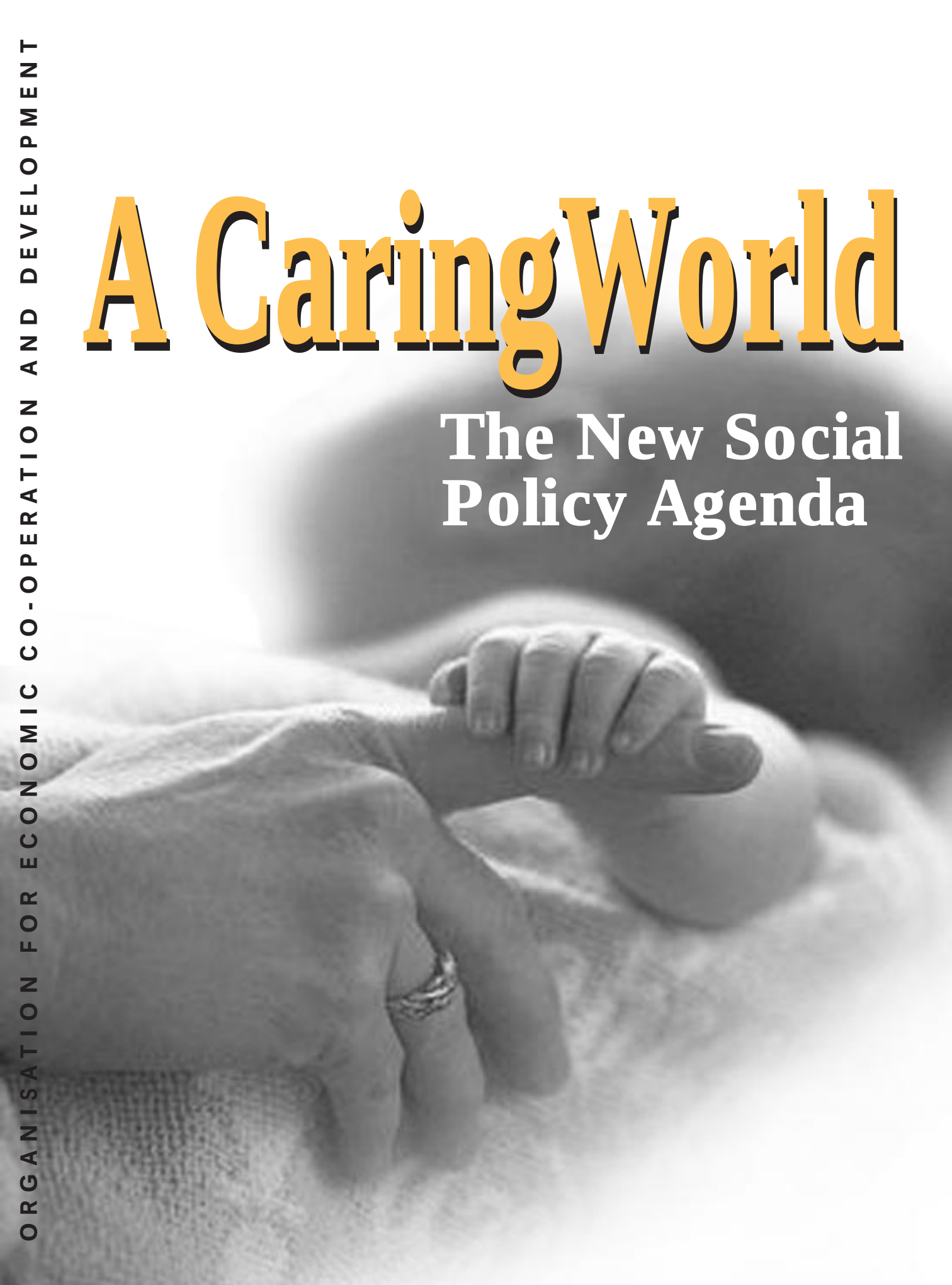
ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

A Caring World

The New Social Policy Agenda



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Publié en français sous le titre :
POUR UN MONDE SOLIDAIRE
Le nouvel agenda social

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Preface

by
Donald J. Johnston
Secretary-General of the OECD

Since I became Secretary-General in 1996, I have been promoting what I call a "triangular policy paradigm" for the OECD which gives proper recognition to each of the three crucial elements of progress, namely, economic growth, social stability and good governance. In the future, the continued economic development of our increasingly knowledge-based economies will be closely tied to our capacity to keep this paradigm in balance, with human capital being one of the driving forces of economic growth. Therefore, the adaptability and capacity of our populations to respond quickly to accelerating change is critical. In June 1998, Social and Health Policy ministers met in Paris to discuss the issues raised in this volume – the importance of effective social and health policies in promoting a healthy, well-educated population, which has the confidence to embrace, rather than resist, change. Effective social policies promote not just the sound social development of our countries, but underpin economic development as well.

Reforming social protection systems can be a dangerous exercise for politicians, with voters ready to punish governments which move ahead of public opinion. Nevertheless, when I look across OECD countries, I see a range of fascinating policy experiments, as governments try to promote employment and employability, especially for the less-skilled and the long-term unemployed, whilst ensuring families have an adequate income. When Labour Ministers discussed the theme of "employment-oriented social policies" at the OECD in 1997, they concluded that some programmes have proved effective in getting people back to work and many other countries are in the process of developing and implementing such policies. The next few years will show whether employment-oriented social policies are indeed the key (along with a strategy of life-long learning) to ensuring that all can contribute to and benefit from our increasingly efficient – but also increasingly demanding – economies.

Boldness needs to be shown in addressing the challenges posed by population ageing. Reforming old-age pension systems is necessary, but not sufficient to prepare our societies for a demographic structure which will be very different from that existing when systems of social protection were first developed. We at the OECD have been arguing the case for an "active ageing" approach – one in which policies support learning, working, caring and leisure throughout the life course, not just when people reach a particular age.

In health policy, too, a new paradigm is needed. The reforms which many OECD countries have introduced over the past decade have been relatively successful in stabilising the ratio of health spending to GDP. But we do not yet have a full understanding of the policies needed for further sustained increases in population health status at an affordable price. I see this as a major challenge facing all OECD countries.

People are demanding more from government. That is understandable; the current economic and social environment is in many respects perceived as harsher and more unforgiving to the less successful or less healthy than it has been since current systems of social protection were introduced. In response, I believe that we can see emerging across OECD countries a new balance in the rights, obligations and opportunities of individuals and all the different institutions involved in social protection, including developments such as "workfare", "patients' charters", a more responsive public sector and the greater involvement of the private sector and not-for-profit organisations in the delivery of social policy. This is a novel direction in social and health policy. *The new social policy agenda* is how to achieve social solidarity through enabling individuals and families to support themselves.

Acknowledgements

This report sets out some of the challenges to systems of social protection arising from social, demographic, fiscal and labour market trends and outlines the ways in which policies can be adapted in order to meet these challenges. It is based on contributions from Willem Adema; Tetsuya Aman; Libbie Buchele; Stéphane Jacobzone; Melissa Jee; David Kalisch; and Marco Mira d'Ercole. Mark Pearson co-ordinated the production of the report. This work was aided by extra-budgetary support from the governments of Australia, Japan and the United States. It is published on the responsibility of the Secretary-General of the OECD.

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Part I

UNDERSTANDING THE CONTEXT OF SOCIAL POLICIES

Chapter 1

The Economic and Social Context

1. Introduction and main findings

With few exceptions, systems of social protection are still recognisably the same as they were some forty or fifty years ago. They still revolve around cash support to individuals who are temporarily absent from the labour market, and ensuring that those who are elderly receive an adequate standard of living. Some form of contributory principle exists in most countries, with those who earn more contributing more, and in return receiving more when and if they become jobless. Yet much has changed subsequent to this framework being adopted. This chapter provides a summary of the long-term trends which are requiring a new approach to social and health policies. The key messages are:

- People are living longer. Dependency ratios will rise.
- The increase in elderly people living alone raises the demand for care services.
- The proportion of children in lone-parent families has risen.
- The increase in dual-earner households, caused by increased female labour force participation, makes child care and parental leave policies more important for the well-being of families.
- Fertility rates have fallen. Those countries with the highest female employment rates are those with higher completed fertility rates. Labour market developments appear to strongly influence family formation.
- Low-skilled workers have a higher risk of unemployment, other forms of non-employment, or low wages insufficient to support their families.
- People are leading healthier lives because of declining disability. Demographic changes will nevertheless lead to an increase in demand for health services unless remedial action is taken.
- Previously fatal illnesses are being converted into chronic conditions, implying a need for long-term support.

2. Demographic and social trends

2.1. Dependency ratios

Declines in fertility rates, increased life expectancy at birth and falling mortality rates have led to population ageing. Dependency ratios (here defined as being the sum of those aged over 65 and under 15 as a proportion of the population of working age) have fallen in many countries as the "baby-boom" generation reached working age (Table 1.1). In Germany and Japan, this ratio fell to 45 per cent or less. Population ageing means that OECD countries are at the end of a period which saw a steady increase in the share of 15-64 year-olds in the total

Table 1.1. **Dependency ratios,[1] 1960-2030**

Percentages

	1960	1990	2000	2010	2020	2030
Australia	62.8	49.4	48.9	48.4	54.7	61.8
Austria	51.9	47.9	46.0	44.5	49.0	62.1
Belgium	55.0	49.7	51.0	49.5	56.8	68.0
Canada	69.6	47.0	46.8	45.1	54.8	67.6
Czech Republic	53.3	51.4	43.3	41.0	48.6	50.9
Denmark	55.8	48.4	50.0	52.5	57.3	65.0
Finland	60.3	48.6	49.1	50.1	62.8	69.9
France	61.3	52.1	52.9	50.5	59.0	67.5
Germany	48.8	45.0	45.4	47.3	49.8	62.1
Greece	53.2	49.1	49.5	52.4	56.0	62.7
Hungary	52.4	50.5	46.0	44.2	49.9	51.3
Iceland	74.3	54.9	53.8	51.7	55.0	62.1
Ireland	73.2	63.1	48.2	47.5	55.5	56.8
Italy	51.7	45.3	46.8	49.7	54.4	66.9
Japan	56.1	43.7	46.4	56.0	65.6	67.4
Korea	82.7	44.6	38.9	40.3	41.6	52.5
Luxembourg	47.4	44.9	47.8	49.3	55.0	64.3
Mexico	98.4	74.0	61.0	52.4	48.1	49.1
Netherlands	63.9	45.1	46.6	45.8	54.1	68.5
New Zealand	71.0	52.7	52.4	50.3	53.8	58.9
Norway	58.7	54.5	53.5	51.4	57.7	64.7
Poland	64.6	54.3	46.3	42.8	51.1	54.5
Portugal	59.1	50.6	48.1	49.3	52.1	58.8
Spain	55.4	49.5	46.2	46.9	50.0	60.2
Sweden	51.4	55.6	55.6	55.0	63.3	69.0
Switzerland	50.8	45.4	46.8	47.2	54.5	70.3
Turkey	81.1	64.7	52.2	48.4	45.4	48.5
United Kingdom	53.7	53.5	52.9	51.1	57.5	66.1
United States	66.7	52.2	51.1	48.0	56.2	64.5
OECD	61.6	51.6	49.6	48.9	53.8	60.7

1. Dependency ratios: population aged 0-14 and 65 and over as a percentage of the working-age population.
Source: United Nations (1996), medium variant estimates.

population. Dependency ratios in most countries are set to rise over the next 30 years, with some countries showing particularly sharp increases after 2010. In contrast, in countries which are relatively young (*e.g.* Mexico) dependency ratios are still high, but are projected to fall.

This renewed increase in dependency ratios is being fuelled mainly by life expectancy gains at advanced ages (see below). These gains are evidence of the positive effects of the general economic and social changes in OECD countries which reflect, overall, an improved level of well-being in terms of quality of life and access to good health care. Nevertheless, they alter social needs with the emergence of four-generation families (children, parents, grandparents and great-grandparents) replacing the three generation model of the second half of this century. The proportion of the population in aged groups with a high risk of requiring care will rise. Finally, the decline in the proportion of the population aged 15-65 raises issues about the financing of expenditures targeted at meeting social needs, whether through public or private interventions.

2.2. Gender, family formation and lifestyles

The gender dimension[1]

Social policies based on the male-breadwinner model of family relations have become outmoded. In particular, the pursuit by women of labour market careers interacts in a complex

manner with traditional, insurance-based social protection systems. First, the growth in female labour force participation itself provides a form of self-insurance to households, with the income risks attached to involuntary non-employment reduced. Second, working women become entitled to insurance-based benefits in their own right. Third, demands increase for some sorts of social support (in particular, child care, and maternity and paternity leave).

The extent to which female labour market experience differs from that of males is considered in the next section. Here it suffices to note that the effects of labour market insecurity and the desire for career development have led to family formation being deferred until education and integration into the labour market has been completed (see Table 1.2). Age at first marriage and at first childbirth are both increasing. Families are formed when parents have received more education and when one or – increasingly – both members of a couple are more securely established in their careers.

Table 1.2. **Age of women at first childbirth**

	1970	1980	1990	1993
Australia[1]	23.2	25.3	27.6	28.3
Austria	..	..	..	25.0
Belgium	..	..	26.0	..
Canada	23.1	24.6	26.4	26.8
Czech Republic	22.5	22.4	22.4	22.3
Denmark	23.2	24.1	..	26.7
Finland	..	..	26.3	26.7
France	23.8	25.0	27.0	27.6
Greece	..	..	..	25.7
Iceland	..	..	..	24.3
Italy	..	24.4	26.2	26.9
Japan	25.6	26.4	27.0	27.2
Korea	28.2	24.4	25.9	26.3
Netherlands	..	27.5	29.2	27.8
New Zealand[2]	..	24.9	27.6	28.7
Norway	..	..	..	25.5
Portugal	24.4	23.6	24.7	25.2
Spain	..	..	26.0	27.1
Sweden	24.8	25.0	25.8	26.5
Switzerland[3]	25.1	26.4	27.6	28.1
United Kingdom	..	24.6	26.6	27.5
United States	25.4	25.7	26.3	26.4

.. Data not available.
1. Data for 1971 and 1981.
2. Data relate to live births in current union only. Data are for 1981, 1991 and 1995.
3. Married women only.

Sources: EU members: Eurostat (1996); Australian Bureau of Statistics, *Social Trends;* Statistics Canada; Czech Ministry of Labour and Social Affairs; National Statistics Office, Republic of Korea, *Annual Report on the Vital Statistics*; Japanese Ministry of Health and Welfare, *Vital Statistics;* Statistics Netherlands, *Statistical Yearbook;* Portuguese Ministry for Skills and Employment; Statistics New Zealand; United States National Center for Health Statistics, *Annual Report on Vital Statistics.*

Even after marriage or first childbirth, completion of family formation is further deferred in the light of employment and child-care opportunities. It can even be deferred indefinitely, so that completed family size falls.[2] United Nations projections of world population state that although population growth will continue in most countries outside Europe, according to their medium-fertility scenario, countries in southern Europe, the Czech Republic, Poland and Japan will show declines in population through the 1990s.

Chart 1.1 illustrates the major changes in female life-patterns. Fertility has declined sharply and labour force participation increased substantially. Furthermore, the cross-country relationship between the two has changed. Up until the 1970s, the level of completed fertility was negatively related to the level of women's labour force participation. Now, completed family size is lowest in countries where women's labour force participation rate is lowest.[3] Although such simple comparisons do not prove that increasing female labour force participation will inevitably increase fertility rates, they do suggest that child-rearing and paid work are *complementary*, rather than *alternative* activities. Indeed, exception proves the rule – the sharp fall in fertility in Sweden in recent years following a steep rise in unemployment does not seem to be coincidental.

Young people appear to be deferring both marriage and childbirth until they can achieve economic autonomy – and this is taking longer (see Chapter 4). In addition, entry-level jobs often do not confer full entitlement to health insurance or maternity leave which are the supports most needed by families with children. Postponement of family formation in such circumstances is no surprise.

The decline in fertility, even if it reflects only deferment of family formation, when generalised across a community, will have wide social and economic consequences:

- There will be a fall in the future ratio of working-age to retirement-age adults.
- A smaller cohort will be moving through the education system.
- Intergenerational ties may be changed. There may be more grandparents than grandchildren, with consequences both for the informal care of children and the frail elderly.

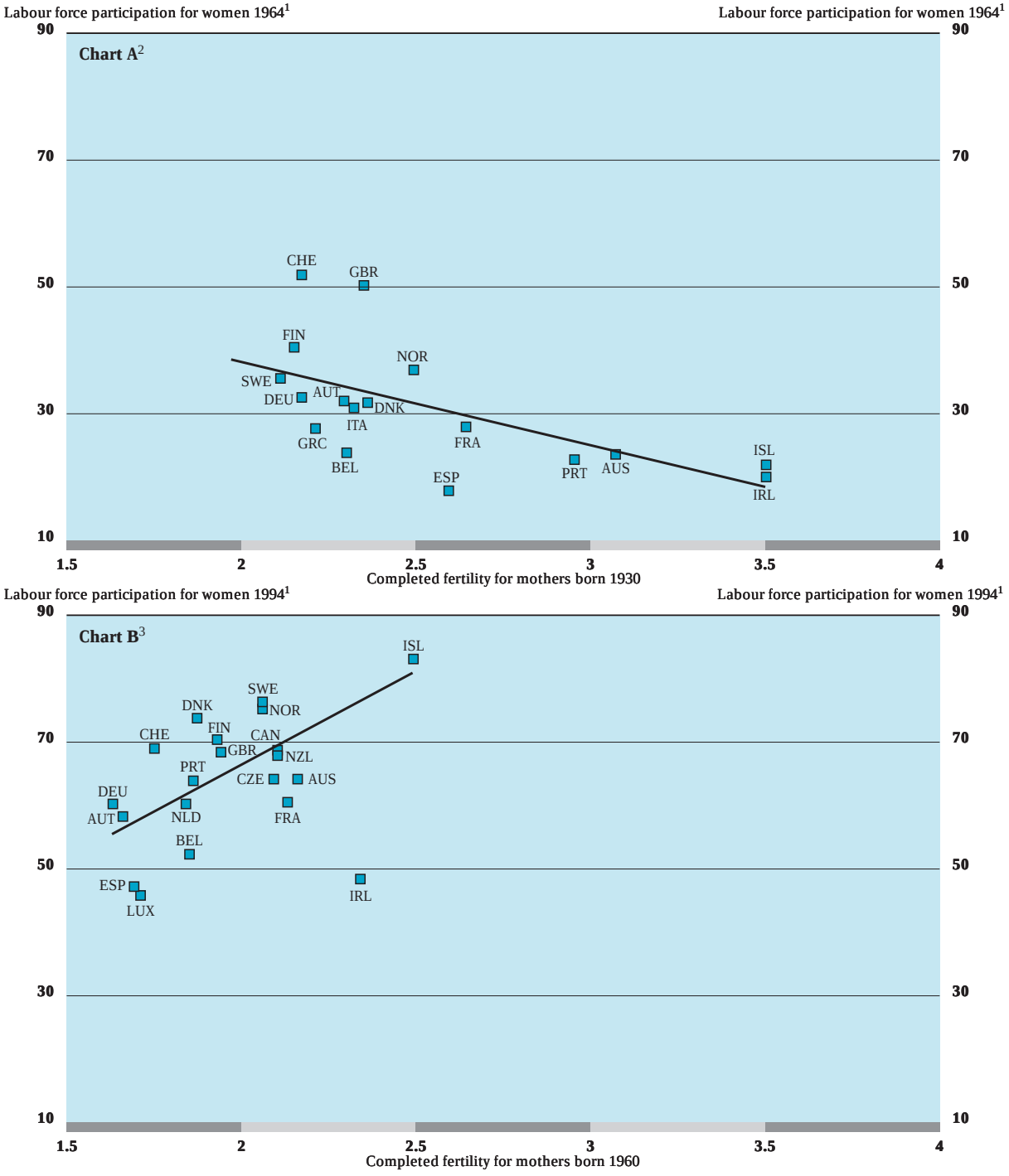
Growing instability of marriage and the father-child relationship

There is a growing proportion of children living with only one parent, and a growing number of women acting as the only, or main, responsible parent both for care and for maintenance.[4] National rates of lone parenthood vary: children in Canada, Great Britain, Sweden and the United States are more likely to be in lone-parent families than those in France or Germany, and far more likely than in Italy, Portugal or Spain (OECD, 1997*c*). Nonetheless, the increase in the number of lone-parent families is general.

The proportion of children living in one-parent households in the United States rose by a factor of 2.5 between 1960 and 1986. However, this trend increase slowed in the 1990s (Table 1.3). The proportion of lone-parent families in total families is 20 per cent or more in many countries. If the rate of separation and divorce is the main factor in the increase in the proportion of lone-parent families in recent years, the growth in the number of children born outside marriage is an important secondary factor. With the exception of the Mediterranean countries, the number of children born to unmarried mothers has increased substantially in recent decades: for example, in the United Kingdom one-third of all births are to unmarried mothers, in Ireland one in six. The proportion is also high in the United States and in the Scandinavian countries, although in the latter a substantial proportion are born to cohabiting parents (Roussel, 1989; CEC, 1994). It is also noticeable that the likelihood of lone parenthood at some stage appears greater where there has been early child-bearing, whether in or out of marriage.

Lone mothers must carry the dual responsibility of being the main breadwinner and the main carer wishing to enter the labour market where caring responsibilities may not be recognised, and in the face of social arrangements which often continue to take for granted the flexibility and availability of a mother's time (*e.g.*, the time schedule of schools, the offer of child-care services, the opening hours of shops, public offices, etc.).

Chart 1.1. **Relationship between completed fertility and female labour force participation**



1. Participation rates refer to 1968 for Austria and Finland, 1969 for Switzerland, 1965 for Denmark, 1961 for Greece, 1966 for Ireland and 1970 for Spain.
2. Correlation (outlier Ireland excluded) between fertility 1930 and female labour force participation 1964 is -0.61 (Adjusted R Squared = 0.42).
3. Correlation between fertility 1960 and female labour force participation 1994 is 0.68 (Adjusted R Squared = 0.33).

Sources: OECD, *Labour Force Statistics*, Part III (1998); Part II (1974); EUROSTAT (1996).

Table 1.3. **Recent trends in the number of lone-parent families**

		Number	Index[1]	Incidence[2]			Number	Index[1]	Incidence[2]
Australia	1983	296 025	100	13.6	Japan	1980	1 480 000	100	8.9
	1993	417 420	141	17.2		1995	2 120 040	143	12.8
Austria	1981	257 276	100	19.3	Korea	1985	593 840	100	8.8
	1991	282 102	110	19.7		1995	743 900	125	8.5
Belgium	1981	252 096	100	14.6	Luxembourg	1981	8 946	100	14.1
	1991	362 000	144	20.0		1991	11 000	123	15.7
Canada	1981	..	..	..	Netherlands	1981	294 543	100	11.9
	1991	954 710	..	20.0		1991	388 000	132	15.9
Denmark	1981	144 704	100	18.0	New Zealand	1981	..	..	..
	1991	131 000	91	18.0		1996	148 000	..	25.5
Finland	1983	100 000	100	13.0	Norway	1983	111 000	100	17.8
	1993	103 584	104	11.9		1993	117 600	106	19.7
France	1981	842 680	100	9.9	Portugal	1981	227 000	100	14.5
	1991	1 544 000	183	15.6		1991	254 000	112	13.1
Germany	1981	1 559 400	100	14.6	Spain	1981	..	..	..
	1991	2 232 000	143	16.4		1991	133 000	..	12.8
Greece	1981	..	..	..	Sweden	1983	204 000	100	19.0
	1991	193 000	..	10.9		1993	182 880	90	18.0
Hungary	1980	300 000	100	15.6	Switzerland	1981	125 000	100	12.1
	1990	450 000	150	23.6		1991	146 000	117	13.7
Iceland	1984	6 000	100	23.1	United Kingdom	1981	1 679 440	100	17.8
	1993	8 000	133	21.1		1991	2 007 000	120	20.7
Ireland	1981	86 754	100	15.8	United States	1986	7 040 000	100	22.7
	1991	110 000	127	17.9		1996	9 285 087	132	27.1
Italy	1981	1 522 455	100	13.6					
	1991	1 700 000	112	14.9					

1. The index represents the growth rate of the number of lone-parent families over the given period for each country.
2. Incidence is defined as the number of lone-parent families as a percentage of all families with dependent children.
Source: OECD, Eurostat Demographics 1996 and information from national authorities.

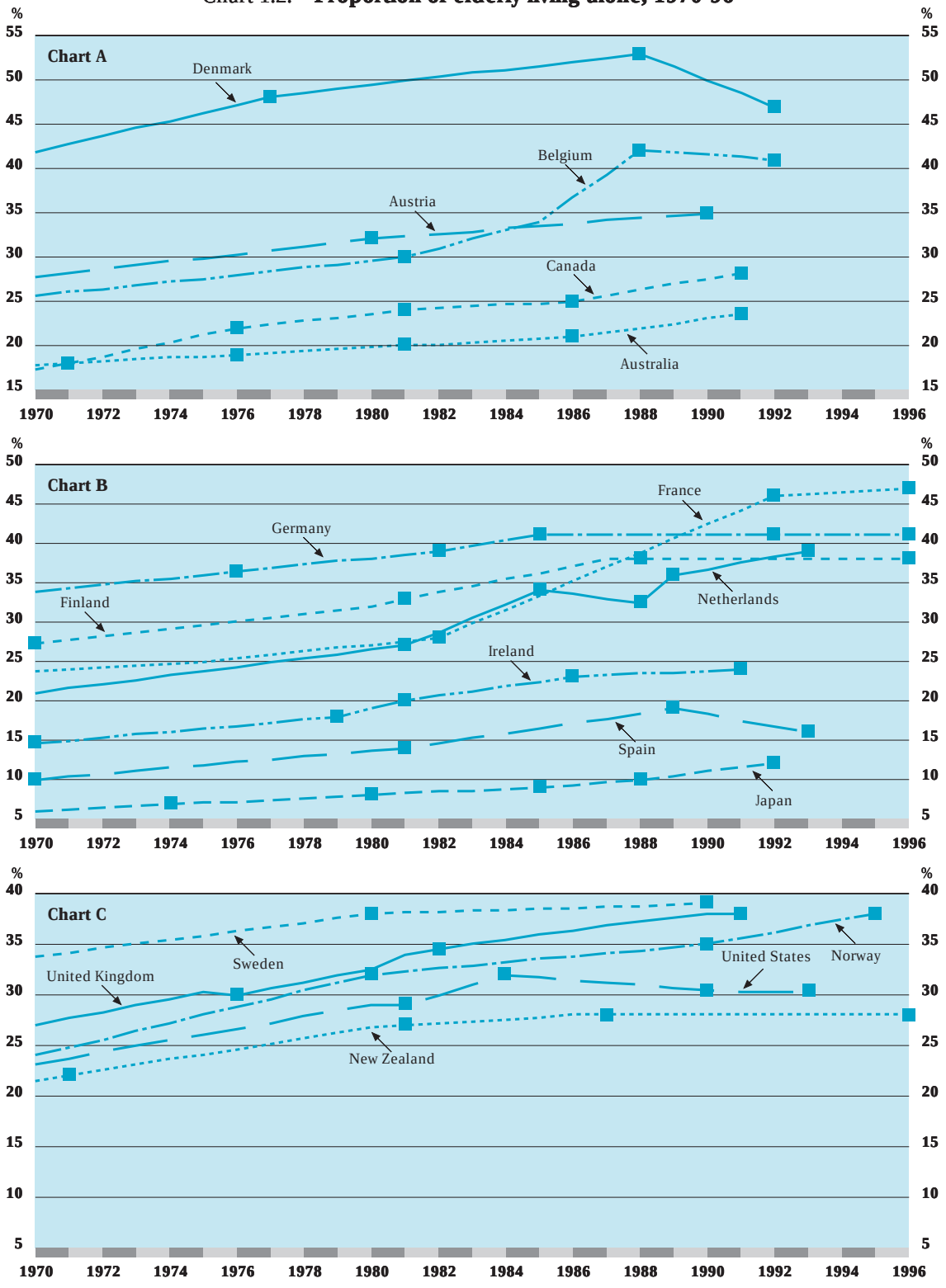
2.3. The transformation of the living arrangements of the elderly

Growing individualisation of social arrangements – the shrinkage of households to nuclear families, and their fragmentation – is reflected in the living arrangements of the elderly. These are being transformed through the desire for greater autonomy (on the part of both parents and children) – even though members of a family may in fact live in close proximity to one another. Privacy has a high income elasticity (Borsch-Supan *et al.*, *199*6; Costa, 1997) and incomes of succeeding cohorts of elderly have risen (see OECD, 1998*h*).

As a consequence, the proportion of elderly people living alone has been rising steadily. It is high in Scandinavian countries which have relatively generous social protection systems and a high standard of living (Chart 1.2). It has risen sharply to high levels in Austria, Belgium, the United Kingdom and the Netherlands. In southern Europe, the proportion living alone is low but has been increasing – in Spain it is now over 20 per cent. Although increasing it is still much lower in Japan, where only one in seven elderly people lives alone.

However, the proportion of the elderly living alone may not continue to rise. One cause of the increase in some countries has been the movement of the cohorts most affected by war into the old-age group. There are more couples in succeeding cohorts. Furthermore, as discussed

Chart 1.2. **Proportion of elderly living alone, 1970-96**[1]



1. Boxes indicate observations.
Source: OECD (1994*b*), updated by the Secretariat.

below, a narrowing of the mortality differential between males and females will increase the number of couples surviving to advanced ages (Wolf, 1995). There are some signs that the increase in the proportion of the population living alone has slowed and has stabilised or even fallen in those countries with the highest rates of individual living.

These trends have implications for the need by elderly people for care services. Where spouses are not available or able to help, female children have in the past been the most common source of informal care. This, of course, reflected an economic environment with low female participation rates and relatively fewer people surviving to an age such that they require help. Demographic and labour market trends mean that the situation in future will be more complex. Female labour force participation has risen rapidly. Fewer women will be in a position to offer informal help and there will be many more in the age groups most likely to need help. But set against this decline in one potential source of informal care providers are some factors which may increase the volume of supply:

- males may well play a more significant role in care-giving. Already one third of primary carers in Australia are male;
- given the improved health status of the elderly, the amount of informal care (including for children) provided by the retired themselves could increase substantially in the future; and
- a more flexible distribution of work, leisure and care-giving over the life cycle may permit care to be given during career breaks and combined with more flexible working patterns.

3. Labour market challenges: unemployment, inactivity and low pay

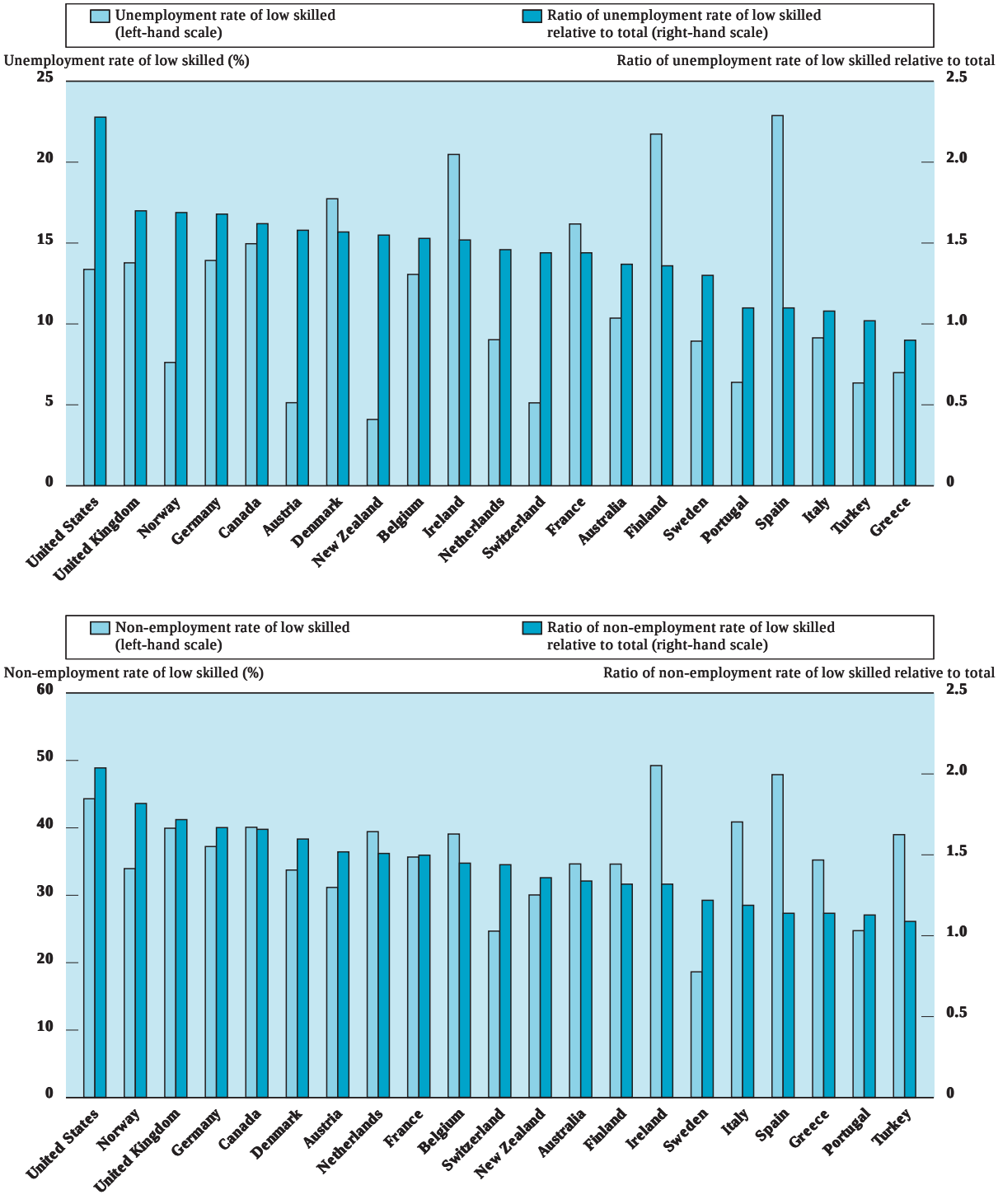
A number of OECD countries face a growing gap between those who are well placed to profit from the new career opportunities being created by technology and globalisation and those who are not. Unemployment, inactivity and low pay appear to be different manifestations of the same underlying problem. The evidence suggests that there has been a structural shift in the labour market to the detriment of the less educated and low-skilled. They are at high risk of unemployment; even if they have a job it may pay wages which are insufficient to support them and their families. Systems of social protection are left to take the strain.

