by readjusting public services, particularly health services, to satisfy the current levels of demand.

**Conclusions**

Population ageing is presenting Iceland with a long-term challenge to provide public services to its growing elderly population. Institutional changes to adjust public service delivery to demographic changes appear to be relatively limited. Instead, Iceland has opted for a cost-effective home-based oriented tactic to
strengthen the capacity in the long-term of its health service. As there is no evidence that more financial resources will be available to finance for more infrastructure and extra staffing to provide long-term care services to the elderly, Icelandic authorities need to make the most of the resources available via better management. Although changes in the allocation of resources seem to be on their way, Iceland should also consider the productivity issue to keep or even increase the level of supply. Iceland, on the one hand, epitomises the adoption of a proactive policy since the effects of ageing are not to be felt but in the long-term. However, the fact that the public health system is already struggling to cope with the level of demand, it evidences the need for timely adaptations and reflects what an ageing scenario would be if reforms are not implemented to respond to demographic changes. On the other hand, Iceland exemplifies the adoption of a multi-sectoral approach to reform the public service delivery system by allocating a role to every sector to reach the targets of the strategy to modernise public service provision.

Population ageing does not seem to be the main driver of reforms in the public service delivery system. However, the measures adopted to transform the culture of health care and the organisational approach of service delivery may result in a more prepared public health system to deal with the demands caused by ageing. It may also be argued that the results of the ongoing national health plan will determine to a large extent government’s capacity to face the challenges of ageing in the medium and long-term.
9. AGEING AND PUBLIC SERVICE DELIVERY IN ITALY

Demographic Trends and Projections

Italy faces one of the most acute demographic problems among the OECD member countries. The ageing process is well underway and it represents a short and a medium-term challenge for Italian authorities. Population is expected to decrease while the old dependency ratio is forecasted to increase. According to the Italian National Institute of Statistics (ISTAT) in 2007 Italy’s population was over 59.1 million inhabitants and is expected to continue growing until 2015 and then experience a steady decrease until 2050 (Figure 21). Over the next four decades, the population is projected to shrink around 5 million people to be around 55.9 millions in 2050.

As Figure 22 shows, the Italian population is ageing rapidly as the younger cohorts are expected to reduce drastically to the point that Italy may have one of the lowest proportions of young people and, in contrast, one of the highest proportions of older people in the world. Indeed, the old age dependency ratio (65 + in % 20 – 64) in 2000 was 29 but by 2050 is envisaged to be 71 (Figure 24). This has been a historical process that has been exacerbated in recent years by a rising life expectancy that is one of the highest in the OECD area (Figure 23), and low fertility rates (1.34 children per woman in 2007).
Increase in life expectancy has been an achievement for Italian authorities what shows that population has access to health and social services of high quality and its basic needs (food, shelter, sanitation, education and health) are covered. Nevertheless, changes in the demographic landscape suggest that people in general will require a different type and number of services for what the current organisation of the public service delivery system may not be prepared.
Institutional Arrangements in Multi-level Governance for Public Service Delivery

Decentralising public service provision

Italian government places a strong emphasis on familial support structures as a result of its welfare model. Public services are highly fragmented and there are significant regional inequalities in the distribution of services, particularly between the north and south of the country. As shown in Table 16 social welfare expenditure at local level was over EUR 5 billion what represents 0.4% of GDP. Comparing the expenditure per capita across regions reveals considerable disparities. For instance, whereas the north-east region of the country spends EUR 135.2 per person on social welfare, the south region spends only EUR 92.4. This is also reflected in the differences of health service staff across regions where the south region has the lowest number of medical staff per thousand inhabitants.

Table 16. Communal expenditure on social services per geographic area - 2004

<table>
<thead>
<tr>
<th>Geographic Regions</th>
<th>Expenditure</th>
<th>Average expenditure per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Absolute value</td>
<td>Percentage</td>
</tr>
<tr>
<td>North-west</td>
<td>1,714,796.092</td>
<td>31.9%</td>
</tr>
<tr>
<td>North-east</td>
<td>1,481,425.313</td>
<td>27.5%</td>
</tr>
<tr>
<td>Centre</td>
<td>1,159,226.002</td>
<td>21.6%</td>
</tr>
<tr>
<td>South</td>
<td>534,974.247</td>
<td>9.9%</td>
</tr>
<tr>
<td>Islands</td>
<td>487,192.384</td>
<td>9.1%</td>
</tr>
<tr>
<td>ITALIA</td>
<td>5,377,614.038</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Italy spends a high proportion of its public expenditure on social security whereas expenditure on services like health, education and active labour policies account for a smaller proportion of GDP. Decentralised powers and responsibilities allow for a great deal of local autonomy in service planning and in local tax raising powers. In Italy, the regions have legislative powers over health, welfare, and
employment services whereas local authorities are responsible for delivering and/or funding social public services.

**Services provided by regional and local authorities**

Regional and local authorities are in charge of planning and providing welfare, health care and social services. They offer a wide range of services to the population as a whole but in particular to the elderly. The professional social service and the domiciliary assistance are widely diffused on the territory and they represent 16.2% of the general expenditure. The professional social service offers consultation and information to single people and families on the services provided, analyses consumers’ needs and finds the most suitable solutions to their necessities. The domiciliary assistance is the most widely spread service in the country used mainly by old and disable people. These services include care for the elderly and their homes, distribution of meals, telephone assistance, among others.

**Table 17. Main social services provided by regional and local authorities**

<table>
<thead>
<tr>
<th>Social services</th>
<th>Consumers</th>
<th>Expense</th>
<th>% of total expenditure of the service</th>
<th>% of total expenditure in Italy</th>
<th>% of comuni covered by the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional social service</td>
<td>303.656.051</td>
<td>100,0</td>
<td>5,6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and children</td>
<td>711.929</td>
<td>121.075.802</td>
<td>39,9</td>
<td>2,3</td>
<td>76</td>
</tr>
<tr>
<td>Elderly</td>
<td>522.946</td>
<td>76.849.111</td>
<td>25,3</td>
<td>1,4</td>
<td>65</td>
</tr>
<tr>
<td>Domiciliary assistance</td>
<td>569.256.513</td>
<td>1000,0</td>
<td>10,6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>456.924</td>
<td>397.556.737</td>
<td>69,8</td>
<td>7,4</td>
<td>88</td>
</tr>
<tr>
<td>Disable</td>
<td>38.135</td>
<td>115.882.492</td>
<td>20,4</td>
<td>2,2</td>
<td>69</td>
</tr>
<tr>
<td>Childcare facilities</td>
<td>146.152</td>
<td>850.630.482</td>
<td>100,0</td>
<td>15,8</td>
<td>34</td>
</tr>
<tr>
<td>Residential structures</td>
<td>1.091.894.245</td>
<td>100,0</td>
<td>20,3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and children</td>
<td>32.417</td>
<td>343.259.783</td>
<td>31,4</td>
<td>6,4</td>
<td>62</td>
</tr>
<tr>
<td>Elderly</td>
<td>87.946</td>
<td>479.722.459</td>
<td>43,9</td>
<td>8,9</td>
<td>62</td>
</tr>
<tr>
<td>Total selected services</td>
<td>2.815.437.291</td>
<td></td>
<td>52,4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Italy</td>
<td>5.377.614.038</td>
<td></td>
<td>100,0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Residential structures are centres for the reception and assistance to people in need. Municipalities spend around 20% of their resources in the provision of this service that are mainly used by the elderly and families with children in need.

**Implications for Public Expenditure due to Population Ageing**

Population ageing is clearly having repercussions on national accounts as, for instance, public expenditure on health has been growing over the last decade passing from 7.4% of GDP in 1996 to 8.9% in 2005. The public sector has been the main investor in health care services as private investment in the area has had a rather limited growth over the last years (Figure 25). Furthermore, as Table 18 shows, the cohort of 65 years and over is the major consumer of drugs and consumption has been raising as population ages. This suggests that as the number of people aged 65 and over increases the pressures on public expenditure
in health care will also rise to satisfy the demand for treatments of chronic diseases such as osteoarthritis, hypertension, allergies, bronchitis and others that affect mainly people in their senior years.

![Figure 25. Expenditure on healthcare by sector](image)

**Figure 25. Expenditure on healthcare by sector**

2002-2007, billions of euro


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 14</td>
<td>1,524</td>
<td>1,396</td>
<td>1,166</td>
<td>1,520</td>
</tr>
<tr>
<td>15-34</td>
<td>2,753</td>
<td>2,626</td>
<td>2,636</td>
<td>2,832</td>
</tr>
<tr>
<td>35-64</td>
<td>7,317</td>
<td>7,687</td>
<td>8,490</td>
<td>9,567</td>
</tr>
<tr>
<td>65 and over</td>
<td>5,986</td>
<td>6,933</td>
<td>7,730</td>
<td>8,864</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17,580</strong></td>
<td><strong>18,643</strong></td>
<td><strong>20,022</strong></td>
<td><strong>22,784</strong></td>
</tr>
</tbody>
</table>

Table 18. Drug consumers by age

1993-2006, thousands of people


Public expenditure in pension payments has also grown as a consequence of more people reaching age limits for work and more assistance to disabled and low-income people aged 65 and over is provided. As Figure 26 reveals, there is a considerable percentage of the GDP (15.16%) that goes to pension and almost doubles public investment in healthcare services.
Figure 26. Total expenditure for pensions

1980-2006, % of GDP

Although the increase of public expenditure in pensions has been slower since 1995 than during the 1980s and first half of 1990s, it certainly reflects the number of people reaching retirement age.\textsuperscript{18} Moreover, the pressures on public finances may continue rising as a consequence of demographic changes. The fact that people are living longer and that the increases in the number of pensioners creates financial pressures for the pension system demands from Italian authorities to find out mechanisms to finance the expenditure in social services in a sustainable way.

\textit{Implications for the human resource management system}

The process of decentralisation in public service delivery leads regional and local governments to look for not only more financial resources but also for more qualified staff to meet the demands for public services due to ageing. Indeed, in 2004 Italian authorities began a process of transfer of personnel from the central public administration to local governments as a way to increase their capabilities to provide public services. Table 19 shows an example of the number of staff to be transferred and the areas that are intended to be covered. However, the transfer of personnel has faced some complications derived from misinterpretations of the regulatory framework regarding the extent of the autonomy of regional and local authorities in the management of financial and human resources.

\textsuperscript{18} The effective retirement age is 57 for women and 59 for men.
Table 19. Transfer of personnel from central administration to local governments

<table>
<thead>
<tr>
<th>Topic or area</th>
<th>Ministry involved</th>
<th>Extent of the transfer</th>
<th>Staff to be transferred</th>
<th>Transferred staff</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour market</td>
<td>Ministry of Employment</td>
<td>Finished</td>
<td>6,026</td>
<td>5,639</td>
<td>93.6</td>
</tr>
<tr>
<td>Incentives to enterprises</td>
<td>Ministry for Business</td>
<td>Finished</td>
<td>20</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Energy and mining</td>
<td>Ministry for Business</td>
<td>Finished</td>
<td>54</td>
<td>44</td>
<td>81.5</td>
</tr>
<tr>
<td>Road network</td>
<td>Ministry of Infrastructure</td>
<td>Finished</td>
<td>3,421</td>
<td>1,854</td>
<td>54.2</td>
</tr>
<tr>
<td>Health</td>
<td>Ministry of Health</td>
<td>Finished</td>
<td>27</td>
<td>9</td>
<td>33.3</td>
</tr>
<tr>
<td>Public transport</td>
<td>Ministry of Infrastructure</td>
<td>Finished</td>
<td>30</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Disabled civilians</td>
<td>Ministry of Interior</td>
<td>Finished</td>
<td>454</td>
<td>229</td>
<td>50.4</td>
</tr>
<tr>
<td>Civil protection</td>
<td>PCM</td>
<td>Finished</td>
<td>48</td>
<td>14</td>
<td>29.2</td>
</tr>
<tr>
<td>Professional institutes</td>
<td>Ministry for Instruction</td>
<td>No action</td>
<td>331</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

Source: Ministry for Economics and Finances, Italy.

Furthermore, the transfer of personnel has been hampered by the lack of information on the profile and quantity of staff required by local governments. Transfers cannot take place based on assumptions regarding the necessities of regional and local administrations. In addition, political motivations have led to request more staff than really needed creating pressures for local finances as the payroll increases.

Paradoxically the number of healthcare staff to be transferred to local authorities has been minimal compared with the mounting pressures for increases in healthcare expenditure. This is partly explained by the fact that there seems to be an even distribution of health staff across the different regions of the country as Figure 27 reveals. The number of general practitioners per one thousand inhabitants is in average 4.3, one of the highest among the OECD countries. According to ISTAT, the south region of Italy has a larger population than the centre what means that there may be the need to look for a better distribution of human resources, at least in the health sector, to respond to the demands for health services in the area. However, some other variables need to be considered for the movement of personnel such as the distribution of elderly people and their good health conditions across regions.
Regional and Local Initiatives for the Provision of Services to the Elderly

Italian regional and local authorities have implemented measures to provide social and health care services to the elderly. They have developed some schemes that include the participation of private institutions and voluntary organisations. In some cases, these initiatives have adopted a bottom-up approach in the definition of priorities and alternatives for improving the quality and coverage of services.

*Comune of Bologna – social services for the elderly*

The *Comune* of Bologna has experienced significant increase in the number of elderly people who require assistance in their daily life. Since the 1980s the *Comune* has had a policy for the elderly but in the 1990s, due to the deep demographic changes and the new demands for services, created a new policy aimed to support the elderly and maintain their independence by integrating local agencies in order to provide personalised and co-ordinated services. The local government offers a wide range of services through the integration of the social and welfare system and the health system from both the structural and procedural point of view as well as coordination between public agencies under the planning agreement. This agreement intends to upgrade and reorganise the network of social and health services for the elderly, reduce institutionalisation and develop home care services. It defines and gives an active role to the private and voluntary sectors in public service provision. The plan is directed at those members of the community who are over 65 and in need of material and practical assistance for activities of daily living.

Social and health services are provided by a network of public and private partners with the *Comune* overseeing their provision through integrated procedures and an accreditation process. Moreover, the *Comune* has a total quality plan which covers issues of communication, service improvement and user empowerment. The management of services has been decentralised with the creation of the ‘Elderly Assistance Services’ (EAS) in each neighbourhood providing a single access point to the network of social and health services. Decisions are made at neighbourhood level after consultation with the Communal Council. The elderly are represented by the pensioner’s federations which advise the *Comune* on service planning and provision.
Box 18. Support services for assisting the elderly to remain at home

The region of Emilia Romagna has organised a network of social and sanitary services aimed at facilitating the elderly to remain at home and enhancing their individual autonomy. Some of the services provided are:

- **Telesoccorso** (tele-assistance). A telecommunications system that connects the home of the elderly with an operative centre so that service providers may locate the person and provide the required service.
- **Assegno di cura** (economic support). This is a programme that provides economic support to families that look after a non self-sufficient old member of the family.
- Home assistance. The purpose is to allow old people to remain at home, close to their families and in their own social environment through social, socio-sanitary services.
- **Daily care centres.** They are semi-residential structures that provide assistance and care for the elderly during day time.
- **Temporary Relief** (temporary accommodation for the elderly). This programme offers temporary accommodation for old people in nursing homes so that their families may have a break and do not have to send their elderly members to a retreat on a permanent basis.
- Contributions and advice for home adaptations. These are economic contributions for adapting a house so that people with movement limitations may move freely and be able to remain at home.
- **Special fiscal conditions and assistance for non self-sufficient old people and their carers for obtaining a house or a vehicle.**

Source: www.emiliaromagnasociale.it

The point of access to the special services for the elderly is the neighbourhood EAS that arranges appointments with the social worker responsible for the case. A personalised and integrated social welfare programme, detailing the services the client will receive and the mode of delivery, is established with the social worker who, in turn, will make the necessary arrangements with the health services. These services are supported by two main charitable organisations: Auser and Caritas. The use of voluntary labour has been considered as an alternative to cut down costs but their participation has been crucial as without voluntary organisations many projects would not function. The status of the workers in the network of services differs greatly. For instance, public employees work a 36 hour week over five days whereas co-operative employees work up to 38 hours over six days. Local authorities have faced difficulties in the management of the services due to the different working conditions of the organisations involved and the workloads depending on the type of neighbourhood.

**Fostering inter-comune planning for services for the elderly in southern Italy**

The north-west area of the province of Salerno (Agro nocerino-sarnese) is one of the pioneers in southern Italy in inter-comune planning based on a bottom-up approach to plan social and welfare services through a local authority initiative rather than a specific statutory obligation. The ‘Area Development Plan’ aims to integrate social and welfare services, institutional services and the local community, and public, private and non-profit organisations. The area’s ‘social policy co-ordination unit’ is made up of all the social policy commissioners of the communal authorities, the social policy commissioner of the province of Salerno and a representative from the local health trust and the Diocesan Caritas. The Plan is an inter-comune planning measure that binds the bodies that adopt it to provide public services following certain organisational models, quality standards, resources, and implementation and evaluation methods for the various projects. Regional and communal authorities provide the necessary funds for the plan. In each Comune there is a multi-purpose centre, an elderly people information unit, the alarm call assistance...
service and operating premises for integrated home care in the health districts. Prior to the launch of the programme, services for the elderly were practically non-existent.

The implementation of the initiative has not been without its difficulties. Administrative delays and lack of coordination between central and local authorities have been some of the problems faced during the operation of the plan. However, coordination of private, public and non-profit-making bodies in the health, social and cultural areas is a major innovation of this initiative. The plan was drawn up by representatives from all 14 of the area’s communal authorities, its six health districts and the voluntary sector. Moreover, this initiative emphasises the importance of enhancing work by associations of elderly people for other elderly people but employee training needs to be reinforced.

Diversifying the offer of public services – the ‘Estate Serena’ (Carefree Summer) programme

In 1997, the province of Bolzano began to fund the ‘Estate Serena’ programme run by a network of seven voluntary organisations. This is a programme of action during the summer aimed at preventing elderly people from facing new or worse hardship. An analysis of the circumstances of the elderly people in the province showed that despite the fact the population of the Alto Adige can be considered relatively young in comparison with other Italian regions, the percentage of the elderly was constantly growing. Therefore, the ‘Estate Serena’ programme focuses on maintaining elderly people’s independence within their normal family environment and preserving their normal social relations through the provision of social, welfare and health services. The principle of the programme is that elderly people are a social resource that represents the values and culture of the community.