3.1. Unemployment and inactivity

OECD countries as a whole have experienced modest output growth of some 2½ per cent over the past four years. But unemployment remains high – 35 million or 7 per cent of the workforce (though down from a peak of 38 million or 8 per cent in 1993) – and the risks for social cohesion have not been reduced. Unemployment remains above 10 per cent in Belgium, Finland, France, Germany, Greece, Hungary, Italy, Spain and Poland. In many of these countries, there is little hope of substantial falls in unemployment in the short term. The incidence of long-term unemployment remains disturbingly high in a number of countries. Over half of all unemployed persons had been so for more than 12 months in Belgium, Hungary, Ireland, Italy, Portugal and Spain in 1996 (OECD, 1997*b*). Less-educated workers typically experience much higher unemployment rates than more educated workers (Chart 1.3) and the difference is getting larger in most countries (Chart 1.4).

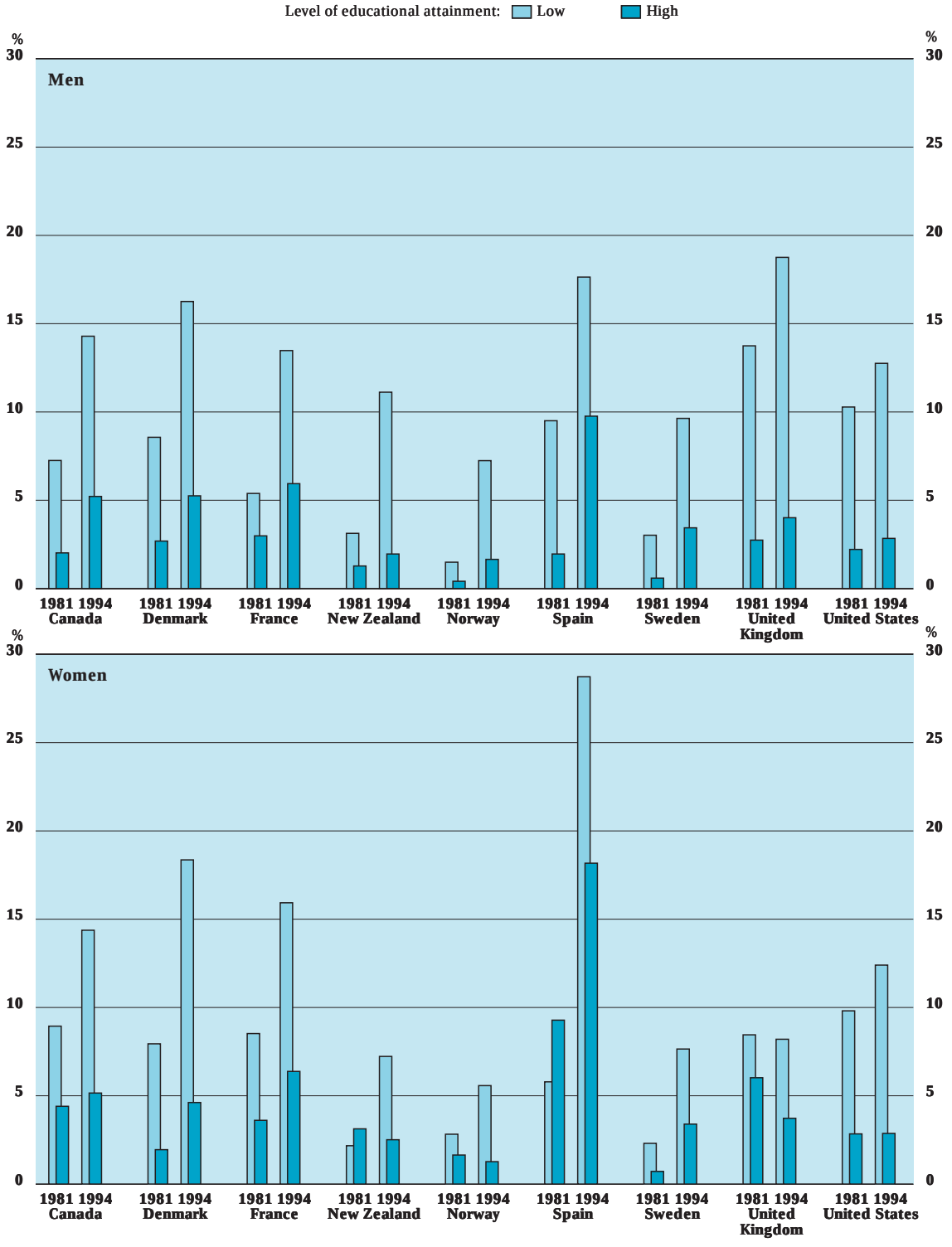
The female labour force participation rate has risen by over 5 percentage points since the beginning of the decade in Austria, Belgium, Ireland, the Netherlands, New Zealand and Spain, though the recession of the early 1990s reduced rates in Nordic countries.[5] In contrast, male labour force participation has fallen almost everywhere, particularly for the older age group (see

Chart 1.3. **Unemployment and non-employment rates by educational attainment, 1994**[1]
Population aged 25-54



1. Persons with less than upper secondary education are classified as low skilled.
Source: OECD (1996), *Education at a Glance – OECD Indicators*, Paris.

Chart 1.4. **Trends in unemployment rates by level of educational attainment**[1]
Percentages



1. Data refer to persons aged 25-64. A low level of education corresponds to upper secondary or less. A high level corresponds to tertiary education.

Sources: OECD (1996*f*), *Lifelong Learning for All*, Paris; OECD (1996), *Education at a Glance – OECD Indicators*, Paris.

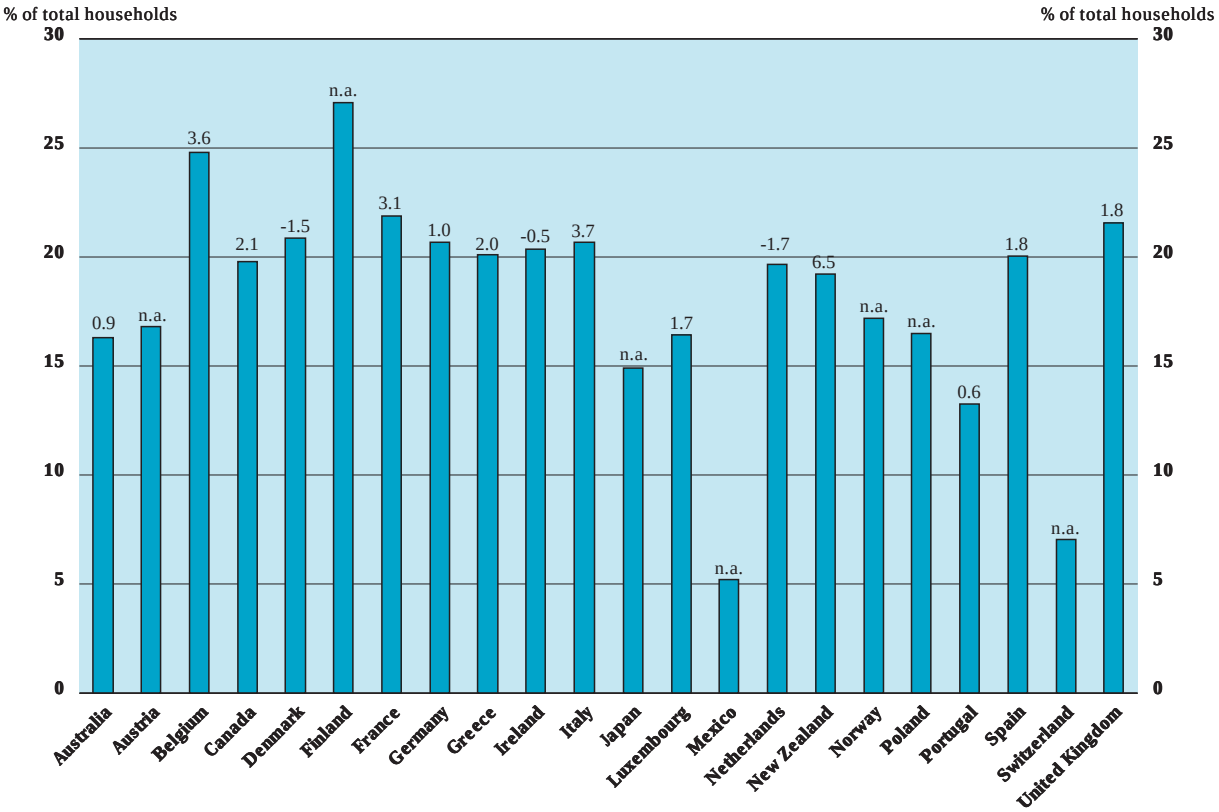
OECD, 1998*f*), with a corresponding increase in the numbers claiming early retirement, sickness and invalidity beneficiaries. As a result, total labour force participation ratios have stayed relatively stable on average across the OECD area.

3.2. Work-rich and work-poor households

While non-employment at an individual level can be used as a broad measure of under-utilisation of labour resources, joblessness at the household level will lead to hardship if there are no other sources of income in the household. Different welfare policies may be required if a substantial proportion of the unemployed and the inactive are living in households with no other adults in employment or in households with some members at work.

In many OECD countries, about one household in five of working age has no employment income of any sort (Chart 1.5), ranging from a low of just over 5 per cent in Mexico to a high of over 27 per cent in Finland. This proportion has risen in 12 of the 15 countries where information is available from the mid-1980s, with particularly sharp increases in New Zealand, Belgium, Italy and France.

Chart 1.5. **Non-employment rates for working-age households**
Levels in 1996 and percentage point changes between 1985 and 1996[1, 2]



n.a. = not available.
1. Working-age households are those with at least one person of working age (15-64). A household is non-employed if no member of the household is in employment (part-time or full-time) at any point during the reference period.
2. 1985 data is not available for Austria, Finland, Japan, Mexico, Norway, Poland and Switzerland.
Source: OECD (1998*a*), *Employment Outlook*, Paris.

The rise in joblessness at the household level is explained largely by the shift towards household types with a high incidence of joblessness – that is, single-adult households, with an additional impetus arising from multi-adult households becoming "sorted" into working and non-working households. Unsurprisingly, evidence suggests that workless households constitute the majority of those in the bottom quintile of the income distribution, and usually have cash benefits as the main source of household income (OECD, 1998*a*).

3.3. Low pay

Even if low-skilled workers are working, they may not earn enough to support their families and may not generate enough private savings or receive sufficient social benefits to support themselves in periods of non-employment or retirement. One-quarter of all full-time workers in the United States earn less than two-thirds of median earnings compared with under 6 per cent of workers in Finland and Sweden.[6] This pattern mirrors differences in earnings' dispersion: countries with greater earnings' inequality – measured as the ratio of median earnings to bottom decile earnings – have a higher incidence of low-paid jobs. Over time, the incidence of low pay has not increased greatly in any of the countries for which data are available, although it has tended to drift upwards in Australia, the United Kingdom and the United States in line with increases in their earnings' inequality (Chart 1.6).

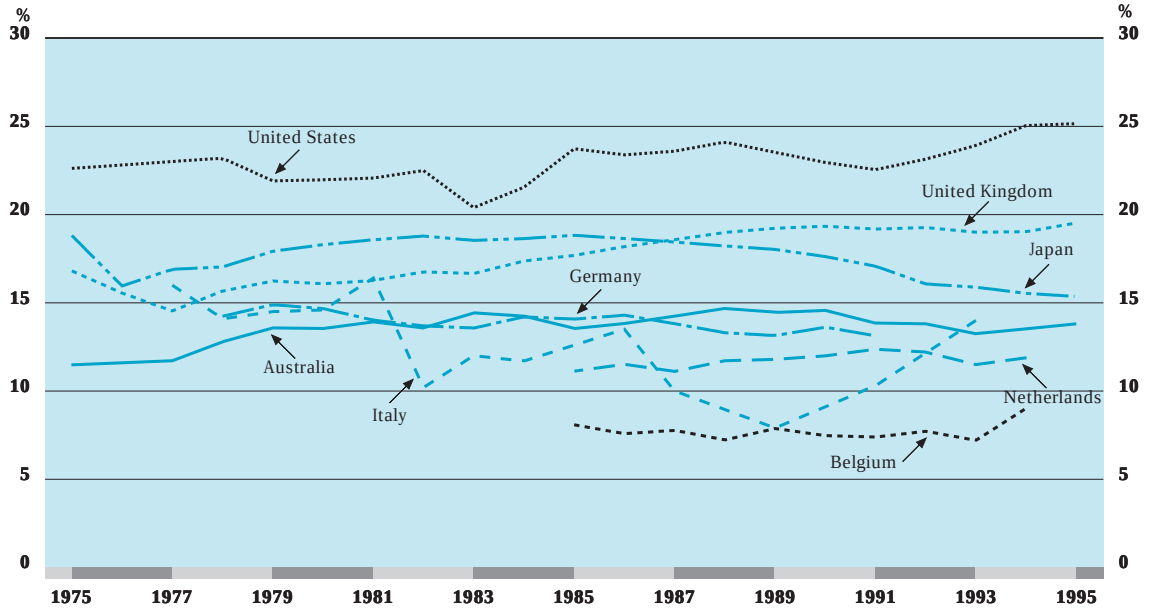
3.4. Non-standard forms of employment

In some countries, non-standard forms of employment give rights to lower levels of social protection than do full-time permanent contracts:

- In most OECD countries, around 10 per cent of workers are employed with temporary employment contracts (see OECD, 1996*a*). There has been little increase in the

Chart 1.6. **Trends in the incidence of low-paid employment**[1]

Percentages



1. Low pay is defined as less than two-thirds of median full-time earnings. Data refer to full-time employment only.
Source: OECD (1996*a*, Chapter 3).

proportion of temporary employment since the mid-1980s with the notable exception of Spain, where over one third of all employment is temporary.

- Part-time employment has increased in most countries, typically accounting for over 20 per cent of total female employment; around 10 per cent or less for males. These ratios have increased by two percentage points or more since 1990 in Australia, Austria, France, Japan, New Zealand and Turkey for both sexes, with similar increases in female part-time employment shares in Belgium, Ireland, Portugal, Spain and Switzerland (OECD, 1998*a*).
- Self-employment as a percentage of total employment increased by three or more percentage points in most OECD countries since the start of the 1980s (OECD, 1994*c*).[7]

4. The health status of populations

The growth in living standards, accompanied by better access to health care and continuing progress in medical technology, has contributed to a significant improvement in health status, regardless of whether the indicator used life expectancy at birth; at any other age; premature mortality; or reduction in infant mortality and perinatal mortality (Chart 1.7).

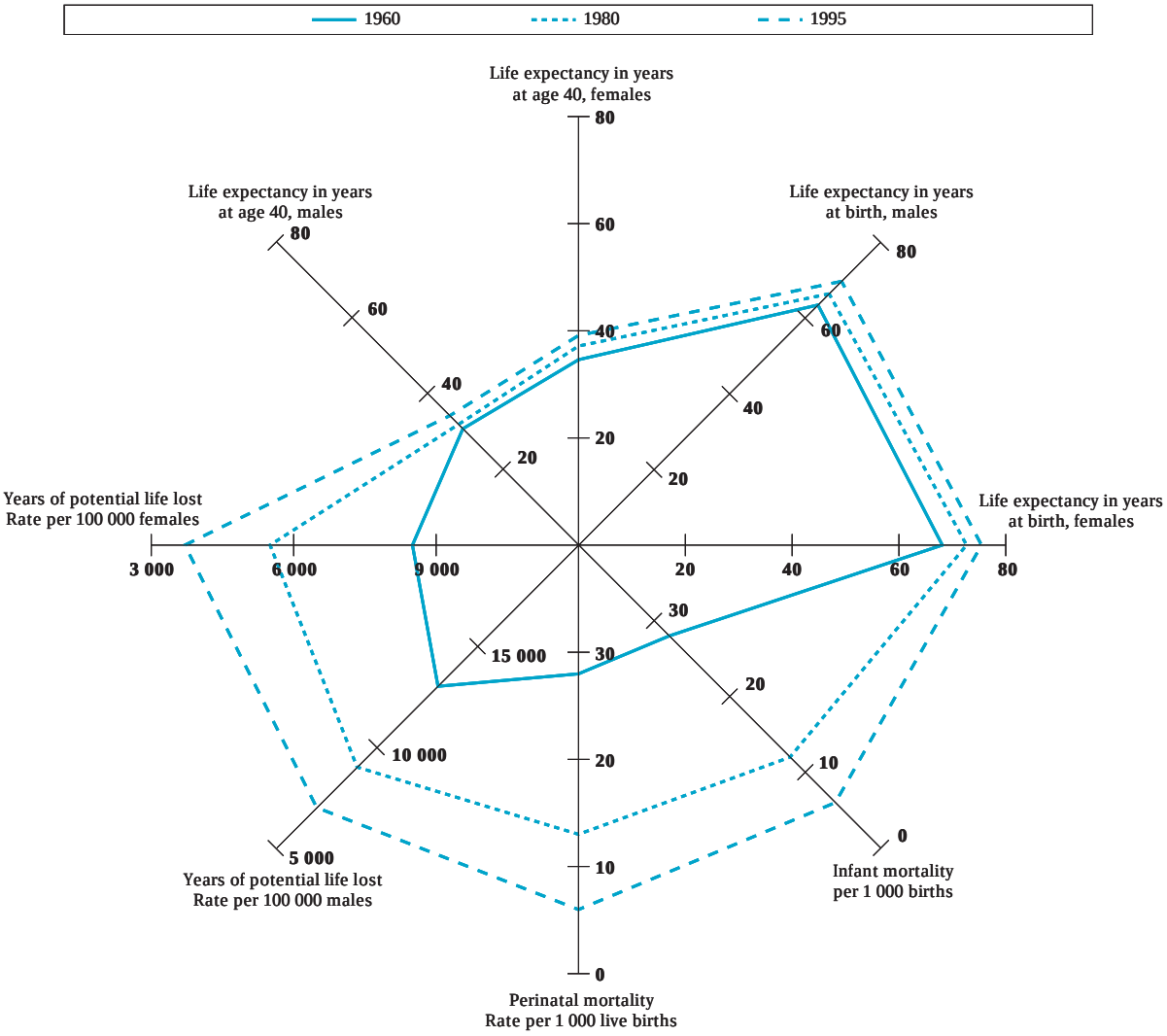
4.1. Increased longevity

Longevity continues to increase in OECD countries because of reductions in infant mortality and in mortality at advanced ages. Because of changes in the population structure, this latter effect now contributes more than previously to changes in longevity. According to the most recent data, life expectancy at the age of 65 ranges from 16 to over 21 years for a woman and 12 to 17 years for a man. The highest longevity is to be found in Japan, France, Canada and Switzerland (Table 1.4). These gender differences can also be observed at the top of the age pyramid. At age 80, the difference between male and female life expectancies narrowed slightly but is still significant: life expectancy at that age is close to ten years for women and seven years for men in those countries where life expectancy is the highest. Demographers project these trends to continue.

Since the early 1960s, mortality rates in the majority of OECD countries have fallen by 1-2 per cent per year for women and by 0.5-1.5 per cent per year for men between the ages of 80 and 99 (Kannisto, 1994). However, throughout the period under review the central and eastern European countries experienced only modest reductions in mortality rates. The divergence of experience with western Europe is stronger for environmental-linked diseases (reflecting the effects of high levels of pollution and a strong impact on respiratory deaths) and for life-style related diseases (cardio-vascular death). After the fall of Communism, many of these countries recorded sharp increases in premature mortality, including those linked with poverty and depression, from which several of them are now recovering. In contrast, life expectancy in Japan, where life expectancies were already among the highest, has grown more rapidly than almost anywhere else.

Ageing is an inevitable biological process, with the maximum age for humans lying between 80 and 100. However, if a number of ageing-related deficiencies were to become treatable *(e.g.*, osteoporosis, Alzheimer's disease), longevity could be substantially increased.[8] Studies suggest that senile dementia, in all its diverse forms, affects around 5 per cent of the aged population. (Ritchie, 1998). The primary form of senile dementia is Alzheimer's disease. Nevertheless, other types of dementia are also linked to ageing, such as vascular dementia, linked to cerebral vascular disease. Otherwise, beyond the most severe forms of dementia, diverse forms of depression continue to be one of the challenges for which the use of heavy medication presents some limits. Finally, and paradoxically, the very high consumption of medicines by elderly people is not without iatrogenic risks, notably in the countries where consumption is highest (*e.g.* France and Sweden).

Chart 1.7. **Indicators of health outcomes**[1]



1. OECD average less Czech Republic, Hungary, Mexico, Poland and Turkey.
Source: Diskette OECD Health Data 1997.

4.2. Reductions in premature mortality

Steady decreases in infant mortality have continued, tailing off in the 1990s. There is a strong link between infant mortality and the relative level of development, as is shown by rates in the new Member countries of the OECD, Mexico or Turkey. In 1995, in the majority of the most developed countries, rates were under 8 per 1 000 births (though with notable disparities) (Table 1.5). Nevertheless, there has been an improvement in all countries, and it has been stronger in those countries where there have been programmes focused on the problem. The lowest levels are observed today in Scandinavia.

Reductions in premature mortality have also benefited older age groups. Those countries with the highest level of potential life years lost in 1970 have experienced the most significant reductions. This reduction has been weaker in the new OECD member countries of Eastern Europe (see Chart 1.8).

Table 1.4. **Life expectancy at age 65 and 80**

	65 years		80 years	
	Male	Female	Male	Female
Australia	15.8	19.6	7.0	8.9
Austria	15.2	18.7	6.6	7.9
Belgium	15.3	19.7	6.7	8.7
Canada	16.2	20.1	7.5	9.5
Czech Republic	12.8	16.4	5.8	6.9
Denmark	14.1	17.6	6.4	8.1
Finland	14.6	18.7	6.5	7.9
France	16.1	20.6	7.1	9.0
Germany	14.9	18.6	6.6	8.1
Greece	16.1	18.4	7.3	7.7
Hungary	12.1	15.8	5.5	6.5
Iceland	16.5	19.4	7.4	8.7
Ireland	13.5	17.1	5.4	6.7
Italy	15.7	19.6	6.8	8.3
Japan	16.9	21.5	7.5	9.9
Korea	13.2	16.9	5.8	7.0
Luxembourg	14.2	18.5	5.3	6.8
Mexico	15.6	18.8	7.2	9.5
Netherlands	14.4	18.6	6.2	8.1
New Zealand	15.4	19.0	6.9	8.7
Norway	15.5	19.5	6.7	8.6
Poland	12.9	16.6	6.0	7.1
Portugal	14.3	17.7	5.7	7.0
Spain	15.8	19.8	7.0	8.5
Sweden	16.1	19.7	6.9	8.8
Switzerland	16.1	20.2	7.2	9.0
Turkey	n.a.	n.a.	5.2	5.9
United Kingdom	14.7	18.4	6.7	8.6
United States	15.7	18.9	7.3	8.9

n.a. : Data not available.
Notes: For age 65, data refer to 1996 with the exception of Austria (1995); Canada (1995); Czech Republic (1995); Denmark (1994); France (1995); Greece (1994); Hungary (1995); Iceland (1995); Ireland (1993); Korea (1995).
For age 80, the data refer to the same year cited above with the exception of France (1992); Ireland (1982); Italy (1994); Luxembourg (1987); Turkey (1990).
Source: Diskette OECD Health Data 1998.

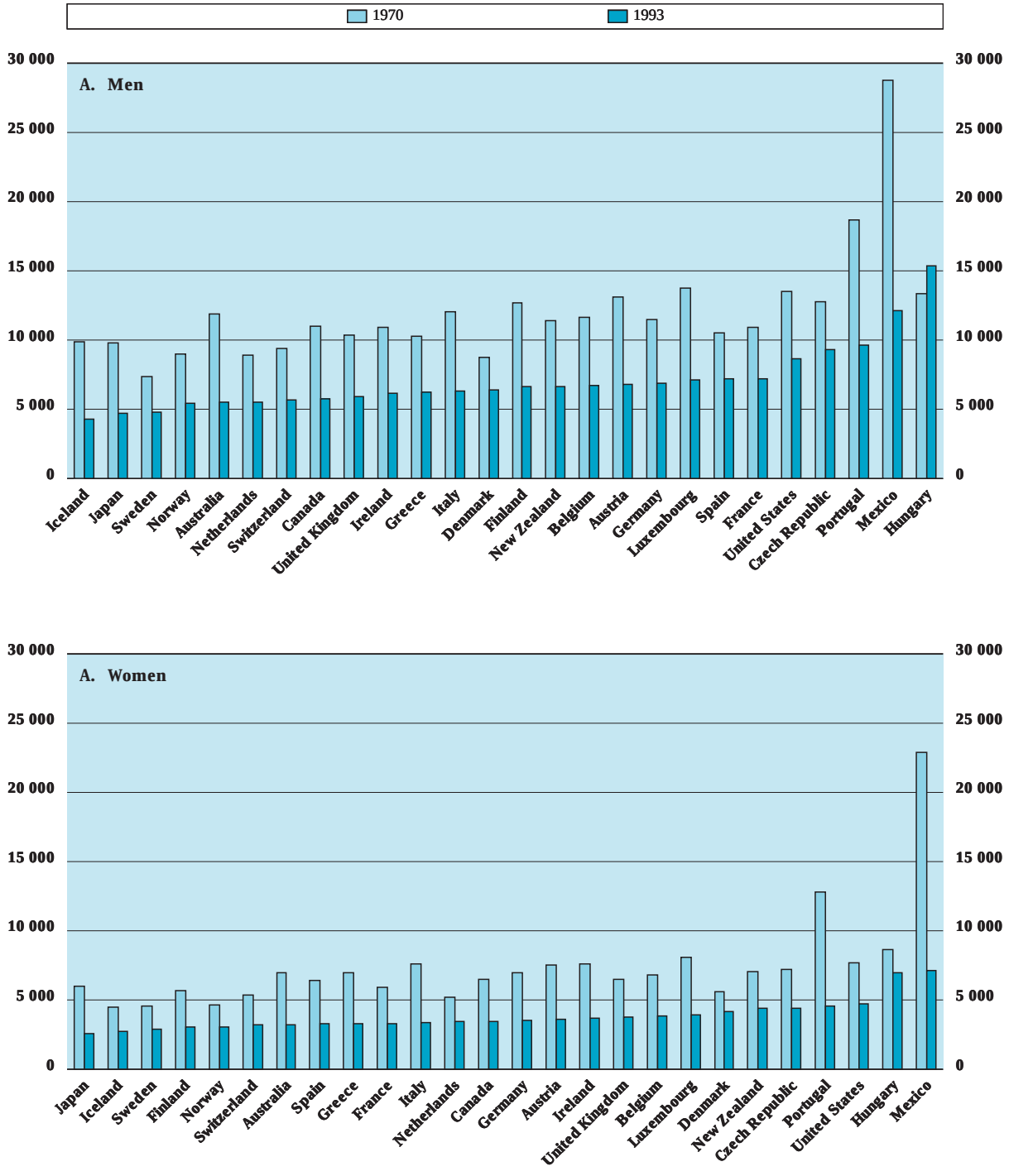
Table 1.5. **Trends in infant mortality rates,[1] 1970 and 1995**

	1970	1995
Australia	17.9	5.7
Austria	25.9	5.4
Belgium	21.1	7.0
Canada	18.8	6.0
Czech Republic	20.2	7.7
Denmark	14.2	5.5
Finland	13.2	4.0
France	18.2	5.0
Germany	23.4	5.3
Greece	29.6	8.1
Hungary	36.0	11.0
Iceland	13.2	6.1
Ireland	19.5	6.3
Italy	29.6	6.2
Japan	13.1	4.3
Korea	45.0	9.0
Luxembourg	24.9	5.0
Mexico	69.0	16.5
Netherlands	12.7	5.5
New Zealand	16.8	7.0
Norway	12.7	4.0
Portugal	55.1	7.4
Spain	26.3	5.5
Sweden	11.0	4.1
Switzerland	15.1	5.0
Turkey	151.0	44.4
United Kingdom	18.5	6.0
United States	20.0	8.0
Average	27.7	7.9

1. Number of deaths of infants aged under one year of age per 1 000 live births.
Source: Diskette OECD Health Data 1998; National Statistic Office, Republic of Korea.

Chart 1.8. **Potential years of life lost in 1970 and 1993**[1]

Potential years of life lost (all causes except suicide)
per 100 000 females or males



1. Data not available for Korea, Poland and Turkey.

Source: Diskette *OECD* Health Data *1998*, Paris.

The disease categories shown in Table 1.6 account for about 70 per cent of male premature mortality and more than 60 per cent of female premature mortality in 1993. There are clear differences in the causes of premature mortality between men and women. For instance, in 1993, external factors such as traffic accidents and violence explain about 28 per cent of premature mortality for males but only 15 per cent of premature mortality for females. Malignant neoplasms explain about 30 per cent of female premature mortality, as compared to 21 per cent for males. In the case of circulatory diseases, the reduction in the number of years of life lost is around 50 per cent for women and 41 per cent for men between 1970 and 1993. For cancer, the reduction has been just 14 and 10 per cent respectively. The reduction is large for tuberculosis, which represented even in 1970 only a small part of the total number of years of life lost. However, premature mortality for men still remains higher than for women.

Circulatory disease plays a comparatively large role in the United States, the United Kingdom, in Eastern Europe, Portugal and New Zealand. In contrast, it is less important in the Mediterranean countries, Japan, Australia and France. There is no link between levels of premature mortality due to lung cancer and the level of development in the country, *e.g.* the United States has particularly high rates. In Eastern Europe and Mexico, potential years of life lost because of cancer have not declined significantly.

The successes indicated in Table 1.6 in turn raise new challenges. Modern medical progress often prevents illness from being fatal, but does not often reduce its incidence. Thus, illness takes on chronic characteristics where the central issue is the quality of life which individuals enjoy. A better quality of life can benefit not only the elderly, where difficulties in accomplishing everyday tasks can drastically reduce quality of life, but also those of intermediate age (suffering from, for example, stress, or back or eye problems) enabling an improvement in labor market participation.

4.3. The incidence of disability

The growth in older populations increases the share of groups in the population at risk of a frail health status, not because of age itself but because of a greater incidence of disease and disability at this age. In order to assess better whether gains in life expectancy result in extra years lived in disability, there is a need for more sophisticated indicators like "Disability Free Life Expectancy" – DFLE (as advocated in OECD, 1992 and more recently by Mathers, 1997 and Robine, 1997). The DFLE indicator is centred around a notion of active life expectancy in terms of autonomous participation in everyday life. "Severe Disability Free Life Expectancy" often corresponds to a more restrictive definition of incapacity – the inability to perform those activities essential for everyday life without significant help. Moderate incapacity supposes the availability of a certain amount of formal or informal help, not necessarily through social services.

Although there is no standardised definition as to how it is measured, DFLE represents between 45 to 80 per cent of life expectancy of those at age 65 for the most recent years for which the data are available (Table 1.7). This data, supported by country-level data (*e.g.* Manton *et al., 19*97), shows that at age 65, the population of Member countries can expect to have a significant number of years in good health. Furthermore, life expectancy without disability at age 65 is increasing (although this trend is less pronounced in Australia, New Zealand and Norway). This can be asserted with most confidence for severe disability, where differences in definitions across countries are likely to be few as compared with the harder-to-define moderate disability measures. More detailed analysis reveals that these positive trends occur mainly for the younger elderly, between 65 and 80. Over 80, the trends are not clear-cut. Life expectancy is lower for men but the proportion of this which will be without incapacity is longer. In

Table 1.6. **Potential years of life lost between 1970 and 1993 by type of disease**

	Circulatory system				Liver cirrhosis				Lung cancer				Tuberculosis				Malignancies				% of total PYLL[1] explained			
	Females		Males		Females		Males		Females		Males		Females		Males		Females		Males		Females		Males	
	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993	1970	1993
Australia	1 583	431	3 478	1 107	1 379	1 142	1 587	1 311	1 072	518	3 022	1 686	66	40	129	119	82	123	384	284	57	64	67	70
Austria	1 077	616	2 527	1 568	1 583	1 204	1 775	1 508	1 019	668	3 722	2 184	141	162	484	496	59	106	413	407	49	70	61	77
Belgium	1 059	488	2 517	1 157	1 450	1 233	1 867	1 683	1 048	715	2 662	2 012	69	96	132	183	53	109	593	588	52	63	60	69
Canada	1 044	431	2 843	1 178	1 489	1 208	1 557	1 309	1 144	618	3 135	1 795	98	46	207	114	90	246	406	405	56	65	67	69
Czech Rep.	1 387	929	3 136	2 691	1 502	1 457	2 079	2 332	934	660	3 330	2 427	77	92	268	347	62	111	566	763	52	68	64	79
Denmark	811	564	2 057	1 258	1 782	1 556	1 635	1 480	1 017	678	2 294	1 645	56	119	110	277	105	265	382	386	62	66	65	67
Finland	1 452	558	4 421	1 937	1 215	944	1 909	1 149	903	706	3 793	2 876	25	75	111	217	42	60	614	302	61	70	75	80
France	738	323	1 667	937	1 205	1 012	1 866	1 936	1 020	739	3 002	2 181	293	122	564	269	36	66	320	509	54	62	63	67
Germany	1 067	613	2 066	1 606	2 038	1 306	1 761	1 650	1 073	502	3 221	1 620	112	185	357	440	58	107	349	436	59	71	61	72
Greece	821	499	1 412	1 402	1 087	962	1 355	1 425	457	467	1 625	1 633	61	30	223	104	82	67	302	475	35	59	44	72
Hungary	1 538	1 587	2 892	4 336	1 514	1 727	1 686	3 106	856	910	3 034	3 287	76	719	200	2 071	90	252	351	1 049	44	68	54	77
Iceland	605	271	2 848	1 093	1 086	1 445	1 548	845	816	335	3 404	1 465	33	24	74	24	52	261	228	199	55	72	74	73
Ireland	1 510	632	2 953	1 836	1 668	1 372	1 683	1 457	636	404	1 721	1 512	47	37	45	59	124	147	491	331	51	65	58	73
Italy	1 061	470	1989	1 145	1 379	1 126	1 852	1 625	528	366	1990	1 369	159	97	492	262	59	77	433	472	41	60	52	67
Japan	1 204	463	2 100	1 028	1 278	870	1 556	1 284	897	469	2 512	1 311	83	42	279	190	57	70	134	190	55	67	63	74
Korea	n.a.	509	n.a.	940	n.a.	87	n.a.	528	n.a.	62	n.a.	174	n.a.	74	n.a.	168	n.a.	818	n.a.	1 386	n.a.	n.a.	n.a.	n.a.
Luxembourg	1 235	663	2 918	1 247	1 597	1 250	2 295	1 635	1 545	909	3 993	2 858	215	103	349	296	48	69	827	448	55	73	67	77
Mexico	1 873	871	2 020	1 239	1 101	1 031	653	762	914	689	4 514	3 616	350	230	1 157	1 069	47	50	81	120	19	40	29	54
Netherlands	786	508	2 242	1 262	1 514	1 267	1 780	1 449	740	371	1 875	963	32	40	50	74	46	160	611	437	57	61	65	64
New Zealand	1 479	699	3 293	1 640	1 605	1 490	1 763	1 483	850	776	2 822	2 359	39	31	68	55	114	180	424	275	55	66	67	76
Norway	717	418	2 327	1 293	1 404	1 169	1 397	1 151	536	434	2 398	1 449	25	38	44	86	43	116	190	249	57	64	66	67
Portugal	1 159	635	1 934	1 485	1 306	1 119	1 466	1 570	714	693	2 744	2 457	267	192	593	513	46	50	158	316	27	57	36	61
Spain	1 385	422	2 209	1 241	1 171	1 000	1 478	1 694	457	445	1 747	1 696	148	69	397	283	57	42	244	475	49	58	55	66
Sweden	688	408	1 802	1 214	1 350	1 108	1 195	992	896	542	2 286	1 347	55	28	147	103	55	114	168	171	61	68	67	70
Switzerland	689	350	1 722	1 002	1 359	1 050	1 646	1 273	939	656	2 961	2 000	57	71	226	123	35	123	417	347	55	62	65	70
United Kingdom	1 251	657	3 058	1 690	1 630	1 371	1 875	1 399	624	377	1 549	1 152	26	62	38	101	162	175	691	346	54	64	62	70
United States	1 551	806	3 707	1 801	1 511	1 253	1 730	1 453	1 223	831	3 613	2 602	210	78	392	200	141	254	528	466	57	61	68	66
OECD	1 145	589	2 544	1 515	1 431	1 218	1 654	1 498	879	595	2 806	1981	108	109	275	311	71	131	396	402	48	66	61	75

1. Potential Years of Life Lost: number of years of life lost with an implicit life expectancy of 70 for all premature deaths. Based on death certificate information for disease identification.