This programme was set up based on the evidence that older people have diverse needs which result in new demands for services. It aims at elderly people and their needs during the summer on the assumption that it is during this period that those most in need of assistance are likely to be lonelier and more exposed to risk, despite the area’s social, welfare and health services. The programme provides a network of multi-functional services for the elderly, integrating services already available in the area and ensuring continuity of services through resource planning, in order to promote their personal and social independence and prevent forms of hardship developing.

The positive results of the initiative’s multi-functional nature have led the province and its partners to turn this summer initiative into a programme that operates throughout the year. A number of voluntary associations from various backgrounds supply the volunteers working for the project. Users are indirectly involved as the network includes a number of voluntary associations for the elderly.

Box 19. The ‘Estate Serena’ programme in Napoli

The ‘Estate Serena’ programme has been implemented in other regions and localities in Italy. For example, in Napoli local authorities have also put into practice the programme with the purpose of providing assistance to lonely and marginalised elderly people during the summer. However, it also provides social activities for old people who decide to remain in the city during the holiday season. This programme is organised by the Comune of Napoli in cooperation with other private and voluntary organisations.

Source: www.comune.napoli.it

Conclusions

Despite having one of the most rapidly ageing populations among the OECD countries, adapting the public service delivery system to meet the challenges posed by the demographic changes is not a priority
for Italy’s national authorities. There are no general provisions or strategies to adjust the mechanisms for the delivery of public services to the context of an ageing population. Even more, the decentralization of public service provision and the transfer of personnel across levels of government do not seem to have been the product of the demographic changes but of a general public management reform strategy aimed at improving the performance of the public service as a whole. The reason for this is probably because the provision of public services is under the scope of activity of regional and local governments mainly. Hence, it is at these levels of government where initiatives for dealing with population ageing can be found.

Indeed, the initiatives of local governments to face the consequences of ageing are characterized by the creation and coordination of networks integrated by public, private and voluntary organisations; inter-regional planning and provision of public services; the adoption of a bottom-up approach in priority definition; and of managerial techniques for service delivery such as personalised services and the installation of ‘one-stop shops’. Nonetheless, these experiences have implications for the management of financial and human resources. The increments in the number of pensioners and demands for public services in the health sector, for instance, will require additional sources of revenue for the different levels of government to maintain the level of coverage. Moreover, the normalisation of working conditions not only across levels of government but across sectors is crucial to facilitate the coordination of the activities performed by the networks of public, private and voluntary organisations. In order to enhance the transfer of personnel from central to local levels of government two important issues require further attention: a) the legal framework needs to clarify the responsibilities and level of autonomy of regional and local authorities in the management of financial and human resources, this, in turn, may enhance the decentralisation process; and b) collaborative workforce planning across levels of government to establish the real necessities of local governments in relation to their staffing needs (profile and number) and the alternatives to meet them. Although regional and local governments are adopting measures to respond to the needs of an ageing population, their efforts remain isolated due to the lack of a national strategy for adjusting the public service delivery system.
10. AGEING AND PUBLIC SERVICE DELIVERY IN JAPAN

Demographic Trends and Projections

Japan has been experiencing deep demographic changes over the last years and forecasts indicate that those changes will continue over the next 40 years. Japanese population is ageing fast leading to profound cultural changes. The demographic trends show a ‘super-aged society’ where one out five citizens is 65 years old or above. In 2007, the total population of Japan was around 128 million inhabitants of which 27.4 million were aged 65 or above which is the highest proportion of elderly people in Japan’s history. According to Japanese estimations, the old dependency ratio (65+ in%15-64) in 2000 was 26 and in 2050 it is expected to be 76. Moreover, one to 2.5 person will be 65 or above and one to 4 will be 75 years old or above by the middle of the 21st century. In 2008, approximately 20 thousand people will be 100 years old in addition to the current 36 276 people who are already over 100 (86% are women). The number of people aged 100 has been in constant increase in the last 40 years but in recent years the rhythm has accelerated. Figure 28 shows the population estimations for Japan between 1980 and 2050. It reveals a huge transformation of the age structure of the population in Japan as the cohort of 65 and above will constitute more than 40% of the total population by 2050s.

Figure 28. Population estimates for Japan by age and gender groups

![Population estimates for Japan by age and gender groups](image)

Source: Based on OECD DELSA database.

Figure 28 uncovers two main phenomena; on the one hand, total population will decrease from 128 million inhabitants in 2007 to just below 100 million in 2050. On the other hand, the ratio of the aged population (65 years and above) will continue growing but the working age population (15-64) will decrease considerably. As a result, it is expected that 1.3 working age people will support one aged person by 2050. These demographic changes have been caused, to a large extent, by the constant increase in the life expectancy, particularly in women, as showed in Figure 29. In 2050s it is expected that the average life expectancy for male people will be 83.6 years whereas for female people it will exceed 90 years of age.
The Budgetary and Staffing Implications of Ageing

The changes in the demographic context are creating some pressures for government to provide public services, particularly regarding the financial and human resources required for public service provision. For instance, the fiscal demand for social security has increased enormously during the last years. Nowadays more than a quarter of the general account of the budget of Japan (21.1 trillion yens) goes to social welfare. Between the fiscal years of 2001 and 2007 social welfare expenditure grew 28.5% generating a public debt of JPY 773 trillion (148% of GDP). In the fiscal year 2006, the total expenditure in social welfare benefit which includes pensions, medical services, nursing care and other social services was approximately JPY 90 trillion and it is expected that by 2025 it will reach JPY 141 trillion. According to Japanese authorities, population ageing is the main reason for the enormous increase of public expenditure in social security.

Consequently, Japanese government has been forced to reduce the number of personnel to cut expenditure. In 1969, the national government established by law the ceiling of non-industrial civilian staff of no more than 500 000 personnel approximately. Since then, there has been a reduction in the number of personnel only allowing hiring staff in strategic areas such as security and safety. Areas such as services for old people have not seen an increase in the number of staff.

Reductions in the workforce have been made via natural attrition. However, due to the recent fiscal constraints, the Japanese government has been forced to reduce the number of personnel more drastically. Thus, between 2006 and 2011 the central government, which currently employs around 332 000 people, expects to reduce the number of staff by 5.7% (18 900 people approximately). Since natural attrition is not enough to reach this target, Japanese government intends to reallocate staff from sectors to be streamlined for instance staple food control and statistics of agriculture, forestry and fisheries, to sectors that need to be reinforced. Nevertheless, the areas where public servants are being reallocated do not include services for old people as they are mainly provided by local governments, except pension insurance. Local governments have also been requested to reduce the level of staffing at the same ratio as the national government to meet the fiscal targets.
Organisational Changes to Adjust Public Service Delivery to an Ageing Context

Defining a strategy to face the challenges of an ageing society

Japanese government has established a basic framework to face the challenges posed by population ageing. It consists of two legal instruments: the Basic Law on Measures for an Ageing Society and the General Principles Concerning Measures for an Ageing Society.

The Basic Law on Measures for an Ageing Society contains the basic framework to address the problems faced by Japan's ageing society. It aims to ensure the sound development of the national economy and society and enhance the stability of people's life. The final objective is the creation of a prosperous society with equitable local communities characterised by a spirit of independence and solidarity. It stipulates that both central and local governments are responsible for the formulation of specific measures to address the challenges of an ageing society so as to reach the objectives of the law. However, it is the responsibility of central government the design of policies on work and income, health and welfare, learning and social participation, and the living environment. Furthermore, central government is in charge of establishing a set of comprehensive general principles to guide the formulation of measures to tackle the challenges of population ageing. In addition, it has to submit to the National Diet an annual report on the state of society regarding ageing and the progress made by the implementation of policies and programmes in the area. Government should also establish an Ageing Society Policy Council as an auxiliary organ of the Cabinet Office. This council is chaired by the Prime Minister and is integrated by all members of the cabinet.

In 1996, the central government established the first set of principles to guide the policies and programmes on ageing. However, due to the changes in the economy and society, in 2001 the Ageing Society Policy Council defined a new set of general principles based on the fact that Japan is in the process of transition to a full-fledged ageing society. The aim of these principles is the creation of a society characterised by solidarity where people are proud to be able to live a long life. The principles state that in order to ensure the development of the economy and society and improve people’s living conditions, it is necessary to: revise the socio-economic system on a regular basis to guarantee its suitability for the coming ageing society; and, support individual independence and roles of the family. These principles aim to create a society characterised by self, mutual and public support. This requires the commitment of central and local governments, corporations, local communities, non-profit organisations, families and individuals to pursuing the same objective. The general principles look for a cultural change, a shift in perceiving and appreciating the advantages of an ageing society:

- **Revision of conventional stereotypes regarding older people.** Nowadays older Japanese people are living a more active, healthier and financially secure life than other generations. Thus, policies should be developed based on the diversity found among older people and free from conventional stereotypes of physically and financially frail old people.

- **Emphasis on prevention and preparation.** The Ageing Society Policy Council considers that support should be provided for citizens’ self-help efforts to build up their financial assets, improve their health, engage in learning, and participate in social activities from a young age in order to prevent and prepare them for problems that may arise at an older age.

- **Activation of local community functions.** The required infrastructure should be set up to foster the proactive participation of the elderly in the activities of local communities and to activate community functions such as the provision of mutual support.

- **Gender equality perspective.** Policies should be developed from a gender equality perspective that considers the different situations of the elderly, paying special attention to the situation of
older women with regard to lifestyle, finance and health, as women’s life expectancy is higher than that of men.

- **The use of practical technology in medical care, welfare, information and communications.**
  The Ageing Society Policy Council considers that infrastructure should be put in place to promote research and development and the utilisation of advanced technologies in the provision of medical care, welfare, information and communication to elderly people.

In addition, the General Principles also stipulate that in order to meet the objectives of the policies and programmes on ageing, the central government has to identify issues that require a cross-sectoral as well as a basic sector-specific policy framework such as:

- **Support for independence in old age to make possible a range of lifestyles.** Given the growing number of active elderly citizens who seek to lead a range of lifestyles and the growing number of elderly persons living alone or requiring nursing care, policies and programmes should be implemented to satisfy the needs of these people.

- **Revision of systems and practices that treat older people differently because of their age.** The Ageing Society Policy Council considers of paramount importance to change the practices that limit the participation of the elderly in society, addressing the infringements of human rights of elderly people.

- **Strengthening of intergenerational solidarity.** Japanese government aims at creating the conditions to strengthen intergenerational solidarity in ways compatible with the family structures. Aged-related policies and programmes should promote intergenerational interaction where the elderly and young people participate in a diverse range of social activities including employment.

- **Promotion of participation in the local community.** Japanese authorities aim to provide support for the provision of infrastructure that serves as a foundation for the activities of non-profit organisations. Moreover, the Council recommends adopting measures to facilitate the start-up of local businesses with close ties to the local community. The aim is to promote lifelong local community participation for all citizens, including those of working age.

The General Principles Concerning Measures for an Ageing Society also provide guidelines in five specific sectors regarding the efforts to make Japanese society age-friendly. These guidelines make evident the responsibilities and the job distribution among sectors aimed at meeting the objectives of the ageing policies. The ‘Work and Income’ sector is in charge of ensuring employment and work opportunities for older people; maximising workers’ abilities throughout their lives; ensuring a stable operation of the public pension system; and, securing income for people in old age through self-help efforts. The ‘Health and Welfare’ sector is responsible for the definition of a comprehensive strategy for the promotion of health; the implementation of the long-term care insurance system; the enhancement of nursing care services; the reform of the medical system for older people; and the design of measures to support childcare. The ‘Learning and Social Participation’ sector is expected to create a lifelong learning system and promote activities of social participation. The ‘Living Environment’ sector is in charge of ensuring elderly people are provided with stable and comfortable housing through the promotion of urban planning that utilizes universal designs; and the creation of living environments that offer comfort and vitality. Finally, the sector of ‘Research Promotion’ has under its responsibility the promotion of research that contributes to solving the challenges related to an ageing society.

**Reforming the social security system**

Despite the remarkable gains in health over the past years, the economic and demographic factors are creating pressure on health and welfare services. For instance, although Japanese people are living longer
and, in general, in good health, there has been an increase in the number of elderly people who are bedridden and living with dementia. Hence, the provision of long-term care for the dependent elderly population has become a major social issue. Consequently, the Japanese social security system has been reformed in several occasions so as to face the challenges posed by a rapidly ageing society. During the 1990s the Japanese government promoted the development of an infrastructure for community-based care of the elderly. This approach was based in the expressed desire by the public to be more involved in decisions about health and community services at the local level.

One of the challenges of the social security system is the huge increase in the costs of health care and long-term care services provision for elderly people. Indeed, as Figure 30 reveals, the public expenditure in health has been growing over the last decade constituting a burden for public finances. In 2000, the Japanese government implemented a Long-term Care Insurance System (LTC) to cope with the growing demand for long-term care services. The main characteristic of this system is that it enables users to choose between public and private service providers as it integrates private providers of long-term care and health care into the strategy. Moreover, the government created the Long-term Care Insurance Division within the Health and Welfare Bureau for the Elderly in order to manage the new LTC.

**Figure 30. Public expenditure on health (% of GDP)**

From 1996 to 2005

<table>
<thead>
<tr>
<th>Year</th>
<th>6.4</th>
<th>6.6</th>
<th>6.8</th>
<th>7.0</th>
<th>7.2</th>
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<td>2000</td>
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<td>2004</td>
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<td>2005</td>
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</tbody>
</table>

Source: Based on OECD DELSA database.

In 2006, Japanese authorities conducted a reform of the healthcare system introducing a new Health Care Insurance System for those aged 75 and above. The aim of this new system is to simplify and make clearer the mechanisms available in the country for the provision of healthcare for the elderly tackling the growing costs due to a higher demand. In this sense, the prefectoral governments have been required to design a plan to control the costs of the healthcare provision by focusing on the inherent factors of healthcare namely the increasing life-style related diseases and the long average length of hospitalization. To implement these reforms, the Policy Planning Office of Healthcare for Elderly and the Healthcare cost Adjustment Office were established within the Ministry of Health, Labour and Welfare.

The use of Information and Communication Technologies (ICTs) in public service delivery

Information and Communication Technologies (ICTs) are considered as a trump to tackle the challenges posed by population ageing and the decline of birth rates in Japan. To maximise the potential of ICTs, the Ministry of Internal Affairs and Communications (MIC) is promoting a systematic ICT policy called ‘u-Japan Policy’. The aim is to create an ICT network that allows members of society to have access to services and information anywhere in the country. As Figure 4 shows, Japanese government expects to provide with high-speed or ultra-high speed internet access to the entire population by 2010, making at least 80% of the population to appreciate the role of ICT in solving social problems and feeling comfortable with ICT.

![u-Japan Policy - an overview](image)

The Japanese government has been continuously expanding the range of online services available to its citizens and business. The IT Basic Law and policies along with the e-Japan Strategy focused on building the infrastructure to accelerate the online availability of the administrative procedures. In 2006, IT Strategic Headquarters (ITSH), which consists of all ministers and some advisors, decided the “New IT Reform Strategy” to improve the IT-enabled operations and services to meet citizens’ expectations and achieve a network society where anyone could have access to the benefits of IT at any time and at any place. The emphasis of the e-government strategy for the future is on customer-oriented public services and the optimisation of business processes and systems. In June 2008 the Japanese authorities formulated the “IT Policy Roadmap” that is expected to 1) further expand the use of on-line services, mainly through electronic procedures, and 2) establish the standard model of next generation one-stop e-administrative services by 2010. In September 2008, after revising former programs for promoting on-line use, the ITSH implemented the “Action Plan for Expanding on-line Use” and each ministry is starting to design specific programmes based on the general action plan.

In order to revitalise local economies, reverse the declining birth rate and face the problems originated by population ageing, the Ministry of Internal Affairs and Communications started the construction of local community models through ICT utilization in 2007, which promote the development of local ubiquitous ICT networks to solve local challenges through the use of ICTs. In 2007, 29 municipalities were part of the pioneering projects for the construction of ICT versatile models to assist in the solution of local challenges. The central government is committed to share the results with other municipalities to encourage them to use ICT models for problem-solving.

Through the use of robots and a ubiquitous network, Japanese government expects to create a new lifestyle and address various social challenges like the ones posed by an ageing population. Telework is considered a flexible way of working and helps to promote a lifestyle with a balance between work and life. It is expected to increase the levels of productivity and effectiveness contributing to address problems generated by population ageing as elderly people with mobility problems, for instance, would be able to work from home and have access to public services. At present, telework is at the stage of consolidation and improvement. There are still corporations that do not have a full understanding of telework and, in consequence, fail to recognise its economic and social advantages. According to Japanese authorities, this is mainly due to the difficulties to control and evaluate work at home and the necessity to assure information security. Therefore, telework is not yet considered as an alternative employment format and further promotion is required.
Institutional Changes in the Provision of Public Health Nursing

The provision of public health nursing in Japan has undergone several changes over the last decade to meet health care challenges throughout Japan, for example, the ones posed by an ageing society. In Japan, registered nurses must pass a national examination before being eligible for licensure as a ‘public health nurse (PHN)’. Japanese PHNs provide a wide range of services including: health guidance to families, health screening for children and adults, rehabilitation and support for the frail elderly, identification of community health issues, among others. They are mainly employed by municipalities or prefectures and their services are provided free of charge. PHNs are an example of community-based care in Japan as they interact with people of all types and ages. They are assigned a geographic area where they provide services to a population ranging from 5,000 to 8,000. There is one chief PHN who manages all public health nursing in the municipality. However, in recent years, the provision of PHN has experienced a period of change in three major areas: 1) restructuration of employment; 2) nursing education; and, 3) new developments in the practice of public health nursing.