Source: Diskette OECD Health Data 1998; National Statistic Office, Republic of Korea.

Table 1.7. **Trends in life expectancy without disability at age 65**

	Life expectancy at 65	Disability-free life expectancy	Life expectancy at 65	Disability-free life expectancy
	Males		Females	
	Moderate disability-free life expectancy[1]			
Australia				
1981	13.9	7.9	18.1	10.1
1993	15.7	6.5	19.5	9.1
Canada				
1986	14.9	8.5	19.2	9.4
1991	15.6	8.3	19.7	9.2
France				
1981	14.1	8.8	18.3	9.8
1991	15.7	10.1	20.1	12.1
Netherlands				
1983	14.0	8.0	18.6	7.4
1990	14.4	9.0	19.0	8.0
United States				
1980	14.2	6.8	18.4	9.3
1990	15.1	7.4	18.9	9.8
New Zealand				
1981	13.3	9.9	17.1	10.5
1993	14.8	10.0	18.4	10.2
Germany				
1986	13.8	10.6	17.6	13.0
1995	14.9	12.2	18.7	14.9
	Severe disability-free life expectancy[1]			
Australia				
1981	13.9	11.9	18.1	13.8
1993	15.7	13.4	18.7	14.8
Canada				
1986	14.9	12.8	19.2	14.9
1991	15.6	13.3	19.7	15.4
France				
1981	14.1	13.1	18.3	16.5
1991	15.7	14.8	20.1	18.1
Japan				
1980	14.6	13.2	17.7	15.8
1990	16.2	14.9	20	17.3
United Kingdom				
1980	12.9	11.8	16.9	15.0
1991	14.5	13.6	18.1	16.9
Norway				
1975	14.0	13.3	17.2	16.1
1985	14.4	13.3	18.2	16.9

1. Health expectancy concepts are not yet totally harmonised. The "severe disability" measures are more comparable than those for "moderate disability". Levels for other OECD countries have been estimated for single years only: extrapolating from indirect evidence brings a prognosis of analogous trends. Additional details and country specific data can be found in Jacobzone (1999 forthcoming).

contrast, there are much smaller gains in female life expectancy without incapacity. However, it is unfortunate that the quality of data (see Crimmins *et al.*, *19*97) concerning such an important issue for the future of social protection is not as reliable as would be desirable.

Table 1.8 indicates the proportion of the population who cannot pursue everyday life without formal or informal help for essential activities. The extension of dependence depends on the general state of the health of the population of a given age; the medical performance of health care systems; and the age structure of the population, notably the proportion of very elderly aged over 80 years old. The share of the frail elderly in the total population aged over 65 is between one person in eight and one person in four according to the country. In contrast, severe dependence, for those confined to bed or chair, and for whom the only solution appears to be institutionalisation, will concern only one elderly person in 25.

Table 1.8. **Prevalence of severe disability**

	Share of population aged over 80 in total population 1995	Share of frail elderly in population aged over 65 % of total	Share of very severe disability in population aged over 65 % of total
	(1)	(2)	(2)
Australia	2.5	16.7	n.a
Austria	3.5	25.0	2.9
Belgium	3.6	5.9 to 16.4	3.3
Canada	2.6	16 to 32	n.a
Finland	3.2	18 to 20	n.a
France	4.1	13 to 17	3.7
Germany	4.1	12.1	3.5
Italy	3.6	22.1	2.0
Japan	2.8	11.2	4.2
Korea	0.9	13.5	n.a
Netherlands	3.0	18.9	n.a
Norway	3.9	18.0	n.a
Sweden	4.5	15.1	3.4
United Kingdom	3.8	14.1 to 28	n.a
United States	3.0	12 to 26	n.a

n.a.: Data not available.
Sources: (1) OECD Health Data 1998 for population and expenditure on health as of March 1998. Population data refer to 1994 for Denmark.
(2) The share of frail elderly refers to the prevalence of severe disability. Data refer to the most recent published national disability survey, currently between 1990 and 1995. Secretariat estimates using various sources and experts reports, Pacolet (1997) for European countries together with national sources. Additional details and country specific data can be found in Jacobzone (1999 forthcoming).

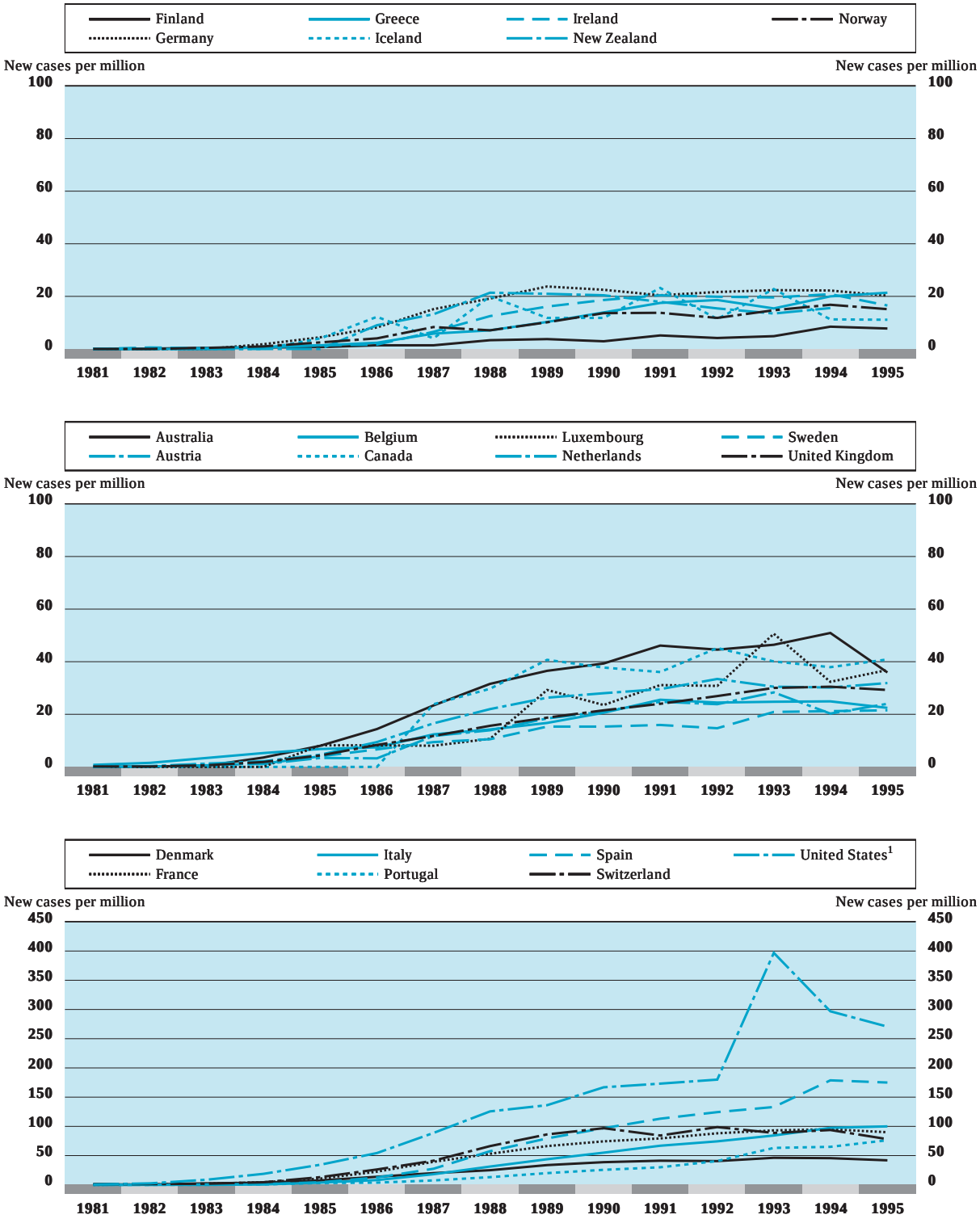
4.4. New health challenges

Social challenges

There are strong links between social status and health. It is among the most disadvantaged groups in society, the least educated or unemployed, that the greatest concentration of morbidity is found and, often, the shortest longevity. As a result, health status of some categories of the population has not improved, and it may have worsened, even while overall there have been improvements in most indicators.

These disparities might have been caused by inadequate access to health care, but this is only part of the explanation. Insufficient medical insurance coverage or co-payments which are too high can lead to a failure to seek medical help. Furthermore, insufficient medical services in some geographical regions can lead to implicit rationing. Consequently, policies targeted on the most disadvantaged parts of the population in order to improve health care coverage or better regional planning can offer a solution to some of these problems.

Chart 1.9. **AIDS incidence rates, 1981-1995**



1. A definitional change in 1992 partly explains the sharp rise in reported AIDS cases in the United States.

Source: Diskette OECD Health Data 1998.

In contrast, the challenges are more difficult to resolve for health care systems when the causes arise from problems outside of the health care system. Where a decline in health status is caused by interrelated social conditions such as unemployment and inadequate housing, health care policies alone cannot suffice.

The resurgence of infectious diseases and chronic disease

Some diseases have emerged or re-emerged, such as tuberculosis (which continues to exist in pockets of poverty), hepatitis and AIDS. Modern lifestyles, notably, increased international travel, have allowed some diseases to expand outside initially restricted areas. The most well-known example is AIDS which has provoked a spectacular epidemic in OECD countries. Consequently, as of the 1980s, health services and programmes of care have had to be developed to institute preventative measures and to educate groups at risk. These policies have contained the progression of the epidemic in the countries where they were applied most rigorously. In some countries, there have been very few cases (Japan, Korea, Poland, Czech Republic and Hungary).[9] In another group, the spread of the disease has been relatively low – Finland, Germany, Greece, Iceland, Ireland, New Zealand and Norway. In contrast, in a third group, Denmark, France, Italy, Spain, Switzerland and the United States, the epidemic has attained the highest rates. Since 1993, however, the evolution of the epidemic seems to have flattened, particularly in the Netherlands, Spain, the United Kingdom and the United States (Chart 1.9).

The success encountered in treating diabetes, but also more recently AIDS, transforms fatal illness into health problems which, although still significant, need not prevent a normal everyday life. This increasingly necessitates a close follow-up of patients. Furthermore, illnesses linked with hypertension, diabetes, chronic respiratory diseases, musclo-skeletal (arthritic) problems can all require additional resources. Finally, the treatment of depression and mental problems, with a continuing transformation away from institutional setting towards community care and an ambulatory approach, is one of the most important evolutions in modern medical practice.

Notes

1. This section draws on Saraceno (1997).
2. As discussed below, conjecture suggests that this may reflect access to childcare facilities and systems of family support.
3. In some countries, very early family formation has also been evident, with fading confidence in career opportunities advanced as a plausible explanation. Some young women despair of finding a place in the labour market or finding a steady partner, and bear children without either, often without completing their secondary education. However, even in the United States, where this tendency has been most pronounced, it does not outweigh the general tendency to defer family formation.
4. Marital instability is not a new phenomenon. Only during the 20th century has the death of a parent-spouse at a young age ceased to be a common event (Anderson, 1985). In most of the industrialised nations, with the possible exception of the Scandinavian countries and the United States, the rate of family break-up today, due to separation and divorce, is far less than that a century ago arising from the death of the husband or wife.
5. Although females with low skill levels often have lower unemployment rates than males, a broader perspective considering the various sorts of non-employment (including those forming lone-parent families) suggests that any differences in non-employment rates between the sexes are less significant than the differences by skill level.
6. Part-time workers are not included in this calculation.
7. The different categories of non-standard employment are not mutually exclusive.
8. Empirical analysis of insurance annuities shows that private markets have factored in the fall in mortality and expect it to fall further in the future (Mullin and Philipson, 1997).
9. Hence, their data are not represented on Chart 1.9.

Chapter 2

Expenditure Trends

1. Introduction and main findings

The socio-demographic, labour market and health-status trends outlined in the previous chapter suggest that demands on systems of social protection are both changing and, in some respects, increasing. This chapter provides an overview of how governments have altered the level and composition of social expenditures in response, taking due account of public finance constraints. A final section looks in more detail at why some social programmes have involved rapidly increasing expenditures whereas similar programmes in other countries have not. The main findings are as follows:

- Most OECD countries are committed to maintaining low budget deficits or to running a surplus. There is little prospect of increasing taxes: the capital tax base is at risk of erosion through globalisation, and increased labour taxes may harm employment, especially of low-skilled workers.
- Due to budgetary constraints, the rapid expansion of public social expenditure recorded during the 1960s and 1970s has abated over the past 15 years, but the public social expenditure to GDP ratio is still rising in most OECD countries.
- Accounting for the impact of the tax system and the private provision of social benefits leads to convergence in the volume of social protection available across countries.
- Since 1980, non-health related social spending directed to the elderly has risen at the same rate as transfers to the working-age population in most OECD countries. Sharp increases in public pension expenditures are projected for the 2015-2035 period.
- Over the past 15 years, public expenditure on health as a percentage of GDP has grown relatively slowly in most European countries. The largest increases in public expenditure on health have been recorded in France, Switzerland and the United States. The public share in total health spending peaked in the 1980s. It has declined in sixteen countries since 1990.
- Early-retirement, disability and unemployment programmes have been used as early exit vehicles to enable older workers to retire early in many OECD countries. Recently, the upward trend in beneficiaries has been reversed in a few countries (Greece, the Netherlands and Portugal).

2. Fiscal constraints

2.1. Budget deficits

OECD area general government expenditure increased from just under 30 per cent of GDP in 1960 to a 1995 level of nearly 50 per cent.[1] Over half of this increase has been due to the

increase in transfers to households (cash benefits), which rose from around 9 per cent of GDP to 20 per cent. To meet these increased outlays, taxes (including social security contributions) rose – although until recently, by somewhat less than the increase in expenditures. The resulting budget deficits led to increases in the overall debt/GDP ratio, increasing the proportion of GDP devoted to servicing the debt.

Most OECD countries have recently taken determined steps to reduce their budget deficits, to the extent that by 1997, virtually every country (except Japan) was running a primary surplus (OECD, 1998*b*).[2] This aim of improving the state of public finances has been expressed in terms of a government commitment to achieve a balanced budget (see Table 2.1). In EU member states and those applying to join, the Maastricht criteria for economic and monetary union have given an additional impetus towards fiscal rectitude.

Table 2.1. **Budgetary targets in OECD countries**

Fiscal constraint	Member of EU seeking to satisfy Maastrich criteria[1] for economic and monetary union	Countries negotiating for entry into EU in the next wave	Other governments with a commitment to surplus or balanced budget[2]
Countries	Austria, Belgium, Denmark,[3] Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden,[1] United Kingdom[3]	Czech Republic, Hungary, Poland	Australia, Canada, Iceland, New Zealand, Norway, Switzerland, United States

1. Current deficit of no more than 3 per cent of GDP; public debt to GDP ratio of 60 per cent or below.
2. Definitions of balance (*e.g.* over the cycle, excluding some items of expenditure, accruals or cash basis) differ.
3. Countries which are Members of the EU but did not join EMU when it was first introduced.

Source: OECD.

The improvement in public finances has been achieved in part by increases in taxation. As Table 2.2 shows, the ratio of taxes to GDP has risen across the OECD area since 1985. Many countries have also sought to reduce social spending. An OECD report (1998*g*) identifies Australia, Canada, Denmark, Finland, Italy, Mexico, Poland, Sweden and Switzerland as having cut some social spending programmes because of budgetary constraints.

Other things being equal, the ageing of the population and the consequent increase in the dependency ratio will increase social spending as a percentage of GDP in most OECD countries. This raises the question as to whether this projected increase can be financed by increasing the tax/GDP ratio still more, or whether reductions in government spending (almost inevitably requiring reductions in social spending) will be demanded.

Table 2.2. **Taxation as a percentage of GDP**

	1965	1975	1985	1990	1995
OECD Total	26.1	31.5	34.9	36.2	37.4
OECD America	25.1	29.6	25.4	26.8	27.0
OECD Pacific	22.1	23.7	27.0	29.8	30.0
OECD Europe	26.8	33.3	38.0	39.0	40.1

Source: OECD Revenue Statistics.

2.2. Taxation and the labour market

Labour taxation has been the traditional source of revenue for much of the social security budget, either explicitly through levies on payrolls and wages of employers and employees, or implicitly through personal income taxes and taxes on consumption out of labour income. However, the *OECD Jobs Study* (1994*c*) concluded that labour taxation may adversely affect the labour market, thereby perversely increasing the demand for the transfers and services it was initially intended to finance. Increased labour taxes can either increase the cost of employing someone or reduce the after-tax incomes which may be received (OECD, 1994*c*).[3] In the latter case, an increase in employers' contributions will eventually be reflected in lower wages, reducing the financial incentive to work and increasing the risk of in-work poverty. Where wages do not or cannot fall – as is often the case at the lower end of the labour market, because of wage floors caused by minimum wages or the level of benefit income paid to those without work – the effect of increased labour taxes may be to reduce demand for low-skilled labour still further.

The taxation of labour has been reformed in most OECD countries since the mid-1980s. The defining characteristic of personal income tax reforms has been to lower the top rates of marginal taxation and to broaden the personal income tax base. However, simultaneously, pressures to finance social spending have led to *increases* in social security contribution rates.

In Belgium, Hungary, Finland, Italy and Germany, employees on average earnings eventually receive less than half the cost to employers of hiring them (see Chart 2.1). The rest goes to the public purse in the form of social security contributions by employees and employers and personal income taxes. Compared with 1979, the labour tax wedge has increased in 15 of the 22 countries for which there is full information.[4]

Furthermore, there has been a change in the distribution of labour taxes. Whereas average tax rates have generally risen throughout most of the earnings distribution (OECD, 1995*a*), they have risen *more* at *low* earnings levels than at *higher* levels. Marginal tax rates have generally been stable or have fallen for higher earnings; they have risen for those with lower earnings. As a result, initiatives have been taken in some countries to reduce employers' social security contributions for some who are particularly disadvantaged in the labour market, or to increase the in-work incomes of those who accept work at low wages (see Chapter 5 and OECD, 1997*f* for a discussion of these issues).

2.3. Globalisation and taxation

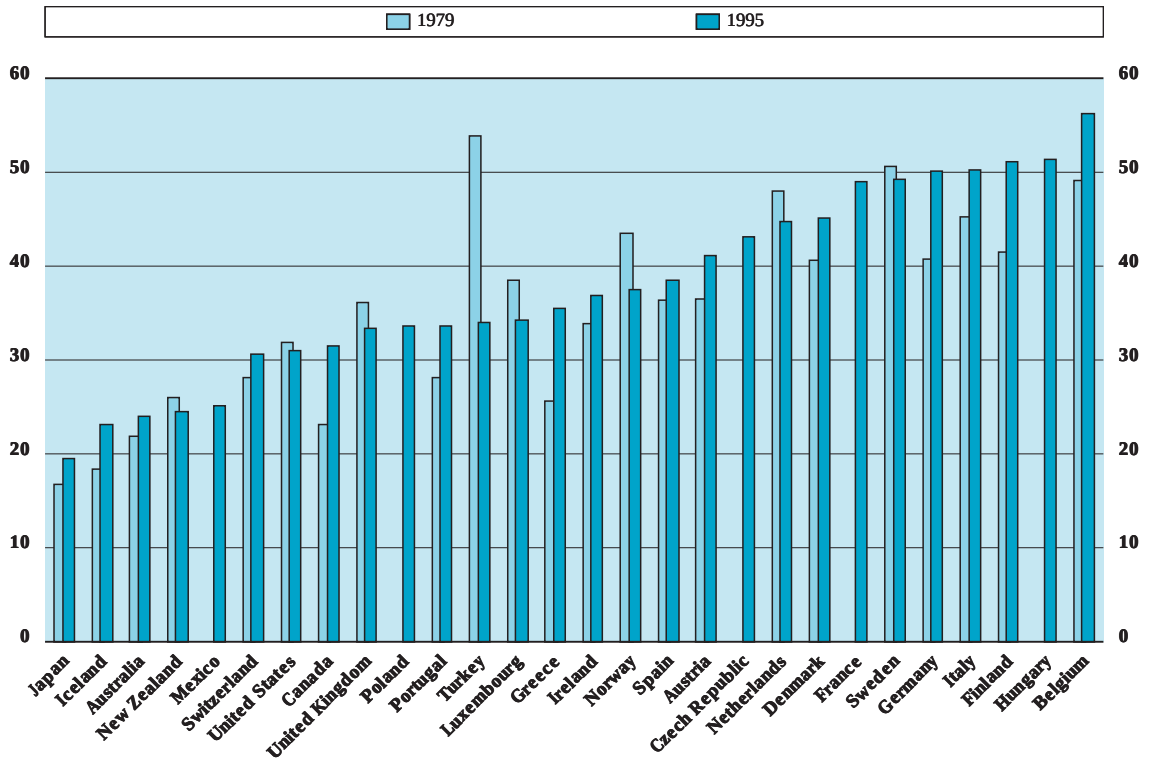
If increases in traditional labour taxes in order to finance future social spending look unappealing, attention turns to possible alternative tax bases. In practice, there are few convincing candidates for a tax base which would permit a large shift away from labour taxation.

As a result of globalisation, capital may be becoming more mobile, and thus more difficult for any one state to tax. Some countries have sought to expand the tax base through greater use of environmental taxes. However, with the major exception of mineral oil taxation, few environmental taxes which raise considerable amounts of revenue are yet in place. The reasons are easily found: insofar as the incidence of such taxes is on capital, they risk discouraging or displacing investment. If the burden is borne by consumers, the distributional impact of the taxes – which is often regressive – pre-empts much of the revenue in the form of compensation to vulnerable groups. The result is that the burden of such taxes is borne mainly by labour.

In sum, governments across the OECD have taken the view that continued deficit financing of government expenditure is no longer an acceptable option. Labour taxes in many OECD countries are already substantial at almost any wage level, and may have contributed to high

Chart 2.1. **The labour tax wedge**

Employees' and employers' social security contributions and personal income tax as a percentage of gross labour costs 1979-95 (single person, average production worker's earnings)



Source: OECD (1998*i*).

and persistent unemployment. There are no obvious candidates to provide an alternative revenue source to labour taxation. Two (unsurprising) conclusions follow. First, there will be continued pressure to restrain social protection expenditure. Second, governments will seek to find alternative revenue sources, such as transferring the costs of programmes to employers or private citizens, in order to relieve the public budget constraint.

3. Trends in gross public social expenditure

During the 1960s and early 1970s, there was very rapid growth of social expenditure: on average across the OECD area public social expenditure doubled from 10 per cent of GDP in 1960 to 20 per cent in 1980 (OECD, 1994*d*, pp. 57-58).[5] This rapid expansion was directed towards extending the coverage of social protection programmes to a larger proportion of the population and improving the level of individual services and benefits.

In comparison to the preceding two decades, growth of public social spending was relatively moderate during the 1980s, especially in the latter half of the decade. However, driven in part by cyclical factors, the social spending to GDP ratio increased sharply in several countries in the early 1990s, with increases of 2 percentage points or more in Austria, the Czech Republic,

Denmark,[6] Finland, France, Germany, Japan, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States. Chart 2.2 shows that during 1980-95:

- increases in public social spending as a percentage of GDP were in the range of 2 to 6 percentage points in most Member countries (more rapid growth was recorded in Finland and Sweden – due to the recession of the early 1990s –, Greece and Norway). The expenditure/GDP ratio decreased in Ireland and the Netherlands;[7]
- the growth rate of public social spending since 1980 is correlated with the initial expenditure/GDP ratio. Countries with spending ratios in 1980 below 15 per cent recorded relatively strong increases (5 percentage points) over the 1980-95 period (Canada, Greece, and Portugal; Japan is an exception);
- there is no strong tendency towards convergence in the expenditure/GDP ratio. However, if Finland and Sweden are excluded (on the grounds that the surge in their spending/GDP ratio in the 1990s is cyclically induced), there has been some convergence in social spending levels.[8]

3.1. The composition of public social expenditure

Over the 1980-95 period, non-health related public spending as a percentage of GDP increased by an average of 4.7 percentage points. The growth of public expenditure on health as a percentage of GDP was much more modest (0.6 percentage points). The trends in expenditure on particular programmes are the following:

- There are significant differences across countries in the proportion of public social expenditure which is directed to the *working-age* population. Public spending on income maintenance benefits in case of unemployment, sickness and disability, family support and ALMPs accounts for between one-third and two-thirds of public social spending on items other than health in most OECD countries (OECD, 1996*c*).
- *Income maintenance payments* are mainly insurance-related in most countries, while income-tested payments account for virtually all public cash transfers in Australia and New Zealand and are also important in Canada, Ireland, the United Kingdom and the United States (MacFarlan and Oxley, 1996).
- Over the past 15 years there has been little change on average across OECD countries in the proportion of total public social spending directed to the *elderly*. This proportion increased significantly in Japan and Turkey (about 10 percentage points over 15 years),[9] whereas it declined by about 10 percentage points in Germany, Ireland, Switzerland and the United Kingdom and by almost 20 percentage points in Australia. In Greece, Japan, Italy and Turkey, 75-85 per cent of the public non-health spending is targeted towards the elderly in one form or another.[10]
- Across the OECD area, the value of public social spending devoted to *services* (health care, occupational injuries and diseases, services to families, the elderly and disabled and ALMPs) is about 60 per cent of the value of public cash transfers, and there has been little variation in this share over time. Compared with the magnitude of cash transfers, the public provision of care services is relatively large in Australia, Canada, the Czech Republic, Denmark, Germany, Japan, Korea, Mexico, Norway, Sweden and the United States.
- The provision of *family services*, for example, formal day-care facilities, is most prevalent in the Nordic countries where spending is about 1.7 per cent of GDP as compared with 0.4 per cent of GDP across the OECD area.

Chart 2.2. **Cash transfers and expenditure on services**

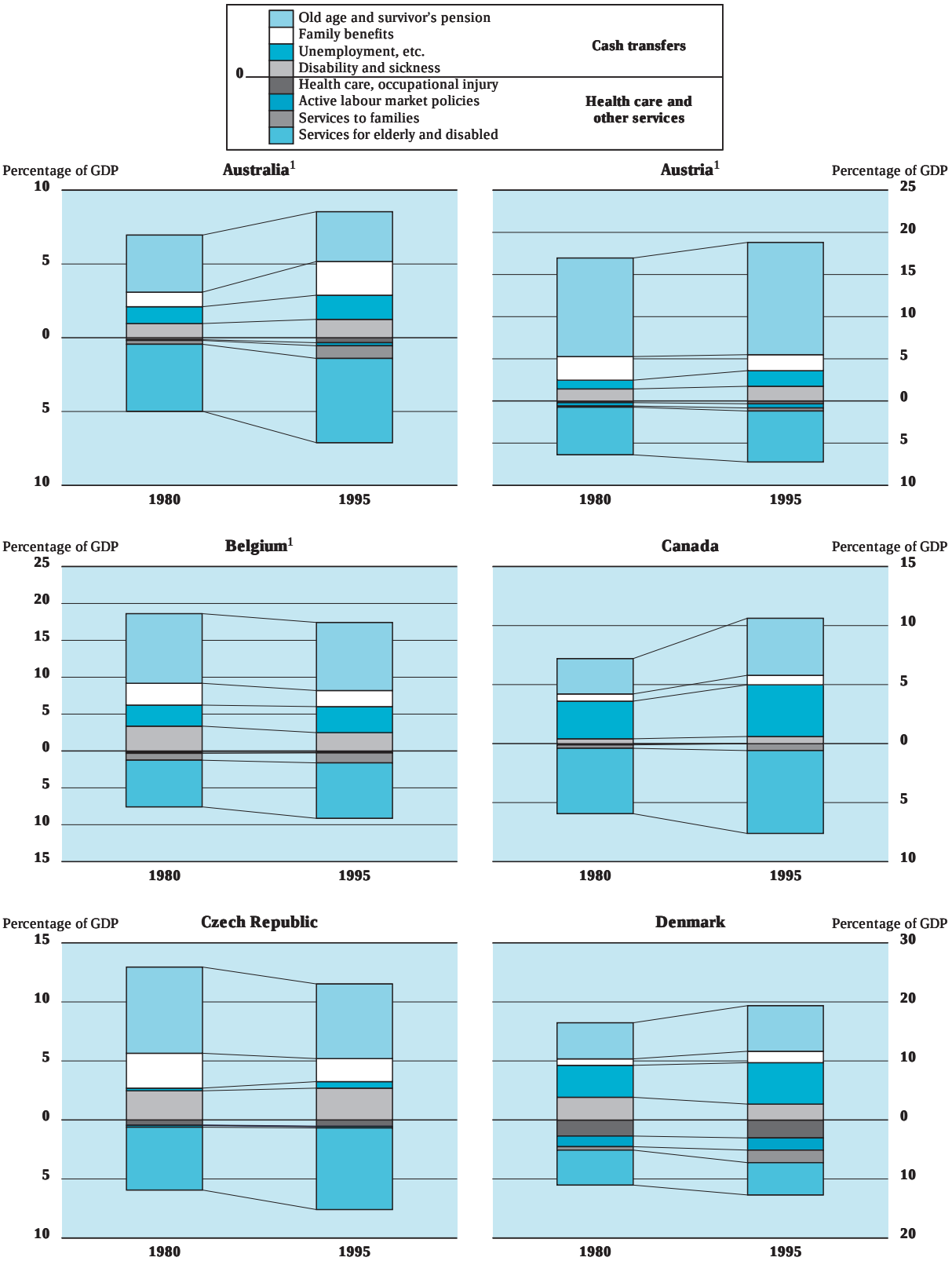


Chart 2.2. *(cont.)* **Cash transfers and expenditure on services**

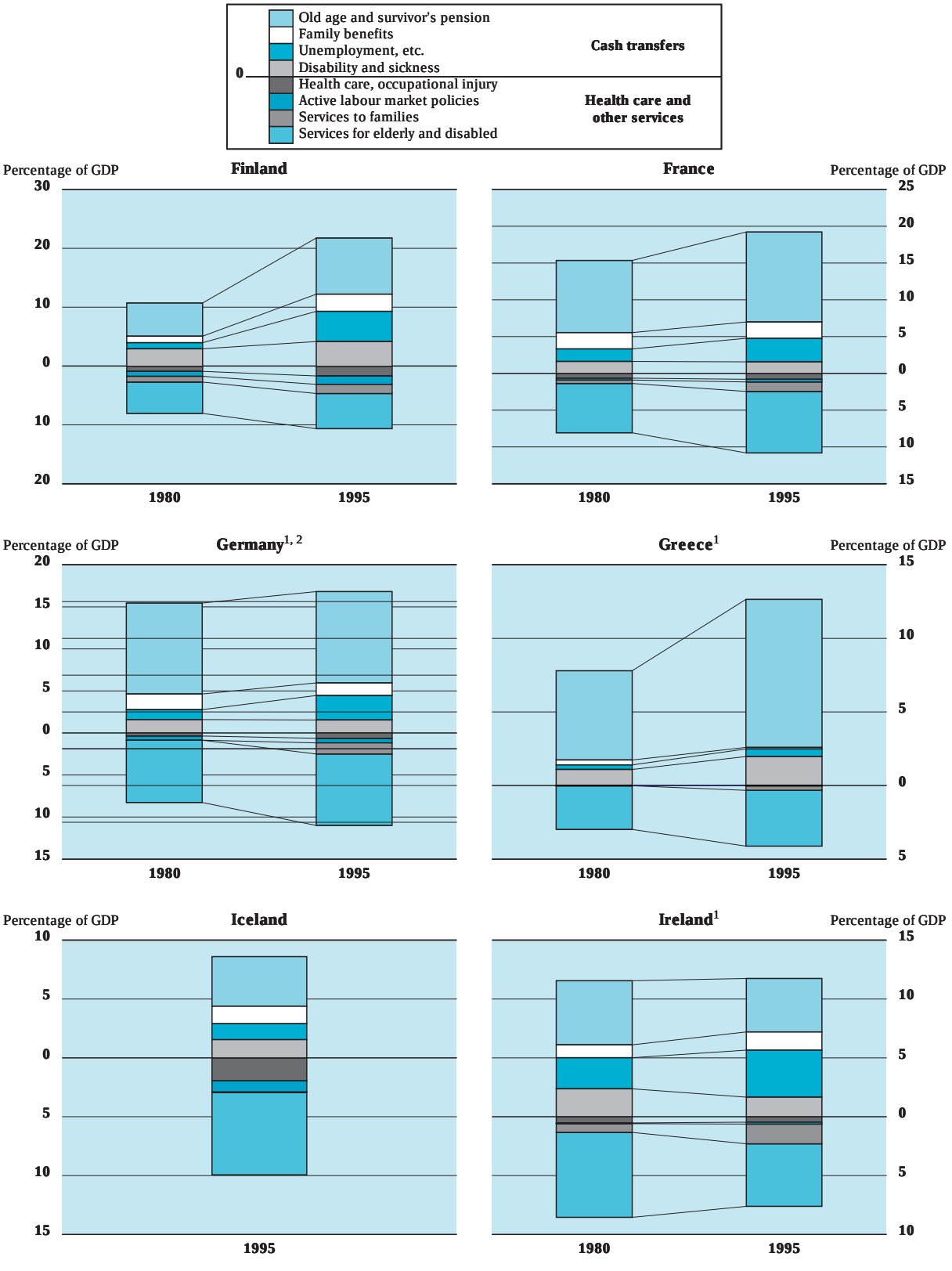


Chart 2.2. *(cont.)* **Cash transfers and expenditure on services**

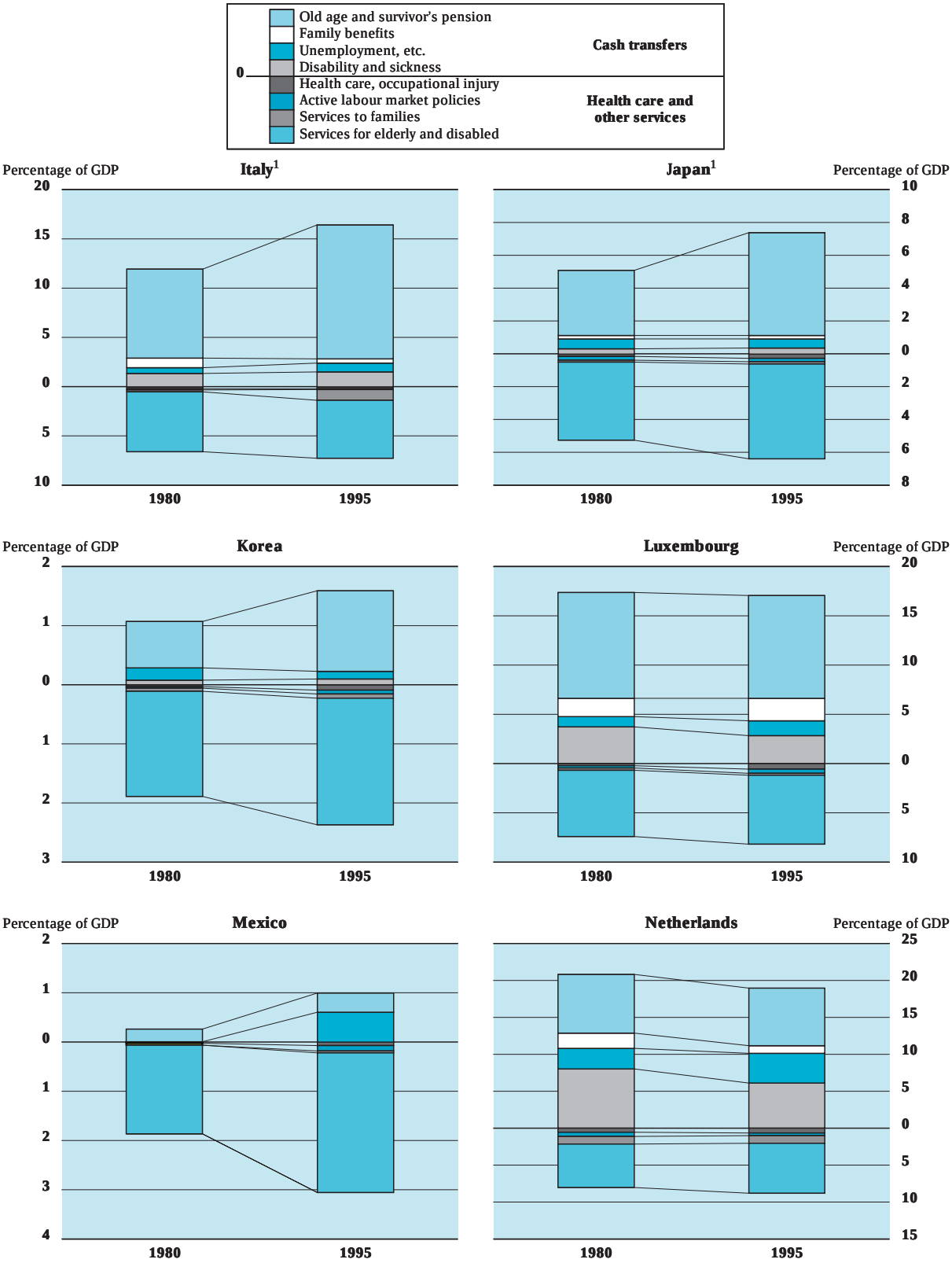


Chart 2.2. *(cont.)* **Cash transfers and expenditure on services**

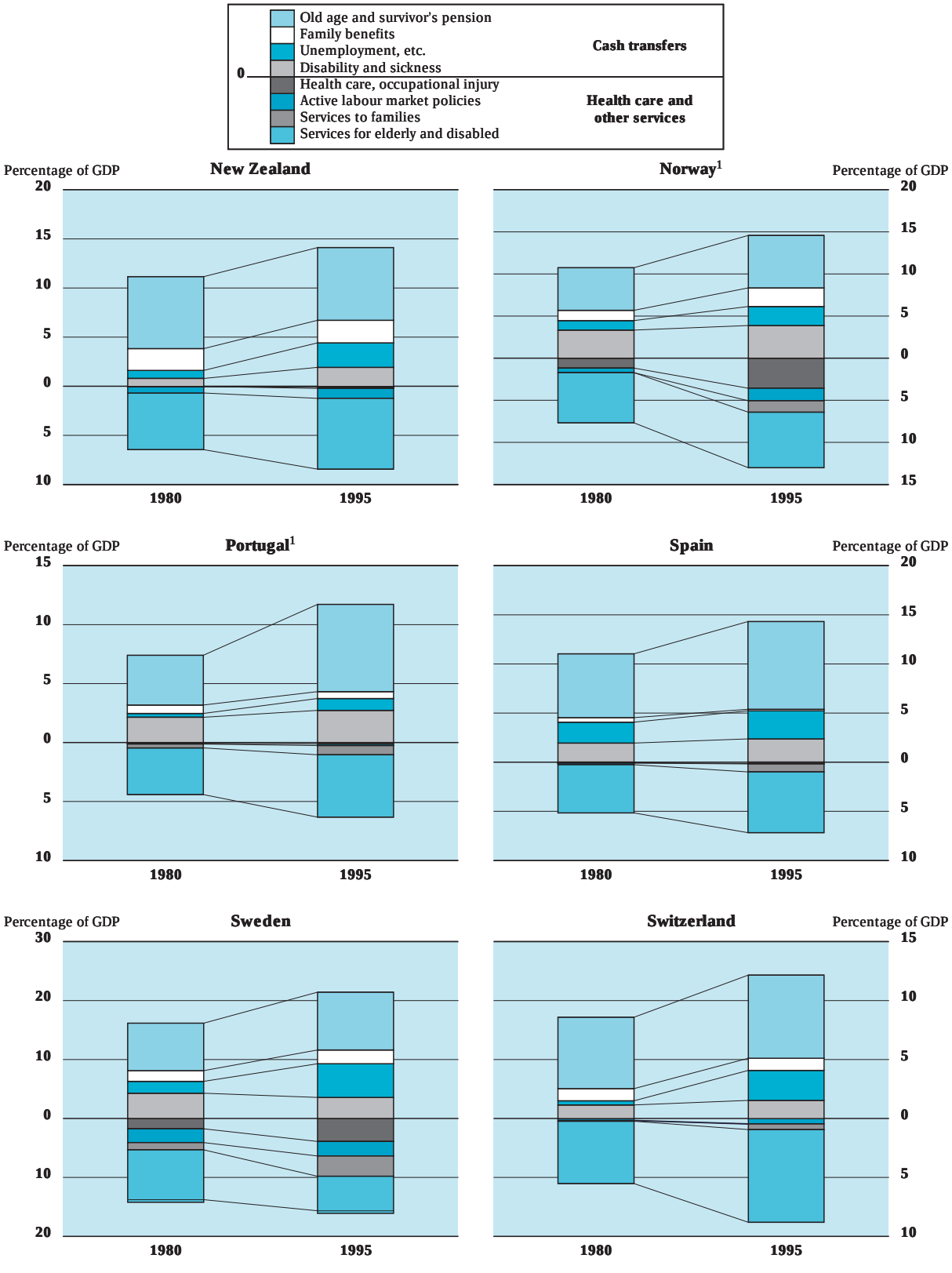
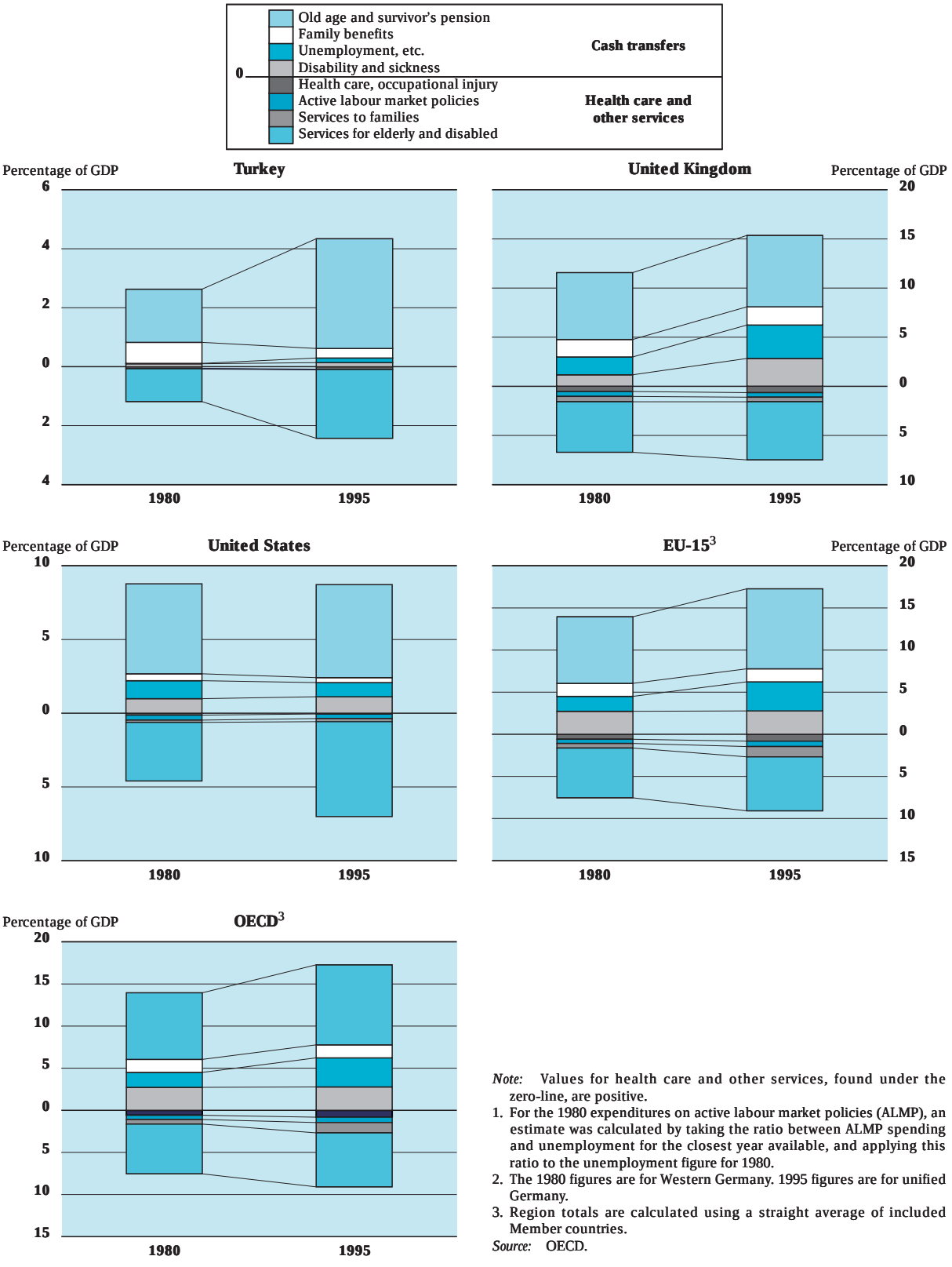


Chart 2.2. *(cont.)* Cash transfers and expenditure on services



Note: Values for health care and other services, found under the zero-line, are positive.

1. For the 1980 expenditures on active labour market policies (ALMP), an estimate was calculated by taking the ratio between ALMP spending and unemployment for the closest year available, and applying this ratio to the unemployment figure for 1980.
2. The 1980 figures are for Western Germany. 1995 figures are for unified Germany.
3. Region totals are calculated using a straight average of included Member countries.

Source: OECD.

- There has been an upward trend in expenditure on parental leave benefits in Austria, Canada, Denmark, Finland, France, Germany, Italy, Norway and Sweden while expenditure on maternity benefits stabilised for the 1985-92 period (OECD, 1995*d*). In many countries where *child-care services*, *parental and maternity-leave* provisions are relatively generous (the Czech Republic, Denmark, Finland, Iceland, Norway, and Sweden) labour force participation rates of female prime-age workers exceeded 80 per cent in 1996 (OECD, 1997*h*).
- The expenditure data on unemployment compensation and *Active Labour Market Programmes* (ALMPs) do not indicate a shift in public spending on labour market policies from passive to active measures, despite this having been endorsed as a goal of policy.[11]

3.2. Public expenditure on health

Health care spending for the OECD area as a whole more than doubled as a share of GDP over the period 1960 to 1996 (Table 2.3), from under 4 per cent to about 8 per cent of GDP (the United States being an outlier with 14 per cent of GDP devoted to health care). However, most growth took place in the early part of this period; since the mid-1980s, the percentage of GDP devoted to health services has been relatively stable. This stabilisation was accompanied by a decrease in the share of public expenditure on health in total social spending in a majority of OECD countries.

Table 2.3. **Health spending as a percentage of GDP, 1960-96**[1]

	1960	1970	1980	1990	1995	1996[2]
Australia	4.9	5.7	7.3	8.3	8.6	8.5
Austria	4.3	5.3	7.7	7.2	8.0	8.0
Belgium	3.4	4.1	6.5	7.5	7.9	7.8
Canada	5.5	7.1	7.2	9.1	9.6	9.5
Czech Republic				5.4	7.5	7.2
Denmark	3.6	6.1	6.8	6.5	6.4	6.3
Finland	3.9	5.7	6.5	8.0	7.6	7.4
France	4.2	5.8	7.6	8.9	9.9	9.7
Germany	4.8	6.3	8.8	8.7	10.4	10.5
Greece	2.9	4.0	4.3	5.2	7.2	4.7
Hungary				6.1	7.1	6.7
Iceland	3.3	5.0	6.2	7.9	8.2	8.2
Ireland	3.8	5.3	8.7	6.7	7.0	5.9
Italy	3.6	5.2	7.0	8.1	7.8	7.7
Japan		4.4	6.4	6.0	7.2	7.2
Korea		2.1	2.9	3.9	3.9	4.0
Luxembourg		3.7	6.2	6.6	7.0	7.3
Mexico					4.9	4.6
Netherlands	3.8	5.9	7.9	8.3	8.7	8.5
New Zealand	4.3	5.2	6.0	7.0	7.1	7.1
Norway	2.9	4.5	7.0	7.8	8.0	7.9
Poland				4.4		5.0
Portugal		2.8	5.8	6.5	8.2	8.3
Spain	1.5	3.7	5.6	6.9	7.3	7.4
Sweden	4.7	7.1	9.4	8.8	7.2	7.3
Switzerland	3.1	4.9	6.9	8.3	9.6	9.7
Turkey		2.4	3.3	2.9		
United Kingdom	3.9	4.5	5.6	6.0	6.9	6.9
United States	5.2	7.3	9.1	12.6	14.1	14.0
Total OECD[3]	**3.9**	**4.9**	**6.6**	**7.1**	**7.9**	**7.7**

1. Notwithstanding considerable efforts at homogeneity, part of the intercountry differences are due to differences in measurement.
2. 1996 ratios are preliminary estimates.
3. The arithmetic average for OECD excludes the Czech Republic, Hungary, Poland and Turkey, and does not include Portugal, Luxembourg, Korea, or Japan for 1960.

Source: Diskette OECD Health Data 1998.

The shares of the main components of health care in total expenditure on health are shown in Table 2.4. Over the period 1970-95, *inpatient* spending accounted for about 45 per cent of total health care spending. The most significant growth took place between 1970 and 1980, when inpatient spending rose from 43 to 48 per cent of total spending. The share of *ambulatory* care spending in total health spending increased in most OECD countries over the same period, reflecting the growing trend towards providing care in less costly ambulatory settings. *Pharmaceutical* costs as a percentage of total health care costs have increased sharply in nearly all OECD countries since 1990. This reflects *inter alia: i)* a trend towards consumer demand for improved pharmaceutical treatment (see OECD, 1998*g*), and *ii)* increased demand for pharmaceuticals created by the tendency towards treating illness in ambulatory care settings.

Public health spending increased as coverage expanded in the 1960s and 1970s. The public share in total health spending rose rapidly during this period, reaching a peak in the 1980s (Table 2.5). The public share has declined in sixteen countries since 1990, with this trend being particularly pronounced in Canada, Finland, Italy, New Zealand, Portugal and Sweden. This is in part a reaction to public budget constraints and recent efforts to shift more of the financial burden to the private households and individuals – for instance, through higher patient cost-sharing in the form of co-insurance, co-payments and deductibles. It also reflects a more rapid growth of individual demand for individual health spending, relative to the growth in the public sector care provision.

3.3. The impact of the tax system on public social expenditure

The public expenditure figures discussed above fail to reflect the true extent of public "social effort" because they do not adjust for the effects of different tax systems across countries. The tax system can affect international comparisons in two ways (Adema *et al.*, 1996):

- the level of taxation of benefit income affects the real value of expenditures;
- governments pursue social policy objectives through tax concessions.

In some countries, almost all social benefits are paid net of tax; in others they are taxed in the same way as income from work. For example, in 1995 an unemployed person in the Netherlands whose last earnings were at the level of the Average Production Worker (APW) and who lived in a one-earner family would find that tax payments reduced the value of their benefits by one third (OECD, 1998*e*). Countries with relatively low public social spending levels such as the United Kingdom and the United States tax income transfers much less heavily than high public social spending countries (Denmark, Germany, the Netherlands and Sweden). Similarly, as cash transfers are used by recipients to buy goods and services, their value is affected by the rate of indirect taxation. As the indirect tax rate is relatively low in low public spending countries, in particular in the United States, the difference in the net value of cash transfer spending across countries is much lower than indicated by gross expenditure levels (compare lines 1 and 3 in Table 2.6).

Tax allowances which mirror the effects of a cash benefit can be substantial. For example, in Germany the value of tax allowances for families with children amounted to almost DM 21 billion in 1993 or 0.6 per cent of GDP (German Federal Ministry of Labour and Social Affairs, 1994). This is also the case for tax breaks to promote the purchase or use of private sector alternatives to public expenditure. For example, in the United States the value of tax advantages concerning employer contributions to medical insurance premiums and medical care amounted to almost 0.8 per cent of GDP at factor cost in 1993 (United States Office of Management and Budget, 1994).

Table 2.4. **Main components of health care expenditures,[1] 1970-95**

	Pharmaceutical 1970	Ambulatory care 1970	Inpatient 1970	Pharmaceutical 1980	Ambulatory care 1980	Inpatient 1980	Pharmaceutical 1990	Ambulatory care 1990	Inpatient 1990	Pharmaceutical 1995	Ambulatory care 1995	Inpatient 1995
Australia	–	–	29.1	7.9	22.3	52.9	8.9	26.4	47.2	11.4	29.3	44.2
Austria	16.2	23.9	28.8	12.0	20.2	28.3	13.4	22.5	21.7	14.1	23.4	20.6
Belgium	28.1	42.5	25.7	17.4	39.2	33.1	15.5	39.8	32.8	18.1	37.7	37.4
Canada	11.2	22.4	52.1	8.4	23.2	53.3	11.3	23.7	48.4	13.3	–	45.6
Denmark	9.1	29.3	55.8	9.1	21.1	65.1	8.9	23.4	61.2	11.5	18.9	62.1
Finland	12.6	37.2	49.5	10.7	39.9	48.4	9.4	44.3	44.2	14.2	49.9	40.2
France	23.2	26.6	38.0	15.9	24.8	48.1	16.7	28.2	44.4	16.7	–	44.5
Germany[2]	15.9	31.7	30.2	13.1	33.4	32.6	13.9	30.4	34.2	12.5	29.7	36.3
Greece	43.3	38.7	46.4	34.8	45.4	48.9	24.4	–	58.4	19.3	–	–
Iceland	17.4	–	47.8	15.9	17.0	62.1	15.5	22.9	55.5	15.8	23.5	55.6
Ireland	22.2	–	–	11.2	–	–	13.6	–	–	13.4	–	–
Italy	14.5	36.2	47.8	13.7	27.5	46.7	18.3	29.1	45.3	17.2	30.0	47.1
Japan[2]	–	48.4	26.4	–	44.6	30.9	21.4	43.9	33.0	–	–	–
Korea	–	–	–	–	–	–	278	43.3	23.8	31.8	39.4	23.1
Luxembourg	19.7	22.4	–	14.5	49.5	31.3	14.9	49.3	26.4	–	52.1	34.7
Netherlands	7.5	–	55.1	7.9	27.7	57.3	9.6	29.6	52.3	10.8	28.1	52.5
New Zealand	–	–	–	–	8.4	72.2	15.0	7.4	60.4	16.2	–	–
Norway	7.8	–	68.2	8.7	18.4	63.9	7.2	20.8	61.6	8.7	–	–
Portugal	–	–	–	19.9	–	28.7	24.9	–	31.0	25.2	–	–
Spain	–	–	–	21.0	12.6	54.1	17.8	10.8	44.1	–	–	–
Sweden	–	–	–	6.5	–	–	8.0	–	–	14.6	–	–
Switzerland	19.1	–	41.7	15.2	45.5	42.6	8.2	39.5	49.5	7.6	37.4	51.7
United Kingdom	–	–	–	12.8	–	53.5	13.8	–	43.9	15.9	–	–
United States	12	27.1	44.0	8.7	27.2	48.7	8.6	32.4	44.1	8.4	33.2	43.3
Total EU	**19.3**	**32.1**	**41.9**	**14.7**	**31.0**	**44.3**	**14.9**	**30.7**	**41.5**	**15.7**	**33.7**	**41.7**
Total OECD[3]	**17.5**	**32.2**	**42.9**	**13.6**	**28.8**	**47.7**	**13.9**	**29.1**	**44.7**	**14.4**	**33.1**	**44.0**

1. Notwithstanding considerable efforts at homogeneity, part of the intercountry differences are due to differences in measurement.
2. Preliminary estimates for Japan and Germany in 1995.
3. Arithmetic average for OECD countries excludes Poland, Czech Republic, Korea, Hungary or Turkey.

Source: Diskette OECD Health Data 1997.

Table 2.5. **Public share in total health spending,[1] 1960-96**

	1960	1970	1980	1990	1995	1996[2]
Australia	47.6	56.7	62.9	67.3	66.7	64.7
Austria	69.4	63.0	68.8	73.5	73.3	72.0
Belgium	61.6	87.0	83.4	88.9	87.8	87.7
Canada	42.7	70.2	75.6	74.6	71.1	69.9
Czech Republic		96.6	96.8	96.2	92.6	92.4
Denmark	88.7	86.3	85.2	82.3	82.7	82.3
Finland	54.1	73.8	79.0	80.9	74.7	78.4
France	57.8	74.7	78.8	74.5	80.6	80.7
Germany	66.1	72.8	78.7	76.2	78.2	78.3
Greece	64.2	53.4	82.2	82.3	75.8	82.9
Hungary					69.8	69.3
Iceland	76.7	81.7	88.2	86.6	84.1	83.6
Ireland	76.0	81.7	81.6	72.9	74.7	
Italy	83.1	86.9	80.5	78.1	69.5	69.0
Japan	60.4	69.8	71.3	77.6	79.6	78.3
Korea		8.3	25.3	44.0	52.5	57.1
Luxembourg		88.9	92.8	93.1	92.8	92.7
Mexico					57.2	59.4
Netherlands	33.3	84.3	74.7	72.7	76.7	72.1
New Zealand	80.6	80.3	88.0	82.4	76.4	75.9
Norway	77.8	91.6	85.1	83.3	82.8	82.5
Portugal		59.0	64.3	65.5	60.5	59.8
Spain	58.7	65.4	79.9	78.7	78.7	78.7
Sweden	72.6	86.0	92.5	89.9	81.6	80.2
Switzerland	61.3	63.9	67.5	68.4	72.9	72.9
Turkey		37.3	27.3	35.6		
United Kingdom	85.2	87.0	89.4	84.1	84.4	84.5
United States	24.8	37.8	42.4	40.7	45.9	46.7
Total OECD[3]	**63.9**	**71.3**	**75.8**	**75.8**	**75.4**	**76.8**

1. Notwithstanding considerable efforts at homogeneity, part of the intercountry differences are due to differences in measurement.
2. 1996 ratios are preliminary estimates.
3. The arithmetic average for OECD excludes the Czech Republic, Hungary, Poland and Turkey, and does not include Portugal, Luxembourg, Korea or Japan for 1960.

Source: Diskette OECD Health Data 1998.

Table 2.6. **Net public social expenditure[1]**

	Denmark	Germany	Netherlands	Sweden	United Kingdom	United States
1. Gross public social expenditure	**35.3**	**32.5**	**34.0**	**42.4**	**26.9**	**16.3**
– Direct taxes and social contributions paid on transfers	4.5	2.9	6.5	5.9	0.7	0.1
2. Net cash public social expenditure	30.7	29.6	27.5	36.5	26.2	16.2
– Indirect taxes	4.5	3.3	2.8	4.1	2.6	0.5
3. Net direct public social expenditure	26.3	26.3	24.8	32.9	23.6	15.7
+ Tax breaks for social purposes[2]	0.1	0.9	0.1	0.0	0.3	1.3
4. Net current public social expenditure	**26.4**	**27.2**	**24.9**	**32.4**	**23.9**	**17.0**

1. The indicators developed here aim to measure that part of domestic production to which recipients of public social support lay claim, and by doing so, they account for the value of indirect taxation on the consumption of benefit income. Consequently, the indicators presented are related to GDP at factor costs which do not include the value of indirect taxation and government subsidies to private enterprises and public corporations.
2. These estimates of the value of tax breaks for social purposes (TBSP) do not include the value of TBSPs towards pensions. Due to methodological and measurement issues such data are not available for all countries. Some information is available for the United Kingdom and the United States which indicates that the value of such tax advantages can be significant. For example, in the United Kingdom tax relief for personal and occupational pension programmes and the contracted-out rebate of national insurance contributions amounted to 3.1 per cent of GDP factor cost in 1993. This figure reflects the cost to the public budget – on a cash basis – of the current tax system in the current financial year on tax breaks on contributions, regardless of what effects the current tax system may have on revenues in future years.

Source: Adema *et al.* (1996).

The importance of the impact of the tax system on cross-country comparisons of "public social effort" is apparent from Table 2.6. Accounting for the impact of the tax system leads to marked convergence in the volume of social protection available across countries.

3.4. The extent of private sector provision

Tight constraints on the public budget have led to three developments in social spending. First, access to some programmes has been restricted and benefits cut (see OECD, 1998*g*). Second, there has been a greater emphasis on making programmes more effective in achieving their goals. This has often involved management and administrative reforms (see Chapter 6) but also in some cases a reorientation of policy has resulted. New partnerships between the state and private providers are being developed; individual contributions to programmes encouraged and the role of employers in covering their workforce against some risks emphasised. Already, the benefits derived from collectively provided employer-based plans and tax-advantaged individual plans are significant in some countries, including the United States, the Netherlands and the United Kingdom, and their importance is likely to increase in the future (see Box 2.1).

As Table 2.7 shows, private provision is higher in those countries where public provision is lower. Differences in the total amount of resources being devoted to social purposes remain substantial, but by no means as dispersed as the gross figures suggest. The economic impact of social provisions is, for most purposes, better measured by also taking account of private expenditures.

4. Trends in expenditure by broad social policy areas

4.1. Expenditure on the elderly

As already noted, the relative public spending shares devoted to support of the aged and non-aged proportions of the population have changed little over time in most OECD countries. Nonetheless, in some countries, there are significant shifts when attention is focused on individual social protection programmes.

Non-health related social support to the aged consists mainly of public cash transfers (old-age cash benefits and survivors benefits). Pension expenditure is in the range of 10 to 14 per cent of GDP in Austria, Belgium, Finland, France, Germany, Greece, Italy, Luxembourg and Sweden. However, in the Nordic countries support to the aged by means of in-kind benefits is also considerable, exceeding 3 per cent of GDP in Norway and Sweden.

In all OECD countries, the increase in life expectancy and increases in the proportion of elderly people in the population are putting pressure on the financing of public pension systems. As documented in OECD (1996*g*) and OECD (1996*h*), projections (assuming existing pension rules are maintained) indicate that in most OECD countries public pension expenditures will increase rapidly during the 2015-2045 period. However, projected pension payments would still vary considerably across countries. For example, among the G7 countries public pension expenditure would rise above 15 per cent of GDP in Japan, Germany and Italy but remain below 10 per cent of GDP in Canada, the United Kingdom and the United States.

Demographic trends, combined with maturation of earnings-related public pension systems, have already led to increases in pension expenditure over the 1980-93 period in some OECD countries. The public pension spending to GDP ratio increased by 1.5 to 2 percentage points in Canada, France, Japan, Portugal, Spain, Sweden, Turkey and Switzerland, while 4 percentage point increases were recorded in Finland, Italy and Greece (Chart 2.2). In other countries, the public pension spending to GDP ratio increased at a much more moderate pace or not at all (Australia and Ireland).

Box 2.1. Private social provision

Employer-provided social benefits: Governments sometimes mandate employers to make transfers to target groups, while exercising control over the terms – level, coverage and duration – under which these private benefits are provided. Prominent examples are employer-provided sickness benefits or benefits related to occupational injuries and diseases. The responsibility of employers to make such payments has increased in some countries, making them responsible for sickness payments and lengthening the period for which they have to pay benefits (Denmark, the Netherlands, Sweden, and the United Kingdom). These reforms have led to falls in public social expenditures on related programmes. The aim of such reforms is not simply to transfer expenditures from government budgets. Doing so also gives employers incentives to ensure their workplaces are safe, healthy environments and to implement mechanisms to reduce the level of absenteeism.

In some countries (*e.g.* Australia, Switzerland and the United Kingdom), governments mandate individuals and employers to make contributions to private pension funds. Employer involvement in pension provision can also arise from collective agreements, established at national, industry or enterprise level; in Australia, Finland and the Netherlands, industry agreements can be extended to cover all employers, including non-members of the association which signed the agreement. Such voluntary employer-provided social benefits often top up public and mandatory private benefits and their provision is often subject to favourable tax treatment. The generosity of public provision determines the demand for additional private arrangements. In Denmark and Germany, for example, the generosity of public pension plans seems to have left little demand for additional pension insurance. On the other hand, private pension payments are important in the Netherlands, the United Kingdom and the United States where benefit payments amounted to 2 to 3 per cent of GDP in 1993. Moreover, their importance has increased significantly over time: gross private pension expenditure as a percentage of GDP increased by 1.2 to 1.6 per cent of GDP in the Netherlands, the United Kingdom and the United States over the 1980-93 period, while over the same period public pension expenditure increased by less than 1 per of GDP (Adema and Einerhand, 1998).

Private social health expenditure in the United States is more prevalent than in other countries. In the absence of universal public health care coverage and stimulated by tax reliefs, employers in the United States, particularly those with large numbers of employees, also provide health care coverage for their employees. Until recently growth rates for both public and private expenditure in the United States outpaced similar growth rates in other countries (Schieber *et al., 19*94).

Some employers also provide family benefits to their workers, such as child-care facilities and paternal leave benefits. The importance of such benefits is growing in some OECD countries. For example in Germany, employer-paid family allowances to workers with children amounted to DM 1.3 billion in 1995, while in the United States the incidence of unpaid paternity leave in medium and large establishment more than tripled from 1988 to 1993 (US Census Bureau of Labor Statistics, 1996).

Individual provision: A greater reliance on individuals to take care of their own needs can arise as a result of an absence of public provision. By its very nature, this is difficult to quantify. One area where it is possible to make some rough estimates is for spending on long-term care. Although only indicative, total expenditure on care provision for the dependent elderly is estimated to vary between 1 and 3 per cent of GDP (see Jacobzone, 1999 forthcoming). The availability of public provisions appears to be strongly negatively correlated with reliance on private arrangements.

Significant pension reforms which took place in the 1980s in Australia and the United Kingdom have not yet led to substantial pension payments but contributions to these plans have risen sharply. Contributions to tax-advantaged pension plans in the United States amounted to $87 billion in 1990 while payments were only to $143 million (EBRI, 1995; and Kerns, 1997).

Box 2.1. **Private social provision** *(cont.)*

Non-profit organisations: The pressure on governments to do more with less has encouraged some to make greater use of the networks and skills of non-profit organisations (NPOs). The main community value of the voluntary sector comes from their activities in niche markets, providing assistance to those households at risk of social exclusion (*e.g.*, services for the homeless) and some well-established services (such as advice centres, youth centres, respite care services, meals for the elderly/infirm in their own home, housing organisations, long-term care). Available information suggests that expenditure by NPOs in the field of social services in Germany, the United Kingdom and the United States amount to 0.9, 0.6 and 0.7 per cent of GDP respectively, and on housing, 0.4, 0.2 and 0.1 per cent of GDP (Salamon *et al., 199*6). These data abstract from the value of time of volunteers which could be considerable. Governments often support NPOs through direct funding and tax concessions. For example, in Germany and France, the non-profit sector draws more than half of its revenue from the public sector (*ibid.*). Tax concessions can also be significant. For example, tax relief for charitable organisations in the United Kingdom in 1995-96 has been estimated by the Inland Revenue to be worth over £1 billion (Williams, 1997).