PHNs were mainly employed by Health Departments at either municipal or prefectural level. At the end of the 1990s restructuring of employment has caused some PHNs to be transferred from Health Departments to Welfare Departments. According to Japanese studies, this movement has been largely due to demographic and economic factors. Programmes for care of the elderly are the responsibility of the welfare departments, whose staff do most of the case management. In order to provide comprehensive home care for the elderly, a collaborative relationship among health, welfare and medical professionals is essential. Hence, since 1995 the demand for PHNs in welfare departments has increased as staff carrying the dual role of health assessor and case manager is needed. This movement has also strengthened the community-oriented approach in the provision of public services. Nurses who have taken on the roles of health assessor and care manager bring their expertise from a community-oriented work, where they used to assist communities in the determination on local needs and coordinate service delivery for the geographical area.

Changes in nursing education point to a trend towards higher education and the introduction of new curricula for public health nursing. In the past it was only necessary to pursue a 3 year training course to obtain a PHN license after high school. Nowadays, a growing number of practicing PHNs are graduates from universities. Indeed, there has been a rapid increase in baccalaureate programmes for nursing. For instance, in 1989 only 10 universities offered a baccalaureate in nursing, by the end of the 1990s the number rose to 65. Moreover, there are more postgraduate courses available which includes master’s degrees and doctoral programmes. The new curricula for the training of PHNs stress their role as part of a community as it looks to develop students’ ability to observe people’s health, to provide local residents with health education, to understand existing health problems in the community, and to tap social resources necessary for solving health problems in the community and evaluate and coordinate health and welfare services.

The role of PHNs in the provision and management of health services is expanding to include identification of the community’s situation through interaction with community members, assessment of local health problems by collecting information, statistics, results investigation, and research from related organisations. Based on these assessments, PHNs formulate plans to resolve health problems, carry out preventive programmes, and promote networking. The underpinning to improve the provision of public health services is a greater emphasis on cooperation between residents and related professions. Therefore, PHNs have four new roles: community developers; facilitator; resource manager, planner and coordinator; and policy formulator.
The Involvement of the Voluntary Sector in Public Service Provision

The voluntary sector plays a major role in the provision of public services to senior citizens and it is expected that its activities will increase in the next decade when the ‘baby boom’ generation reaches 65 years of age. Hence, central and local governments intend to have a closer working relationship with non-profit organisations (NPOs) in the promotion of regional activities aimed at satisfying the needs of services of an ageing population.

However, NPOs face the problem of an unstable workforce and the low interests of senior citizens in their activities as they quit after a short period of time. Central and local governments are expected to provide training for human resources and information and advice on how to stabilise the workforce. Moreover, NPOs face the lack of information on governmental programmes and the complex administrative structure limits their cooperation with central and local governments. Therefore, it is necessary to build systems that support the activities of NPOs at different levels of governance.

In Japan, retired senior citizens are considered to have enough time to spare, therefore authorities expect them to be leaders of the activities organised by NPOs. Moreover, senior citizens are expected to join various regional activities, making use of their experience in nurturing children, caring elderly people etc. This is similar to the UK’s programme to encourage the involvement of senior citizens, for instance, in providing advice to other citizens in health care related issues. In this sense, it is necessary to establish the conditions for a society with the spirit of cooperation and solidarity where energetic senior citizens can join local activities and not only support each other but also younger generations. For this purpose, Japanese authorities consider that action as a ‘matchmaker of local communities’ is of crucial importance to disseminate information and undertake social activities across local communities. Since senior citizens are expected to play a major role in these activities, fare-paying for volunteering work is under consideration.
Box 20. Creating an age-friendly living environment

In the past, Japanese cities and means of transportation were designed for people free of any handicap. However, the fact that Japan will be an aged society in the short-term and the willingness of handicapped people to play a major role in society has led to the transformation of cities by adapting buildings, roads, public transportation systems and other public spaces so that they can be used by disabled elderly people.

1982.- the building design standards that consider the use of handicapped people were enacted.
1983.- the guidelines for the provision of facilities in public transportation terminals to be used by handicapped people were enacted.
1991.- it was determined that all new public rental housing should be barrier-free to facilitate its use by handicapped and elderly people.
1993.- the Road Structures Regulations were revised in order to facilitate the use of wheelchairs in a safe and smoothly manner.
1994.- the Act on Buildings Accessible and Usable by the Elderly and Physically Handicapped was enacted.
2000.- the Law for the Promotion of Easily Accessible Public Transportation Infrastructure by Aged and Disabled (later called ‘Transportation Barrier-Free Law) was enacted.
2006.- the Law for Promoting Barrier-free Transportation and Facilities for the Elderly and the Disabled was enacted.

Conclusions

Demographic changes are presenting Japan with the challenge to adjust the system of public service delivery to meet the needs of a growing elderly population. The main strengths of the Japanese strategy are the reallocation of resources to increase efficiency, the pursuit of a cultural change regarding the perception of the elderly, and the creation of a society characterised by intergenerational solidarity and community work. Indeed, the Japanese strategy suggests that cultural changes and the adoption of a community-oriented approach in the definition of priorities in terms of public services for an ageing society are the main factors to face the demographic changes in the context of limited financial and human resources. The use of information and communication technologies (ICTs) is expected to make up for the lack of staff to provide long-term care and as a mean to facilitate people’s independent life. However, what it is not clear in the Japanese strategy is how the development of new technologies is being financed and how the elderly are being trained to use these technologies as part of their daily life. Moreover, the Japanese experience shows that it is possible to give a double role to health care staff as managers of these services; however, further investment in education is needed to adjust the educational system to prepare personnel to take over new roles. Furthermore, the educational system would need to be reinforced to produce the desired cultural change that leads to a culture of prevention and community work, without conventional stereotypes regarding older people. In this regard, the Japanese strategy seems to underestimate the importance of the voluntary sector as a provider of public services and as a facilitator in the generation of cultural change.
11. AGEING AND PUBLIC SERVICE DELIVERY IN KOREA

Demographic Trends and Projections

Korea’s population is ageing at one of the world’s fastest rates. According to Korean authorities’ projections ageing is a short and medium-term challenge as Korea is expected to reach the ‘aged’ society (more than 14% of total population aged over 65) in 2018 and ‘super-aged’ (more than 20% of total population over 65) in 2026. Seven percent of Korea’s population was already over 65 in 2000 and by 2005 the proportion was 9.1%. Indeed, the old age dependency ratio (65+ in % 20-64) is predicted to change dramatically from 11 in 2000 to 68 in 2050. Even more, the total population is expected to decrease from 47 million inhabitants in 2000 to 44.3 million in 2050 when the cohort of people aged over 65 will be the second biggest group of the population structure as Figure 32 shows.

![Figure 32. Population estimates for Korea by age and gender groups](image)

There are two main factors that account for the demographic changes. On the one hand, Korea’s fertility rate is one of the lowest of the world at 1.08 children per woman in 2005. On the other hand, as Figure 33 reveals, life expectancy at birth has been increasing over the last 25 years, the national average was 78.6 in 2005 (81.9 for women and 75.1 for men) one of the highest among OECD countries. The combination of low fertility rates and increase in life expectancy exacerbates the process of ageing leading to a decrease in the population. As Figure 34 shows, although the mortality rate has been kept steady over the last decade, the decrease in the number of births has hampered the natural increase of the population resulting in a society characterised by its longevity and shrinking population.

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20 In 2004 other OECD countries with critical demographic changes had higher fertility rates than Korea. For example, Finland had 1.80, Czech Republic 1.22, Italy had 1.33, and Japan 1.29.
According to the Korean National Statistics Office, the transition period from ‘ageing’ to ‘aged’ and from ‘aged’ to ‘super-aged’ society, has been one of the fastest among the OECD member countries. For instance, it took the USA 73 years to reach the ‘aged’ stage and 21 years the ‘super aged’ stage while in the case of Korea it took 18 and 8 years respectively. Table 20 shows a comparison of five OECD countries regarding the time span it took them to reach the ‘aged’ and ‘super-aged’ stages revealing the rapid changes in the demographic structure of Korea.
### Table 20. The speed of ageing in key OECD countries

<table>
<thead>
<tr>
<th>Year and per cent of population at age 65</th>
<th>Time span between</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Ageing - 7%</td>
<td>(b) Aged - 14%</td>
</tr>
<tr>
<td>Korea 2000</td>
<td>2018</td>
</tr>
<tr>
<td>Germany 1932</td>
<td>1972</td>
</tr>
<tr>
<td>USA 1942</td>
<td>2015</td>
</tr>
<tr>
<td>France 1864</td>
<td>1979</td>
</tr>
</tbody>
</table>

Source: Korean National Statistics Office, 2006

In sum, Korea’s ageing process is considered to be the cause of low fertility rates and the increase in life expectancy. While increase in life expectancy is an achievement for Korean authorities, low fertility rates highlight the need to establish policies to support young people to have more children so as to enable the natural recovery of the population. These demographic changes may lead to a reduction in productivity levels and private savings causing pressures to the economy as a whole. Moreover, a larger proportion of the public budget will have to be used for the provision of public services and support for the elderly. However, less tax income is expected as the total number of the population, and particularly the working age population, decreases.

### Changing Priorities for Service Delivery

In 2008, 10.3% of the Korean population was over 65 years old (5 million people approximately). Increases in the life span mean that the number of old people grows too and therefore it is necessary to expand the coverage of services such as pensions, health and social care. In addition, the process of industrialisation of Korean society has produced changes in the composition and roles of the members of families. Women, for instance, had the traditional role of looking after the elderly but since they are now having a more active role in economic activities, the demand for services for the elderly and child care has increased. The size of the families has also shrunk in recent years and there are less members of the family able to provide care for the elderly. Table 21 highlights some of the facts affecting the composition of Korean society.

### Table 21. Changes in Korean society

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Ratio of women participating in economic activities</td>
<td></td>
<td>42.8</td>
<td>47.0</td>
<td>48.8</td>
</tr>
<tr>
<td>Ratio of dual income families</td>
<td></td>
<td></td>
<td>27.4</td>
<td>33.4</td>
</tr>
<tr>
<td>Size of a family (persons)</td>
<td>5.0</td>
<td>4.5</td>
<td>3.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Ratio of early divorce</td>
<td></td>
<td>0.6</td>
<td>1.1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Source: Korean National Statistics Office, 2006

The Ministry of Health, Welfare and Family Affairs (MIHWAF) and the Ministry of Labour (MOL) expect increases in the demand for public services as a consequence of the ageing population. For instance, the increments in the number of cases of chronic degenerative diseases will lead to more demand for
services such as: outpatient care, hospices, organ transplantation, health counselling, treatment of dementia, and home visit care programmes.

Elderly security matters and welfare, long-term medical treatment, and health guarantee are the three main causes for increases in the demand for health services for the elderly. Therefore, Korean authorities are under pressure to design policies about minimum income guarantee, health, employment, housing, and leisure activities based on the particular necessities of the elderly.

Changes in the structure of the population and life style such as old people living alone have produced a number of social challenges like child and elderly abuse and family violence. Moreover, it is considered that divorce leads to poverty mainly in female and elderly led families. Hence, Korean government needs to implement policies and programmes aimed at providing security and protection to families where parents are divorced as well as support for families looking after their elder relatives.

Institutional Changes to Adjust the Public Service Delivery System

Korean government expects a negative impact of ageing on economic development. Population ageing may cause a decrease in the size of the working age population, reduction in productivity, increase in public expenditure on pensions and health care for senior citizens, deficit in tax revenue, and increases in conflict between generations as a result of support burden. The public service delivery system, while also affected by population ageing and lower levels of revenue, needs to be adapted to the new structural conditions where most of the users are now working-age and retired citizens and not young people. Hence, a redefinition of priorities may lead Korea to reallocate responsibilities and resources across levels of government to respond more efficiently and effectively to the demands for public services.

Reallocation of responsibilities across levels of government

The provision of social services in Korea is the responsibility of the local governments. Since 2002, Korea has pursued a policy of decentralisation of public administration that delegates the responsibility for public service delivery, particularly social services, to local governments. The principle behind this allocation of responsibilities is that local governments have a closer relationship with citizens and are in a position to respond faster to the needs of the population. Central government provides assistance and facilitates the means for local authorities to manage and provide public services. The Ministry for Health, Welfare and Family Affairs, for instance, has transferred 67 out of 127 major projects to local governments regarding social welfare services. Those projects account for KRW 595.9 billion (Korean wons).

Decentralisation is not a new issue in Korea. The Roh’s administration (2003 – 2008) established a Presidential Committee on Government Innovation and Decentralisation to promote the delegation of authority and resources from central to regional and local authorities in several policy areas such as social services provision.

In 2008 Korean government amended the Special Decentralisation Act to speed up the process of decentralisation. The new provisions include the designation of concrete tasks, deadlines and the mechanisms to enhance decentralisation. It establishes a clear distribution of tasks and responsibilities between central and sub-national governments, and a concrete timeline to amend the necessary laws and by-laws to have a comprehensive handover of central government affairs to regional and local governments. In addition, the Act reinforces the legislative powers of regional assemblies regarding the management of financial and human resources.
Reallocation of staff across levels of government

Although the deep demographic changes that Korean population is experiencing are creating some challenges for the public sector, there is no evidence to suggest that population ageing has played a key role in triggering reforms such as the reallocation of staff across levels of government. At most, population ageing appears to have been one of the factors considered for the adoption of, for instance, decentralisation policies. For instance, in December 2005, the total number of Korean civil servants was 931 025, of them 910 452 civil servants worked within the executive branch (63% at national level and 37% at local level). The percentage of civil servants at national level working in the fields of social service, welfare and environment is only 2.0%. This scenario reveals the necessity to increase the number of workers in key areas such as social affairs and mainly at local level of government. However, the current national administration pursues a policy to reduce the size of the public service what means that increases in the number of civil servants in social services will be restricted. This leads Korea to explore other possibilities to meet the demands for extra staffing in priority areas such as the transfer of personnel from national to local governments and across sectors. Undoubtedly this may imply higher investments in training and the adoption of mechanisms to facilitate the movement of staff across levels of government.

There are no significant differences in working conditions in the different levels of government and Korea may take advantage of this fact to encourage staff reallocation. The central government, through the Ministry of Public Affairs and Security (MOPAS), adjusts remuneration levels every year considering factors such as inflation, economic growth rate, private sector salary levels, etc. There is no bargaining process with trade union but only consultation. Local governments adjust their salary levels according to the adjustment carried out by the central government. They are also able to formulate suggestions to central government regarding the criteria for the salary adjustment. MOPAS is responsible for the analysis and assessment of personnel management of local governments and publishes an annual statistic for personnel policy based on the data collected from local authorities. It also disseminates best practices on personnel management among local governments through workshops, informal meetings and ICT.

The central and sub-national governments have already held conversations regarding the alternatives to improve the management of human resources at different levels of government. However, the mechanisms adopted, for instance the Best Human Resource Developer Scheme implemented in 2005, are the product of more managerial priorities than of concerns regarding the staffing requirements of local governments to comply with their new responsibilities on public service delivery. Moreover, the limited availability of staff and financial resources in local governments constrain the effectiveness of authority transfers. Korean authorities acknowledge that the long centralised-oriented practices have prevented local governments from building up their own capabilities and competences in the management of human resources.

The Korean government has been implementing an exchange program between the central and local governments as a way of strengthening the manpower of the local governments since the late 1990s. Once a staff is selected with the agreement of both governments, he/she works for a specific period time (usually one or two years) changing the positions in the different levels of government. To encourage the more staff to apply for these positions, the government provides some incentives such as housing and additional allowances. As this program proves to be very productive for both sides, the numbers of applicants are on the increase.

Another example of collaborations with different levels of government is through the recently established four major entities. There are four associations of sub-national governments: the Governors Association of Korea, the National Association of Majors, the Association of Metropolitan and Provincial Council Chairs, and the National Council Association of Chairmen. Each association promotes exchange of information and knowledge, and co-operation among local governments. In particular, the associations...
of chief executives deal with, among other issues, the management of the civil service. Local governments within a given region also organise policy discussion groups like the Policy Association and the Personnel Exchange Association to share ideas on inter-governmental human resource management.

**Financial implications of population ageing**

Structural changes such as low fertility rates, population ageing, polarization and slowdown of potential growth rate have been the cause of reforms in the Korean economy and financial markets. An input-based growth strategy is no longer effective in a context of polarization and unemployment. Hence, Korean government has pushed reforms focused on developing a positive growth distribution loop through technical innovation, human resource development, institutional modernisation and expansion of the social safety net. As a result of the adjustments to the financial sections, since 2004 the public expenditure on welfare has exceeded the one on economy and defence as Table 22 shows. One of the results of these measures has been the increment in social sector expenditure of 20.1% between 2004 and 2007.

**Table 22. Sectional comparison of the evolution of government expenditure**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare</td>
<td>14.3</td>
<td>17.9</td>
<td>17.9</td>
<td>19.9</td>
<td>20.2</td>
<td>24.5</td>
<td>26.7</td>
<td>27.9</td>
</tr>
<tr>
<td>Economy</td>
<td>17.7</td>
<td>18.7</td>
<td>24.5</td>
<td>22.6</td>
<td>28.7</td>
<td>23.2</td>
<td>21.0</td>
<td>18.4</td>
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<tr>
<td>Defence</td>
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<td>19.3</td>
<td>13.3</td>
<td>11.6</td>
<td>11.4</td>
<td>11.4</td>
<td>10.3</td>
<td>11.5</td>
</tr>
</tbody>
</table>


The rapid process of ageing has obligated government to guarantee income and health care for the elderly. Hence, Korea introduced the Basic Old Age Pension Scheme (BOAPS) in January 2008. This scheme focuses on people at age 65 and over and with limited financial resources who receive around 5% of the average income of National Pension subscribers. It is expected that by 2011 the scheme will cover 3,660 people with an investment of more than KRW 2.8 trillion (Korean wons).

The quality and quantity of health care services are also under pressure. Consequently, as Figure 35 shows, Korean authorities have been increasing the amount of financial resources for the health sector to reach around 6% of the GDP in 2005. Nonetheless, more resources do not necessarily mean more quality as the experience in child-care services reveals. Although Korean authorities have increased the amount of financial resources for child care, the quality of services provided remains under satisfactory levels.
Figure 35. Total expenditure on health (% of GDP)

From 1995 to 2005

Source: Based on OECD DELSA database.