Table 2.7. **Net private social expenditure**[1]

	Denmark	Germany	Netherlands	Sweden	United Kingdom	United States
1. **Net current public social expenditure**	**26.4**	**27.2**	**24.9**	**32.4**	**23.9**	**17.0**
2. **Net current mandatory private social expenditure**	0.3	0.9	–	0.4	0.2	0.5
3. **Net current voluntary private social expenditure**[2]	0.4	1.5	3.4	1.0	3.2	7.8
of which:						
Net private pension expenditure	0.7	0.6	2.0	0.8	2.1	2.3
Private health expenditure[3]	0.2	0.7	1.5	0.1	0.4	5.6
4. **Net current total social expenditure**[4]	**27.1**	**29.5**	**28.2**	**33.8**	**27.3**	**24.2**

1. The indicators developed here aim to measure that part of domestic production to which recipients of collectively decided direct and indirect social support lay claim, and by doing so, they account for the value of indirect taxation on the consumption of benefit income. Consequently, the indicators presented here are related to GDP at factor costs which do not include the value of indirect taxation and government subsidies to private enterprises and public corporations.
2. The estimates on net private social benefits are net of consumption and direct taxes paid by recipients of private cash transfers – which are largely private pension benefits, but also include voluntary employer-provided sickness benefits.
3. The estimates include only collectively financed health care, insured on a group basis by employers. Individual payments for health care or individual insurance are not included.
4. Net current total social expenditure is the total of net current public, net current mandatory private and net current voluntary private social expenditure. However, some government expenditure on tax advantages (TBSPs) are tantamount to financing private social benefits and therefore the value of such TBSPs has to be ignored to avoid double counting. Therefore, net current total social expenditure is not necessary equivalent to adding the values in lines 4, 5 and 6.

Sources: Adema *et al.* (1996), and Adema and Einerhand (1998).

4.2. Expenditure on the working-age population

Public support to the working-age population includes income maintenance benefits to those who are not in employment and family support benefits (see below). The income maintenance benefits to the working-age population are: unemployment compensation; social assistance benefits; early-retirement benefits; and sickness and disability benefits. Unsurprisingly, the volume of income maintenance payments to the working-age population is affected by labour market trends (and *vice versa* – see Chapter 5). In many OECD countries, employment

growth has not been strong enough over the past 15 years to avoid increases in unemployment and non-employment. Hence, except in Japan and the United States, the burden of non-employment related cash transfers has increased significantly (OECD, 1996*c*).

Changing labour market conditions for older workers

In addition to high and persistent unemployment in many countries, the composition of employment has also changed over the past two decades (see Chapter 1). The increase in non-employment for older workers has made early withdrawal from the labour force more widely accepted. In most Member countries, the increase, if any, in ultimate pensions due to an additional year of work is limited. The implicit tax on work after the age of 55 has increased significantly over recent decades due to the lowering of standard retirement ages, higher pension replacement rates and flatter pension accruals at older ages, and higher pension contribution rates (OECD, 1998*f*).

Income-support programmes, which were originally designed to deal with other contingencies, have been used in some countries to finance early retirement. Some European countries, *e.g.*, France and the Netherlands, have developed their unemployment programmes into *de facto* early-retirement schemes for older workers by extending benefit periods to the pensionable age, removing the active job-search requirement for older workers and establishing special unemployment pensions. Disability programmes have also been used for this purpose in Austria, Australia, Finland, Germany, Italy, the Netherlands, Norway, Spain and the United Kingdom, particularly where a labour-market criterion has been explicitly used to assess entitlement to benefits. In addition to these income support programmes, some countries, *e.g.*, France and Belgium, have special programmes to facilitate early retirement. The availability of these various benefits increases the disincentives to work prior to the pensionable age: the cost of an extra year of work is not only paid pension contributions but also foregone benefits, whereas ultimate pensions are often unaffected. Furthermore, disability and early-retirement programmes are generally more generous – both in terms of income and duration of benefit – than unemployment programmes (Blöndal and Pearson, 1995; and OECD, 1998*f*).

In those countries where the general pension scheme allows for retirement before the normal retirement age,[12] trends in the numbers of pension recipients who have not yet reached the standard retirement age point to changes in the take-up of early retirement (Table 2.8). It appears that, since the mid-1970s, the proportion among older male recipients of the population with a public pension before reaching the standard retirement age has trended upwards in Belgium, Denmark, Finland, Germany, Greece, Luxembourg, Portugal, Sweden and Spain. In other countries, the increase of older workers in receipt of public pensions has abated recently after substantial growth during the 1980s (Austria, the Netherlands and the United States). In Austria, the coverage of early pension recipients relative to the population was reduced by 20 per cent over the past five years, while the coverage of recipients of special public early-retirement provisions for civil servants and teachers in the Netherlands has declined since 1985.

The most substantial income maintenance programmes are unemployment compensation and disability cash benefits, both in terms of beneficiaries and expenditures. Spending on unemployment compensation is highest in Belgium, Canada, Denmark, Finland, Ireland, the Netherlands, Spain and Sweden (Chart 2.2). Spending trends follow the fluctuations in the economic cycle, but are also influenced by the accessibility of other benefits, such as disability benefits paid to workers who are not in employment.

Table 2.8. **Men, aged 55-64, receiving an old-age cash benefit, as a percentage of the population,[1] 1975-95**

	Programme	1975	1980	1985	1990	1995	Coverage[2]
Austria	Anticipated old age pension in case of long insurance time	..	11.4	16.0	16.3	13.0	55.1
Belgium	Private employees and public temporary personnel	..	..	..	8.2	9.8	48.8
Denmark	Early retirement in the form of Basic Pension	..	..	5.5	4.6	5.8	68.3
Finland[3]	Standard Retirement Pension	..	7.9	7.8	9.6	9.7	91.8
France	General scheme for employees in industry and trade (CNAVTS)	..	..	..	..	37.9	35.3
Western Germany	General pension insurance scheme: employees and self-employed	4.6	6.4	9.6	9.6	11.2	67.7
Greece	General scheme for employees (IKA)	4.4	3.9	6.6	9.5	10.5	26.4
Italy[4]	Old age benefit	..	..	..	..	24.8	57.6
Japan[5]	Employees' pension insurance (KOUSEI-NENNKINN)	..	..	..	0.6	0.4	46.3
Korea	National Pension Insurance	..	..	..	0.1	0.2	41.9
Luxembourg	Vieillesse-contributif	..	..	8.4	21.4	29.7	65.2
Netherlands	Civil servants and teachers (ABP)	2.6	4.3	4.9	4.2	3.6	13.0
Portugal	General (non-ag.) scheme: employed and self-employed (IGFSS)	0.9	2.1	2.6	2.5	3.8	49.5
Spain	Employees and self-employed, social security pension	..	4.4	6.8	10.8	14.3	76.6
Sweden	Old-age basic pension	0.6	1.3	2.2	1.7	2.9	35.4
Turkey	Old-age pension	..	..	..	..	48.5	100
United States	Old-age retired workers	8.7	9.5	12.0	12.9	12.7	53.2

1. Information concerns individuals receiving old-age cash benefits (based on administrative data) divided by the population aged 55-64.
2. For each country, data concern benefit recipients of a public pension programme which in terms of benefit payments accounts for a large share in public spending on old-age cash benefits ("coverage"). However, the coverage of the programmes varies from country to country. For example in Denmark (1990), Finland (1993), Germany (1990), Luxembourg (1990) and Spain (1989) benefit payments through the relevant social expenditure programme cover about 70 to 90 per cent of all public spending on old-age cash benefits. For Austria (1995), Belgium (1992), France (1990), Greece (1989), Italy (1990), Japan (1995), the Netherlands (1995), Portugal (1990), Sweden (1995) and the United States (1995), the coverage rate of the benefits included in the table is about 15 to 50 per cent. The Netherlands data are for pensions paid to civil servants and teachers prior to the standard age of retirement (it also includes survivors benefits). The Austrian data concern the largest, but not the only early-retirement programme in Austria.
3. Information refers to age group 50-64.
4. Information refers to age group 40-64.
5. Information refers to age group 55-59.

Source: OECD Beneficiary Database (1998), OECD Population Database (1998).

In the mid-1990s, public spending on disability cash benefits exceeded 2 per cent of GDP in Finland, Luxembourg, the Netherlands, Norway, Portugal, Sweden and the United Kingdom (OECD, 1996*c*). High disability spending levels were already prevalent in 1980 in most of these countries and continued to increase, except in Luxembourg and the Netherlands.[13] Sharp increases (exceeding 1 per cent point of GDP) over the 1980-95 period were recorded for Finland[14] and the United Kingdom.

Not surprisingly, the same countries which have high disability-spending to GDP ratios also have relatively high beneficiary-to-population ratios and receipt of a disability cash benefit is most prevalent among older workers (Table 2.9).[15] The proportion of disability benefit recipients among the working-age population has increased over the 1975-95 period in Australia, Austria, Canada, Finland, Luxembourg, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and in particular since 1990, in the United States (see also, OECD, 1995*c;* and SZW, 1997). Other countries with a significant proportion of disability claimants include

Table 2.9. **Recipients of main social protection programmes (disability, sickness, unemployment and social assistance) as a percentage of the population, 1975-95**

Social policy area[1]	Programme[2]	Age group 25-54					Age group 55-64					Working age population[3]					Coverage[4]
		1975	1980	1985	1990	1995	1975	1980	1985	1990	1995	1975	1980	1985	1990	1995	
Australia																	
Disability[5]	Disability support pension	..	1.4	1.5	1.6	2.6	..	6.2	6.7	8.0	10.9	..	2.3	2.4	2.7	4.1	68.9
Sickness	Sickness allowance	..	..	0.7	0.8	0.4	..	..	0.8	1.0	0.3	..	..	0.6	0.7	0.3	100.0
Unemployment	Job search allowance	..	2.0	4.2	3.0	6.1	..	1.1	2.5	2.5	4.0	..	3.1	5.4	3.6	6.9	48.5
Austria																	
Disability	Invalidity pensions (employees)	..	1.1	1.5	1.5	1.5	..	9.3	12.8	16.8	17.3	..	2.1	3.0	3.5	3.6	40.3
Unemployment[6]	Unemployment benefit	..	..	..	2.3	2.6	..	..	..	2.2	1.7	..	..	..	2.1	2.3	90.6
Canada																	
Disability	CPP Disability	0.1	0.2	..	0.5	0.9	1.7	2.8	3.9	4.9	6.6	0.3	0.5	0.5	1.0	1.5	59.8
Sickness	UI sickness benefits	0.2	0.2	0.1	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	100.0
Unemployment	UI regular benefits	3.6	3.1	5.2	4.7	3.5	2.6	2.2	4.1	2.9	2.3	3.9	3.2	5.2	4.4	3.1	97.2
Denmark																	
Social assistance	Assistance up to 9 months	..	..	..	2.3	2.0	..	..	..	0.8	1.0	..	..	..	3.4	3.2	42.2
Unemployment	Unemployment compensation	..	..	8.1	8.4	8.8	..	..	4.8	5.9	8.8	..	..	7.4	7.8	8.1	72.4
Finland[7]																	
Disability	Standard invalidity pension	..	8.4	7.1	7.3	7.1	..	20.9	19.5	23.3	23.1	..	8.5	7.7	9.0	9.1	65.4
Social assistance	Living allowance	6.5	5.3	7.0	9.6	17.2	4.0	2.9	2.7	2.2	2.8	4.9	4.2	4.6	6.3	12.0	69.7
Sickness	Sickness insurance (daily allowance)	24.4	20.2	19.7	19.6	13.9	10.3	8.3	8.5	7.8	5.5	13.2	11.3	11.6	11.9	8.4	85.7
Unemployment	Basic daily unemployment allowance	..	..	..	4.2	14.5	..	..	..	1.0	2.3	..	..	..	3.8	11.4	..
Germany																	
Disability	General scheme for employees and self-employed	0.8	1.0	1.1	1.0	1.0	9.2	10.5	13.6	9.7	9.4	1.9	2.1	2.9	2.2	2.3	51.3
Social assistance	Social assistance maintenance	..	1.0	1.9	2.3	2.9	..	..	..	..	..	..	0.8	1.6	2.0	2.4	68.2
Unemployment	Unemployment insurance	..	..	1.1	1.3	1.5	..	..	1.3	2.4	4.5	..	..	1.3	1.4	2.0	65.1
Greece																	
Disability	General scheme for employees (IKA)	0.7	0.7	0.8	0.8	0.7	2.8	3.4	4.4	4.6	3.8	0.9	0.9	1.2	1.4	1.1	51.8
Social assistance	Other contingencies	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Sickness	Private sector employees, sickness allowance (IKA)	6.2	9.3	9.7	6.5	5.2	3.6	6.1	6.1	6.2	2.6	4.7	7.7	7.7	5.0	3.9	100.0
Italy[8]																	
Disability	General scheme for employees (INPS)	..	..	..	..	0.2	..	..	..	..	3.5	..	..	..	..	1.6	16.3
Unemployment	Unemployment benefits	..	..	..	..	..	..	..	..	1.5	..	..	..	..	0.7	35.1	
Japan																	
Disability	National pension (KOKUMIN-NENKIN)	..	..	..	1.0	1.1	..	..	..	2.0	2.0	..	..	..	1.0	1.1	74.4
Sickness	Government managed health insurance (SEIKAN-KENPO Syobyo-teate-kin)	..	..	..	1.3	1.2	..	..	..	2.7	2.7	..	..	..	1.3	1.3	63.4
Unemployment	Unemployment insurance	0.1	0.3	0.2	0.1	0.3	0.6	1.0	0.7	0.4	1.6	0.3	0.5	0.4	0.3	0.6	100.0

Table 2.9. **Recipients of main social protection programmes (disability, sickness, unemployment and social assistance) as a percentage of the population, 1975-95** *(cont.)*

Social policy area[1]	Programme[2]	Age group 25-54					Age group 55-64					Working age population[3]					Coverage[4]
		1975	1980	1985	1990	1995	1975	1980	1985	1990	1995	1975	1980	1985	1990	1995	
Luxembourg																	
Disability	Disability	..	..	1.9	2.7	3.7	..	..	26.2	27.0	29.5	..	..	5.4	6.3	7.1	78.3
Social assistance	Guaranteed minimum income	..	..	..	1.3	1.6	..	..	..	1.6	1.7	..	..	..	1.8	2.1	80.1
Netherlands																	
Disability	General scheme for residents (AAW)	3.6	6.3	6.9	7.8	6.9	12.4	21.4	23.4	24.1	23.5	4.0	7.0	7.7	8.5	8.1	50.5
Social assistance	Periodic assistance (ABW)	2.4	1.5	2.3	2.1	1.7	..	1.4	1.7	1.7	2.0	1.4	1.2	1.8	1.7	1.5	87.3
Sickness	Employees, sickness benefit (ZW)	3.1	3.2	2.4	3.5	2.3	1.4	1.0	1.9	0.7	0.5	3.1	3.1	2.5	3.4	2.1	63.2
Unemployment	Unemployment compensation (WW/WWv)	..	..	..	5.3	7.4	..	..	..	5.8	8.7	..	..	..	5.1	7.0	84.7
New Zealand																	
Disability	Invalids benefit (all categories)	0.7	1.2	1.0	1.3	1.7	..	..	1.5	1.9	2.9	0.5	0.8	1.0	1.2	1.7	65.7
Social assistance	Special benefit	..	..	..	..	2.0	..	..	..	..	1.0	..	..	..	..	1.6	65.6
Sickness	Sickness benefit (all categories)	2.4	2.2	0.5	0.8	1.4	..	..	0.5	0.9	1.3	1.9	1.6	0.6	0.9	1.3	31.5
Unemployment	Unemployment and emergency Unemployment benefit	0.3	5.3	1.2	5.0	5.4	..	..	0.9	3.0	3.8	0.2	4.7	1.8	6.1	6.3	100.0
Norway[9]																	
Disability	Supplementary disabled pension	1.8	2.3	3.9	6.1	6.7	18.8	26.2	35.4	52.3	57.3	2.4	3.3	5.0	6.9	7.3	41.1
Social Assistance	Social assistance, cash benefits	..	..	..	..	0.1	..	..	..	..	0.0	..	..	..	..	0.8	
Sickness	Sickness benefit, employees	..	..	..	..	2.1	..	..	..	..	5.1	..	..	..	..	1.6	59.4
Portugal																	
Disability	General (non agriculture) scheme for employed and self-employed) (IGFSS)	2.1	2.9	3.3	3.0	2.5	8.6	14.1	18.2	19.4	17.8	2.5	3.7	4.9	5.0	4.4	56.5
Sickness	Employees and self-employed (IGFSS)	..	..	..	9.7	12.6	..	..	..	7.3	11.8	..	..	..	8.4	11.1	99.4
Unemployment	Unemployment compensation	..	..	..	1.2	0.9	..	..	..	0.9	11.1	..	..	..	1.0	2.7	73.7
Spain																	
Disability	Current general scheme for employed and self-employed permanent pension	..	1.5	1.9	1.4	1.4	..	11.5	13.4	10.4	9.9	..	2.6	3.3	2.5	2.4	69.8
Sweden																	
Disability	Permanent/Temporary Sup. Disability Pension (ATP)	1.4	2.0	2.4	3.2	4.2	13.3	14.6	19.5	23.8	24.9	3.3	3.9	4.8	5.7	6.6	52.6
Social Assistance	Social welfare allowance	..	..	7.0	6.5	8.3	..	..	2.0	2.0	2.7	..	..	6.2	5.8	8.0	66.4[5]
Sickness	Sickness cash benefit	..	56.6	62.8	67.2	13.5	..	35.3	45.2	45.4	13.6	..	53.4	55.1	59.3	11.6	100.0
Unemployment	Unemployment benefits	..	..	..	..	17.6	..	..	..	..	10.2	..	..	..	..	16.6	97.3
Switzerland																	
Disability	Ordinary pension for simple disability	1.3	..	1.2	1.5	2.0	5.5	..	5.6	6.5	6.7	1.7	..	1.6	2.0	2.4	59.4
Unemployment	Unemployment benefits (except during training)	..	..	..	..	6.1	..	..	..	..	3.9	..	..	..	..	6.0	79.6

Table 2.9. **Recipients of main social protection programmes (disability, sickness, unemployment and social assistance) as a percentage of the population, 1975-95** *(cont.)*

Social policy area[1]	Programme[2]	Age group 25-54					Age group 55-64					Working age population[3]					Coverage[4]
		1975	1980	1985	1990	1995	1975	1980	1985	1990	1995	1975	1980	1985	1990	1995	
United Kingdom																	
Disability[10]	Disability cash benefits	0.9	1.2	1.6	2.2	3.2	3.8	5.0	6.8	9.0	12.7	1.2	1.6	2.1	2.8	4.1	45.5
Social assistance	Other contingencies	..	..	..	7.9	8.9	..	..	..	15.0	11.8	..	..	..	9.2	8.8	99.6
Sickness	Sickness benefit	1.1	1.0	0.5	0.3	0.3	1.7	1.4	1.0	0.6	0.6	1.1	1.1	0.5	0.3	0.3	57.2
Unemployment	Unemployment benefit	..	2.1	2.1	1.0	1.2	..	2.2	1.8	0.7	0.7	..	2.6	2.3	0.9	1.0	68.1
United States																	
Disability	Disabled workers	1.3	1.3	1.2	1.4	2.1	7.0	7.6	6.5	6.6	8.0	1.8	1.9	1.7	1.8	2.4	57.1
Social assistance	Food stamps (Food and nutrition service)	..	5.6	5.6	6.4	7.7	..	..	..	11.1	5.5	..	5.1	4.9	6.6	8.3	50.0

1. Comparability of information across countries is hampered by differences in measurement: beneficiary data sometimes concern annual averages (Norway) while others reflect the number of beneficiaries at one point during the relevant year (Finland). Some countries, for example, the United Kingdom, have provided information based on samples of their beneficiary data, and sample sizes differ per programme. All these differences limit the value of cross-country comparisons of the presented beneficiary population ratios.
2. Over the 1975-95 period social expenditure programmes have been subject to many changes in terms of eligibility and generosity. Furthermore, some of these programmes protection arrangements have been abolished or replaced by others. For example, "Unemployment benefit" in Australia was abolished in July 1991 while three new benefits were introduced: "Job search", "Newstart" and "Youth training allowances". Such institutional changes have occurred in all countries and the data are therefore not fully comparable over time.
3. Working age population refers to individuals aged 15-64.
4. The data represent information for one cash transfer programme within each broad social policy area per country. For example, in Australia the disability support programme covers about 69 per cent of all disability cash benefits; the sickness programme capture all (100 per cent) of the relevant payments: while the "Job search allowance" covers 48.5 per cent of unemployment payments. Coverage refers to the year 1995 for Australia, Austria, Canada, Japan, the Netherlands, Sweden, Switzerland and the United States. For the remaining countries: 1990 for Canada, 1990 for Denmark, 1993 for Finland, 1990 for Germany, 1989 for Greece, 1993 for Italy, 1990 for Luxembourg, 1992 for New Zealand, 1993 for Norway, 1990 for Portugal, 1989 for Spain and 1992 for United Kingdom.
5. Age group 25-54 refers to 20-49.
6. Age group 55-64 refers to 55-59.
7. Age group 25-54 refers to 30-49 and 55-64 refers to 50-64.
8. Age group 25-54 refers to 30-39 and age group 55-64 refers to 40-64.
9. Age group 25-54 refers to 26-55 and 55-64 refers to 56-64.
10. Age group 25-54 refers to 30-59.

Source: OECD Beneficiary Database (1998).

Germany and Italy. In the Netherlands, the proportion of disability recipients continued to rise from 1985 to 1990 while spending stabilised, reflecting a reduction in the benefit replacement rate from 80 to 70 per cent. In contrast to most other countries, the number of disability recipients has declined in Greece, the Netherlands and Portugal over the past five years.

The highest incidence of disability has been among older workers. Disability-to-population ratios for older workers are about 6 to 10 times higher than those for prime-age workers in Austria, Canada, Germany, Luxembourg, Norway, Portugal, Spain, and Sweden, reflecting trends in health status by age and cohort and the use of disability programmes to facilitate early retirement.

In some other countries, disability benefits may be used as substitutes for unemployment benefits (see Box 2.2). There are some cases where this was – for a period – tolerated by public authorities (the Netherlands, the United Kingdom). Even when this has not been the case, levels of disability benefit receipt in the prime-age population vary substantially across countries, suggesting that they may be acting as a substitute for other benefits. Disability population ratios for prime-age workers exceeded 3 per cent in 1995 in Finland, Luxembourg, the Netherlands, Norway, Sweden, the United Kingdom.

On the whole, the proportion of the working-age population in receipt of public sickness benefits has remained fairly stable during the 1980s (Table 2.9). In recent years, some countries have even experienced a decline in the number of public sickness beneficiaries, in part related to greater emphasis on rehabilitation (Australia and Finland) and a shift of responsibility from public institutions to employers concerning the initial period of sickness (the Netherlands, Sweden and the United Kingdom).

In general, benefit take-up among men is significantly higher than among women. This reflects contributory records, benefit rules regarding earnings of spouses and patterns of female labour participation which are also dependent on the availability of child-related benefits. It is therefore not surprising that the Nordic countries have a high degree of gender equality in benefit take-up which is not matched anywhere else in the OECD. For example, the disability-to-population ratios for females (aged 15-64) are about 60 per cent of those for males of the same age. In Norway and Sweden, the female disability ratio is 20 per cent above that for males. Nonetheless, there are signs which could well reflect gender equalisation patterns. For example, overall gender differences are much smaller for prime-age workers than for older workers in Australia, Canada, the Netherlands and the United Kingdom.

Provisions for persons with low incomes

Benefit payments for persons with low incomes, although of great importance in the continuous struggle against social exclusion (see Chapter 4 and OECD, 1998*c* and 1998*d*), do not constitute a large share of public social expenditure. Except in Denmark and Canada, spending on non-categorical social assistance payments[16] does not exceed 1 per cent of GDP. However, the number of social assistance claimants is rising in countries such as Canada, Finland, Germany, Sweden and the United States. This evidence is corroborated by Eardley *et al.* (1996) who find that the number of beneficiaries of social assistance, including such categorical assistance benefits as unemployment assistance benefits, increased substantially over the 1980-92 period in Australia, Canada, Ireland, Germany, the United Kingdom and the Scandinavian countries (see Chapter 5 for a discussion of the causes of this increase). Information on more recent years confirms this upward trend for European countries (Guibentif and Bouget, 1997).

Family support

Among OECD countries, the Nordic countries spend the most on family support benefits (cash and services), ranging from 3 to 5 per cent of GDP. More than in other OECD countries, a

Box 2.2. Trends in disability and unemployment benefits

The expenditure and beneficiary data for the **Netherlands** most clearly reflect the relation between changing labour market opportunities, the use of income maintenance programmes other than unemployment compensation and changing policy responses to budgetary implications and the dissuasive effects of the design of such income maintenance programmes (OECD, 1997*a*). The increase in the beneficiary-to-population ratio began in the 1970s; by 1980, public spending on the disability cash programme already amounted to about 4 per cent of GDP. A reform process aimed at tightening access to the disability programme started at the end of the 1980s. As a result, the number of recipients decreased. At the same time, the number of persons in receipt of unemployment benefit increased while survey-based unemployment declined. Among those in receipt of unemployment benefit, the proportion of older workers who are dispensed from the obligation of active job search – and thus not included in the survey-based measure – was about 20 per cent in 1995 (LISV, 1997).

Labour market conditions are also related to trends in the take-up of sickness and invalidity benefits in the **United Kingdom.** In contrast to the Netherlands, labour market conditions have never been explicitly included in the determination of eligibility for Invalidity Benefit (IVB). However, in practice when assessing eligibility, doctors took account of the probability of claimants finding a job (Ritchie *et al.*, 1993). Substantial increases in the number of recipients of Invalidity Benefits (IVB) materialised during the first part of the 1990s, at a time when the number of recipients of unemployment benefits declined (Table 2.9). Furthermore, there is a continuous increase in the proportion of IVB claimants whose employment status is "unemployed" at the moment of entering the IVB-stock: from 31 per cent in 1985, to 43 per cent in 1990, and 49 per cent in 1995 (Adema, 1993, and data supplied by the Department of Social Security).

In **Australia,** the number of recipients of both sickness and disability benefits (Sickness Allowance and Disability Support Pension, DSP) increased significantly until 1990. Over the period 1990-95, the growth in disability take-up outpaced the decline in the number of sickness beneficiaries. The growth in recipients of disability benefits prior to 1992 is to a certain extent related to adverse labour market conditions – Carson *et al.* (1989) document that a significant proportion of sickness beneficiaries were transferred from unemployment benefits. In 1991, reforms tightening access to both sickness and disability programmes were implemented, putting greater emphasis on rehabilitation. Furthermore, the duration of sickness allowance was limited to 12 months.

The sickness allowance reform seems to have been successful in reducing the number of recipients over the 1990-95 period, while the number of disability pensioners continued to grow during the same period (Table 2.9). These diverging trends are related to several economic, demographic and institutional factors. First, the latest recession occurred in the 1991-93 period and the recovery has been relatively slow until 1997. Second, in view of the characteristics of claimants it is likely that rehabilitation measures directed towards sickness beneficiaries more easily lead to positive results than those directed to DSP recipients. Third, the changes in disability criteria were not applied to existing beneficiaries in 1991. Finally, fewer people will have become eligible for old-age veteran's pension and these persons may have turned to disability support pension instead.

large proportion (35 to 55 per cent) of family support benefits in the Nordic countries is provided in the form of in-kind benefits (*e.g.*, child-care facilities). However, it should be noted that these public expenditures do not cover other items of public family support such as health and housing support. An indicator of public support to families which takes such support into

account was developed by Bradshaw *et al.* (1993). This index of average income support to families identifies the Scandinavian countries, Belgium, France and Luxembourg as the most generous, while Greece, Japan, Ireland, Italy, Portugal, Spain and the United States are identified as the least generous (OECD, 1997*c*).

Moreover, fiscal measures and privately provided child-support measures can be substantial in value. For example, in Germany employers pay family allowances to workers while child-support measures through the tax system are also considerable (see above). Similar tax measures and employer-provided child-care facilities, maternity pay and parental-leave arrangements are also prevalent in many other OECD countries (OECD, 1995*d*).

Lone-parent families (LPF) constitute a significant target group. Relevant trends are difficult to discern from expenditure data as not all countries do have specific social protection arrangements for LPFs, nor is information on payments of child benefits to LPFs separately identifiable. Nonetheless, public expenditure on lone parent cash benefits have increased significantly in Australia, Ireland, Norway, New Zealand and the United Kingdom since 1980, reflecting the rise in numbers of LPFs (Chapter 1).

4.3. Conclusions

This section identified some trends in expenditure and in beneficiary numbers which help explain current policy priorities. The rise in number of people of older working age in receipt of benefit is worrying in the light of the need to finance public spending and, in particular, public pensions. The sharp rise in public spending on lone parents in some countries is a major cause of the increased interest in child-care facilities being shown in many countries. Finally, the apparent contradiction between the improved health status of the population and the rise in numbers receiving sickness and invalidity benefit has encouraged countries to consider reforms in access to and delivery of these benefits.

Notes

1. Figures in this paragraph are based on *OECD National Accounts*. Figures may not always coincide with the OECD Social Expenditure Statistics (see OECD, 1996*c*).
2. In other words, if interest payments on the debt were to be ignored, there would be a budget surplus.
3. The balance between the two effects is determined by the relative size of the elasticities of demand and supply (see OECD, 1993). Other possibilities – that labour taxes may be absorbed wholly or in part in the form of lower profits (so the incidence of labour taxes is borne partly by the owners of capital) or increased prices charged to consumers – may be increasingly ruled out because of pressures to maximise the return on capital and be competitive in product markets. Increased financial and product market competition may therefore be having the effect of raising the incidence of taxation onto labour.
4. This measure of the tax wedge does not illustrate the full extent of the increased tax burden on labour. Consumption financed out of labour income is subject to consumption taxes and these have increased almost universally in OECD countries (including all of the countries where other labour taxes have fallen).
5. Social benefits are defined as public when relevant financial flows are controlled by general government – central, state, and local governments, including all compulsory social security funds (SNA, 1993, Sections 8.63 and 8.64).
6. In 1994, old-age cash benefits and some social assistance payments became taxable in Denmark. Benefit payments were raised to preserve their net value which led to an increase in gross social expenditure of about 2 per cent of GDP (Adema, 1997).
7. Without the "mandatory privatisation" of sickness benefits which started in 1994 (see below), public social spending in the Netherlands in 1995 would have been at its 1980 level.
8. As exemplified by a decline in the standard deviation of spending ratios from 6.7 to 6.0.
9. Public spending directed towards the elderly includes old-age cash benefits, survivors benefits and services for the elderly and disabled.
10. Spending on services to the elderly and the disabled cannot always be separately identified with regard to the two relevant groups of beneficiaries.
11. See OECD (1996*d*) for a discussion of the reasons for the failure to achieve this objective.
12. Expenditure data on old-age cash benefit programmes do not generally allow for separate identification of payments to persons who have retired before reaching the standard age of retirement.
13. Public spending on benefits specified in legislation on occupational accidents and diseases is much less susceptible to large fluctuations than spending on disability cash benefits.
14. The increase in the disability spending to GDP ratio for Finland is also related to the sharp recession in the beginning of the 1990s.
15. The trends in beneficiary-to-population ratios for selected income maintenance programmes other than retirement benefits are presented in Table 2.9. These data concern one social protection programme which in terms of expenditures accounts for a large share in the relevant broad social policy area. However, there are significant cross-country differences in coverage. For example, the Canadian data refer to the programme "CPP Disability", which accounts for approximately 63 per cent

of total spending on disability cash benefits in Canada. The Dutch disability programme covers all residents except civil servants and accounts for about 90 per cent of all spending on disability cash benefits in the Netherlands (for more information on the nature of the data, see the notes to Table 2.9). Thus, the beneficiary-to-population ratios do not reflect *all* recipients of disability, sickness and social assistance benefits in an individual country and are therefore not comparable across countries.

16. Income testing of benefits is a central element of social protection systems in Australia and New Zealand, but also important in Ireland, Canada, the United Kingdom and the United States. Most of these means-tested payments, for example means-tested benefits to pensioners and unemployment assistance benefits, are grouped under the relevant broad policy area ("categorical assistance"). The expenditures referred to here concern payments to persons on low incomes which are not related to a particular contingency.

Chapter 3

The Distribution of Income

1. Introduction and main findings

Chapter 1 outlined various pressures which might increase social needs. The changes in the labour market described in that chapter might be expected to widen the distribution of earned income. Greater family instability leaves some households less able to share some consumption costs and more dependant on government programmes. Ageing and the extent of disability in the working-age population influence the labour force participation rate. These social trends are therefore important in understanding developments in *market* incomes – earnings and income from capital before taxes. The taxes and social benefits involved in channelling large proportions of GDP from one sector of the population to another through social programmes affect how this market income is transformed into a *final* (*i.e.* after-tax) distribution of income. This final distribution of income gives a first approximation of the living standards which different families will be able to enjoy. Of course, the distribution of market income should not be seen as representing what would happen were systems of social protection to be ended. Social protection systems alter the behaviour of individuals and families and imply long-term commitments which, for example, change the way families prepare for retirement. Indeed, many of the new social policy initiatives of governments have been aimed at improving self-sufficiency by appropriate interventions. But the allocation of taxes and benefits across different family types illustrates both country priorities and their effectiveness in achieving their goals. This chapter illustrates how the tax and transfer system affects the income distribution and how this has changed over time.

The key findings are:

- There is no *general* trend in the distribution of disposable income and of relative poverty across countries over the past decade or so.
- The labour market has played a key role in shaping these trends. The number of people working in a household is the most important indicator of the well-being of individuals.
- Direct taxes and public transfers substantially reduced the inequality of market income. However, much of their impact has tended to favour the elderly.
- There is a generalised worsening of the position of those in households with a young head. Households with children are doing noticeably less well than previously in several countries. This contrasts with an improvement in the position of the elderly in most countries.
- The incomes of the elderly are much *higher* and exhibit greater *uniformity* across countries when taking account of *all* sources of retirement income.

2. General trends in income distribution and poverty

During the period of rapid post-war economic growth before the first oil shock, increases in average incomes in the OECD area were associated, in most cases, with, narrowing income distributions. However, in the past two decades the growth in average incomes has slowed and there is evidence that in some OECD countries, income inequalities and poverty rates are increasing. These trends have a number of implications for social policies. Although social programmes are generally directed at mitigating the consequences of special contingencies affecting individuals, they also alter the distribution of income and of economic opportunities at large. In fact, governments in all OECD countries have policy objectives regarding equity, although the specific equity targets may differ. Some countries emphasise the need to limit poverty, others to reduce income inequality, while others prefer broader objectives, such as reducing exclusion or enhancing social cohesion.