Box 21. The Korean policy for the elderly - the 'Saeromaji Plan 2010'

According to the Korean Institute for Health and Social Affairs four factors condition the way of living of the elderly in Korea: income, health, loneliness/isolation and loss of role in society. The ‘Saeromaji Plan 2010’ intends to address those issues in a threefold strategy:

1. **Securing a basic income for the elderly.** Income support is the main social concern for 50% of the elderly population. In 2006, only 33% of the elderly population was beneficiary of the public pension system. Consequently, the Korean government has adopted several policies to establish the old-age income security system. For instance, it has developed a multi-level old-age income security system to revitalise both the public and private pension systems in order to secure an optimal level of old-age income. In 2008, Korean authorities implemented the ‘Basic State Pension’ that intends to cover all those not eligible for national pension. As a result 60% of the elderly population receive KOR 84 thousand (Korean wons) every month. In order to overcome the limitations of the pension system, Korean authorities aim to create partnerships between the public and the private pension systems expecting to increase the number of old people covered in the scheme.

2. **Healthcare provision.** In 2008, the Korean government started the development of the ‘Healthcare system for the Elderly’ that will focus on preventive and treatment services. The Ministry of Welfare, Health and Family Affairs implemented the “Long-term Sustainable Development of Care Insurance Scheme for the Elderly” aimed to provide social protection to the elderly with dementia and stroke. Moreover, a ‘lifetime healthcare system’ has been established for each lifecycle comprising mother and child healthcare, healthcare for schools and workplaces, and elderly healthcare. In order to enhance the policy of disease prevention, health promotion programmes are offered by public health centres and health insurance corporations.

3. **The promotion of an active and secure living.** In order to guarantee safe living spaces, Korean authorities are establishing the standards for elderly households and provision of housing to the elderly. Moreover, elderly-friendly public transportation and infrastructure are being introduced to facilitate the movement of the elderly around cities and towns. Furthermore, to reinforce the social integration of the elderly in society, cultural programmes and leisure activities have been implemented.
Organisational Changes to Adapt Service Delivery to an Ageing Context

Acknowledging the necessity to increase the supply of health care and social services in both quality and quantity, Korean authorities established the organization in charge of making policies for ageing population in 2005. Local government and private sector have been encouraged to provide more public social services by central government. But reorganising the public service delivery system to an ageing context still remains limited.

Policy initiatives to face demographic changes

In order to respond to the challenges posed by an ageing population, the government of Korea enacted the ‘Framework Act on Ageing Society with Low Birth Rate’. The Ministry for Health, Welfare and Family Affairs (MIHWAF) is in charge of the implementation of the Framework Act through the Ageing Society and Population Policy Bureau. Its scope of action covers topics such as policies on ageing society, senior support, long-term care insurance, family policies, etc. This regulatory framework aims to establish the underpinnings to improve the quality of life, reverse the low birth rates, and improve the environment for raising children. Moreover, the Presidential Committee on Ageing Society and Population Policy aims to define policies and strategies for reform and service provision to respond to the needs of an ageing population. In 2006 Korean authorities launched the Plan for Ageing Society and Population which together with the Framework Act on Ageing Society with Low Birth Rate are considered as the cornerstone of the Korean government strategy to face population ageing. The Plan is divided into three stages as shown in Table 23.


<table>
<thead>
<tr>
<th>Stages</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>First stage 2006 - 2010</td>
<td>Establishing a friendly environment for giving birth and raise children. Reverse the low fertility rates.</td>
</tr>
<tr>
<td>Third stage 2016 - 2020</td>
<td>Birth rate recovery up to OECD average and successful adaptation to an ageing society.</td>
</tr>
</tbody>
</table>


Korean government has also established service facilities for the elderly like residential homes, nursing homes, and other health care institutions for senior citizens and old people with disabilities. These establishments are divided into three categories: free, low price and private facilities. Korean government subsidised 295 free and 17 low price facilities in 2002 which account for KRW 49.3 billion (Korean won). Thus, only senior citizens with low income are allowed to make use of free or low price facilities. Moreover, government is financing the construction of more facilities so as to satisfy the growing demand for nursing homes for the elderly, particularly for those suffering from dementia. In addition, due to the increase in the number of old people living alone, the demand for support services for activities of daily life (meal service, bath service, companion service, etc) has grown. These services are free of charge for seniors under public assistance, and at a reasonable price for those at other income levels.

The Korean government enacted the Aged Employment Promotion Act in 1991 in order to provide support for employment to the elderly. Through this Act, the level of employment among the elderly group, reached 60.6% in 2007, a relatively high employment rate among the OECD countries. But, as Korean population is ageing rapidly, the Ministry of Labour is making additional efforts to use labour force of the aged and to secure income for them. In March of 2008, the Aged Employment Promotion Act was amended, imposing obligations on firms to make efforts to guarantee their workers’ retirement age at 60 or
over, preventing age discrimination in the Act, and providing support for wage peak system to stem early retirement practices resulting from firms’ wage costs under Korea’s seniority-based wage system, thereby paving the way for workers to be able to remain at work until 60 years of age or over. In addition, the government is setting up organizations and programmes to re-employ elderly people by providing training and job placement services tailored to them through the New Start Program, developing appropriate jobs for those forced to retire early or need reemployment after retirement. Currently, the Ministry of Labour is operating consultation booths for the aged in its 82 Employment Services Centres, and designating 49 private organizations as the Manpower Banks for the Aged, expanding non-governmental organizations’ roles.

Diversifying public service delivery – the use of market type mechanisms

Senior population in Korea constituted 10.3% of total population in 2008. Thus, the provision of social services requires to be extended to cover the growing population in the cohort of 65 years of age and over. Social services are provided by local governments through market type mechanisms such as the use of vouchers.

The Korean strategy to reinforce social services delivery is integrated by three main parts. First, local governments aim to improve the quality of life by lessening the burden of family care for the aged. It also establishes the basis for social investment services by supporting individuals in the improvement of their capabilities. Second, the Korean government intends to encourage the participation of the private sector in the provision of social services through the use of vouchers and the elimination of regulation that hampers competition and the creation of new markets. Four voucher initiatives have already been introduced. Users of social services are supposed to receive the voucher to have access to services such as: senior care, support for handicapped, and community service innovation. In order to create competition and give users the opportunity to choose between providers, the government has designated two entities in charge of the provision of social services through vouchers. Finally, Korean authorities try to raise the quality of social services by the improvement of qualification schemes, setting national quality standards for social service, and monitoring and assessing performance.

In addition, Korean government has adopted an integrated policy approach to face the challenges of an ageing population. For example, under the suggestion of local authorities, central government set up a single integrated unit for support services as this would help local authorities to strength their policy-making function in the area. Moreover, front line offices were transformed into community centres for the provision of welfare services and information. Those centres constitute collaborative networks as they link several institutions that have a role in the provision of social services bringing closer provider and consumer. The Ministry for Health, Welfare and Family Affairs has not designed specific ICT programmes for service delivery for the elderly. However, in 2005 it launched an integrated portal for a quick and competent social services information provision for the whole population regardless of their age. This portal works as a ‘one-stop shop’ to inquire about and demand services.21

The voluntary sector in service delivery

The participation of the voluntary sector in public service provision is rather limited in Korea. Social welfare services are provided by central and local governments or social welfare corporations that receive financial transfers from government. NGOs also receive financial support from local governments. At most, voluntary organisations have a role as supporters or facilitators of government’s activities in service delivery acting on its behalf.

Conclusions

Korea is being affected by deep demographic changes that have institutional and organisational implications for the delivery of public services. There are four main elements that characterise the Korean strategy to face the challenge of an ageing population. Firstly, it is based on the repercussions ageing is having on the composition and the traditional roles of members of the family. Secondly, its focus on reversing low fertility rates by setting the conditions for raising children like the provision of high quality child care services to facilitate parents the pursue of professional activities. Thirdly, the adoption of an integrated approach and market-type mechanisms for the provision of public services to promote the participation of private organisations in public service delivery to diversify the offer and support economic development. Finally, the emphasis on the decentralisation of public services to regional and local governments, although not produced by the ageing phenomenon directly, may allow for a more timely and adequate response to citizens’ needs. However, local governments still lack the necessary managerial capabilities and expertise to take up their new responsibilities as a consequence of the long history of centralisation. It is not clear in the Korean strategy how staff and financial resources will be reallocated across the public service giving priority to areas where demand has increased due to ageing. It seems likely that the Korean public service will have to concentrate on a strategy to increase the level of productivity to cope with raising demands for services and the shortages of staff and financial resources.
12. AGEING AND PUBLIC SERVICE DELIVERY IN MEXICO

Demographic Trends and Projections

Mexico, like many other OECD member countries, is experiencing deep demographic changes that will impact the way public services are provided. Although Mexico’s population is ageing, it is still relatively young compared to the population in other OECD countries. However, the nature of these changes and the extension of the challenges created by ageing are comparable to the ones presented in other OECD countries participating in this review. According to the estimations of the Mexican National Council for Population (Conapo), Mexico’s population will continue growing but the rate is expected to slow down by 2050. In 2005, Mexico’s population was over 106 million inhabitants, in 2020 it is expected to be 115.5 million and by 2050 it is estimated to be around 122 millions. Two factors may explain these changes; one is the decrease in the fertility rate from 2.10 in 2008 to 1.85 between 2040 and 2050; the second one is the reduction in the infant mortality from 27.6 in 1995 to 19.7 in 2004 (per 1,000 live births). Moreover, as Figure 36 shows, the cohort of people over 65 years old is growing and by 2050 it will constitute 20% of the total population compared with the 5% approximately in 2000.

Figure 36. Population estimates for Mexico by age and gender groups

The reasons for these changes in the demographic landscape may be, among others, the increase in life expectancy of the population and improvements in the quality of life as a result of better provision and coverage of the health care and other basic public services such as education, drinking water and sanitation. Figure 37 shows a constant increase in the life expectancy at birth of Mexican population that, although it is not yet at the levels reached by other OECD countries like Iceland and Japan, has impacted the distribution of the population among age groups.

Source: Based on OECD DELSA database.

22 OECD Health Data 2006, StatLink: http://dx.doi.org/10.1787/065360534501

23 It must be noted that there is a significant difference between the estimations of the OECD and Mexican Conapo. While the OECD projection for Mexican population for 2050 is more than 140 million inhabitants, Conapo estimates over 120 million. Hence, the estimations are only indicative and should be taken with caution.
Figure 37. Life expectancy at birth in Mexico

From 1980 to 2005

Source: Based on OECD StatLink database.

According to Conapo, in Mexico approximately 800 people become 60 years old daily and in 2050 one in four people will be over 60. Indeed, as Table 24 shows, although the old age dependency ratio in Mexico is low compared to other OECD countries, the extent of the challenge is the same or even larger for Mexican authorities as the raise in the number of people aged 60 and over will constitute a larger share of the total population. Even more, the state of the public service delivery system may struggle to respond efficiently and effectively to the new demands of public services generated by an ageing population. This is of crucial importance because while most of the OECD countries have already reached universal coverage in terms of public services, their main priority is to improve the quality of the services provided. Moreover, in those countries, population growth rates imply that increasing access to public services is simply to maintain access rates.

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>25</td>
<td>52</td>
</tr>
<tr>
<td>Iceland</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Japan</td>
<td>28</td>
<td>72</td>
</tr>
<tr>
<td><strong>Mexico</strong></td>
<td><strong>9</strong></td>
<td><strong>35</strong></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>58</td>
<td>69</td>
</tr>
</tbody>
</table>

Source: OECD DELSA database

Changing Priorities for Service Delivery

Mexico has made considerable progress over the past two decades in terms of increasing access to public services and in some instances it has reached near universal coverage like in primary education and electricity. However, guaranteeing full coverage of public services to all citizens, regardless of their age, is a pending task for Mexican authorities. As Figures 38 reveals, at least until 2004, Mexico had not reached
universal coverage in drinking water provision, improved sanitation facilities and access to health care services. Consequently, the public service delivery system would need to be adapted not only to improve coverage and quality but to be in accordance with the new demographic landscape reflecting the new composition of the population. For instance, population projections suggest that future cohorts entering primary school-age will decline in absolute and relative terms. Hence, it will be necessary to reallocate human and financial resources to show this change in the composition of the population in school age. Particularly, resources will need to be reallocated giving a higher percentage of the education funds to the secondary and tertiary levels without neglecting primary education in its quality of service provided.

Figure 38. Access to basic public services in selected OECD countries

The fact that Mexico still has a relatively young population has at least two implications. On the one hand, pressures on the pension system are still moderate as the share of the old age group (65+ years old) is relatively small and therefore there is some room to manoeuvre to adapt the pension system to an ageing context. On the other, these medium and long-term demographic changes provide a window of opportunity for proactively designing and implementing policies to address the challenges posed by population ageing. However, although at first sight the demographic landscape looks manageable in terms of timing, the reality is that Mexico faces a triple challenge. First, it has to guarantee universal coverage of basic public services to the population including the coverage of the pension system. Second, it has to improve the quality of the basic services including education, health care and social services. And thirdly, it needs to reorganise the public service delivery system to cope with the changing and growing demands for public services due to population ageing. Such changes may include strengthening the role of local and municipal authorities in public service provision and a more active participation of the private and voluntary sector in the delivery of public services.

Moreover, the fact that Mexico’s population will continue growing during the next three decades demands designing mechanisms to guarantee universal coverage of public services in a sustainable way.
The effects of ageing are already being felt in terms of the increasing share of government expenditures being allocated to health care services and pension programmes. Demand for the services provided by the main social security institutes is expected to grow, therefore, a larger amount of resources will be probably be allocated to those institutions in the medium and long-term. However, there has not been any assessment or study conducted to determine the sectoral needs derived from demographic changes.

**Institutional Changes in Multi-level Governance to Adjust Service Delivery**

**Decentralising public service delivery**

During the twentieth century, Mexico experienced a process of increasing concentration of taxation attributions at the federal level, mostly at the expense of the taxation attributions at the local level. In recent years, however, Mexico began the implementation of a process of decentralisation of expenditure attributions from the federation to the states. The process began in 1992 with the *National Agreement to Modernise the Provision of Basic Education Services*. In 1996 Mexican government published the *National Agreement to Decentralise the Provision of Health Services*. Since then, a series of state and municipal level funds and expenditure have been created to increase the amount of resources received by the local and municipal governments. In some cases these resources have been earmarked whereas in others there has been complete leeway in the way financial resources are managed by local and municipal governments.

One of the objectives of the decentralisation process is to increase the coverage and quality of public services through the redistribution of responsibilities in terms of service delivery, and the management of financial and human resources between the federal, local (states) and municipal governments. Nevertheless, Mexico is still in a trial-and-error phase and, for instance, it has not reached a stable division of tax collection responsibilities and public expenditure attributions among the three levels of government. Moreover, the lack of ability of local and municipal governments to manage these resources adequately has hampered an efficient provision of public services to the population, particularly in rural areas.

The increase in concentration of taxing responsibilities at the federal level and the extension in resources and expenditure attributions to local and municipal governments have created a significant vertical imbalance that needs to be corrected. Thus, in 2007 Mexican Congress approved a fiscal reform to address this problem by providing incentives to local governments to raise their tax revenues. Nonetheless, the fact that Mexico has not yet reached a stable fiscal agreement poses additional challenges for the reorganisation of the public service delivery system to reach universal coverage.

**Improving budgetary and fiscal practices**

Solid, transparent and effective budget and fiscal practices and procedures are paramount to obtain the necessary financial resources to provide public services to the population. Nonetheless, Mexico began only recently to link budgetary decisions to programme performance and to criteria based on needs, efficiency, and equity. Prior to these changes, budget allocation decisions were largely based on political considerations. These new budgetary practices include the distribution of resources across expenditure items and programmes as well as across levels of government. One of the most important changes in this regard was, for instance, the introduction of the *Oportunidades* conditional cash transfer programme in 1996. This is the first large-scale social programme in Mexico to have been evaluated rigorously using a randomized trial.

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24. ‘Oportunidades’ Human Development Programme, formerly called ‘Progres’.
Moreover, between 1999 and 2007 a series of changes were successfully introduced to the annual federal budgets or expenditure bills. These are clauses or conditions needed to be met by programme administrators in order for the budget allocations to be approved and completed throughout the fiscal year. Another movement towards linking programme performance to budgeting allocation decisions was the creation of the Technical Committee for the Measurement of Poverty in 2001 which was the precedent for the creation of the National Council for the Evaluation of Social Development Policy (CONEVAL) in 2006 as part of the Social Development Law enacted in 2003. CONEVAL requires all social programmes to be evaluated independently every year. This has been a very valuable tool to identify the programmes that are achieving their objectives and which ones are falling behind. However, CONEVAL still needs to reinforce the link between the results of the independent evaluations and the budgeting process since their relationship is still rather weak.

In 2008, the Ministry of Finance issued an official procedure and a series of guidelines which constitute the National Performance Evaluation System. This is the latest development in a series of important changes in the way public policies and social programmes are evaluated and financial resources are allocated. However, population ageing has not had a crucial role in its adoption; in fact, there is no evidence that an ageing population had been a variable considered for the reform of the budgetary process and allocation of resources. It seems that fiscal constraints and the need to improve the management of limited resources have been the central elements of these budgetary reform initiatives. Nonetheless, these measures may, indirectly, help financing the pension system and health care services as government’s total expenditure is expected to increase in per capita terms due to population ageing.

Furthermore, the pressures created by an ageing population on the fiscal budget may be more important for Mexico than for any other OECD member country as the old age dependency ratio and people reaching retiring age increase. Indeed, Mexico has relatively high payroll taxes but lower-than-average income taxes. This problem is exacerbated by a low capacity to collect revenues in general and non-oil taxes in particular. Therefore, one of the remaining historical challenges for Mexico is to increase its capacity to collect taxes so as not to depend on oil revenues and have the necessary financial resources to provide public services. This is of paramount importance if public expenditure on health is to be increased as, for instance, the current levels of expenditure in this area is one of the lowest ones in the OECD area (Table 25).
Table 25. Health spending and resources in OECD countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>Total expenditure on health % of GDP</th>
<th>Public expenditure on health % of total expenditure</th>
<th>Health expenditure Per capita USD PPP</th>
<th>Pharmaceutical expenditure % of total expenditure</th>
<th>Acute care beds Per 1 000 population</th>
<th>Practising physicians Per 1 000 population</th>
<th>MRI Scanner units Per million population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>9.0 9.8</td>
<td>71.4 70.3</td>
<td>2057 3 326</td>
<td>13.8 17.7</td>
<td>4.0 2.9</td>
<td>2.1 2.2</td>
<td>1.4 5.5</td>
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<td>Denmark</td>
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<td>1843 3 108</td>
<td>9.1 8.9</td>
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<td>2.9 3.6</td>
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<td>Finland</td>
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<td>84.2 83.6</td>
<td>1892 4 364</td>
<td>9.0 9.1</td>
<td>3.8 3.0</td>
<td>2.6 3.7</td>
<td>N N</td>
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<tr>
<td>Sweden</td>
<td>8.1 9.1</td>
<td>86.6 84.6</td>
<td>1733 2 918</td>
<td>12.3 12.0</td>
<td>4.1 2.2</td>
<td>2.9 3.4</td>
<td>6.8 N</td>
</tr>
<tr>
<td>UK</td>
<td>7.0 8.3</td>
<td>83.9 87.1</td>
<td>1384 2 724</td>
<td>15.3 N</td>
<td>N 3.1</td>
<td>1.6 2.4</td>
<td>N 5.4</td>
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<tr>
<td>USA</td>
<td>13.3 15.3</td>
<td>45.3 45.1</td>
<td>3656 6 401</td>
<td>8.9 12.4</td>
<td>3.7 2.7</td>
<td>2.1 2.4</td>
<td>12.3 26.6</td>
</tr>
</tbody>
</table>

Notes:
The figures are indicative and should be interpreted with care. Some data belong to previous or later years depending on the information provided by member countries. See http://dx.doi.org/10.1787/OIF2007en2 for further details.

N = No Information


Even more, as Figure 39 shows, although the levels of public expenditure on health in relation to the GDP have increased in the last decade, the increments have been limited in comparison to other OECD countries like Korea that passed from 4.1% in 1995 to 6.0% of the GDP in 2005. More importantly is the fact that if Mexico is to fill the gap in health coverage it will have to allocate a larger percentage of the GDP to health expenditure. Thus, the establishment of priorities and increases in productivity levels are essential as there is no evidence that financial resources will rise. The diversification of the sources of revenue is critical to have a more reliable source of income non-dependent on the volatile oil markets.
Human resource management issues for public service delivery

In terms of human resources Mexico has two main issues to sort out to be in conditions to meet the challenges of an ageing population in the medium and long-terms. On the one hand it has to improve the mechanism for the management of human resources at federal, local and municipal levels of government. On the other, it needs to reinforce manpower planning to assure the availability of staff in the areas were demand for public services is expected to increase due to ageing. These two factors may hamper Mexico’s efforts to take the necessary steps to reallocate staff to areas mostly affected by the increase in demand of public services due to ageing.

Over the past two decades, many OECD countries have initiated reforms to improve the performance and responsiveness of the public service. These reforms have questioned the traditional public models of the core public service – position-based and career-based systems –, and thus is becoming increasingly difficult to fit countries into either category. This has been the case in countries with consolidated bureaucracies and mechanisms to manage the civil service. This factor has enabled countries to adjust their human resource management system to the needs of an ageing population in terms of public service provision. However, Mexico only implemented a career civil service in 2003. The Professional Career Service Law (Ley del ‘Servicio Profesional de Carrera’, SPC) installed, at the federal level, a mechanism to administer human resources in the public sector bringing to an end, to a certain extent, the high level of turnover associated to changes in administrations and the resulting loss of specialised, and highly qualify and experienced human capital.

However, the implementation of the law and by-laws has not been smooth; several important problems remain to be solved. The SPC was enacted and implemented with the back-up of the different sectors of society: academic, political and bureaucratic. The reason was that it meant the possibility of pursuing a career in the public administration based on merits and performance rather than on political links and personal loyalties. Nonetheless, the lack of information on the evolution of the SPC, the limited debate on its results, and the lack of discussion with specialists on the possible solutions to the drawbacks uncovered through the implementation stage have created a sense of distrust among members of society and political parties. The recruitment and selection processes used in the SPC have not been able to eliminate the distrust in its possible politicization. The implementation of the SPC is still highly centralised causing delays, conflicts and complications. Moreover, the mechanisms to certify capacities to pass from a status of “libre designación” to a ‘career functionary’ appear to be long, confusing and unconvincing. Hence, Mexico still has to address the political and technical limitations of the SPC in order to be able to
manage effectively and efficiently the allocation of staff according to the needs created by factors such as population ageing.

As for the supply of human resources, Mexico is still behind other OECD countries in having enough qualified personnel to meet the growing demands generated by an ageing population, for instance in health care. According to the Mexican Ministry of Health, there is 1.5 practising physician per 1 thousand inhabitants, and as Table 25 (above) reveals this is below the average in other OECD countries. Moreover, the challenge is not necessarily to have more personnel but to have a better planning and a more even allocation of staff across sectors and regions in the country. For example, as Annex 1 shows, only 12 out of 32 states have a number of doctors above the national average and in comparable rates with other OECD countries.

**Box 22. Facts and figures regarding staff availability in the health sector**

- From the total of practising physicians in 2007, 70.2% are located in the public sector and 29.8% in private institutions.
- 84.2% of the total number of nurses works in the public sector.
- Between 2000 and 2007, the number of medical staff grew 27.7% in the public sector what represents more than 30 thousand physicians (from 119 512 physicians in 2000 to 152 566 in 2007).
- In the private sector, the medical staff increased 59.8% between 2001 and 2007 what represents more than 24 thousand physicians (from 40 515 physicians in 2001 to 64 754 in 2007).
- The number of nurses has been more limited, in the public sector it has increased 9.6% (from 190 335 in 2000 to 208 612 in 2007) whereas in the private sector the number increased 25.4% over the last seven years (from 31 269 in 2001 to 39 212 in 2007).


Moreover, as part of the demographic changes in the medium and long-term, Mexican authorities expect an increase in demand for more qualified teachers for secondary and tertiary school levels, including college professors, as the school-age population moves to higher levels. Thus, an absolute decrease in the number of primary school teachers may be experienced in the long-term. In health care there will be a raise in the demand for physicians and specialists in chronic and degenerative diseases (cardiology, oncology, radiation, neurology, neurosurgery, urology, geriatrics, nutrition, etc.). In addition, there will be a higher demand for support staff such as nurses, physiotherapists and care givers. Demographic changes may lead to a relative decrease in the demand of obstetricians. Therefore, schools and universities will have to revise and update the curricula in order to respond to the new demands of the labour market.

**Social Protection and the National Pension System**

Mexico has a highly fragmented social protection system with several social security providers. Moreover, a large percentage of the old age population is not protected by any of these systems. In recent years, Mexico has implemented some important reforms to transform the main social security systems from pay-as-you-go or defined benefit regimes to fully funded or defined contribution regimes.

In 1997 Mexican government reformed the Social Security Law which regulates the Mexican Social Security Institute (IMSS) which is the largest pension system and health care provider in Mexico for
workers in the private sector. With this reform the retirement system was transformed from a pay-as-you-go or defined benefit regime to a defined contribution or individual retirement account system. In 2007 the Public Employees Retirement Law which regulates the Institute for Security and Social Services of Government Employees (ISSSTE), the operator of the retirement system and health care provider for employees in the public sector, was also transformed from a pay-as-you-go to an individual retirement account system. Both reforms imply the creation of individual retirement fund accounts with an increase in contributions from the workers. However, these reforms have been challenged and opposed by workers because they consider that the ISSSTE and the IMSS were built under a model of cooperation and mutual support which has now been disrupted by the reforms approved by Congress. Nevertheless, the reforms remain in effect. Financing the pension system has been one of the priorities for Mexican government over the last decade not only to cope with current levels of pension payments but also to be able to pay pensions for longer periods due to the increase of population’s life expectancy.

Box 23. The management of pensions - the individual retirement account system

In 1996 Mexican Congress passed the Law on Systems for Retirement Savings (Ley de los Sistemas de Ahorro para el Retiro). This law regulates the systems for retirement savings and its 'participants' (institutions of credit, investment societies, etc) through the National Commission of the System for Retirement Savings (Comisión Nacional del Sistema de Ahorro para el Retiro, Consar) which is a technical autonomous organism from the Ministry of Finance. It laid the foundations for the subsequent amendments to the Social Security Law and Public Employees Retirement Law regarding the creation of individual accounts for the management of pensions. The basic attribution of Consar is to establish the general dispositions for the operation of the systems for retirement savings, the reception, deposit, and transmission and administration of the quotas and contributions for the systems. It also regulates the transmission, management and interchange of information among the different organisms of the federal public administration, the institutes of social security and the participants in the systems. The administrators of retirement funds (administradoras de fondos para el retiro) are, in general private credit institutions, for instance banks, in charge of managing the individual retirement savings accounts based on the dispositions of the social security system applicable to each individual either IMSS for employees in the private sector or ISSSTE for public servants.

Source: 'National Commission of the System for Retirement Savings (Consar); www.consar.gob.mx
Table 26. Mexican National Health System

Number of external treatments by type of institution, 2006

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total</th>
<th>General</th>
<th>Specialized</th>
<th>Urgencies</th>
<th>Odontology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
<td>274 747 180</td>
<td>191 856 517</td>
<td>42 307 394</td>
<td>26 896 526</td>
<td>13 686 743</td>
</tr>
<tr>
<td>Population not covered by any social security system</td>
<td>129 092 509</td>
<td>99 426 087</td>
<td>13 547 256</td>
<td>8 593 411</td>
<td>7 525 755</td>
</tr>
<tr>
<td>SSA (1)</td>
<td>107 935 644</td>
<td>80 765 278</td>
<td>12 432 521</td>
<td>7 690 994</td>
<td>7 046 851</td>
</tr>
<tr>
<td>IMSS - Oportunidades</td>
<td>20 073 396</td>
<td>18 507 876</td>
<td>390 176</td>
<td>720 884</td>
<td>454 460</td>
</tr>
<tr>
<td>Others (2)</td>
<td>1 083 469</td>
<td>152 933</td>
<td>724 559</td>
<td>181 533</td>
<td>24 444</td>
</tr>
</tbody>
</table>

| Population covered by the social security system | 145 654 671 | 92 430 430 | 28 760 138 | 18 303 115 | 6 160 988 |
| IMSS (3)                                       | 108 958 151 | 71 699 845 | 17 494 138 | 15 630 417 | 4 133 751 |
| ISSSTE (4)                                      | 22 831 188 | 14 347 399 | 6 335 494 | 902 955  | 1 245 340 |
| PEMEX (5)                                       | 5 125 937  | 1 926 892  | 2 152 920 | 799 315  | 246 810  |
| SEDENA (6)                                      |           |           |            |           |            |
| SEMAR (7)                                      | 1 587 496 | 835 941   | 442 825    | 150 342   | 158 388    |
| Estatal (local govts) (8)                     | 7 151 899 | 3 620 353 | 2 334 761 | 820 086  | 376 699    |

Notes: Includes information of institutions of the public sector only.
(1) Ministry of Health
(2) Includes information of university hospitals and ‘Hospital del Niño Poblano’.
(3) Mexican Social Security Institute.
(4) Institute for Security and Social Services of Government Employees.
(5) Mexican Oil company ‘Petroleos Mexicanos’.
(6) Ministry of National Defence. No information provided.
(7) Mexican Navy
(8) Includes also information of the Sistema de Transporte Colectivo (Metro).

In 2004, Mexican government implemented the Seguro Popular (Popular Insurance) programme which introduced important changes in the way the health care system works. This programme aims to provide health care services and social security benefits to unprivileged members of the population and be the basis for the wider implementation of social support throughout the country. In particular, this programme presents a new way of financing health services for the population not covered by any of the social security systems and in the way those services are provided by local governments. Seguro Popular has significantly facilitated access to health care services to the population previously uncovered or unprotected by IMSS, ISSSTE or any other social security institution. Box 24 explains the new logic for financing Seguro Popular differentiating it from the financing schemes followed by the other major health security providers. However, Seguro Popular has created important contingent liabilities in terms of financing health care coverage to future generations. Moreover, it has raised questions regarding the potential disincentive effects it may be creating for workers to become part of the formal sector.
Box 24. A new logic for financing the health sector

In 2003 Mexican government approved changes to improve the financing mechanisms for the health sector. This structural reform seeks to respond to the challenge of attaining fair financing and offering universal social protection in health. It is expected that after a seven year transition period all Mexicans not currently affiliated to a social security institution will be covered by the new Seguro Popular (Popular Insurance). The basis for this reform is that Mexican government considers that health care should be provided to all citizens and residents irrespective of income, ethnicity or employment status. This new insurance scheme seeks to bridge the gap in health coverage created by the logic of the design of the health system.

The premise of the reform is that extending risk pooling through public health insurance combined with an improvement in the quality and coverage of health services, will generate the necessary financial protection to achieve a reduction in catastrophic health spending among families, as well as incentives to make health finance more efficient, competitive and equitable. The financial logic of the reform separates funding between personal health services and health related public goods. Seguro Popular may then be considered an instrument to deal with uncertainty. For funding purposes, personal health services are divided between an essential package of primary and secondary interventions in ambulatory settings and general hospitals, and a package of high-cost tertiary-level care financed through the Fund for Protection against Catastrophic Expenditures.

The funding is based on a tripartite logic of financial responsibilities and rights that is similar among all three of the major social protection institutions. The financial structure intends to provide for solidarity and co-responsibility between levels of government and families. The social quota from the federal government is based on the right of citizenship and is equal for all families (15% of the mandatory minimum wage). The second source of funding is from the co-responsible contributor, but since there is no employer (IMSS for private workers and ISSSTE for public servants), co-responsibility and solidarity are established between the federal and local governments to redress the differences among states (the federal contribution is 1.5 times the social quota, but it is increased for poorer states at the expense of the wealthier ones). The third contribution comes from affiliated families. It is progressive and redistributes family income (in the cases of IMSS and ISSSTE the employee's contributions come from the payroll). The family contribution in Seguro Popular is based on a sliding-scale subsidy on the principle that no family should have to contribute more than a fair share of their disposable income. Families in the lowest two income quintiles do not contribute in monetary terms. For other families, the amount of their contribution is a fixed, equal proportion of disposable income. It is expected that a fixed proportion of the disposable income guarantees its progressivity in terms of total family income. This funding model implies a radical change in incentives for local governments and providers as funding for local governments are largely determined by the number of families affiliated to Seguro Popular.


Affiliation to Seguro Popular is voluntary, although, as showed in Box 24, local governments have the budgetary incentive to affiliate the entire population. The affiliation process is gradual over a seven-year period (2004-2010) and a maximum of 14.3% of the uninsured population can be included each year beginning with the poorest families. The large percentage of the old age population not covered by any of the social protection systems has led to the creation of a series of initiatives at local level of government. For instance, in 2001, the government of the Federal District has created a non-contributory, old-age pension system called Universal Old Age Pension (see Box 4 for further details).

Another distinguishing characteristic of the Mexican social protection system is that, unlike other OECD countries, it is financed through a combination of general taxes and payroll taxes. Mexican population has a high share of out-of-pocket medical expenditures relative to other OECD member countries. This is partly explained by the low coverage of social security.

Underpinnings of a Social Policy for the Elderly – an individual ageing approach

In 1979 Mexican government created the National Institute of the Old Age (Instituto Nacional de la Senectud, INSEN) to provide social and medical assistance to people aged over 60. However, the
demographic changes that Mexico began to experience in recent years have forced authorities to reform the social policy strategy and include measures to satisfy the needs of a growing elderly population. Hence, in 2002 Mexican government published the Law for the Rights of the Elderly (Ley de los Derechos de las Personas Adultas Mayores) and created the National Institute for the Elderly (Instituto Nacional de las Personas Adultas Mayores, INAPAM) that replaced the former INSEN.

This new law establishes the basis for the social policy aimed to define and protect the rights of the elderly regarding: their integrity, juridical support, access to education and health care services, employment, social assistance, participation in social policy definition affecting their rights, and denunciation of violations to their rights. Moreover, the law gives families the social task of looking after their elderly members. In that sense, families are entitled to receive subsidiary support from public institutions to look after the necessities of their members aged over 60.

In addition, the Law for the Rights of the Elderly defines the obligations of several public bodies regarding their role in the definition, implementation and evaluation of the social policy for the elderly. Table 4 summarizes the main tasks of each public body in the implementation of the national social policy for the elderly as they also integrate the Directive Council of the INAPAM. However, although the Law recognises the participation of the three different levels of government in designing and implementing public policies for the elderly, it only establishes the general basis for cooperation but does not make any distinction of responsibilities in public service delivery.

The INAPAM has the leading role in the design, promotion, coordination and evaluation of the public policies aimed to satisfy the needs of the elderly. One of its basic attributions is to oversee the implementation of measures to guarantee the integral human development of the elderly. The aim is to provide old people with employment opportunities, fair remunerations, and the necessary assistance to improve their welfare levels and quality of life with the purpose of reducing extreme inequalities and gender inequities to guarantee the satisfaction of their basic needs and the development of their capacities. The Institute has a Council of Citizens integrated by elderly people in charge of providing opinions and proposals to the Directive Council.

The Institute has agreements with different public and private institutions as well as large, medium and small enterprises throughout the country to provide discounts to old people affiliated to it in the acquisition of goods and provision of services. There is a wide range of service providers that grant discounts between 5% and 50%, for instance: pharmacies, hospitals, laboratories, commercial centres, museums, galleries, public transportation, etc.
Table 27. Responsibilities of public bodies in social policy for the elderly

<table>
<thead>
<tr>
<th>Public Sector Body</th>
<th>Main Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Social Development</td>
<td>Promote the participation of the social and private sectors in the financing of programmes related to the elderly.</td>
</tr>
<tr>
<td>Ministry of Public Education</td>
<td>Guarantee the access of the elderly to public education in all its levels and modalities to enhance their intellectual development.</td>
</tr>
<tr>
<td>Public Institutions of the Health Sector</td>
<td>Guarantee the access of the elderly to public health services of high quality. Particularly, public health institutions should establish programmes aimed at detecting and preventing chronic diseases.</td>
</tr>
<tr>
<td>Ministry of Labour</td>
<td>Implement programmes to promote remunerative employments for the elderly as well as voluntary activities according to their abilities and professional skills.</td>
</tr>
<tr>
<td>Ministry of Communications and Transportation</td>
<td>Guarantee an easy and secure access to public communication and transportation services provided by the three levels of government.</td>
</tr>
<tr>
<td>Public Institutions for Housing</td>
<td>Design housing programmes to guarantee old citizens access to credits to buy or refurbish their accommodations.</td>
</tr>
<tr>
<td>System for the Integral Development of the Family</td>
<td>Guarantee the free access of the elderly to juridical services.</td>
</tr>
<tr>
<td>Ministry of Tourism</td>
<td>Promote activities for the recreation of the elderly under preferential prices.</td>
</tr>
</tbody>
</table>

Source: Based on the Law for the Rights of the Elderly.