Evidence on trends in the distribution of final income *(i.e.* after transfers and taxes have been paid) in the decade from the mid-1980s to the mid-1990s, points to considerable diversity across countries.[1] Overall, the indices of inequality presented in Table 3.1 suggest that

Table 3.1. **Trends in inequality indices, mid-1980s to mid-1990s**[1]

Equivalence scale elasticity = 0.5

Gini index

	Levels		Changes	
	Initial	Final	Relative	Absolute
Australia, 1984-1993/94	31.2	30.6	–1.9	–0.6
Belgium, 1983-1995	29.3	29.9	2.3	0.7
Canada, 1985-1995	28.9	28.4	–1.9	–0.6
Denmark, 1983-1994	22.9	21.7	–4.9	–1.1
Finland, 1986-1995	21.0	23.0	9.7	2.0
France, 1979-1990	29.6	29.1	–1.7	–0.5
Germany, 1984-1994	26.5	28.2	6.4	1.7
Italy, 1984-1993	30.6	34.5	12.7	3.9
Japan, 1984-1994	25.2	26.5	4.9	1.2
Netherlands, 1985-1994	23.4	25.3	8.2	1.9
Norway, 1986-1995	23.4	25.6	9.4	2.2
Sweden, 1983-1995	21.6	23.0	6.5	1.4
United States, 1985-1995	34.0	34.4	1.1	0.4

	SCV		MLD		Atkinson	
	Changes					
	Relative	Absolute	Relative	Absolute	Relative	Absolute
Australia, 1984-1993/94	4.5	1.6	1.4	0.3	–0.8	–0.1
Belgium, 1983-1995	19.2	7.6	–3.6	–1.0	1.5	0.1
Canada, 1985-1995	–17.5	–6.6	–6.8	–1.0	..	..
Denmark, 1983-1994	2.0	0.4	–14.3	–1.5	–11.1	–0.5
Finland, 1986-1995	47.7	7.8	12.8	1.0	0.0	0.0
France, 1979-1990	2.1	1.3	–13.6	–4.7	–3.0	–0.2
Germany, 1984-1994	–6.3	–2.2	13.0	1.6	29.9	2.0
Italy, 1984-1993	44.7	18.0	41.2	7.0	32.7	2.6
Japan, 1984-1994	21.7	5.3	13.5	1.5	10.9	0.6
Netherlands, 1985-1994	6.0	1.4	21.3	2.0	17.9	0.8
Norway, 1986-1995	8.1	2.3	31.1	3.1	..	..
Sweden, 1983-1995	58.9	8.0	23.0	2.1	20.6	0.8
United States, 1985-1995	2.9	1.2	2.4	0.5	2.0	0.2

1. Absolute change is the difference in the value of the index.
Source: Burniaux *et al.* (1998).

inequality in the distribution of disposable income increased in seven of the thirteen countries considered (Finland, Italy, Japan, the Netherlands, Norway, Sweden and the United States) and declined in one (Canada). In the remaining five countries, results depend on the choice of the inequality index.[2]

There are also large differences in the extent to which movements in aggregate inequality have affected the position of the different groups on the income scale. Chart 3.1 shows the extent to which each quintile has lost or gained income shares of disposable income in the period from the mid-1980s to the mid-1990s. In a majority of countries, individuals at the top of the distribution have gained income shares, these gains being especially large in Belgium, Finland, Italy and the United States. However, declines in the share of income accruing to persons in the top quintile were recorded in Australia, Canada and Denmark. There are larger cross-country differences in developments at the bottom of the income scale, with losses in around half of the countries considered. Some of the largest changes in income shares appear to have occurred in the three central quintiles, leading to a "hollowing out" of the distribution of disposable income.

These differences in developments at the bottom of the income ladder are reflected in trends in relative poverty, defined here as those with income falling below 50 per cent of the median equivalent disposable income. As shown in Table 3.2, the proportion of the population in poverty increased in Germany, Italy, Japan, the Netherlands, Norway and Sweden. Movements in the average income of the poor (relative to the economy-wide median) – labelled "income gap" in Table 3.2 – in general follow changes in the proportion of the population in poverty. However, in Australia and the United States declines in the proportion of the population in poverty were associated with a fall in the relative income of the poor, while the opposite occurred in the Netherlands. Overall, a composite measure of poverty such as the Sen index (which combines information on the proportion in poverty and the relative income of the poor with a measure of income dispersion among the poor; see Forster, 1994) suggests that poverty increased in half of the countries considered, while declining in the others.

3. Inequality at the level of market income and the impact of the tax and transfers system

The widening of market incomes (the sum of gross earnings, self-employment income and capital income) is responsible for most of the widening in disposable income. Chart 3.2 shows, first, that in all countries, inequality of disposable income is much less than that of market income, demonstrating that tax-transfer systems play a strong redistributive role. Second, the inequality of market income rose over time in all countries except France. Thirdly, in all countries except Denmark, France and Germany, inequality of disposable income also rose.[3]

Evidence limited to five OECD countries, based on a different data set, shows that the proportion of the overall population in poverty is significantly higher and increased more over time at the level of *market* income than for *disposable* income. This is largely due to the fact that a significant proportions of the retired population receive a large part of their incomes from public pensions and have no substantial sources of market income. As the proportion of the elderly in the population increases, so is there a greater proportion of the population who are poor before, but not after, taxes and transfers.

Table 3.3 shows the percentage of public transfers and taxes going to individuals with different levels of income. In many countries, transfers are rather evenly spread across the income scale, the most striking exceptions being Australia and France, where more than half the transfers went to the low-income group. Moreover, there was no generalised shift in public transfers towards the low-income group – in around half the countries their share of transfers fell. By

Chart 3.1. **Disposable income, gains and losses by quintile**[1]
Elasticity scale = 0.5

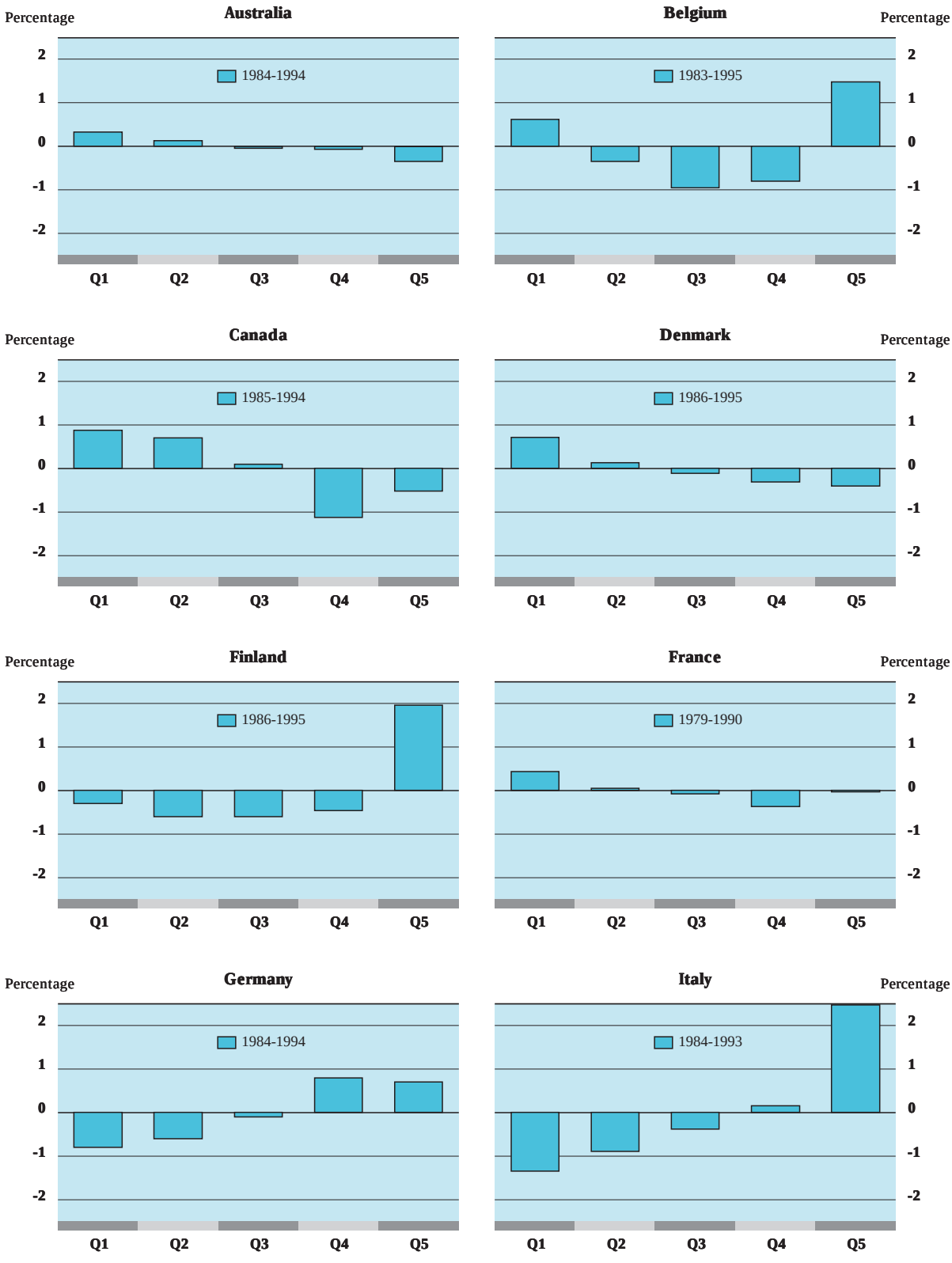
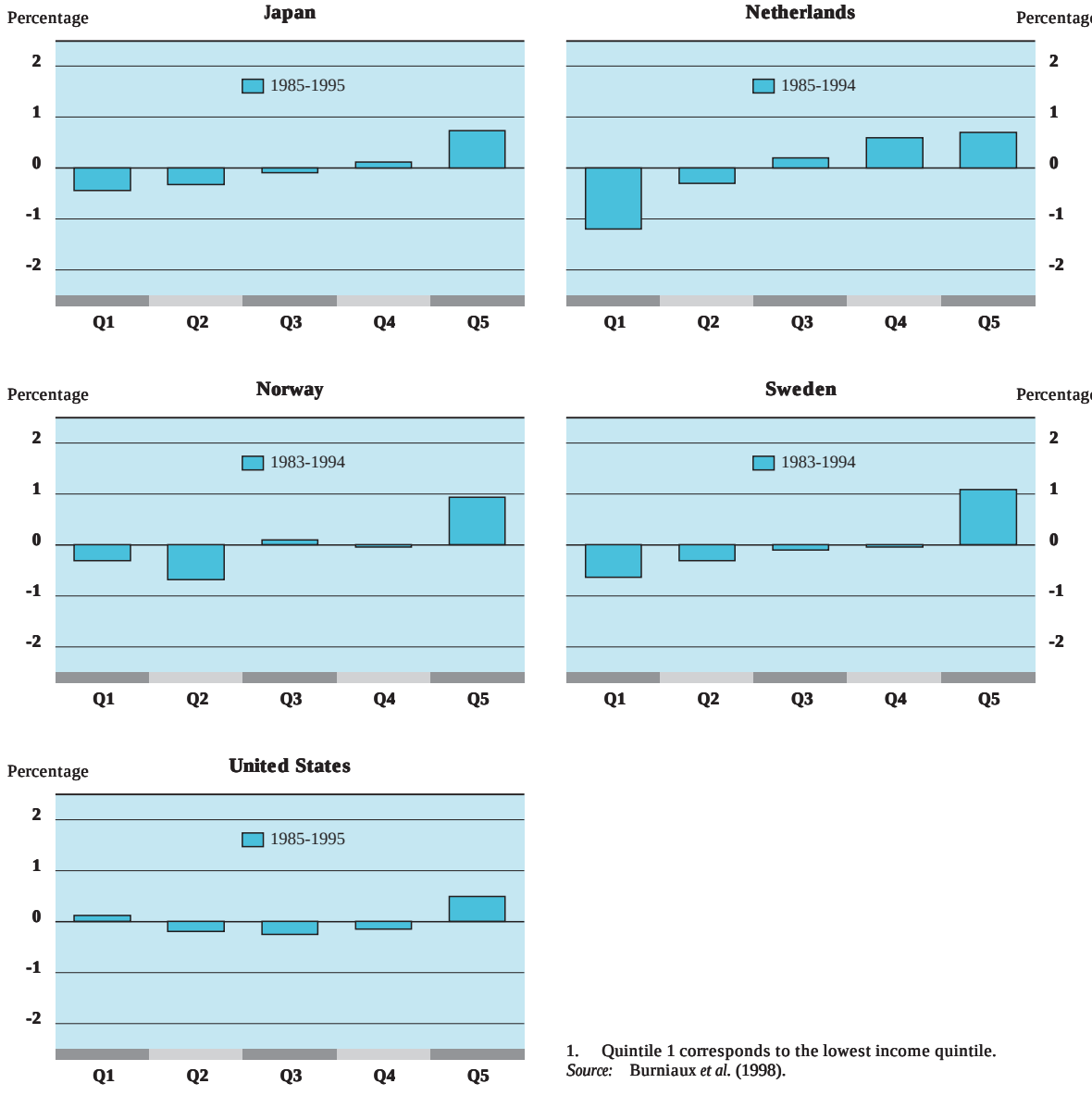


Chart 3.1. *(cont.)* **Disposable income, gains and losses by quintile**[1]
Elasticity scale = 0.5



1. Quintile 1 corresponds to the lowest income quintile.
Source: Burniaux *et al.* (1998).

contrast, in all countries the bulk of taxes was paid by the high-income group. As a result, taxes had a stronger effect than public transfers in equalising the distribution of income in eight of the twelve countries considered.

4. The position of selected groups in society[4, 5]

Individuals in households with an older *head of working age* (between 50 and 65) and with a *prime-age head* improved their relative position in most cases (Table 3.4). However, relative disposable income of those in households with a *young head* declined in all countries (Table 3.4). This mainly reflected a decline in the share of earnings accruing to this group. This in turn has

Table 3.2. **Trends in poverty, mid-1980s to mid-1990s**[1]

Equivalence scale elasticity = 0.5

Changes in percentage points, unless otherwise indicated

	50 % median income			
	Head-count		Income gap	Sen index[2]
	Level (end period)	Changes (absolute)	Changes (absolute)	Changes (absolute)
Australia, 1984-1993/94	9.5	–2.7	5.0	–0.2
Belgium, 1983-1995	10.8	–7.7	–1.9	–6.8
Canada, 1985-1994	8.9	–0.8	–1.4	–0.5
Denmark, 1983-1994	5.0	–2.0	–0.8	–0.9
Finland, 1986-1995	4.9	–0.2	–4.2	–0.4
France, 1979-1990	3.1	–1.5	–4.9	–1.1
Germany, 1984-1994	9.1	2.9	2.5	0.4
Italy, 1984-1993	14.2	3.9	5.6	2.9
Japan, 1984-1994	8.1	0.8	2.5	0.6
Netherlands, 1985-1994	6.1	3.0	–3.6	1.1
Norway, 1986-1995	8.0	1.1	0.0	0.6
Sweden, 1983-1995	6.4	0.4	7.9	0.8
United States, 1985-1995	17.1	–1.2	0.2	–0.4

1. "Relative threshold" poverty lines are fixed in terms of real median income in each period.
2. Absolute change is the difference in the value of the index.

Source: Burniaux *et al.* (1998).

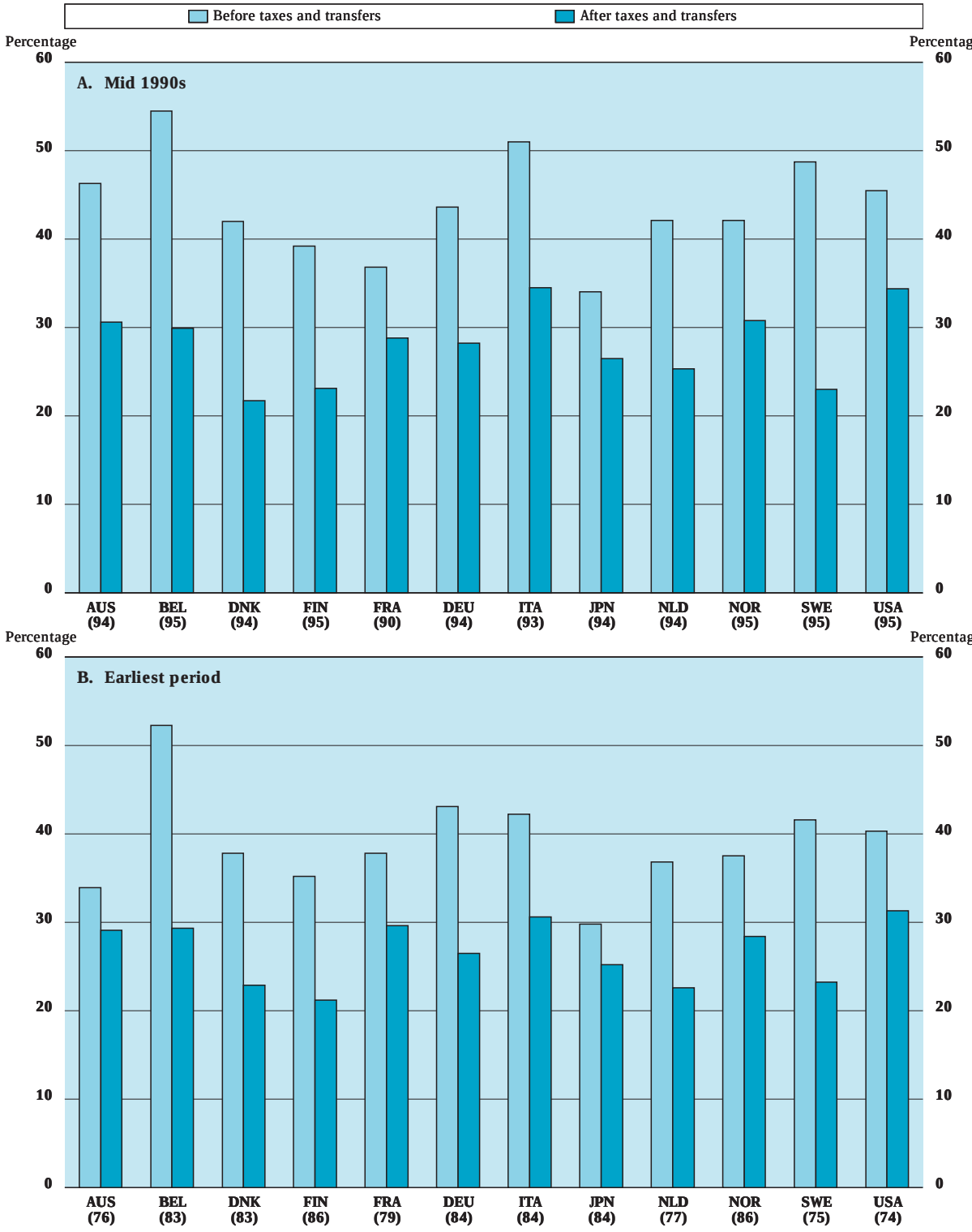
been caused by a combination of factors discussed in Chapter 1 including the longer periods spent in education and delayed entry to the labour force.[6] Relative incomes vary systematically with the number of adults and children in the household (Table 3.5). With few exceptions, households with one adult have lower disposable income than those with two, and *lone-parent families* have the lowest relative incomes of all. Such households are often headed by single mothers, who either do not work or, if they do, earn substantially less than single male household heads. The share of lone-parent households increased in all countries considered,[7] while their relative income declined in nine of the twelve countries considered.

Table 3.4 shows that the relative position of individuals in households with a *retirement-age head* has improved (Australia and the Netherlands being the main exceptions, and, to a lesser extent, Canada and Japan). However, the table also shows that such households still had somewhat below-average disposable income in all countries examined. The following two sections look in more detail as to what might explain the trends in incomes of working and retirement-aged families.

5. Earnings and work attachment of household members

Trends in the labour market have tended to increase the degree of polarisation in society (see Chapter 1 above). At the aggregate level, the importance of the labour market in shaping trends in the distribution of income can be highlighted by looking at the contribution of earnings to changes in income inequality.[8] As shown in Tables 3.3 and 3.6, earnings are highly concentrated among individuals at the top of the income ladder, with the proportion accruing to those in the three top deciles ranging from just over 50 per cent in Japan and Norway to over 60 per cent in Australia and Canada. In all countries except France and (to a lesser extent) Belgium and Japan, the share of earnings going to the top deciles increased over time. By contrast, the share of earnings going to individuals in the three bottom deciles ranged from 3.5 per cent in Australia to around 11 per cent in France. In all countries except Belgium, France and Japan this share declined. Declines in the share of earnings accruing to those in the four middle deciles were also recorded in a majority of countries.

Chart 3.2. **Income inequality before and after taxes and transfers**[1]



Note: Figures in parenthesis refer to the year corresponding to the given country's data.

1. Income inequality as measured by the Gini coefficient. Gini coefficients for the entire population are defined in terms of total income for all countries except France, where non-zero income is used.

Source: Burniaux *et al.* (1998).

Table 3.3. **Distribution of income components across income deciles**

Equivalence scale elasticity = 0.5 (percentage of total of each source of income)

	Earnings			Capital and self-employment			General government transfers			Taxes			Total disposable income		
	Three bottom deciles	Four middle deciles	Three top deciles	Three bottom deciles	Four middle deciles	Three top deciles	Three bottom deciles	Four middle deciles	Three top deciles	Three bottom deciles	Four middle deciles	Three top deciles	Three bottom deciles	Four middle deciles	Three top deciles
Australia, 1993/94	3.5	33.5	63.0	10.6	33.9	55.5	58.0	34.6	7.4	1.9	27.8	70.4	13.8	35.1	51.1
Changes, 1975-1994	–5.8	–4.2	10.1	–8.5	3.4	5.2	1.1	5.2	–6.3	–7.9	–6.0	13.9	–0.4	–1.0	1.4
Belgium, 1995	4.8	36.0	59.2	5.1	16.2	78.7	30.0	45.7	24.3	2.1	29.3	68.6	13.8	36.6	49.6
Changes, 1983-1995	0.3	–0.1	–0.2	–2.2	–6.4	8.6	0.0	1.2	–1.2	–1.5	0.6	0.9	0.5	–1.7	1.1
Canada, 1994	5.6	32.9	61.5	9.0	36.9	54.1	41.7	41.0	17.3	2.9	29.2	67.9	14.0	35.9	50.1
Changes, 1975-1994	–0.5	–3.5	4.1	–7.2	2.7	4.5	–7.6	7.2	0.4	–0.7	–2.0	2.7	1.2	–0.9	–0.4
Denmark, 1994	6.7	38.7	54.6	14.4	30.8	54.8	45.8	37.5	16.7	12.7	36.5	50.8	17.6	38.2	44.2
Changes, 1983-1994	–1.0	–0.9	1.9	–5.8	–3.9	9.6	3.8	–1.1	–2.7	2.1	–3.0	0.9	0.8	–0.2	–0.6
Finland, 1995	6.3	36.1	57.6	20.0	32.3	47.8	39.8	41.4	18.7	9.5	32.9	57.6	17.5	37.2	45.3
Changes, 1986-1995	–3.4	–2.0	5.4	–3.2	–1.4	4.5	2.4	4.4	–6.8	0.3	–1.1	0.8	–0.6	–1.2	1.7
France, 1990	10.8	35.7	53.5	13.2	27.0	59.9	53.5	36.1	10.4	2.1	15.5	82.4	15.3	34.6	50.1
Changes, 1979-1990	1.4	0.8	–2.3	–3.0	–0.5	3.5	9.4	–6.7	–2.8	–1.1	–2.1	3.2	0.4	–0.2	–0.2
Germany, 1994	7.5	34.6	57.8	11.0	31.3	57.7	38.6	40.1	21.3	5.3	31.7	62.9	14.8	36.1	49.1
Changes, 1984-1994	–0.2	–0.8	1.0	–1.5	0.7	0.8	–5.0	4.9	0.1	–0.5	0.4	0.1	–1.1	–0.1	1.2
Italy, 1993	9.3	35.4	55.3	5.6	20.0	74.5	20.8	44.7	34.5	5.8	29.8	64.4	12.1	34.4	53.5
Changes, 1984-1993	–3.1	–2.2	5.3	–2.2	–2.5	4.6	–5.8	0.8	5.1	–4.8	–2.3	7.1	–1.9	–0.7	2.6
Japan, 1994	13.0	36.5	50.5	17.8	27.5	54.7	27.5	37.5	35.0	11.3	29.7	59.0	15.7	36.5	47.8
Changes, 1984-1994	1.1	–1.1	–0.1	–5.5	–3.8	9.4	–0.5	4.8	–4.2	–1.3	–1.2	2.4	–0.6	–0.2	0.8
Netherlands, 1994	8.3	37.6	54.2	8.8	30.3	61.0	43.6	35.7	20.7	10.7	34.5	54.7	16.2	36.8	47.0
Changes, 1977-1994	–5.9	0.3	5.6	–0.3	5.5	–5.2	9.8	–2.3	–7.5	–1.6	2.3	–0.7	–1.6	0.4	1.2
Norway, 1995	8.7	40.8	50.5	9.5	22.8	67.7	47.7	35.3	17.0	8.3	35.4	56.3	16.0	37.2	46.8
Changes, 1986-1995	–3.1	–0.2	3.4	–0.8	–2.6	3.4	2.3	–0.9	–1.4	–1.8	–2.4	4.2	–1.0	–0.4	1.4
Sweden, 1995	7.2	35.5	57.2	17.3	28.8	53.9	31.4	41.4	27.2	10.7	34.8	54.4	17.2	37.9	44.9
Changes, 1975-1995	–0.2	–1.8	2.1	–2.1	–6.6	8.7	–8.3	5.9	2.4	3.5	1.2	–4.7	0.3	–0.1	–0.2
United States, 1995	7.6	33.9	58.5	7.5	26.8	65.7	37.2	38.2	24.6	5.2	26.5	68.2	11.5	35.0	53.5
Changes, 1974-1995	–1.1	–3.3	4.4	–1.6	1.0	0.6	–6.8	3.8	3.0	0.3	–3.7	3.5	–1.2	–1.4	2.6

Source: Burniaux *et al.* (1998).

Table 3.4. **Relative disposable income and population share, by age of the household head**

Total population

Equivalence scale elasticity = 0.5

	Young head		Prime-age head		Older working-age head		Retirement-age head	
	Relative income	Population share	Relative income	Population share	Relative income	Population share	Relative income	Population share
Australia, level 1993-94	101.1	13.3	101.4	53.7	110.9	19.9	68.2	13.1
Point changes, 1975-1994	–4.4	–5.3	1.4	0.9	3.1	0.8	–5.7	3.6
Canada, level 1990	87.7	11.3	101.5	48.3	111.9	23.9	87.3	16.6
Point changes, 1975-1994	–1.8	–1.8	0.4	1.8	0.5	–0.6	–0.4	0.6
Denmark, level 1994	89.6	16.7	105.9	48.1	117.3	19.0	73.4	16.2
Point changes, 1983-1994	–10.9	–1.3	–1.5	0.0	10.7	0.6	4.7	0.6
Finland, level 1995	80.3	13.2	106.8	53.8	114.5	18.2	78.1	14.7
Point changes, 1986-1995	–7.6	–4.8	0.3	0.5	6.4	1.4	1.1	2.7
France, level 1990	78.7	10.5	101.7	52.7	110.1	22.1	95.0	14.7
Point changes, 1979-1990	–8.9	–1.1	0.8	2.5	2.3	–1.3	0.8	–0.1
Germany, level 1994	78.5	9.8	100.9	45.7	113.0	25.1	89.3	19.4
Point changes, 1984-1994	–1.9	0.4	–1.5	–1.6	0.6	–1.2	4.3	2.4
Italy, level 1993	92.1	4.5	98.1	46.5	109.9	31.3	84.7	17.6
Point changes, 1984-1993	–4.8	0.2	1.5	–1.1	–2.7	–2.8	2.9	3.6
Japan, level 1994	75.9	5.0	94.2	52.5	120.7	30.3	93.1	12.2
Point changes, 1984-1994	–6.0	–1.2	–0.9	–7.2	3.6	3.7	–0.8	4.7
Netherlands, level 1994	85.2	11.5	100.8	52.9	114.0	20.6	87.5	14.9
Point changes, 1977-1994	–5.9	–1.0	5.0	3.4	–2.2	–3.4	–8.9	1.1
Norway, level 1995	78.0	14.8	107.3	53.1	117.3	17.2	73.7	14.8
Point changes, 1986-1995	–11.5	–0.4	0.6	1.4	4.6	–1.6	4.0	0.4
Sweden, level 1995	73.3	17.8	104.2	46.0	125.8	18.6	89.3	17.6
Point changes, 1975-1995	–15.8	–2.1	–5.3	3.9	12.2	–2.2	16.5	0.4
United States, level 1995	75.0	13.4	101.5	53.4	120.0	18.9	91.9	14.2
Point changes, 1974-1995	–9.5	–3.9	0.9	6.0	1.8	–4.0	6.4	1.9

Note: Young, prime age, older age and retired refer, respectively, to households with heads below 30, between 30 and below 50, between 50 and 65 and above 65 years old.
Source: Burniaux *et al.* (1998).

Table 3.5. **Relative disposable income and population share, by household type**

Total population

Equivalence scale elasticity = 0.5

	Single adult				Two (or more) adults			
	With children		No children		With children		No children	
	Relative income	Population share	Relative income	Population share	Relative income	Population share	Relative income	Population share
Australia, level 1993-94	58.5	5.3	78.6	8.3	95.7	46.9	119.8	39.5
Point changes, 1975-1994	–8.0	2.8	–0.6	12.1	0.4	37.4	–0.1	47.7
Canada, level 1990	54.6	2.8	79.8	12.1	94.3	37.4	112.5	47.7
Point changes, 1975-1994	1.7	0.1	–0.4	0.3	0.3	–1.4	–0.2	1.0
Denmark, level 1994	61.9	4.9	71.1	17.2	104.4	40.7	110.9	37.3
Point changes, 1983-1994	–2.7	0.6	0.3	3.0	–2.2	–7.7	3.5	4.1
Finland, level 1995	77.9	5.5	71.5	16.7	103.1	45.2	108.6	32.7
Point changes, 1986-1995	1.2	2.0	–0.5	3.5	0.7	–4.9	–1.0	–0.6
France, level 1990	70.3	6.3	84.4	10.5	101.2	59.7	108.0	23.4
Point changes, 1979-1990	–7.9	2.1	–1.3	1.7	1.5	–4.0	–2.1	0.2
Germany, level 1994	58.9	3.0	85.0	16.7	97.4	41.9	110.3	38.5
Point changes, 1984-1994	2.7	1.4	2.7	2.9	–0.9	–3.7	0.0	–0.4
Italy, level 1993	54.1	1.2	71.1	5.3	93.6	49.6	112.7	43.9
Point changes, 1984-1993	–4.6	0.6	–4.3	1.1	0.3	–6.1	0.1	4.4
Japan, level 1994	57.4	0.5	82.4	6.6	94.2	57.0	121.5	35.8
Point changes, 1984-1994	–1.2	–0.2	–5.0	1.3	–0.5	–12.5	2.6	11.4
Netherlands, level 1994	58.6	3.6	80.0	15.1	95.0	42.8	118.1	38.3
Point changes, 1977-1994	–3.5	2.1	–10.5	7.4	0.8	–18.4	1.3	8.8
Norway, level 1995	63.1	7.0	38.3	17.9	116.0	44.3	107.3	10.9
Point changes, 1986-1995	–5.6	2.3	–33.8	4.2	12.2	–4.5	–3.2	–21.9
Sweden, level 1995	73.9	7.7	74.5	29.0	103.7	36.2	121.7	27.0
Point changes, 1975-1995	–11.6	2.2	–1.3	5.5	–2.7	–8.1	8.0	0.3
United States, level 1995	49.9	6.8	88.4	9.4	94.9	50.0	122.4	33.7
Point changes, 1974-1995	5.6	1.4	7.0	2.7	–0.9	–9.0	–0.9	4.9

Source: Burniaux *et al.* (1998).

Table 3.6. **Relative disposable income and population share, by degree of work attachment of households**

Population in households with a working-age head

Equivalence scale elasticity = 0.5

	No worker		One worker		Two workers or more	
	Relative income	Population share	Relative income	Population share	Relative income	Population share
Australia, level 1993-94	45.4	13.6	79.9	30.8	121.3	55.6
Percentage point change	3.4	7.6	2.4	–9.6	–2.2	2.0
Canada, level 1990	47.0	7.9	81.9	25.0	110.9	67.1
Percentage point change	–2.9	2.2	0.9	–0.1	–0.1	–2.2
Denmark, level 1994	67.0	9.7	84.8	27.9	111.9	62.4
Percentage point change	1.9	0.7	1.2	–0.9	–0.8	0.2
Finland, level 1995	58.4	6.9	82.7	20.8	106.7	72.3
Percentage point change	–3.8	4.1	2.0	–1.6	–0.5	–2.5
France, level 1990	74.8	9.0	92.0	46.8	116.6	44.2
Percentage point change	–0.2	2.8	0.5	–10.2	–0.7	7.4
Germany, level 1994	55.9	11.5	89.3	48.9	122.3	39.6
Percentage point change	–9.5	1.5	–1.2	1.4	3.6	–3.0
Italy, level 1993	51.0	10.0	77.4	45.2	131.2	44.8
Percentage point change	–1.3	4.6	–5.5	–4.8	6.3	0.2
Japan, level 1994	62.7	2.1	88.7	41.4	110.0	56.5
Percentage point change	5.3	0.4	–5.0	–1.8	3.8	1.4
Netherlands, level 1994	62.0	14.7	89.7	37.2	119.3	48.1
Percentage point change	–10.9	7.8	0.1	–14.8	1.7	7.0
Norway, level 1995	49.4	11.4	85.7	34.7	115.4	53.9
Percentage point change	2.4	4.7	–0.2	–2.4	–0.1	–2.3
Sweden, level 1995	58.2	8.1	80.8	37.3	115.1	54.7
Percentage point change	9.9	3.2	–6.3	1.4	3.0	–4.6
United States, level 1995	39.6	6.2	82.2	30.2	116.7	63.6
Percentage point change	1.3	1.2	–5.0	–7.0	3.1	5.9

Note: Relative disposable income is the equivalent disposable income of the household group as a percentage of the mean income of total population.
Source: Burniaux *et al.* (1998).

At the level of individuals, the employment status of household members – whether the household has no member, one member, or more than one member in employment – is the most important determinant of their well-being. To abstract as far as possible from trends in retirement age, the data presented in Table 3.6 refer to individuals in households with a head of working age (below 65 years of age). Not surprisingly, individuals in such households with no workers had incomes well below the average, ranging from 40 to 50 per cent of mean income of the total population in Australia, Canada, Norway and the United States to more than 60 per cent in Denmark, France, Japan and the Netherlands. At the other extreme, two-earner households enjoyed levels of equivalent income well above the average. The relative income of households with no workers declined in half of the countries.

Table 3.6 shows an increase in the shares of households with no earner; these increases were especially sharp in the Netherlands and Australia and, to a lesser extent, in Italy, Finland and Norway. This trend reflects both increased early retirement and higher unemployment and lower labour force participation among those of working age. This trend was accompanied in seven of the countries, by increases in the share of the population living in households with two or more workers. The polarisation of society between "work-rich" and "work-poor" households (see Chapter 1) has been important in increasing aggregate income inequalities. The third cause of widening earnings inequality is low pay.

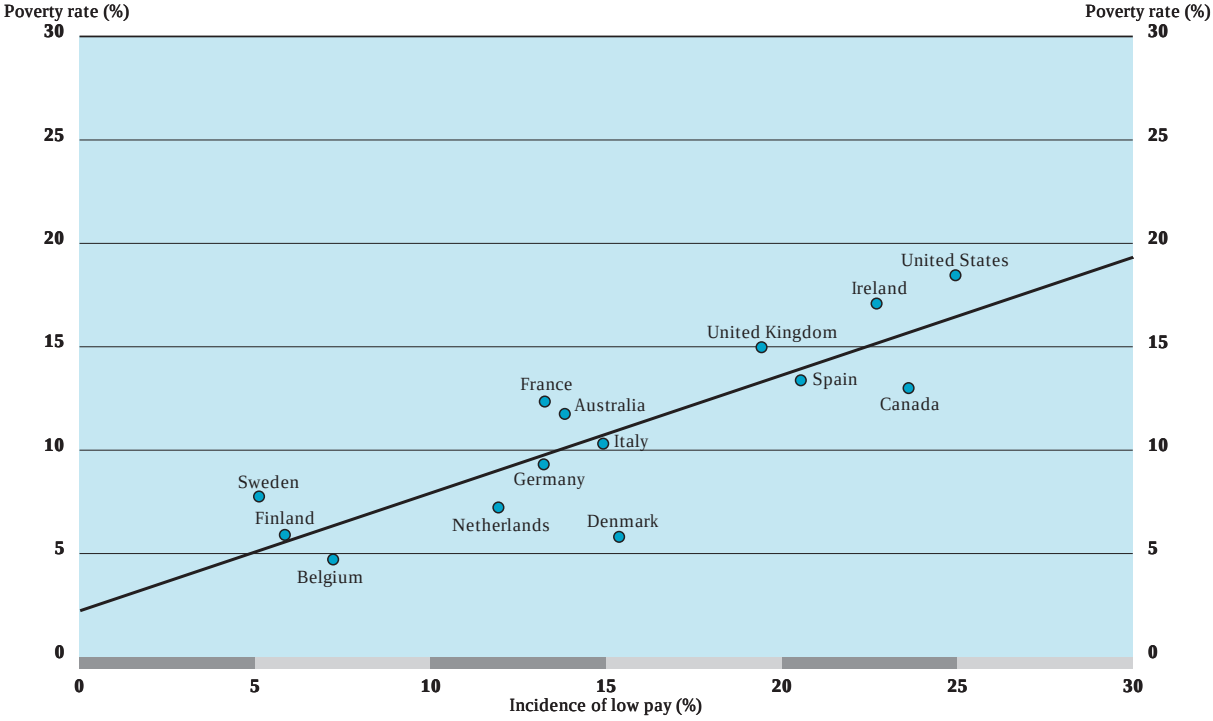
Across OECD countries, a high incidence of low-paid employment is closely associated with a high poverty rate, defined as the proportion of all individuals of working age living in households with total income below one-half of average adjusted household income (Chart 3.3). However, the relationship between low pay and poverty is complex. Generous welfare benefits which lower poverty rates may go hand-in-hand with a compressed structure of earnings and relatively fewer low-paid jobs. Even in countries with less generous welfare provisions and a relatively high incidence of low-paid employment, poverty may be associated more often with having no pay than low pay.

It is difficult to measure the overlap between low pay and poverty or low household incomes on a comparable basis across countries. One of the few studies that has done so suggests that, in most European countries, less than 10 per cent of low-paid, full-time workers live in poverty (Marx and Verbist, 1997). However, in the United States, where the incidence of low pay is higher, one-quarter of low-paid workers are so-called "working poor". If annual earnings of all workers are taken into account, including part-time and part-year workers, the overlap with poverty is considerably higher, with over one-third of workers with low annual earnings in the United States living in poor households.

By focusing on low-paid workers at a single point in time, these static measures underestimate the poverty risk faced by low-paid workers. As shown in OECD (1997*f*), whilst for many low pay is a transitory phenomenon, with a low-paid job being a stepping-stone to higher earnings, the risk of being chronically low-paid or cycling between no pay and low pay is high. This pattern appears likely to be associated with an elevated risk of poverty, particularly in the periods in which the individual is not working at all. Allowing for transitions into and out of poverty also tends to raise its incidence. In the United States, for example, typically less than 4 per cent of full-time workers are poor in any single month, and yet as many as 16 per cent experience a spell of poverty lasting two months or more during any two-year period (Shea, 1995).

In all countries, the incidence of poverty is highest for individuals with no earnings at all, but the number of working poor – or nearly poor – is also considerable. Furthermore, these associations between low-paid employment and family incomes tend to understate the link between low pay and diminished living standards, since they treat family structure as being independent of labour market opportunities. As noted above, workers in low-paid jobs may

Chart 3.3. **Incidence of low pay and poverty**[1]



1. The incidence of low pay refers to the proportion of full-time workers earning less than two-thirds of median earnings. The data generally refer to the mid 1990s. The poverty rate refers to the proportion of all individuals aged 16 to 64 (all individuals for Italy) living in households with total income of less than 50 per cent of average household income (adjusted to take account of household size). The data generally refer to the late-1980s to early-1990s period.

Sources: OECD (1995*c*); OECD (1996*a*, Chapter 3); Marx and Verbist (1997); and Secretariat calculations based on data from the European Community Household Panel.

postpone family formation or dissolve independent households and, instead, live with parents or other relatives. While anti-poverty programmes should place a high priority on increasing employment, successful measures to augment the earnings of low-paid workers would also help to lower poverty.

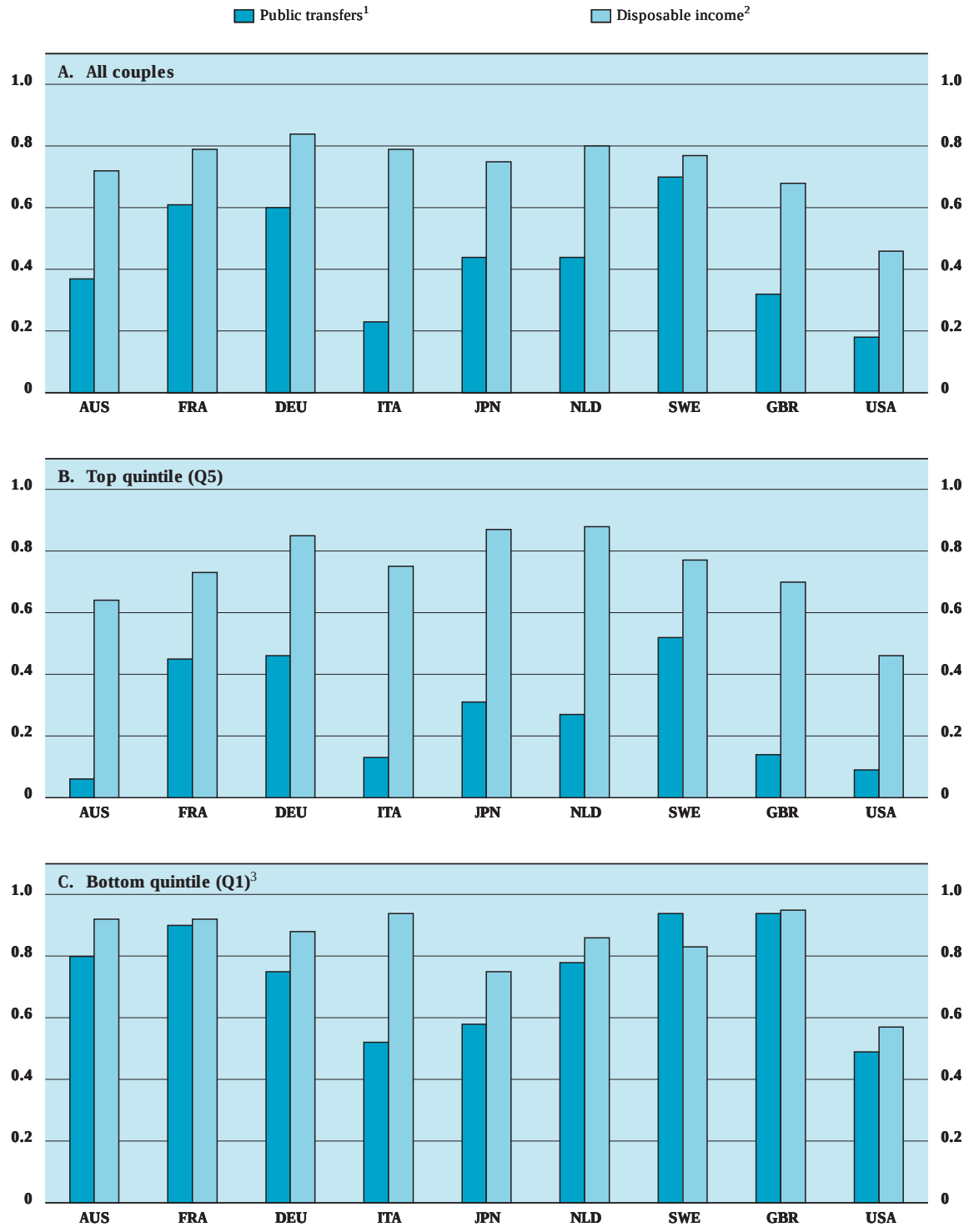
6. Resources in retirement

The elderly on average have higher incomes relative to the rest of the population than previously, but still have a high incidence of poverty. One way of analysing these developments is to compare disposable income available during retirement and that prevailing at the end of the individual's working life.[9]

Chart 3.4 shows two measures of replacement ratios (here defined as the ratio of disposable income of 67-year-olds in each quintile to that of those aged 55)[10] for couples: one which considers *all* components of disposable income and a second which comprise *public transfers only* in the numerator. The latter ranges from less than 0.2 in the United States to 0.6 and above in France, Germany and Sweden. Differences across countries are considerably lower when replacement ratios are based on a disposable income concept. For most countries, these rates cluster around 0.7.[11]

The size of the discrepancy between these two measures of replacement ratios varies along the income distribution (Chart 3.4, lower panels). For couples in the bottom quintile, the range of cross-country variation for replacement ratios based on public transfers only is significantly

Chart 3.4. **Replacement ratios for all couples and along the income distribution**



1. Public transfers of households with head aged 67 relative to income of households with head aged 55.
2. Income of households with head aged 67 relative to income of households with head aged 55.
3. For Australia, the bottom quintile refers to Q2.

Source: OECD (1998*i*).

lower, with values of around 0.5 in Italy, Japan and the United States, and 0.7 to 0.9 in the other countries.[12] When combining all income sources, replacement ratios generally converge to values of around 0.9, with the United States as the main outlier (due, in part, to the pre-tax nature of the income data). In the top quintile, the role of other income sources in smoothing out country-specific variations in social security regimes is considerably stronger. Replacement ratios based on social security vary from less than 0.1 in Australia to above 0.4 in France, Germany and Sweden. When incorporating all income sources, these ratios are in a range between 0.5 to 0.9.

Because replacement rates are higher for lower deciles than for higher, public pensions *reduce* income inequality. But the other sources of income of households in the higher deciles stretch out the income distribution once again. Similar patterns are shown when considering holdings of wealth (OECD, 1998*h*). On average, elderly families have high levels of asset holdings. But these holdings are unevenly distributed – a significant proportion of the population has few assets – especially if relatively illiquid housing wealth is ignored. Furthermore, in some countries the financial instruments necessary for converting housing wealth into an income stream (home-equity conversion) are not available.

It can be concluded that families adjust to the generosity of public pensions. If these are low, then savings (and hence asset-holding and incomes in retirement) are higher than in countries with more generous public pensions. However, the capacity to save in this way differs among families at different points of the income distribution.

7. The response of social policy

The discussion above showed that public transfers to households are not only directed to those on low income. The universalistic model of welfare provision which characterises several OECD countries, while sustaining the political support from middle-income classes for welfare programmes, also lowers their redistributive impact. Public transfers have tended to favour the elderly, irrespective of the existence of a situation of need or not. Public pension programmes have improved the relative position of the elderly and ensured that the retired are less likely to be in poverty than 20 or 30 years ago. However, trends in the distribution of market income have worsened the relative situation of other groups in the working-age population, particularly households with a young head and single-parent households.

This points to the need to adapt social programmes to address shifts in the incidence of low income and poverty among the different population groups. Poverty in old-age has been reduced, but remains significant in some countries. A general reduction in public pension provision may not always be called for. However, there is a case for refocusing resources away from wealthier retired households towards the groups with emerging needs (in particular, families with children).

Notes

1. While the lack of consistent cross-country definitions for components of income and population coverage make cross-country comparisons of levels of inequality less reliable, in practice values of the Gini coefficient shown in Table 3.1 are quite similar to those based on international data sets which try to harmonise definitions. While comparisons of inequality indexes at two points in time, such as those in Table 3.1, may be affected by differences in the cyclical position of the various economies, these results are, in general, broadly in line with those shown by national studies. A more complete description of the methodology and findings is provided in Burniaux *et al.* (1998).
2. Opposite movements in the various indicators reflect differences in the sensitivity of each index to changes at various points in the distribution.
3. For a number of countries, the changes in inequality shown in Chart 3.2 span a longer time period (often starting from the mid-1970s) than that shown in Table 3.1.
4. Estimates of the level of relative income of groups in society are crucially shaped by perceptions about the existence and size of scale economies of households needs. Thus, the assumption of no scale economies (*i.e.* an equivalence scale elasticity of 1) would result in a higher relative income level of the elderly, often higher than for the population average.
5. For reasons of brevity, this section only discusses differences in the distribution of income across different household types. In many countries, examination of other dimensions of the population such as ethnicity reveals substantial and persistent inequalities.
6. Whether this might foreshadow lower lifetime incomes for this cohort is discussed in OECD (1998*a*).
7. The net impact of this change was a sharp fall in average household size. This was particularly large in the Netherlands where it fell by around 30 per cent. If there are economies of scale (and all measures cited in this chapter assume that this is the case) then the fall in household size will reduce resources per person. This will affect the distribution of income if there is a correlation between household size and relative income.
8. The term "earnings" in this context is used to describe "income from paid dependent employment accruing to households, adjusted for scale economies". As such, the data reflect the combined effects of employment, hours of work and hourly wages.
9. Income is generally defined as annual disposable income, net of taxes, although for the United States it refers to gross (*i.e.* pre-tax) income. Definitions and limitations are extensively discussed in OECD (1998*h*).
10. The estimates do not use panel data which follows individuals over time; instead, they compare individuals from different cohorts. Since the cohort of 55-year-olds is more prosperous than the 67-year-old cohort was when they were 55, replacement rates reported here are biased downwards.
11. The exception is the United States, where income is measured on a pre-tax basis, leading to an *understatement* of replacement ratios compared with other countries.
12. In the case of Australia, values for the bottom quintile actually refer to families in the second quintile. "Measured" income for families in the first quintile is in fact disproportionately low, reflecting large losses reported by self-employed persons in this group.

Part II

REDEFINING SOCIAL POLICIES

Chapter 4

Policy Challenges in Adapting to the New Life Course

1. Introduction and main findings

This chapter considers how social policy can contribute to the human capital of the population. Human capital development is not just the preserve of education and labour ministries. Social policy ministries are often directly responsible for some interventions (such as those during early childhood) and jointly responsible for others (young people entering the labour market). Furthermore, social policies influence the extent to which caring and working can be combined, so influencing aggregate labour supply. This part views social policy as a series of interventions over the life course – an approach arising out of the OECD work on ageing. The main conclusions are two-fold: policy interventions should be targeted at the points where they have most impact, so reducing social and labour market disfunctioning; and a better balance needs to be struck between time spent in learning, working, caring and leisure. The social policy priorities suggested by such an approach are:

- Education should not be concentrated in the early years of life, but must become a continuing activity.
- Some early childhood interventions (particularly early education programmes) are successful in reducing significantly the chances of disadvantage in later schooling and adulthood.
- Policies concerning the transition from school to work fail many young people in some countries. The "scarring" arising from a failure to secure a firm foothold in the labour market can afflict some young people for many years.
- People may want to take leisure, engage in continuing education or take responsibility for caring activities at periods during their life other than when they reach a set retirement age. Social policies should not prevent such flexibility in life-course patterns. In particular, policies which help parents to balance labour market and caring activities are needed.

2. The life-course approach

In 1960, in a typical OECD country[1] men lived some 67 years, of which 46 were spent in work. The other 21 years were mainly spent in infancy and school, and short periods of not working and in retirement. Today, men live to 74 with only half of their lives (37 years) spent in employment. The other 37 years consist of longer periods of time in education, unemployment and non-employment, and, especially, retirement. Similarly spectacular changes have taken place in the life course of women. Life expectancy has increased by seven years and average years in employment have increased by the same amount. Working-age years spent outside of paid employment have halved (from 24 to 12 years). The amount of time spent in retirement has increased sharply.

Social policies have supported these extended periods spent in retirement. In some countries, they have also sought to enable a choice to be made about whether to combine working with caring for children. A key policy question is whether social policies have the correct balance in supporting different age groups. The conclusion of the OECD report on ageing is that there is a need to rebalance activity over the life-course.

3. Lifelong learning

OECD Education Ministers, at their meeting in January 1996, identified the goal of lifelong learning for all as a means for anticipating and responding to on-going changes, promoting economic efficiency, and enhancing social cohesion. In discussing strategies for achieving this goal, the Ministers recognised that the task extends beyond restructuring formal education systems. They stressed the need to "deepen co-operation with their colleagues in the areas of social, labour market, economic and communications policies, in order to make sure that policies which affect education are coherent and cost-effective" (OECD, 1996*f*). Labour Ministers also discussed lifelong learning at their meeting in 1997 and endorsed the need for such co-operation (see Press Communique in the Annex).

Lifelong learning has relevance for Social Policy Ministers for two main reasons. First, the absence of adequate learning opportunities contributes to labour market failure, in turn leading to benefit dependence. Second, social policies will have to support, rather than hinder as is too often the case at present, the continued acquisition of competences throughout the life-course.

Poorly qualified adults are of particular concern to social policy-makers. They face higher risks of unemployment and low earnings, and are thus vulnerable to poverty and social exclusion. Current patterns of investment in lifelong learning after formal education tend to widen the gap in qualifications and economic outcomes between the least- and most-qualified workers. Public schemes do little to offset this bias: the numbers of participants on labour market training programmes are far smaller than the number of adults with low levels of educational attainment, and their record is mixed (see OECD, 1997*f*).

Given that low skill levels are associated with non-employment and calls on the benefit system, social policies need to be more flexible in supporting periods out of paid employment for reskilling. For example, participation in appropriate education and training courses may prevent active job search in the short term, but facilitate it over time. Denial of benefit on such grounds may be counterproductive.

OECD Labour Ministers at their recent meeting concluded that, amongst other things, there was a need "to investigate urgently how to strengthen the incentives for individuals and employers to invest in lifelong learning, to make the provision of such learning more cost-effective and simplify the financing of such investment, (…) to improve mechanisms for early identification of individuals who, regardless of their labour market situation, are in need of improved access to lifelong learning; this may involve developing and applying criteria different from those usually used in labour market programmes to identify individuals who are 'at risk' of drifting into long-term unemployment and social exclusion" (see Press Communique in the Annex). Two areas where social policies play an important role in achieving these intermediate objectives are *i)* policies towards young children and their families, and *ii)* the transition from school to work.

4. The importance of early childhood interventions

Economic disadvantage, poor schooling, residence in areas of highly concentrated poverty, young maternal age, single parenthood, low maternal educational attainment and unemploy-

ment have all been identified as factors which are associated with social, cognitive, emotional and physical well-being (Brooks-Gunn, 1994).[2] The well-being of children is drastically reduced by being raised in poverty. Part of any strategy to improve outcomes through interventions early in life must be to prevent child poverty. This, in turn, implies sufficient income support must be available to prevent deprivation and measures to increase employability of parents should be pursued. Both options are expensive. In this context, the attractions of low-cost, high effect early interventions through networks of social services, often operated by local governments, are apparent.

Policies aimed at improving the life-course chances of individuals through early childhood interventions fall (imperfectly) into three categories: *i)* home visiting programmes; *ii)* early childhood education; and *iii)* parental work and education training programmes.

Home-visiting programmes focus on improving parenting skills. They generally consist of health care advice and general social service support. Visits often start before birth (low birth weight being strongly correlated with lessened cognitive ability). Such schemes are relatively common in Europe, less so elsewhere in the OECD area. Visits generally take place between one and four times per month.

Early childhood education programmes (sometimes also called centre-based education programmes) provide the child with experiences to stimulate development (cognitive, linguistic, social, etc.). Many programmes are also aimed at the parents (or, more usually, the mother) on the basis that any positive effects from the programme cannot be maintained without active family involvement.

Parental work and education programmes aim to improve the economic and social environment in which the child is raised. Many countries have developed such schemes from a different perspective and set of policy aims from that of altering the life-course outcomes of the child. Some, however, recognise this directly and may integrate it with elements from one of the other approaches.

Evaluations of such interventions have focused on North-American programmes and show mixed results. When a mother who was on the then AFDC programme in the United States moved off welfare or entered a stable marriage or increased her educational achievement, the result was a significant decrease in the likelihood of the child having grade-failure or behaviour problems. Rapidly increasing family size had the opposite effect. However, the various programmes did not always contribute to these outcomes. For example, families who have received home-visiting programmes are more likely to take up available services (*e.g.* in the United States, Medicaid, AFDC), but whether these translate into better outcomes for the child is unclear (Brooks-Gunn, 1994). Programmes focusing on improving the labour market position of mothers have shown positive results, but are dependent on high-quality child-care being available.

Early education programmes, on the other hand, give positive results in nearly all evaluations and the effects appear to be largest for children of mothers with the lowest education levels. The most comprehensive evaluations (Lazar *et al.*, 1982) suggest that participation in a programme reduced the incidence of children being in the "mildly retarded" category by around one half. These positive effects persisted into school years, even to the secondary school level. However, many of the programmes evaluated have been small-scale and staffed by highly qualified personnel. More broad-based schemes, such as the "Head Start" programme initiated in the 1960s show significant short-term effects, but these do not persist beyond a few years.

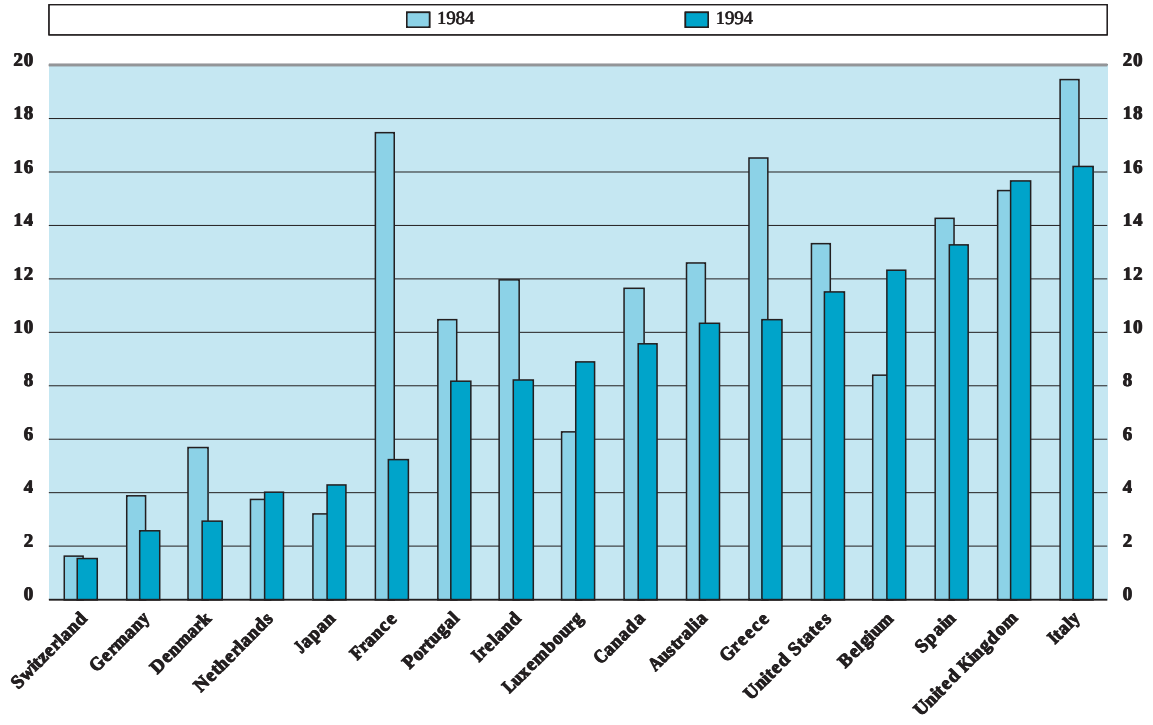
In sum, early childhood interventions can have positive effects. However, these positive effects arise from high quality (and costly) programmes, with a large educational content, requiring co-ordination across social, educational and health workers. Given that the largest effects are sometimes found among the most disadvantaged families, targeted programmes may be effective in preventing transmission of disadvantage across generations.

5. Labour market entry for youth

A second part of the life-course where interventions may make a significant difference is the transition from school to work. Across the OECD area, there has been a general worsening in the employment and earnings' position of young people since the 1980s (OECD, 1996*a*). Failure to become established in an appropriate career path may lead to a permanent "scarring" effect. Those who do not have an easy transition, falling into unemployment or non-employment, may find it difficult thereafter to move into a career with better prospects.

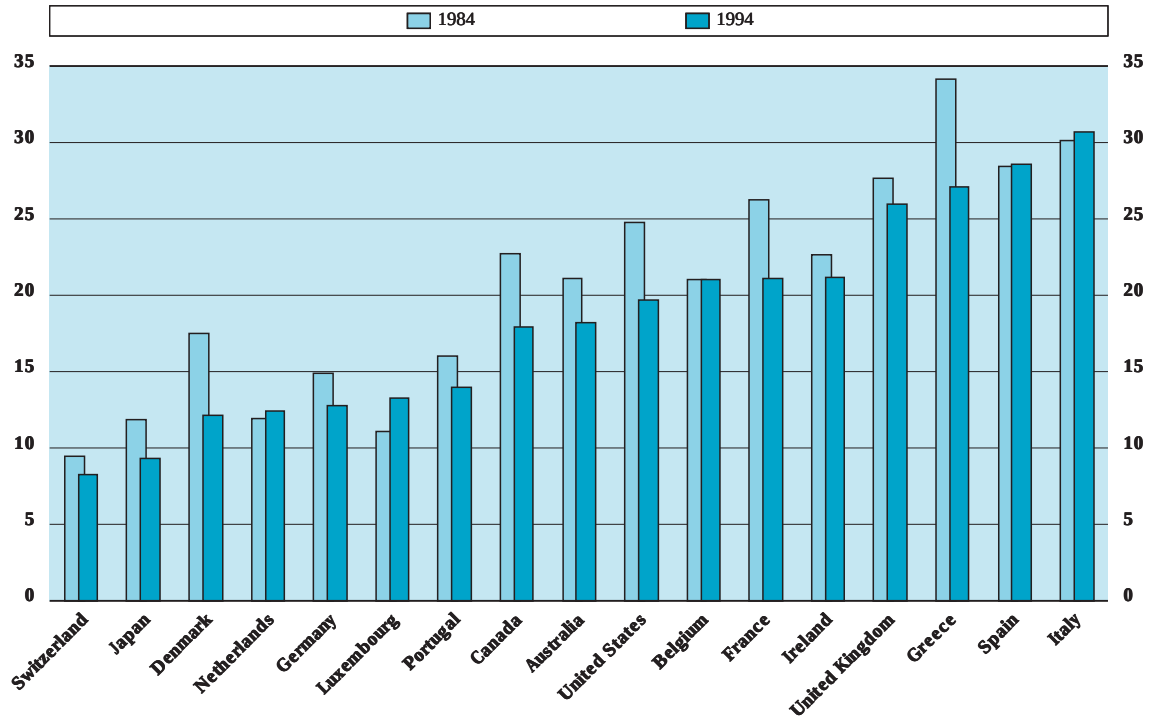
Over the past decade, there has been a significant increase in the length of time young people spend in education (OECD, 1997*c*). Part of the reason for this rise in educational participation has been a rapid decline in full-time employment opportunities for the young in many countries, coupled with systems of financial support that make education a relatively attractive financial and lifestyle option. High rates of youth unemployment mean that, even when young people leave the education system, their entry to employment can be delayed, and some drop out of the labour market altogether. Charts 4.1 and 4.2 show substantial variation in the proportion of teenagers and young adults who are neither in education or in the labour market across

Chart 4.1. **Young people aged 15-19 not at school or work**
Percentage of total in age group



Source: OECD (1998*j*), *Labour Force Statistics*, Part III.

Chart 4.2. **Young people aged 20-24 not at school or work**
Percentage of total in age group



Source: OECD (1998*j*), *Labour Force Statistics*, Part III.

countries. In Switzerland, a negligible number are in this group, whereas in Italy, the figure rises to almost 20 per cent. The proportions are, not surprisingly, somewhat larger for the older age group.

The extension of the period before most young people enter employment leaves a gap between the ages at which parental support is legally or socially the norm and the point at which young people can support themselves. How benefit systems (and in particular social assistance payments, originally designed for very different social risks and groups) support young people during this extended transition period has, therefore, become a prominent social policy issue. Three trends have been apparent:

- access to benefits has been restricted to those with family responsibilities;
- benefits to unemployed young people have been aligned with the income support available to those remaining in full-time education; and
- benefit receipt is conditional on participation in education, work or training programmes.

The first two of these trends have aimed to remove the short-term financial incentive offered by benefit systems to young people to leave education. It is now common to have a minimum age limit of 25 before full social assistance benefits can be received (*e.g.* France, the United Kingdom). Reduced benefit rates are justified on incentive grounds. As youth wages are typically below adult rates, so should benefit rates (*e.g.* the Netherlands).

The third trend has created a problem in co-ordinating implementation of policies for young people between the various responsible agencies. Increasingly, countries have some form of guarantee of education, training or employment for young people who fail to find a job. It is common for benefit receipt to be made conditional on participation in such programmes (*e.g.* Denmark, Norway, the United Kingdom). This can lead to tensions between different agencies involved in such programmes, with benefit agencies concerned about the social consequences of benefit denial and the employment services attempting to preserve the integrity of the system.

6. Reconciling paid work and unpaid work

The level of labour-market participation by women is the outcome of a complex mix of cultural patterns, social and economic behaviour and available child-care. Countries fall into four categories in this respect:

- those in which having children does not influence the mothers' activity rate, because women are expected to be in the labour market and there is a high provision of child-care services. This is the case in the Scandinavian countries;
- those in which having children has a minimal impact on female employment. This is the case in France, where the employment rate of mothers does not fall appreciably until the third child. The same is true of Italy in recent years, although with lower overall employment rates as well as much lower fertility rates;
- those in which the difficulties of combining family life and career result in part-time work. This is the case in Germany and the United Kingdom;
- those in which women's activity rate drops with the birth of the first child, as in Ireland and the Netherlands.

The activity rate of lone mothers (Table 4.1) depends to a greater extent than for married mothers on social policy provisions. It is lower in those countries such as Australia, Germany, the Netherlands, and the United Kingdom, where income-support policies suggest that it is legitimate for mothers to stay home to take care of their children, and to receive, therefore, economic support when in need. In these countries, concern has grown about the development of long-term benefit dependency. The number of years a lone mother may benefit from income support has been reduced, as in the Netherlands and the United States. Education and training programmes to help lone parents enter the labour market have been introduced in Australia and Germany (and, more recently, the United Kingdom). Budgetary constraints limit the expansion of centre-based child care and are encouraging a shift to home care (Millar and Warman, 1996). In Denmark, a home-care supplement has been introduced, and extended parental leave provided for parents who give up work to care for children at home. Similar provisions apply in Finland.

Two areas of social policy have great influence on whether mothers are required to make a choice between labour market participation or child-rearing: the availability and affordability of child-care; and provisions for temporary withdrawal from the labour market through parental leave.

As illustrated earlier (Chapter 2), expenditure on family services (which includes child care) is generally small in most OECD countries with the notable exception of the Nordic countries. However, these gross totals are difficult to interpret as child care is supported in many ways. In France, tax expenditures are important (see OECD, 1996*j*); Australia pays a cash benefit for child-care services; the United Kingdom provides a "free area" in most in-work benefits, so reducing the net cost of child-care.

Table 4.1. **Married and lone mothers employed full-time and part-time**

		Married/cohabiting				Lone mothers			
		Full-time	Part-time	All employed	% of employed who work full-time	Full-time	Part-time	All employed	% of employed who work full-time
Australia	1994	24	32	56	43	23	20	43	53
Austria	1993	28	18	46[1]	61	43	15	58[1]	74
Belgium	1992	36	22	61	59	52	16	68	76
Denmark	–	64	20	84	76	59	10	69	86
Finland	1993	62	8	70	89	61	4	65	94
France	1992	49	20	68	72	67	15	82	82
Germany[2]	1992	21	20	41	51	28	12	40	70
Ireland	1993	–	–	32	–	–	–	23	–
Italy	1993	29	12	41	71	58	11	69	84
Japan	1993	17[3]	20[3]	54[3]	31[3]	53[4]	34[5]	87[6]	61
Korea[7]	1995	–	–	39	–	–	–	49	–
Luxembourg	1992	32	13	45	71	61	13	73	82
Netherlands	1994	13	39	52	25	16	24	40	40
New Zealand	1991	31	27	58	53	17	10	27	63
Norway	1991	40	37	77	52	44	17	61	72
Portugal[8]	1991	48	7	55	87	43	7	50	86
Sweden	1994	42	38	80	53	41	29	70	59
United Kingdom	1990-92	21	41	62	34	17	24	41	41
United States	1992	45	19	64	70	47	13	60	78

Note: Part-time work is less than 30 hours per week.