The INAPAM has recently begun to organise forums of discussion aimed at finding proposals to meet the challenges of population ageing. The purpose is to create a strategic alliance among the executive and legislative powers, and organisations of the civil society to design proactive and preventive public policies to enable government to effectively and efficiently respond to the needs of an ageing population. These forums do not only intend to find sustainable policy solutions to improve the quality of life of the elderly but to find out strategies to deal with discrimination against old and disabled people. Nonetheless these forums are in their early stage and no concrete proposals have been structured so far.

The National System for the Integral Development of the Family (Sistema Nacional para el Desarrollo Integral de la Familia, DIF) is another public organism in charge of the implementation of public policies in the area of social assistance. It was created in 1977 and is currently under a process of administrative reorganisation to be able to meet the challenges of social assistance in Mexico. As part of its responsibilities, the DIF provides a wide range of services to people aged over 60 who are in social disadvantage such as: accommodation; medical, psychological and odontological assistance; cultural, sportive and recreational activities; occupational and physical therapy; and social, nutritional and juridical assistance. The final objective is to keep the integrity and self-sufficiency of the elderly so as to guarantee their security and subsistence, and provide the necessary care assistance to have a peaceful dead.

The DIF also provides assistance services to contribute to family integration, and the individual, social and cultural development of the elderly. Services such as health, accommodation, food provision, and education are provided in nursing homes (casas hogar para ancianos) 24 hours a day throughout the year. All these services are provided free of charge. The DIF has two nursing homes and two National

25. The first forum took place on 29 July 2008.
Centres ‘Modelo de Atención’ that also supply shelter to old people considered as vulnerable. Their activities are coordinated with NGOs, and public and private institutions.

**Box 25. Local initiatives for public service provision to the elderly**

**Federal District.** The government of the Federal District, Mexico, implemented in 2001 a programme to provide free food, medical services and medicines to people aged over 70. This programme laid the foundations for establishing what is called universal citizen pension for the elderly in the Federal District. Beneficiaries of this programme receive a card that they can use in supermarkets, drugstores and clinics to have access to services free of charge. The rationale for using a card is to have a flexible system and give the possibility to every beneficiary to decide what their priorities are and then buy what he/she needs the most. The aim is to create a culture of respect, acknowledgement and revalorisation of the elderly giving them the opportunity to decide and define themselves their necessities and administer their resources.

The programme is coordinated by the local Ministry of Health. It assigned a coordinator in every of the 16 regions of the Federal District (delegaciones) who are in charge of managing a team of trainers or capacitadores (95 in total). In turn, every trainer coordinates a team of 11 - 13 educators specialised in communitarian health (1 200 in total). Every educator is assigned to territorial units and is responsible for home visits and the provision of assistance to every old person aged over 70.

In addition, the government of the Federal District implemented a similar programme at communitarian level. It consists in the evaluation and determination of risk of people aged over 70. Through certificates of risk (cédulas de riesgo), social workers identify three types of risk: health, social and economic and depending on the results they give special follow-up to people with the highest risk levels. Families are an important part of this programme as social workers work with the closest relatives of the beneficiary to provide them with advice and increase their awareness that the elderly are people who have already worked and contributed to society and then deserve a dignified retirement. Local authorities work in coordination with NGOs and other public and private institutions from the educational and health sectors to provide a better service to the elderly, creating ‘social networks’. In this way, when the elder citizens have a special need, they know where to go or whom to approach for assistance.

**Oaxaca.** The government of the State of Oaxaca, Mexico, implemented in 2006 the Integral Programme for the Elderly (Programa Integral para Adultos Mayores en Plenitud) which consists in providing free food to people aged over 60 and has a coverage of around 300 thousand people in the state. UNESCO and DIF support this programme thorough the provision of technical advice. It intends to reach universal coverage of the whole population of the state over 60 years of age. The aim of this programme is to fight against extreme poverty in the state giving priority to the most vulnerable.


All in all, these initiatives depict an individual ageing approach for the provision of public services to the elderly. However, more coordination and cooperation among the three levels of government and the ministries with responsibility in service delivery is necessary to make the most of limited resources.

**Conclusions**

Mexico lacks a comprehensive national strategy to adjust the public service delivery system to the demands generated by a growing older population despite the federal and some local initiatives focused on this issue. Although Mexican population lives longer, the main challenge for Mexican authorities is to improve the quality of life not only of its senior citizens but of the entire population. Mexico’s population is still relative young compared to the ones of other OECD countries. However, the demographic changes experienced so far have uncovered a number of difficulties that Mexican authorities will face in the short-term. For instance, the absence of a solid human resource management system; transparent and performance-oriented budget practices; and diversified sources of revenue are some of the challenges Mexico has to address to improve the management of the public service delivery system. These problems are exacerbated by the fact that Mexico still has to fill the gap in the coverage of basic services to the population and the need to consolidate and secure the funding of the pension system and eradicate the
doubts on the sustainability of the Seguro Popular. In addition, Mexico requires enhancing the decentralisation process of public service delivery. This does not only mean to delegate authority and responsibilities to local and municipal governments in public service provision but to provide them with the necessary tools and means to comply with their new tasks. That includes technical support and advice on the management of their human and financial resources.

The demands and policy priorities in terms of public services are undoubtedly changing as people live longer and the young cohorts begin to diminish. Nonetheless there is no evidence of a coordinated response among the different levels of government to provide public services to an ageing population. Federal and local initiatives seem to be at odds what limits the possibility of an effective response to this challenge at national level. The participation of the private and voluntary sectors and the use of arms’ length bodies in public service delivery are minimal as their role is only of support to public institutions working on this issue. The enactment of the Law for the Rights of the Elderly, the creation of the INAPAM and the local initiatives like the Federal District’s programme for the elderly are uncoordinated and to a certain extent independent initiatives built on political basis rather than on coordinated evidence-based policy reform agendas. Nonetheless, these programmes may constitute the underpinnings of a more comprehensive national strategy that includes organisational and institutional changes to coordinate the work of the three levels of government and the different federal ministries in charge of the provision of public services. In that sense, Mexico may need to adopt a whole-of-government approach to secure the universal coverage of public services to its citizens regardless of their age.
ANNEX 1: INDICATORS OF MATERIAL AND HUMAN RESOURCES, 2006

<table>
<thead>
<tr>
<th>Federal Entity</th>
<th>Acute care beds</th>
<th>Consulting rooms</th>
<th>Physicians (1)</th>
<th>Nurses (2)</th>
<th>Percentage of physicians in training</th>
<th>Relation Physicians/specialists</th>
<th>Nurses per physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>0.8</td>
<td>0.6</td>
<td>1.5</td>
<td>2.0</td>
<td>30.5</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Aguascalientes</td>
<td>4.1</td>
<td>3.0</td>
<td>9.9</td>
<td>15.6</td>
<td>25.2</td>
<td>0.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Baja California</td>
<td>0.5</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
<td>33.2</td>
<td>0.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Baja California Sur</td>
<td>2.4</td>
<td>1.8</td>
<td>4.7</td>
<td>5.9</td>
<td>28.1</td>
<td>1.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Campeche</td>
<td>1.7</td>
<td>1.3</td>
<td>3.6</td>
<td>4.8</td>
<td>16.8</td>
<td>0.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Coahuila</td>
<td>1.0</td>
<td>0.9</td>
<td>1.7</td>
<td>2.2</td>
<td>24.3</td>
<td>0.8</td>
<td>1.3</td>
</tr>
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<td>Colima</td>
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<td>8.4</td>
<td>10.0</td>
<td>31.5</td>
<td>0.7</td>
<td>1.2</td>
</tr>
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<td>Chiapas</td>
<td>0.4</td>
<td>0.4</td>
<td>0.7</td>
<td>11.1</td>
<td>20.0</td>
<td>1.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Chihuahua</td>
<td>0.9</td>
<td>0.5</td>
<td>1.2</td>
<td>1.6</td>
<td>28.8</td>
<td>1.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Distrito Federal (3)</td>
<td>2.0</td>
<td>0.9</td>
<td>3.2</td>
<td>4.1</td>
<td>31.7</td>
<td>0.3</td>
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<td>0.8</td>
<td>1.9</td>
<td>2.2</td>
<td>28.0</td>
<td>0.9</td>
<td>1.1</td>
</tr>
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<td>0.8</td>
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<td>0.8</td>
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<td>1.5</td>
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<td>25.3</td>
<td>1.0</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Notes:
(1) Includes general practitioners, specialists, trainees, interns and residents.
(2) Includes general nurses, specialists, auxiliaries and trainees.
(3) Includes the National Institutes of Health and Federal Hospitals.
13. AGEING AND PUBLIC SERVICE DELIVERY IN THE UNITED KINGDOM

Demographic Trends and Projections

*Estimations of the population ageing*

Like many other industrialised nations, the United Kingdom’s (UK) population is ageing due to improving living conditions, declines in the mortality rate, past fertility rates and a constant increase in life expectancy (Figure 30). In every year since 1901, with the exception of 1976, there have been more births than deaths in the UK and the population has grown due to natural change. Until the mid-1990s, this natural increase was the main driver of the population growth. Since the late 1990s there has still been natural increase, but net international migration into the UK from abroad has been an important factor in population change. Although the population grew by 8% in the last 35 years, from 55.9 million in 1971 to 60.6 million in 2006, this change has not occurred evenly across all age groups. The population aged over 65 grew by 31%, from 7.4 to 9.7 million, whilst the population aged under 16 declined by 19%, from 14.2 to 11.5 million. The largest percentage growth in population in the year to 2006 was at age 85 and over that grew at a rate of 5.9%.

Figure 40. Life expectancy at birth in the United Kingdom

From 1960 to 2005

![Life expectancy chart](chart.png)

*Source: Based on OECD StatLink database.*

As Figure 41 shows, the dependency of the old and young on the population of working age has largely changed too. In 1971 there were 43.8 children per hundred people of working-age; in 2006 this number fell to 30.5. This fall reflects both the smaller number of children in 2006 relative to 1971 and the increase in the working-age population, which was due to the 1960s baby boomers that joined the working-age population from the late 1970s. It is because of this increase in the population of working age that the old dependency ratio only increased slightly between 1971 and 2006, reaching 30.0 per hundred working-age people. The ageing index, the ratio of older people to children, rose sharply from 64.0 in 1971 to 97.8 in 2006.
Moreover, in 2006 the total fertility rate (TFR) in the UK was 1.84 children per woman. In 2001, the TFR hit a record low of 1.63, but it has increased each year since then. Although the current level of fertility is relatively high compared with that seen during the 1990s, the TFR was considerably higher during the 1960s baby boom, peaking at 2.95 children per woman in 1964. According to the Office for National Statistics (ONS), all four UK countries have experienced rising fertility over the past four years. Northern Ireland continued to have the highest fertility rate in 2006 (1.94 children per woman), while Scotland’s fertility remained lower (1.67 children per woman). Fertility in England and Wales was close to the UK average (1.86 children per woman in each country). However, childlessness has increased in recent years. Nearly one in five women born in 1961 was childless, compared to one in ten women born around 1941.

Population forecasts – a constant process of ageing

UK authorities forecast that population will continue ageing during the first half of this century. The rise in the proportion of the population aged 65 and over is set to continue as the large numbers of people born after the Second World War and during the 1960s baby boom age. As the baby boomers move into retirement they will be replaced in the working age population by smaller numbers of people born since the 1960s. Even though fertility has risen recently, the number of people being born is still less than was the case in the 1960s. According to the ONS, the population of the UK is projected to increase from 60.6 million in 2006 to reach 71.1 million by 2031. This is equivalent to an average annual rate of growth of 0.64% during this period. Table 28 shows the projections of the UK’s population growth until 2031. The UK’s population is expected to continue growing after 2031 but at a lower rate.
In mid-2006, the resident population of the UK was 60.5 million inhabitants of which 83.8% lived in England. The average age was 39.0 years, an increase on 1971 when it was 34.1 years. In the same year, approximately one in five people in the UK were aged under 16 and one in six people were aged 65 or over. The old dependency ratio is expected to change dramatically during the first half of the century. In 2000, the old dependency ratio (65+ in %20-64) was 27 and it is forecasted to be 47 by 2050.26

The ONS forecasts that the age structure will become gradually older with the median age of the population projected to rise from 39.0 years in 2006 to 41.8 years by 2031. Longer-term projections show continued ageing with the median age exceeding 43 years by 2056. The number of children aged under 16 is projected to increase by 4.8% from 11.5 million in 2006 to 12.1 million in 2016, and then to increase further to 12.8 million by late 2020s. The number of people of working age is projected to rise by 2.3% from 37.7 million in 2006 to 38.6 million in 2010. The working age population is expected to become much older as the baby boom generations of the mid 1960s age. In 2006, there were 1.7 million more working age adults aged below 40 than were aged 40 and above. However, by 2020, influenced by the change in women’s state pension age, there will be more aged 40 and above than below 40. The number of people of state pensionable age is projected to increase by 7.2% from 11.3 million in 2006 to 12.2 million in 2010. In 2006, there were just under 0.2 million (2%) more children aged under 16, than people of state pensionable age. However, from 2007 the population of state pensionable age is projected to exceed the number of children and by 2031, despite the increases to state pension age, is projected to exceed it by over two million (17%).

The ONS suggests that as the population ages, the numbers in the oldest age bands will increase the fastest. In 2006, there were 4.7 million people in the UK aged 75 and over. The number is projected to increase to 5.5 million by 2016 and to 8.2 million by 2031, a rise of 76% over 25 years. Table 29 summarises the projections of the UK population until 2031 by groups of age.

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**Table 28. Population projections for the UK**

Five year summary 2006-2031, annual averages (thousands)

<table>
<thead>
<tr>
<th></th>
<th>2006-2011</th>
<th>2011-2016</th>
<th>2016-2021</th>
<th>2021-2026</th>
<th>2026-2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population at start</td>
<td>60,587</td>
<td>62,761</td>
<td>64,975</td>
<td>67,191</td>
<td>69,260</td>
</tr>
<tr>
<td>Births</td>
<td>780</td>
<td>799</td>
<td>805</td>
<td>796</td>
<td>788</td>
</tr>
<tr>
<td>Deaths</td>
<td>565</td>
<td>549</td>
<td>552</td>
<td>573</td>
<td>610</td>
</tr>
<tr>
<td>Natural change</td>
<td>215</td>
<td>250</td>
<td>253</td>
<td>224</td>
<td>178</td>
</tr>
<tr>
<td>Net migration</td>
<td>220</td>
<td>193</td>
<td>190</td>
<td>190</td>
<td>190</td>
</tr>
<tr>
<td>Total change</td>
<td>435</td>
<td>443</td>
<td>443</td>
<td>414</td>
<td>368</td>
</tr>
<tr>
<td>Population at end</td>
<td>62,761</td>
<td>64,975</td>
<td>67,191</td>
<td>69,260</td>
<td>71,100</td>
</tr>
</tbody>
</table>


---

26. OECD DELSA forecasts.
## Table 29. Projected population by age, UK, 2006-2031

in thousands

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2006</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
<th>2026</th>
<th>2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>60,587</td>
<td>62,761</td>
<td>64,975</td>
<td>67,191</td>
<td>69,260</td>
<td>71,100</td>
</tr>
<tr>
<td>0-14</td>
<td>10,737</td>
<td>10,912</td>
<td>11,428</td>
<td>11,947</td>
<td>12,026</td>
<td>11,974</td>
</tr>
<tr>
<td>15-29</td>
<td>11,876</td>
<td>12,614</td>
<td>12,458</td>
<td>12,024</td>
<td>12,191</td>
<td>12,706</td>
</tr>
<tr>
<td>30-44</td>
<td>13,302</td>
<td>12,699</td>
<td>12,691</td>
<td>13,492</td>
<td>14,132</td>
<td>13,975</td>
</tr>
<tr>
<td>45-59</td>
<td>11,744</td>
<td>12,295</td>
<td>13,094</td>
<td>12,986</td>
<td>12,398</td>
<td>12,420</td>
</tr>
<tr>
<td>60-74</td>
<td>8,269</td>
<td>9,265</td>
<td>9,824</td>
<td>10,432</td>
<td>11,035</td>
<td>11,802</td>
</tr>
<tr>
<td>75 &amp; over</td>
<td>4,659</td>
<td>4,975</td>
<td>5,480</td>
<td>6,309</td>
<td>7,477</td>
<td>8,223</td>
</tr>
<tr>
<td>Median age (years)</td>
<td>39.0</td>
<td>39.7</td>
<td>40.0</td>
<td>40.2</td>
<td>40.9</td>
<td>41.8</td>
</tr>
<tr>
<td>Under 16 (A)</td>
<td>11,537</td>
<td>11,643</td>
<td>12,096</td>
<td>12,687</td>
<td>12,828</td>
<td>12,781</td>
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<tr>
<td>Working age (B)</td>
<td>37,707</td>
<td>38,934</td>
<td>40,386</td>
<td>41,604</td>
<td>43,000</td>
<td>43,393</td>
</tr>
<tr>
<td>Pensionable age (C)</td>
<td>11,344</td>
<td>12,184</td>
<td>12,493</td>
<td>12,900</td>
<td>13,431</td>
<td>14,927</td>
</tr>
<tr>
<td>Young (B/A)</td>
<td>3.27</td>
<td>3.34</td>
<td>3.34</td>
<td>3.28</td>
<td>3.35</td>
<td>3.40</td>
</tr>
<tr>
<td>Old (B/C)</td>
<td>3.32</td>
<td>3.20</td>
<td>3.23</td>
<td>3.23</td>
<td>3.20</td>
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<tr>
<td>Total (B/(A+C))</td>
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<td>1.64</td>
<td>1.63</td>
<td>1.64</td>
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</table>

These demographic changes will lead to a shift in priorities and requirements regarding public services. Health and social care services, for instance, may face an increase in demand due to ageing. This requires government to adjust its public service delivery system to respond in an efficient and effective manner to population’s demands. In that sense, over the last decade, the UK government has undertaken a number of actions aimed at reforming and making more efficient public service provision. Although ageing is considered as one of the factors that led to the transformation of the public service delivery system, there is no evidence that it was the main triggering force for reforms. Factors such as bureaucracy, lack of financial resources, decrease in customers’ satisfaction, low levels of efficiency and the lack of a whole system approach may be named as the main drivers of reform.

Characteristics and trends in public employment

Demographic changes and the need to increase efficiency and effectiveness in public service provision have led, to a certain extent, to changes in the characteristics and composition of public employment. For instance, if health and social care services which are delivered by local authorities are expected to be in more demand due to ageing, then public employment in local governments may see a more marked increase in the number of staff than in central government. Indeed, as Figure 43 reveals, public employment in local governments is higher than in central government. Local government is one of the largest employers in England and Wales; it employs 2.1 million people in England and 164 000 in Wales. 58% of jobs in local governments are in education (teachers and support staff) 14% in social services and 8% in corporate functions.
Public sector employment has grown following a period of decline in the early mid-1990s. Between 1991 and 1998 public sector employment fell every year reducing by more than 800 000 in total. Between June 1998 and June 2005 public sector employment rose by 680 000 to stand at 5 846 000, 13.2% higher than in June 1998, but still below the 1991 level. Public sector employment as a proportion of total employment fell from 23.1% in June 1992 to a low point of 19.2% in June 1999. Since then, public employment has experienced a gradual recovery to reach 20.4% in 2005. The annual percentage growth in public sector employment has been stronger (1.7%) than for the private sector (1.0%) since 2000.

The recovery in the public employment rates in recent years may be a consequence of changes across industries. As Figure 44 shows, health and social work had the largest increase in 2004 and 2005 (4.1% and 3.2% respectively). Education also had an increase in the same period (2.8% and 1.4%). Since June 1998 employment levels in both health and social work and education increased by 300 000 and 224 000 respectively (18.3% and 19.7%) what represents three quarters of public sector employment.
Moreover, ageing is also reflected in the characteristics of public employment. According to the ONS data, public sector employees are older than the ones of the private sector. As Figures 45 shows, 74% of those working within the public sector in 2006 are over 35 years of age, compared with 62% of those working in the private sector. There is relatively little difference in the proportions aged 25 to 34 (20% and 22% respectively) while the proportion of public sector workers who are aged under 25 is much lower than among private sector workers (6% compared with 16%). There have been increases in the proportions of workers aged over 35 between 1997 and 2006, in both the public and private sectors, especially for those aged 50 or over. In both sectors there has been a decline in the proportions aged 25 to 34. The ONS considers that these changes reflect changes in the workforce as a whole. One of the main changes in the proportions of people working in the public sector is the increase in the number of workers aged 50 or over as there has been an increase from 20% to 23%.
The fact that public sector employees are also ageing, makes the transformation of the public service delivery system more challenging for UK authorities. The number of employees near retirement age increases while the supply of specialised staff in service delivery decreases as part of the demographic changes. However, immigration and the recruitment of specialised staff from abroad like nurses or dentist may help to alleviate the shortages of staff. Nevertheless, this is not a long-term solution and a reallocation of staff and resources across sectors and levels of government more affected by demographic changes and an investment in education and training in priority areas may constitute a suitable alternative to deal with an ageing population.

Institutional Changes to Adjust the Public Service Delivery System

To reform the public service delivery system, the UK government has been conducting organisational and institutional changes under a whole of government approach. Improvements in the coordination across ministries and arm’s length bodies, and better cooperation among the different levels of government in service delivery are the main characteristics of the reform initiatives implemented by UK authorities.

Improving the Management of Financial Resources – the Public Service Agreements

Public sector total managed expenditure represents a large percentage of the GDP. During the last ten years, public expenditure has had a steady increase from 37.7% of the GDP in 1998-1999 to 41.9% in 2008-2009. Public expenditure focuses mainly on social protection, health and education (Figure 46); however, there is no evidence that this allocation of financial resources across sectors is the product of a strategy to adapt public service delivery to an ageing context. What it is clear is that central government is undertaking measures to make the management of financial resources more efficient and effective and in consequence dealing indirectly with the provision of welfare services that are crucial in an ageing society such as health and education (together they represent 31% of public expenditure).
The relevance of healthcare, education and social protection is reflected in their large proportion of government spending and in the constant increase of public expenditure in these areas (Figure 47). As population is ageing, public investment in healthcare is growing faster than in education, but that does not mean that education has a minor role in an ageing strategy. Nevertheless, spending more in public services alone is not enough to adapt the public service delivery system to the context of an ageing population. As the experience of other OECD countries taking part in this study shows, improving government’s coordination and organisation, redefining priorities and improving the management of the resources available are also paramount to respond to the changing needs of an ageing society in an effective and efficient manner. Horizontal coordination across all ministries and arm’s length bodies and joined up service provision across levels of government to make the most of the resources available seem to be at the centre of the UK strategy to improve service delivery.
Indeed, in 1998, the UK government introduced the Public Service Agreements (PSAs) framework. It sets out the key public service outcomes the government wants to achieve in the following spending period. Since then, these agreements have been an integral part of the government’s public expenditure framework, helping to ensure value for money from public services and that outcomes are delivered in return for resources. The PSAs aim to address key challenges facing the UK, from increased life expectancy and rapid technological diffusion to growing pressures on natural resources and the global climate. PSAs mark a transition from focusing the public service delivery approach on levels of investment (financial and human) to how effectively those resources are being used and whether services are delivering the expected outcomes.

For the spending period 2008-2011, every PSAs is underpinned by a single Delivery Agreement shared across all contributing departments and developed in consultation with delivery partners and frontline workers. They also describe the small basket of national outcome-focused performance indicators that will be used to measure progress towards each PSA. Moreover, the British government also issued a Service Transformation Agreement (STA) that sets the government’s vision for building services around the citizens and specific actions for each department involved.

Service transformation is about changing public services so they are tailored more to the needs of people and businesses and less to the structures of government. The key aim of service transformation is to reduce the number of unnecessary contacts that people need to have with government. This requires the whole of government to look critically and fundamentally at the way in which it designs and delivers services, and at the relationships between those organisations, whether in the public, private or third sectors, who have an interest in a particular area or customer group. It is expected that this strategy will improve quality, accuracy and joining up across government and, at the same time, save money and create more satisfying jobs for public sector staff. The UK government’s aim for the STA is to establish across

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27 Public Service Agreement (PSA) is an agreement between each government department and HM Treasury which specifies how public funds will be used to ensure value for money.
the public sector a sustainable culture built upon an understanding of the need and behaviours of citizens and businesses to create service that are better for customers, staff and taxpayers.

The Civil Service Steering Board is responsible for the overall leadership and direction of the STA. This includes endorsing the overall strategy, assigning leadership of cross-government projects to specific departments, and reviewing overall progress against plans. It is chaired by the Cabinet Secretary and consists of a small number of departmental permanent secretaries and non-executive members. It also appointed a lead department to each specific area of transformation.

The UK government intends to track customer satisfaction through at least two key progress measures:

1. **Reduction in the amount of avoidable contact.** The aim is to achieve a 50% reduction in avoidable contacts by the end of the spending period. Reducing avoidable contact means that the public sector delivers existing services more quickly and effectively. It also informs how the public sector fundamentally re-designs those services to be more streamlined and accessible in the future.

2. **Building better online services.** Based on the approach that citizens’ needs are individual and often fall across a number of organisations, the UK government considers that the public sector can better strategically manage customer online access to services by progressively moving e-services onto two websites where they can be presented and linked in ways which customers understand: Directgov for citizens and Businesslink.gov for businesses.

To deliver the vision of service transformation, six areas of strategic action have been established: i) learning from citizens and business; ii) grouping services in ways that are meaningful to the customer; iii) rationalising services for efficiency and service improvement; iv) making better use of the customer information the public sector already holds; v) linking local and central government; and, vi) engaging front line staff. Ensuring that public service delivery is joined up across both central and local government is a key component of the STA which recognises that successful service transformation is dependent on close collaborative working between departments and local government bodies. PSAs constitute an instrument for investment which is linked to reforms to enhance service delivery and ensure that public resources are focused where it counts.

**Local Government’s Responsibility in Public Service Delivery**

As Figure 4 above shows, public employment is higher in local governments than in central government as they are in charge of the provision of a large number of public services. Education, leisure and social services are just some of the areas to which people are employed in local governments. Local government in England and Wales is organised in two different ways. In Wales and in some parts of England, a single tier ‘all purpose council’ is responsible for all local authority services and functions. The reminder of England has a two-tier system in which responsibility for services is divided between district and county councils.

The Audit Commission, through the Comprehensive Performance Assessment (CPA), monitors the standards of service delivery to ensure effectiveness and efficiency. Councils are awarded ratings – excellent, good, fair, weak or poor – on the basis of their service performance. According to the Local Government Association (LGA), there are currently a total of 69 local governments in the excellent category, 146 in good, 119 in fair, 44 in weak and 10 in poor. The money local governments spend comes from central government, from business rates and from council tax. It is estimated that local government spent £83.8 billion on the day to day running of local services in 2005-2006. Council tax only accounts for 26% of all costs.
Local authorities are in charge of promoting the social, economic and environmental well-being of their local community. 91% of local authorities have a cross-agency local strategic partnership in their area which brings together a number of local organisations such as the council, the police and the health service, to improve the quality of life in their locality. Local authorities also provide a wide range of care and support services to children, families, and vulnerable adults; in particular they provide support for older people, adults with physical or learning disabilities or mental health needs and carers. Moreover, they have a major role to support school improvement and a responsibility for schools and education services in their areas. This can range from the provision of adult education services to play schemes, pupil referral centres and educational psychologists. Other public services provided by local governments are: transport, housing, improvement of the local environment, planning and regulation, arts, sports and culture, and policing.

Organisational Changes to Reform the Public Service Delivery System

Towards a Culture of Prevention under a Local Focus – the community services scheme

The fact that people are living longer has led to a change of direction in which public services are provided, particularly health and social care. According to the Department of Health (DH), one of the greatest long-term challenges facing the health and social care system is to ensure that longer life means more years of health and well-being. In 2006, the DH published the White Paper *Our health, our care, our say: a new direction for community services*, which intends to establish a culture of prevention to alleviate the challenges and requirements created by demographic changes as most illnesses are avoidable. As stated above, the number of people over 65 years old with long-term condition doubles each decade. The number of people aged over 85 is expected to double by 2020 and is the age group most likely to need residential or nursing home care. Hence, preventing ill-health and enabling people to play a full role in their local communities are also key parts of the government’s work on regeneration and building sustainable communities.

The White Paper establishes a new approach for the provision of health and social care-related services under a long-term perspective. It delineates four main goals: 1) better prevention services with earlier intervention; 2) increasing people’s choice and participation in their health care; 3) do more on tackling inequalities and improving access to community services; and, 4) increase support for people with long-term needs. With these goals the DH seeks to give a new direction to the whole system of health and social care services provided in community settings, specifically:

- **Social care:** this comprises a wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them from vulnerable situations and manage complex relationships;
- **Primary care:** this refers to all general practice, optician and pharmacy-based services available within the National Health Service (NHS);
- **Community services:** this refers to the full range of services provided outside hospitals by nurses and other health professionals.
- **Other settings** including transport and housing that contribute to community well-being.

In this sense, the White Paper redesigns the system of rules pushing decision closer to communities affected by them emphasising four main areas: public health, long-term conditions, access and patient
experience. Partnerships between local authorities and reformed Primary Care Trusts (PCTs) are central to implement the new policy direction to reform the provision of health and social care services.

The UK government’s strategy to enable health, independence and well-being takes into consideration not only people aged 65 or more but children and people of working age too. Indeed, the culture of prevention that the government wants to create considers that the whole process begins by encouraging children to shift towards a healthier lifestyle. Therefore, a major reform programme includes the integration of local services in children’s trust and the implementation of the National Service Framework for Children, Young People and Maternity Services that seeks that every school in the country promotes physical health and emotional well-being of children and young people.

The White Paper recognises that there is a strong link between unemployment, social exclusion and health inequalities in the UK. Hence, the UK government, through the Department of Health, the Department for Work and Pensions and the Health and Safety Executive, is implementing a strategy to break the link between ill-health and inactivity to advance the prevention of health and injury and to encourage good management of occupational health issues.

As for older people, the aims of the White Paper are: i) to promote higher levels of physical activity in the older population; ii) to reduce the barriers to increased levels of physical activity, mental well-being and social engagement among excluded groups of older people; and iii) to continue to increase uptake of evidence-based disease prevention programmes among older people. A cross-government group is driving the broad health and well-being agenda forwards with involvement of key stakeholders from the National Coalition for Active Ageing. Actions in this respect include a network of one-stop centres developed and controlled locally and containing services such as health, social care, housing, leisure, education, volunteering and social opportunities.

The overall strategy to reform the provision of health and social care services is based on four key elements. First, it stresses the need for more local focus on health and well-being. Therefore, local bodies are taking a more active role in developing services that support people in taking responsibility for their health and well-being. Second, the strategy emphasises that joint action to support health and well-being needs to be driven through strong effective leadership within PCTs and local authorities. This requires greater co-terminosity between health and local government bodies both between PCTs and local authorities, and between Strategic Health Authorities (SHAs) and government offices for the regions. These changes are expected to facilitate better joint working and need to be backed by strong leadership at chief executive and board level, and by individuals who have clear responsibilities for improving people’s health and well-being. The Director for Adult and Social Services and the Director of Health have key roles in advising on how local authorities and PCTs can jointly promote the health and well-being of their local communities through regular joint reviews of the health and well-being status and needs of their populations. They are also responsible for regular strategic needs assessment to enable local services to plan ahead for the next 10 to 15 years.

Third, the success of the strategy requires of better partnership and clear outcomes for services to help partners to focus on what joint working is aiming to achieve for individuals. The Commission for Social Care Inspection (CSCI) is developing indicators to take forward the development of performance assessment regimes reinforced through inspection. In this sense, the Commission for Social Care Inspection and the Healthcare Commission are to be merged by 2008 as a way to improve the role of arm’s length bodies in the provision of health and social care services. The creation of Local Area Agreements

28. Primary Care Trusts (PCTs) are free-standing statutory NHS bodies with responsibility for delivering health care and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.
(LAAs) are deemed key to achieve better partnership, they are made up outcomes, indicators and targets aimed at delivering a better quality of life for people by improving performance of local services. Hence, working across departments, from 2007-2008 the UK government is aligning the planning and budgeting cycle for the NHS with the timetable for local government planning and budget-setting. Finally, the strategy is rooted in a stronger local commissioning so as to get the best out of public resources to improve local people’s well-being and independence, it states that ‘[t]he main responsibility for developing services that improve health and well-being lies with local bodies: PCTs and local authorities’ (Department of Health, 2006: 44).

**Box 26. Partnerships for Older People Projects (POPPs)**

As part of the efforts to build a culture of prevention, the UK government intends to expand evidence base investment in a number of areas, in particular the Partnerships for Older People Projects (POPPs). They are a two-year programme of work led by the Department of Health with £60 million ring-fenced funding (£20 million in 2006/07 and £40 million in 2007/08) for local authority-based partnerships to lead pilot projects to develop innovative ways to help older people avoid emergency hospital attendance and live independently longer. The overall aim is to improve the health, well-being and independence of older people.

POPPs are expected to provide examples of how innovative partnership arrangements can lead to improved outcomes for older people, particularly with respect to reduced hospital admissions and residential care stays. They bring together a range of interventions that have a combined potential to provide a sustainable shift of resources and culture towards prevention across the whole health and care system.

Source: Department of Health (2006), Our health, our care, our say: a new direction for community services.

Indeed, most PCTs directly provide community health services themselves. They employ about 250,000 staff directly, including district and community nurses, community midwives, health visitors, speech and language therapists and physiotherapists. The goal of the strategy is that health and social care services be provided in a more local and convenient setting. As the population ages over the coming decades, it will impose ever greater demands on the health care system. A strategy centred on high-cost hospitals will be inefficient and unaffordable compared to one focused on prevention and supporting individual well-being in the community. Since no increases in expenditure are forecasted, the health service needs to focus even more strongly on delivering better care with better value for money.

In order for specialist care to be delivered more locally, UK authorities are developing a new generation of modern NHS community hospitals that will provide diagnostics, day surgery and outpatient facilities closer to where people live and work. Community hospitals are expected to provide integrated health and social care services to the local community complementing more specialist hospitals, serving catchment areas of roughly 100,000 people, but taking on more complex procedures. Until 2006, there were around 350 community hospitals in England supported by community-based professionals and most of them are owned and run by PCTs.

**The Use of Arm’s Length Bodies to Improve Health Service Provision**

In order to push the reform of the provision of health and social care services forward, the DH is reducing in size by over a third by reconfiguring its network of organisations known as Arm’s Length Bodies (ALBs). ALBs are stand-alone national organisations sponsored by the DH undertaking executive functions, their work ranges from back office administrative functions to complex ethical or clinical-related work. ALBs were created to regulate the system, improve standards, protect public welfare and support local services. However, they have been associated with bureaucratic burdens and the lack of coordination across the different health bodies. Hence, in 2004, the DH began a reconfiguration of its ALBs looking specifically at the work they carried out and for ways in which overlapping and duplicated
functions could be removed, where back-office functions could be rationalised and where bodies could be merged. Box 27 summarises the principles that guided the reconfiguration of the ALBs.

<table>
<thead>
<tr>
<th>Box 27. Key principles for ALB sector</th>
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<tr>
<td>The UK government through its Department of Health developed ten principles to apply in the reconfiguration of the Arm’s Length Body (ALB) sector:</td>
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<td>4. Devolution to the frontline: functions will only be exercised at the national level where it makes the most sense.</td>
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<td>5. Contracting out to the independent sector will only be considered where a case for national functions rests on economies of scale.</td>
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<td>6. The number of ALBs will be kept to the necessary minimum.</td>
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<td>7. Where an ALB is needed now but not in the long term it will be set up for a fixed term.</td>
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<td>8. Setting policy is the role of DH not ALBs.</td>
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<tr>
<td>9. ALBs will be expected to undertake their functions effectively with the minimum bureaucratic burden on the service by working together under a whole system perspective, focusing on outcomes and not on processes.</td>
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<tr>
<td>10. Back office functions will maximise economies of scale while meeting the support needs of each ALB.</td>
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<tr>
<td>11. Where ALBs provide services they will need to be more responsive to their customers. For the NHS, the Top Team forum (of DH and NHS leaders) will maintain an overview of added value and responsiveness of each ALB.</td>
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<tr>
<td>12. ALBs will not be funded centrally for the services they provide to frontline organisations or the overheads they incur. Regulatory ALBs will seek full cost recovery wherever appropriate.</td>
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<td>13. ALBs will be expected to locate outside London and the south East wherever possible.</td>
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<td>Source: Department of Health (2004), Reconfiguring the Department of Health’s Arm’s Length Bodies, p.7</td>
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The expected benefits of this new approach are less bureaucracy, streamline ALB sector and reduce intervention by ALBs, and an appropriate sponsoring and commissioning relationships for ALBs. As a result of the reconfiguration, the relationship between the DH and the ALBs varies depending on the function of the ALB and its statutory form. The DH has considered the ALBs within four categories:

- **Regulation** – ALBs in this category hold the health and social care system to account. They often have their own primary powers and substantial independence from direction by the Secretary of State but the DH remains sponsor.

- **Standards** – ALBs in this category establish national standards and best practice. In order to reflect devolution, the sponsorship role is shared with the NHS Top Team.

- **Public welfare** – ALBs in this category are focused primarily on safety and the protection of public and patients. DH’s sponsoring role is derived from central government’s responsibility to secure public welfare, and prevent unnecessary deaths and harm, in the face of challenges that can range between local, national and international settings.

- **Central services to the NHS** – ALBs in this category provide economies of scale and focused expertise. Services can be commissioned by the recipients of the services and run with commercial discipline. Commissioning is overseen by the NHS Top Team, either itself or using a lead Strategic Health Authority.
The DH develops networks around these four categories to enable ALBs, the Department and others to engage together in strategic discussions, plan ahead and resolve problems. Moreover, the DH has developed a risk-based approach to managing its relationships with the ALBs. This reconfiguration considered 42 ALBs undertaking national functions sponsored by the DH. In 2003-04, ALBs spent a total of £4.8 billion, including operating costs of £1.8 billion, and employed around 25,000 people. As a result of the review it is expected that by 2007-08 at least £0.5 billion would be reduced in expenditure on ALBs. These savings can largely be associated to a reduction in the number of posts in the ALB sector of about 25%.
Table 30. Summary of the reconfiguration of the ALBs

<table>
<thead>
<tr>
<th>Category</th>
<th>Long Term ALBs</th>
<th>ALBs whose functions will be taken on by other ALBs or removed from the ALB sector</th>
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<tbody>
<tr>
<td><strong>Regulation</strong></td>
<td>• Healthcare Commission</td>
<td>Mental Health Act Commission</td>
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<td></td>
<td>• Independent Regulator of NHS Foundation Trusts</td>
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<td></td>
<td>• Commission for Social Care Inspection</td>
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<td></td>
<td>• Regulatory Authority for Fertility and Tissue</td>
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<td></td>
<td>• Council for Regulation of Health Care Professionals</td>
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<td></td>
<td>• General Social Care Council</td>
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<tr>
<td></td>
<td>• Postgraduate Medical Education and Training Board</td>
<td></td>
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<tr>
<td></td>
<td>• Medicines and Healthcare products Regulatory Agency</td>
<td></td>
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<tr>
<td></td>
<td>• Human Fertilisation and Embryology Authority</td>
<td></td>
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<tr>
<td></td>
<td>• Human Tissue Authority</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dental Vocational Training Authority</td>
<td></td>
</tr>
<tr>
<td><strong>Standards</strong></td>
<td>• National Institute for Clinical Excellence</td>
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<td></td>
<td>• Health Development Agency</td>
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<tr>
<td><strong>Public Welfare</strong></td>
<td>• National Patient Safety Agency</td>
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<td></td>
<td>• Health Protection Agency</td>
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<td></td>
<td>• National Treatment Agency for Substance Misuse</td>
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<tr>
<td><strong>Central Services</strong></td>
<td>• Blood and Transplant Authority</td>
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<td></td>
<td>• NHS Litigation Authority</td>
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<td></td>
<td>• NHS Appointments Commission</td>
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<td>• NHSU</td>
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<td></td>
<td>• Health and Social Care Information Centre</td>
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<td></td>
<td>• National Programme for IT</td>
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<tr>
<td></td>
<td>• NHS Business Services Authority</td>
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<tr>
<td></td>
<td>• NHS Purchasing and Supply Agency</td>
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<tr>
<td></td>
<td>• National Clinical Assessment Authority Commission for Patient and Public Involvement in Health</td>
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<tr>
<td></td>
<td>• Public Health Laboratory Service</td>
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<td></td>
<td>• National Radiological Protection Board</td>
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<tr>
<td></td>
<td>• National Biological Standards Board</td>
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<tr>
<td>Source: Department of Health (2004), Reconfiguring the Department of Health's Arm's Length Bodies, p.37</td>
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**Using Market-type Mechanisms for Public Service Delivery – the use of public-private partnerships**

The private sector is largely involved in providing public services in the UK. Public-Private Partnerships (PPPs) are the most recurrent market-type mechanism of service delivery. This organisational arrangement requires that the public and private sectors work together in partnership to better deliver services to the population; they cover all types of collaboration across the interface between the public and private sectors to deliver policies, services and infrastructure. The most common form of PPP used in the UK is the Private Finance Initiative (PFI) which forms part of the government’s strategy for delivering high quality public services.
PFI is only used when the criteria of efficiency, equity and accountability are likely to be met and where clear value for money is ensured, without sacrificing the terms and conditions of staff. The advantage of using PFI is that by requiring the private sector to put its own capital at risk and to deliver clear levels of service to the public over the long term, PFI helps to deliver high quality public services and ensure that public assets are delivered on time and to budget. In 2000, the UK government created an operational taskforce to manage the PFI on behalf of HM Treasury, based in Partnerships UK (PUK).

PUK is a public-private partnership formed out of HM Treasury to bridge the gap between public and private sectors to support and accelerate the delivery of infrastructure renewal, high quality public services and the efficient use of public assets through better and stronger partnerships between the public and private sectors. PUK supports individual projects before, during and after procurement; assists government in developing policy and monitoring compliance; enhances the delivery of investment in public services; and supports the commercialisation of public sector assets. PUK intends is to accelerate the development, procurement and implementation of PPPs where corporate responsibility with the public sector is central.

PUK in itself is a public-private partnership as it has an arm’s length relationship with the treasury, operational independence, and 51% private sector equity ownership, with the balance owned by the HM Treasury and the Scottish Executive. PUK was established on a commercial but non-profit maximising basis to introduce a cultural shift in the way that PPP support is provided within the public sector. PUK only works with the public sector to improve its procurement and service delivery capability. It provides senior strategic support to public bodies, sharing responsibility for delivering successful partnership solutions, from the appointment and management of advisers to the scoping, development, troubleshooting and negotiation of value for money projects. PUK shares risk with its public sector partners by investing its own capital and human resources in projects and programmes. In that sense, PUK has established Framework Agreements with most government departments to allow services to be procured quickly and efficiently including agencies and trading funds. PUK is generally engaged on a sole tender basis or through a Development Partnership Agreement.

PUK operates in a number of areas such as commercialisation, housing, justice and custodial, public services, transport, health, education among others. For instance, it assists public sector bodies such as the Department of Health in England, NHS Trusts and Primary Care Trusts introduce investment so that the government can succeed in modernising the National Health Service (NHS) to deliver new and improved health services. PUK’s health activities have been focused on very large hospitals such as the London NHS Trust and on creating and implementing, with the Department of Health, the NHS Lift programme for investing in primary care premises. PUK acts as a co-sponsor of the investment with public bodies, jointly determining and implementing the chosen procurement policy. The aim is to bolster client-side skills so that procurement of a project or programme is more efficient and effective.

In the area of education, PUK has supported PPPs projects such as Building Schools for the Future (BSF) which focused on rebuilding and renewing every secondary school in England. Moreover, PUK is a 50% partner in Partnerships for Schools, the non-departmental public body set up by the Department for Children, Schools and Families to deliver the BSF programme.

**Involvement of the Voluntary Sector in Public Service Delivery**

The ‘third’ or ‘voluntary’ sector in the UK is a key partner in a mixed economy of public service provision, alongside the public and private sectors. It comprises a wide range of organisations from community groups to social enterprises and charities. These organisations are non-governmental and value-driven; and reinvest surpluses to further their social, environmental or cultural objectives. The third sector has often led the way in developing more community-focused services in a wide range of areas from drugs counselling to giving employment advice and providing housing and childcare. Their work is conducted in
partnership with the public sector. The public sector spends around £10 billion a year on funding the third sector to deliver public services.

In 2006, the UK government created the Office for the Third Sector (OTS) which is part of the Cabinet Office in recognition of the increasingly important role the third sector plays in society and in the economy. The third sector is not limited to be a public service provider but a government’s partner in innovation; a partner in designing services and a campaigner for change. The OTS aims to increase public service delivery by the third sector; hence in December 2006 it published the white paper *Partnership in Public Services – an action plan for third sector involvement* which sets out four different areas of government’s engagement with the third sector.

1. **Improving commissioning.** The National Programme for Third Sector Commissioning aims to improving the working relationships between commissioners and the third sector through the development of their skills, expertise and understanding of the sector. This programme has three work streams: a) identifying the commissioners to be trained and matching them to the appropriate training; b) convincing commissioners across public services on the value of using the third sector throughout the whole commissioning cycle; and c) improving the bidding capacity of the third sector. In that sense, the programme sets out eight principles to improve commissioning in general and the experience of the third sector in particular (Box 28).

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Box 28. Principles for improving commissioning

The government believes that all commissioners of services should:
- develop an understanding of the needs of users and communities by ensuring that, alongside other consultees, they engage with third sector organisations as advocates to access their specialist knowledge;
- consult potential provider organisations, including those from the third sector and local experts, well in advance of commissioning new services, working with them to set priority outcomes for that service;
- put outcomes for users at the heart of the strategic planning process;
- map the fullest practicable range of providers with a view to understanding the contribution they could make to delivering those outcomes;
- consider investing in the capacity of the provider base, particularly those working with hard-to-reach groups;
- ensure contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers, including considering sub-contracting and consortia-building where appropriate;
- seek to ensure long-term contracts and risk sharing wherever appropriate as ways of achieving efficiency and effectiveness; and
- seek feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs.

Source: Office of the Third Sector (2006), Partnerships in public services - an action plan for third sector involvement, p.17
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In order to ensure these principles are met, the UK government intends to: i) embed good practice through commissioning frameworks; ii) improve skills and systems for commissioning from the third sector; iii) ensure that the widest range of organisations, including those from the third sector, can be involved in service delivery; and iv) support commissioning that recognises the wider impact of the third sector. The goal of these actions is to increase the number of third sector organisations involved in service delivery. One of the reasons for this is that smaller third sector organisations, particularly those rooted in the local community, have an expert perspective.
on the needs of local people and how to approach them. Moreover, third sector organisations often have very high levels of public trust, confidence and affection.

2. **Improving procurement.** This area aims to ensure that contracting and procurement processes are fair and proportionate. The use of social clauses constitutes a way for commissioners to promote added social value in public service delivery contracts. For providers, including third sector organisations, social values can be a way of recognising the wider social benefits they bring within a procurement exercise. For instance, a social clause in a public contract could prioritise the need to train or give jobs to the long-term unemployed in the community as part of the contracting workforce. The UK experience in using social clauses has identified some barriers such as their complexity, suppliers’ expectations and maintaining updated the legal position. Moreover, the UK government is working to reduce the burden of the contracting process on both public bodies and providers using template contracts. Central government departments have been identifying and reducing the burdens they place on third sector organisations. For example, the Charities Act 2006 has a number of deregulatory measures which will particularly help small charities, such as the new threshold for charity registration, up from £1,000 income a year to £5,000.

3. **Improving the third sector’s capacity.** In order to support third sector organisations to deliver public services, the UK government established a government-funded investment programme called *Futurebuilders*. This programme includes loans, grants and capacity building support. Since April 2008 the programme supports and is open to all third sector organisations, meaning that a greater range can get involved in delivering services with the support from the government. Moreover, as the third sector often has innovative ways of working, this is an opportunity to learn from its experience and encourage innovation. In that sense, the OTS-funded Innovation Exchange has been launched with a new approach to connecting third sector innovators and providers of investment. The Innovation Exchange is focusing initially on supporting independent living and excluded young people.

4. **Improving accountability.** In order to ensure the role of the third sector in holding services to account, the UK government is supporting the third sector to develop its role in giving local people a greater say in the delivery of their services and is identifying ways to strengthen channels to help the public to hold services to a greater level of accountability.

Furthermore, government departments have been developing additional ways for the third sector to work on partnership with them at national, regional and local level. Many central government departments already have in place or are currently developing third sector-specific strategies. This is because for the UK government, the third sector is a crucial part of the strategy to build more cohesive, empowered and active communities. Many of the delivery agreements, targets and indicators outlining how improvements will be achieved, recognise the contribution of the third sector.
The Department for Communities and Local Government (CLG) is introducing a new local performance framework for local government which focuses on improving people’s quality of life and creating better public services. It requires a new way of working, where public sector organisations work together to achieve better, more responsive services for local people, and where the public, private and third sectors strive together for improved prosperity with plenty ambition for the future. The framework lays out how central and local government can agree priorities for an area and work together to deliver them, involving local people in decisions about services and how they are delivered.

The Association for Public Service Excellence (APSE), for instance, is a not for profit local government body working with over 300 councils throughout the UK promoting excellence in public services. APSE is a specialist body in local authority front line services, hosting a network of front line service providers in areas such as waste and refuse collection, parks, environment services, leisure, school meals, cleaning, housing and building maintenance. It focuses on the delivery base on the idea that what matters to citizens the most is how well they receive their local services.

The role of the third sector in public service delivery has been highlighted by the Charity Commission, the independent regulator for charitable activity in England and Wales, which has found that charities have a growing participation in public service delivery, particularly in the areas of health and social care. The results of its 2006 survey showed that 30% of the more than 3,800 charities that took part in the survey currently deliver services to, or on behalf of, a public authority. Charities with higher incomes are more likely to deliver public services. Indeed, of the charities delivering public services, 62% reported to have an income above £500,000 and in contrast, only 8% of the charities with incomes below £10,000 deliver public services.

The provision of health and social care services account for almost one-third (31%) of the total public services delivered by charities, followed by education (15%) and children’s care (14%). However, the Charity Commission found that 46% of the charities that deliver services in England and Wales do so in more than one category of public services. Moreover, the results of the survey showed that 75% of the charities that provide public services have a local (within one county or city) or regional (across more than one county) basis. According to the Charity Commission this highlights that the majority of charities delivering public services are likely to be contracting with locally based public service commissioners such as local authorities and primary care trusts. Indeed, a mixture of grants, contracts and service level agreements is the most common funding arrangement for charities delivering services in the England and Wales (37%). The Office of the Third Sector in the Cabinet Office reported that in many public service areas contracts are awarded through a prime contractor model, whereby a lead organisation offers sub-contracts to other, generally smaller, organisations. In the right circumstances, this practice allows small third sector organisations to access markets from which they would otherwise be excluded. Nonetheless, the experience of the UK suggests that cultural barriers and the transfer of risk and cost from lead providers have led to a mixed experience of sub-contracting.

Conclusions

There is little evidence that demographic changes have triggered reforms to adjust the public service delivery system in the UK. Although ageing is indeed considered as a driver for some reform initiatives, it is not the most determinant factor that leads the whole reform effort. However, the strategy adopted to improve public service provision is one of the most ambitious and complete among those studied in this project as it includes institutional as well as organisational changes to rearrange the system of public service delivery.
The strengths of the reform strategy lie in its whole-of-government approach to include not only horizontal coordination among ministries and arm’s length bodies but in enhancing cooperation with lower levels of government and voluntary sector in the provision of public services, particularly health and social care. This is of particular importance because the UK experience suggests that co-terminosity is a factor that facilitates joint working. In other words, the fact that public, private and third sector organisations share the same boundaries and risks in service provision and operate, to a large extent, on a one-to-one basis makes possible the ability to evolve and share common services and provides real opportunities for well-planned, joined-up services around the same population in the same local area. Moreover, this strategy also aims at reinforcing local governments in their role as service providers of public services as this approach facilitates community planning through the creation of an environment for collaboration and makes the management of financial resources more efficient. However, as local governments do not always have enough capacity to meet people’s demands for public services, a greater collaboration with the private and third sector has been deemed as crucial. Hence, greater co-terminosity between local bodies (PCTs and local authorities), private and third sector organisations is a key element for the success of this strategy.

Furthermore, the UK experience offers a different alternative on how to face demographic changes by encouraging a culture of prevention. Although the UK population is ageing its implications for the public service delivery system are to be felt in the medium and long-terms; therefore, a culture of prevention seems to be a plausible way to face the challenges ageing will pose on public services, particularly on health and social care.

The UK strategy, however, still faces some challenges in the management of its reform programmes. For instance, a clear and strong leadership will be necessary to make all public, private and third sector organisations to work as a team. This raises the question whether public managers have the necessary leadership and managerial skills to interact with their private and third sector counterparts. Moreover, it is not clear in the UK strategy the implications it will have on the human resource management system. None of the reform programmes reviewed for this study considers a reallocation of staff across ministries, sectors or levels of government where the demand for public services has increased due to ageing. It is also unclear whether there is any action plan to allow or facilitate internal and external mobility of staff to respond more effectively to the new demands for public services.
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