1. Excludes 13 per cent of married/cohabiting mothers and 20 per cent of lone mothers who are on parental leave.
2. 36 + hours
3. For married/cohabiting women with or without dependent children (1992).
4. Including self-employed.
5. Including working for family.
6. Includes self-employed who may work full-time or part-time.
7. Information from Korea National Statistic office.
8. If the definition of lone mothers was restricted to single, separated and divorced women (to counter the bias resulting from the disproportionate number of widowed women in the Portuguese definition of lone mothers), Portugal would have a much higher level of lone mothers in paid work.

Source: Bradshaw (1996).

Access to child care is far from universal. In the United States and Canada, respectively 5 per cent and 1 per cent of the under 2-year olds and 2 per cent and 35 per cent of the 3 to 4-year olds are in publicly-funded child care. The figures for Australia are 2 per cent and 26 per cent (Kamerman and Kahn, 1991, 1994*a*, 1994*b;* Gornick *et al., 19*96; see also OECD, 1998*g*).

Policies concerning maternity and parental leave differ widely between countries, as do the degree of, and criteria for, compensation for lost wages. A study of EU countries found that the Netherlands, Portugal and the United Kingdom had the shortest statutory ante-natal and post-natal leave, Italy the longest (CEC, 1989). Since then, rights in some countries have been extended, following the EU Pregnant Worker's Directive. However, many working mothers have no entitlement because they work in the informal sector or are self-employed. Australia and Canada have mandatory paid leave although in Australia it covers only 10 per cent of working women. In the United States, it is not mandatory and it covers about 25 per cent of working women (Gornick *et al., 19*96).

In Ireland and the United Kingdom, there is no provision for workers' parental duties and family responsibilities beyond those around birth (Pillinger, 1993), though the former has announced its intention to introduce parental leave. In Canada and the United States, there is no entitlement either to parental leave, although labour contracts may provide them. In Australia, extended and paternity leave is available, although only for those who are covered under publicly mandated maternity benefits.

Notes

1. Figures in this paragraph are based on an unweighted average of 15 countries (see OECD, 1998*f*).
2. These factors are of course closely inter-related. The US Census Bureau estimates that 21 per cent of children live in households at or below the poverty level. For children aged under 6, the percentage rises to 23 per cent. Half of African-American and 40 per cent of Hispanic-American children under 6 and 60 per cent of children in lone-mother households were in poverty.

Chapter 5

Policy Challenges in Implementing Employment-oriented Social Policies

1. Introduction and main findings

Whilst the greater emphasis on skill acquisition and preventive interventions suggested in the previous chapter will eventually increase the employability of the population, they are long-term solutions. The poor prospects of low-skilled workers in the labour market also require policies to alleviate their short-term problems of finding jobs and low wages. This chapter considers the balance between supporting those without work and subsidising those who do have work. It concludes:

- There has been a general trend to restrict access to, the duration of, or the level of the main unemployment benefits. But the desire to ensure adequate family incomes for the unemployed has meant that there have been few substantial cuts in benefit entitlements.
- Attention focuses increasingly on balancing equity goals with employment objectives by channelling public funds towards those who work but who have low incomes, rather than focusing solely on those without work.
- Employment conditional tax credits or benefits have proved successful in stimulating employment in some of the countries where they have been introduced.
- Whereas some policies to improve labour market incentives are costly (either socially or financially), a greater concern to assist people at the time that they exit benefits has led to worthwhile and affordable policy innovations.

There is a growing concern about the welfare of a section of society which is dependent on benefits and excluded from the labour market and even from society. The general strategy of investing in human capital and improving incentives in the labour market is likely to be a necessary but not sufficient policy response to the problems faced by people in such situations. Policies to prevent exclusion cut across a range of government agencies. Social policy ministries have responsibility for the policy instrument most closely involved in tackling this problem: social assistance. Building on the results of OECD reviews of social assistance systems in eight countries, the second part of this chapter concludes:

- There are three pillars in an effective social assistance system: cash assistance; social services; and labour market services. If any one of these pillars fails to provide adequate support, in time the others will probably fail as well.
- There is no general trend towards increasing or reducing the level of cash assistance. However, benefit is being made dependant on labour market activity for young people and, after an increasingly short period, lone parents.

- Social support must address new social problems, such as household debt, as well as providing the more traditional services.
- Insufficient attention is sometimes paid to labour market reinsertion. If the public employment service is incapable of providing adequate aid to social assistance clients, innovative new arrangements are required.
- Inappropriate financial relations between different institutions involved in social assistance, particularly different levels of government, can warp institutional incentives and prevent effective policy implementation.

2. Making work pay

The previous chapter outlined policies necessary for people to be able to work without compromising other social objectives such as caring, and suggested that policies promoting lifelong learning could improve the skill base of the labour force. But these are long-term strategies, and job-seekers and those dependent on benefits need help with a much shorter time-horizon.

2.1. Policies aimed at improving work incentives

The financial incentives and rewards to work are clear for the majority of the population, but they may be weak for many with low potential earnings, such as lone parents, partners in couples where one spouse is not working, and when part-time employment is the only realistic alternative to benefits. Reforms to the tax and transfer system may be directed at modifying the key parameters of benefit systems (*e.g.* cutting replacement rates, lowering the maximum duration of benefits, altering eligibility rules, etc.) or directed at increasing income from work (*e.g.* via employment-conditional benefits or statutory minimum wages) or both. In all cases, governments confront difficult trade-offs between sharpening work incentives and providing an adequate income.

Unemployment traps

One manifestation of such trade-offs is the *unemployment trap*. This occurs when the income provided by the unemployment and related welfare benefits system approaches or exceeds that which could accrue from work. As noted in OECD (1997*d*), "if work does not pay, people will be reluctant to work".

Policy adjustments have focused primarily on tightening benefit eligibility criteria and rules, and willingness-to-work requirements (Table 5.1). Reductions in the level of benefit and duration have, with some exceptions, been small, and have been motivated more by fiscal considerations than the desire to improve work incentives. As described in OECD (1997*d*), replacement rates are at their highest for families with children. The reluctance of countries to restrict benefit entitlements for such groups in order to promote work incentives is obvious.

Poverty traps

Disincentives may also arise from social assistance and other means-tested programmes. These programmes are conditional on individual or family resources, and the benefits are withdrawn as incomes rise. Rapid withdrawal of these benefits combined with payment of tax and social security contributions can lead to very high marginal effective tax rates (METRs), and this may negatively affect beneficiaries' decisions to supply work (*the poverty trap*). High METRs are

Table 5.1. **Changes in unemployment benefit systems over the 1990s**[1]

	Changes in initial gross replacement rates[2] (UI)[3]	Changes in maximum duration (UI)[3]	Tighter work availability requirement	Tighter eligibility requirement	Additional information on reforms
Australia	=	=	X	X	Changes in benefit withdrawal regime in July 1995. 1997 reforms to tighten benefit eligibility and administration also changed penalties for non-compliance.
Austria	43% → 36%	=	=	X	
Belgium	=	=	X		1993 reforms: UI eligibility suspended for the dependent person in two-income households if the unemployment spell is "abnormally" long.
Canada	60% → 55%	50 → 45 weeks	X	X	1996 reforms: RR depends on hours worked and declines with repeated spells of UI claims.
Denmark	61% → 55%	2.5 y → 7 y[4]	X	X	As of 1997 the maximum duration will gradually be reduced to 5 years.
Finland	54% → 61%	=	X	X	1996 reforms: employment conditions tightened; requalification options tightened; and earnings in subsidised jobs form the basis for new benefits.
France	57% → 53%	=	=	X	
Germany	40% → 38%	=	X	=	
Greece	=	=	=	=	Benefits have been fixed in recent years at a low level (Dr 2 710 per day) as an emergency measure; the maximum duration has been reduced for people under 30.
Ireland	41% → 32%	=	=	=	The earnings related benefit was ended. Increased incentive for long-term unemployed to return to work (back to allowance schemes), including part-time work.
Italy	15% → 33%	=	X	=	
Netherlands	=	2 y → 1.5 y	X	X	In 1995, the qualifying conditions for UI were tightened for young workers.
New Zealand	39% → 35%	=	X	X	1991 reform: benefit rates reduced. Sanctions and waiting period tightened. 1996 reform: the cut-off point for benefit abatement increased. 1997 reform: work availability tests tightened for single parents and spouses of unemployed beneficiaries if there are no children under 14 years. Changes to benefit targeting have increased incentive to undertake part-time work.
Norway	=	1.5 y → 3 y[4]	=	X	
Spain	80% → 70%	=	X	X	In 1993, the employment requirement doubled from 6 to 12 months; 1994 reform: unemployment benefits were made taxable. 1995 reform: eased UI eligibility for agricultural workers in certain regions.
Sweden	90% → 75%	=	X	X	1993 reform: unemployed become entitled to a training place requalifying them for UI.

Table 5.1. **Changes in unemployment benefit systems over the 1990s**[1] *(cont.)*

	Changes in initial gross replacement rates[2] (UI)[3]	Changes in maximum duration (UI)[3]	Tighter work availability requirement	Tighter eligibility requirement	Additional information on reforms
Switzerland	80% → 70%	250 d → 400 d	=	X	1996/97 reforms tighten eligibility.
United Kingdom	24% → 22%	12 m → 6 m	X	X	Benefits increased in line with prices, implying a decline relative to average earnings.
United States		=	=	=	Changes to other assistance benefits have included mandatory work experience provisions.

1. UI refers to unemployment insurance benefits; RR refers to replacement rates; "=" means no change has been enacted; "X" means that changes have been enacted.
2. The figures refer to the gross replacement rates in the first months of joblessness for unemployed persons with a dependent spouse.
3. In countries with no UI, the figures refer to guaranteed-income schemes. The letter m refers to months, y refers to years and d refers to days.
4. The extension of statutory duration was accompanied by limits on the possibility of requalifying for UI benefits *via* participation in active labour market programmes. Thus, the effective limit on duration may not have been affected.

Sources: OECD database on taxes and benefits; various issues of *OECD Economic Surveys*; and OECD (1998*g*).

mainly concentrated among lone-parent households and those with low incomes (OECD, 1996*a*).

In cases where countries consider that high METRs have had negative effects on work incentives, they have enacted several different kinds of measures. Examples include: lowering the rate of withdrawal of benefits as the recipient's resources increase (Australia, New Zealand); reducing personal income tax rates on low incomes (Denmark and New Zealand); and introducing earnings disregards or further increasing the amount which can be earned before assistance benefits are reduced (Australia, Canada, Denmark, France, Ireland, the Netherlands, New Zealand and the United Kingdom). The move in Australia from a means-tested system based on family resources to one conditional on individual circumstances has also been motivated by the objective of encouraging employment in households receiving benefits. When either partner in an unemployed couple takes a part-time or a low-paid full-time job, the family income is increased.

Supplementing in-work incomes

Employment-conditional tax credits or benefits top-up the income of those in low-paid jobs. The key feature of such a benefit is that it is income tested, but payable only to those employed. Because it is phased-out as earnings rise, it is wholly targeted on low-paid workers. Such benefits are currently available, in various guises, in six OECD countries: Canada, Ireland, Italy, New Zealand, the United Kingdom and the United States. Most of these schemes are limited to families with children (Table 5.2). The schemes differ in terms of delivery mechanisms (through the tax or benefit systems), targeting of beneficiaries (for example, through asset tests), administrative costs, and degree of participation by eligible (take-up rate) and non-eligible individuals (non-compliance).

Trade-offs are inevitably involved in supplementing in-work incomes: either METRs for workers and households further up the earnings distribution will increase, or income support for those on low incomes will fall. While reforms can increase work incentives for low-wage workers, the counterpart is inevitably reduced work incentives for workers higher up the earnings distribution. Some research in the United States suggests that the increase in work effort by the former group, induced by reforms, may be roughly equal to the decrease in work by the latter group (OECD, 1996*a*). Irrespective of the net effect on work effort, there are good social and long-term labour market reasons to introduce reforms that both help promote the employment of those who would otherwise be excluded from the labour market and to aid low-paid workers in general.

But employment-conditional benefits are not a panacea. On grounds of cost and of the necessary ratcheting-up of high METRs further up the earnings distribution, the benefit must be withdrawn from those earning close to the median wage, *i.e.* a relatively dense part of the earnings distribution. Thus, employment-conditional benefits are likely to be most successful in countries where the existing earnings distribution is relatively unequal and the benefits are kept fairly low relative to average earnings. The wider the distribution of earnings, the greater is the number of potential beneficiaries; this has clear implications for the financial costs of these schemes.

2.2. Policies aimed at stimulating the demand for less-skilled workers

Tax and benefit systems can also affect the structure of the demand for labour if non-wage labour costs act as a hiring barrier. Many countries have introduced *wage subsidies* with the aim of reducing the cost of low-skilled labour without reducing these workers' take-home pay. The

Table 5.2. **Key features of employment-conditional tax credit and benefit programmes**[1]

	Canada	Ireland	Italy	New Zealand	United Kingdom	United States
	Child tax benefit (Working Income Supplement)	Family income supplement	Family benefits for employees[2]	Independent Family Tax Credit (to be introduced)	Family credit	Earned income tax credit
Cost		IR£21.9 m = $33.9 m	Lit 5 763 bn = $3.76 bn	NZ$ 210 m	£11 bn = $1.7 bn	$26.7 bn
Number of recipients	0.7 m	11 847	–	150 000	0.5 m	19 m
Average receipt		IR£1 850	–	NZ$ 27	£2 400	$1 450
Responsible department	Tax administration	Social security	Social security	Tax administration	Social security	Tax administration
Maximum benefit	C$ 605 pa: 1st child; CS 405: 2nd child; CS 330: each extra child	[3]	Lit 2.76 m pa	NZ$ 15 pw per child	£67.80 pw[4]	$2 152/3; 556/323 pa
Minimum earnings	C$ 3 750	None	[5]		None	–
Phase in rate	8%	None	None		None	34/40/7.65%
Earnings when phasing out begins	C$ 20 921	Immediately	Lit 15 984 m		£73 pw	$11 610/11 610/5 280 pa
Withdrawal rate	10% of gross income	60% of gross income (net of income tax from October 1998)	10% of gross income	18% between NZ$ 20 000 and NZ$ 27 000, 30% above[6]	70% of net income	16.0/21.1/7.7% of gross income
Minimum working hours for eligibility	No limit	19 hours	No limit[7]		16 hours Supplement for 30 hours or more	No limit
Family type eligible	Families with children	Families with children[8]	Families receiving unemployment benefit[7]		Families with children Pilot scheme for childless	First figure is for 1 child families, 2nd for 2 or more children, 3rd for no children

1. Data on the entitlement rules refer to 1995 except for New Zealand (IFTC, 1997) Ireland and the United States (1996). Data on costs, number of recipients, refer to 1997 for Canada, 1993 for Ireland, 1990 for Italy, and 1994 for the United Kingdom and the United States. IFTC figures for New Zealand are forecasts for when the scheme is fully implemented in 1998-99. New Zealand's current Guaranteed Minimum Family Income (GMFI), which is a smaller employment-conditional payment, will continue to be paid. The GMFI is paid to lone parents working more than 20 hours and couples working more than 30 hours. The maximum benefit is around NZ$ 110 per week. The difference between family income and NZ$ 320 is paid. As all eligible families receive family benefits, and there is a minimum wage of around NZ$ 6.25 per hour, maximum benefit for lone parents is around NZ$ 110, substantially less (around NZ$ 30) for single-earner couples. It has approximately 5 000 recipients. It is operated through the tax administration. Figures for EITC in the United States are total programme costs, including outlays on repayments and the tax expenditure component (the reduction in tax liabilities).
2. In addition to this payment, Italy has income-related tax credits for dependent spouses and children.
3. Payment is 60 per cent of the difference between family income before tax and a weekly threshold of IR£165, plus IR£20 per child with a minimum payment of £5. Family income will be assessed *after tax* from October 1998 and the weekly threshold is IR£212 (as of June 1998) for family with one child plus IR£20 for each additional child.
4. Rates depend on the age and number of children. The above figure is for two children under 11 years old.
5. Ordinary unemployment benefits only last for 6 months in Italy, so the allowance operates *de facto* as an employment-conditional benefit.
6. IFTC and Family Support are subject to the same means test.
7. At least 70 per cent of family income must be from earnings (or pensions).
8. There are other employment-conditional benefits in Ireland. The *part-time job incentive scheme* is open to the long-term unemployed (15 months or more) who work for less than 24 hours a week. A flat-rate payment (IR£40 per week for singles, IR£66 for one-earner couples) is paid where this is more beneficial than means-tested unemployment assistance. The *Back to Work Allowance* is paid to the long-term unemployed (1 year or more) who are aged 23 years and over and to lone parents (no age limit) when the person takes up self-employment or a new job. 75 per cent of the standard means-tested unemployment or lone parent assistance is paid in the first year, 50 per cent in the second year and 25 per cent in the third year.

Sources: United Kingdom, Department of Social Security (1994); United States, Department of the Treasury, United States House of Representatives (1994); and information supplied by national authorities; and OECD (1998*g*).

long-term unemployed are the most commonly targeted group (OECD, 1997*f*). Evaluations suggest many wage subsidies suffer from heavy dead-weight loss and displacement effects (OECD, 1996*d*).[1] Substitution effects are also quite large, but are often justified both on equity and efficiency grounds: "shuffling the queue" of the unemployed in favour of the long-term unemployed helps to prevent social exclusion and could contribute to wage moderation by increasing the effective supply of labour. Recent experience with subsidies for the long-term unemployed in Australia suggests that they need to be substantial (30-50 per cent of wages at least) to encourage employer take-up.

Some European countries – particularly Belgium, France and the Netherlands – have opted for more broadly targeted programmes that reduce total labour costs at the lower end of the earnings scale (Table 5.3). The balance of evidence suggests that the incidence of payroll taxes falls mainly on labour in the form of lower wages in the long-run. However, a review of empirical studies on the effects of taxation on the wage bargaining process and unemployment concluded that there was reasonable evidence that taxes on labour increase wage pressure and, thereby, unemployment, in the short run (OECD, 1995*a*). In many countries, employers' social security contributions are regressive, meaning that a large part of the burden falls on the lower paid (Chart 5.1). Some countries (*e.g.* the United Kingdom, Ireland) have made the incidence of payroll taxes more progressive (CEC, 1997). However, such schemes can be very costly in terms of revenue foregone and they will generally require tax increases elsewhere or corresponding cuts in public spending to make up for the loss.

2.3. Considering "exit routes"

Cutting benefit payments in order to increase work incentives may have harsh social consequences. Other measures to increase the employment chances of low-skilled workers have a high cost on the public budget. However, it is possible to remove some barriers to work at a relatively low financial cost. These new directions for reform arise from considering how people manage to exit benefit receipt into paid work. For example:

- *Transition costs*. Benefits are often paid in advance, pay cheques in arrears. Entering employment requires a family to cope with an extended period without any income. By continuing some benefit payments for a limited period after a job is found, the cash-flow consequences of entering paid employment are reduced (*e.g.* Ireland, New Zealand).
- *Benefit flexibility*. Permitting some part of future benefits to be received as a lump sum may permit greater work preparedness. Appropriate tools or clothing for interviews can be bought (*e.g.* Australia).
- *Passported benefits*. Some benefits are paid only to those without work. Entering work may result in loss of medical insurance, protection from creditors, free school meals. Making benefits dependent on incomes, rather than employment status, reduces attendant disincentives (*e.g.* the United Kingdom, the United States).
- *Casual work*. Lack of labour market contacts hinders those trying to exit benefits. Yet many benefits are paid on condition that no work of any sort takes place, or that all income from employment results in a corresponding loss of benefit. Permitting some casual work helps maintain contact with the world of work (*e.g.* Belgium).

2.4. Conclusions

Two alternative strategies appear to be emerging for increasing employment incentives while also addressing the equity concerns related to low-paid jobs. The first allows wage inequality to

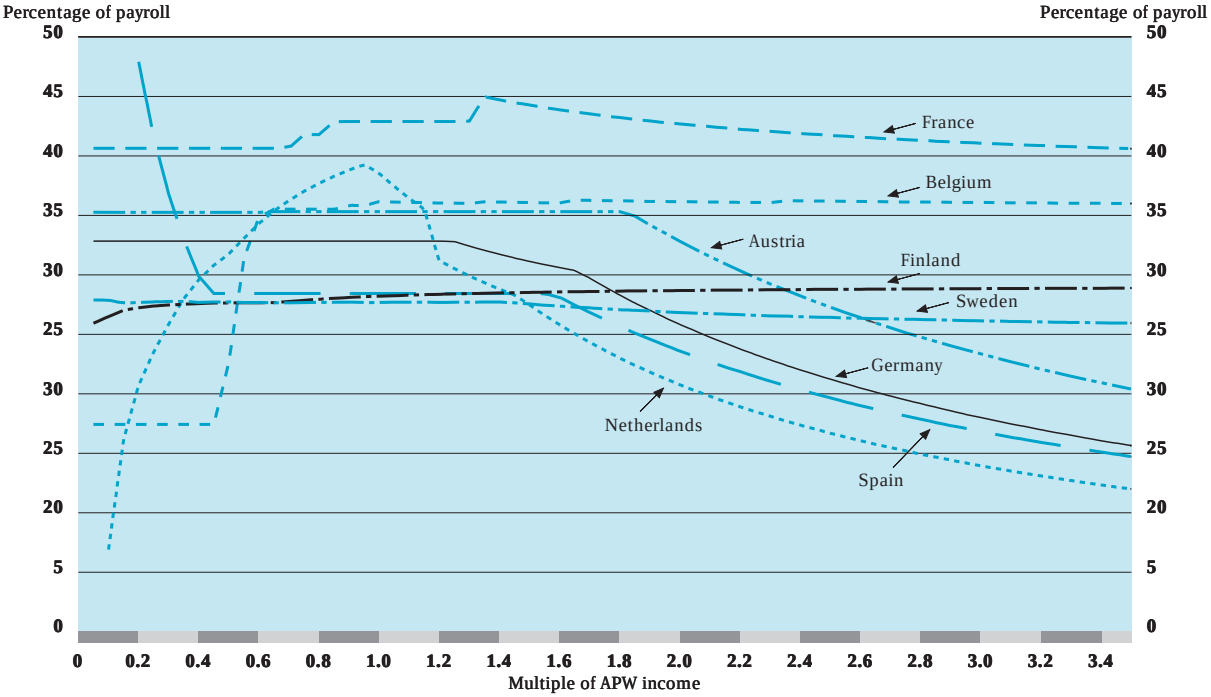
Table 5.3. **Structured reductions in employers' social security contributions in favour of low-wage groups**

	Groups affected	Description of the measure	Number of workers affected	Total cost per year
Belgium				
As from 1/04/94	Workers earning up to 58% of APW in 1995	Reduction of employers' contributions inversely related to the gross wage, varying between 50 and 10%	In 1995, 10% of the labour force	Shortfall in social security receipts equals 0.12% of GDP
Maribel operation, since 1981 (last modified April 1997)	Manual workers	Permanent reduction varying between 1.4% and 3.2% of TLC at APW earnings per worker, depending on the share of manual workers in the total labour force of the enterprise	In 1995, 16% of the labour force	In 1995, shortfall in social security receipts equals 0.19% of GDP
France				
Exemption from family contributions, since July 1993	Workers earning up to 1.3 times the minimum wage ("SMIC") (82.3% of APW in 1995)	Total exemption (3.7% of TLC) up to 1.2 times the SMIC level, and exemption of half up to 1.3 times the SMIC (1.8% of TLC)	Since 01/95, about 18% of the labour force	In 1995, shortfall of social security receipts equals 0.2% of GDP
Degressive reduction, since September 1995	Workers earning up to 1.2 times the minimum wage (76% of APW in 1995)	Reduction of 8.7% of TLC at the SMIC level; falling linearly to 0 at 1.2 times the SMIC. Cumulated with the above exemption	Since its introduction, about 14% of the labour force	In 1995, shortfall of social security receipts equals 0.05% of GDP
Unification of the two previous measures, since 1/10/96	Workers earning up to 1.33 times the minimum wage (84.3% of APW in 1995)	Reduction of 12.4% of TLC at the SMIC level, falling to 0 at 1.33 times the SMIC	Estimation of about 20% of the labour force	In 1996, estimated shortfall in social security equals 0.47% of GDP
Netherlands				
SPAK scheme, since 1/1/96	Workers earning up to 115% of the legal minimum wage (60.5% of APW in 1995)	Permanent reduction of employers' contributions (3.3% of TLC in 1996 and 5.2% of TLC in 1997). An extension of the scheme in 1998 is currently under discussion. For long-term unemployed and apprentices, higher reductions apply for 4 years (16.9% of TLC in 1997). After the gross wage > 115% of the minimum wage, half of the tax reduction continues to be granted for max. 2 years if the worker stays with the same employer.	Target of 13% of the labour force	Estimated tax expenditures equal 0.10% of GDP in 1996, and about 0.15% of GDP in 1997. Including the additional reductions for long-term unemployed and apprentices, tax expenditure equal 0.24% of GDP in 1996 and 0.29% of GDP in 1997.

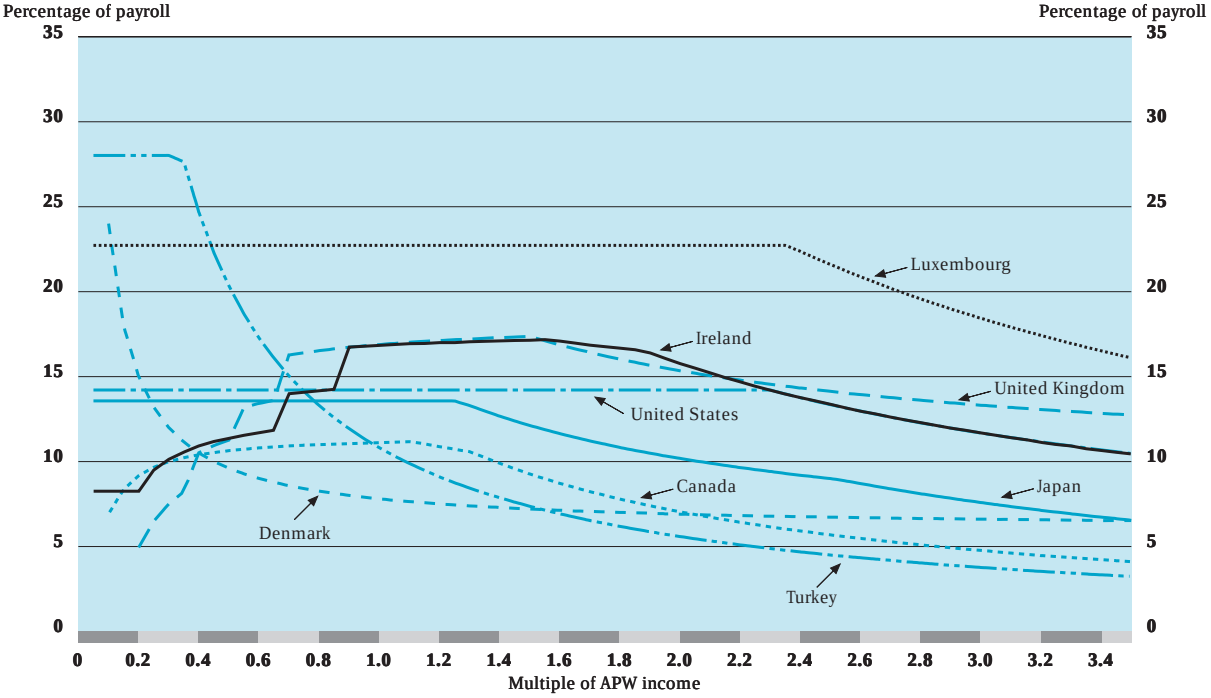
APW: Average production worker
TLC: Total labour costs.
Sources: National submissions; OECD (1996), *Tax/Benefit Position of Production Workers.*

Chart 5.1. **The structure of payroll taxes in OECD countries, 1995**[1]

Countries where payroll taxes represent *over 25%* of total labour costs at APW earnings



Countries where payroll taxes represent *less than 25%* of total labour costs at APW earnings



1. Payroll taxes are calculated as the sum of employees' and employers' social security contributions. The countries for which payroll taxes represent a constant percentage of total labour costs, irrespective of the level of earnings, do not appear in the graphs.

Source: OECD tax equations.

increase, as a spur to hiring, while using employment-conditional benefits to provide income security for those low-wage workers who do get hired. The second uses wage floors to limit earnings inequality and benefit levels set somewhat below the level of income which could be obtained from work, together with targeted wage subsidies or payroll tax cuts to counteract potential disemployment effects (OECD, 1997*d*). Both promise improvements, albeit moderate, in the employment prospects of the low skilled.

What unifies both policy strategies is an emphasis on making social protection compatible with employment through the giving of support to those in employment as well as those without jobs. This "employment-oriented social policy" offers great potential as a way of balancing efficiency and equity goals. It was endorsed by OECD Labour Ministers at their meeting in 1997, who requested the OECD to continue and to deepen their work on such policy options.

3. Policies against exclusion

The "socially excluded", the "outsiders", the "underclass", "benefit dependency", the "new poor": under a variety of labels, there is concern in many OECD countries that there is a section of the community that faces extraordinary barriers to full participation in the labour market and society. The results are well known: benefit dependency leads, sooner or later, to financial deprivation. Access to public services may be denied because of lack of address or employment record. Households are no longer in control of their own destiny. Health status may be damaged by poor diet and living conditions. Upon reaching retirement, lack of contributions to employment-based public pension schemes leads to continued reliance on minimum benefits. Children grow up without examples of the normal status of work in society, increasing the risk that disadvantage is transmitted across generations. In some countries, deprived areas or even regions become detached from the modern economy, becoming unable to take advantage of any improvements in the macroeconomic environment.

Several countries (Belgium, Mexico, the Netherlands) have developed anti-poverty strategies which incorporate policies for, among other things, urban regeneration, improved access to social services, integration of immigrants. The *programme de lutte contre les exclusions* announced by the French government includes actions to be taken under headings ranging from "the right to work", "the right to housing" and access to education, culture and health care, to "guaranteeing equality of access to sport and tourism" and "permitting individuals better to exercise their citizenship". The policy area most directly concerned with dealing with social exclusion and which has therefore taken on added significance in many countries is, however, that of social assistance.

Social assistance policy is not simply, or even mainly, about preventing destitution. Cash is the most urgent need of families which require social assistance aid, but unless the underlying cause of this need is addressed, repeat claims on the system are likely. The efforts which are made to deal with the various social and labour market problems which resulted in families being forced to rely on social assistance in the first place determine whether disadvantage will persist in the long term.

In some countries, social assistance was intended to be a residual support to be received by increasingly few people as social insurance arrangements would cover a greater proportion of the population. Those without other resources would do almost anything to avoid falling back on public assistance, with all its connotations of the workhouse and poor laws. However, assistance receipt has become increasingly related to lack of success in the labour market, the new clientele of social assistance (young people, lone parents, long-term unemployed) is less likely to feel stigma from benefit receipt. The social risks which can lead to social assistance receipt

are no longer unusual, they are commonplace. A relatively high – and growing – proportion of OECD populations rely on social assistance at some point in the year; a significant number of them need it for long-term support (Pearson, 1999 forthcoming).

Social assistance policy rests on three pillars. Failure to ensure the adequacy of one of these pillars eventually undermines the effectiveness of the others:

- *Cash assistance.* This must be set at a level which ensures an adequate living standard for the family requiring help. This may vary according to personal circumstances and local costs of living. But it must also be set at a level which is consistent with families regaining their autonomy by (re)entering the labour market. The policies designed to avoid long-term benefit dependency described in the previous section of this are particularly important when describing social assistance clients.
- *Social help.* Families often require cash assistance because of some underlying social problem, such as disability, homelessness or addiction. Providers of personal social services are often heavily involved with recipients of cash assistance.
- *Labour market reinsertion.* The most effective way in which a family requiring social assistance can regain its autonomy is through earning enough to support itself. Social assistance clients are often not job-ready, but for a variety of reasons have difficulty in accessing the services necessary to become so.

3.1. Cash assistance: balancing adequacy and incentives

There is no universal trend across all OECD countries in the level of social assistance payments. On the one hand, there are well-publicised cases of restrictions in the generosity of payments – the decline in the level of Dutch and British payments relative to average wages; the restrictions on duration of payments (often combined with cuts in benefit levels) under the waivers to the AFDC programme and the new TANF state-run programmes in the United States. Yet in southern Europe, where there has traditionally been little social assistance except in some cities or through charitable institutions, the trend has been to introduce or increase cash benefits. Portugal has a guaranteed minimum payment (since July 1997); in Spain payments now cover all regions other than the Baleares; a new minimum payment will be introduced in Italy. In France, a review of minimum benefit schemes has concluded that there is a need that they be increased somewhat in value.

3.2. The social pillar: moving towards reciprocity

The traditional social assistance client had social problems – disability, homelessness, addiction, need for protection from ex-partners. The traditional response has been social services, usually operated by state or local governments. The pressure on such services has increased in some areas: statistics are unreliable, but an increase in homelessness (both in terms of needing rehousing but also absence of physical shelter) is reported by social assistance officers in most countries covered in the two OECD reviews (OECD, 1998*c* and *d*).

This traditional picture of deprivation being combined with a relatively limited set of easily identifiable social problems is being undermined by the changing social assistance caseload. For many, social treatment is less important than labour market reactivation. In other cases, social needs are of a new form, such as unmanageable household debt (new initiatives have been undertaken in Belgium, France and the Netherlands).

In several countries, a belief has grown that individuals are failing to behave in a socially responsible manner. Social assistance has been made *conditional* on individual behaviour taking a certain form. Policy in many countries is moving towards *reciprocity*, with assistance (in the form

of both cash and services) being made conditional on efforts of the assistance recipients. Examples range from agreements being made between benefit recipients and payment agencies about reintegration efforts (*e.g.* Luxembourg); "workfare" arrangements (especially for young people; more generally in Denmark, the United States); and socially responsible behaviour (*e.g.* not having more children whilst on welfare) in some state programmes in the United States.

3.3. The labour market pillar: self-support as the ultimate goal

Exit from social assistance requires that families become self-supporting. For lone parents, this might come about as a result of forming a new partnership. For other family types, exit from social assistance implies that incomes have increased. This usually means moving into paid employment. Yet despite its self-evident importance, social assistance policy has not always paid attention to ensuring labour market reintegration. Social assistance recipients have too often been faced with an institutional structure which is not oriented towards helping them overcome their problems.

The requirements to be available for work have been tightened in several countries:

- *Lone parents*. Concern has grown about high rates of benefit dependency amongst lone parents. In the Netherlands, those whose youngest child is older than 5 (rather than 12, as was previously the case) must seek work. Norway has sharply limited the duration of benefits to lone parents to three years (but has "compensated" for this change by increasing the benefit paid). In the United States, welfare is now time-limited, and some states require job search activity 14 weeks after giving birth. Elsewhere (Australia, Ireland, the United Kingdom), job-search has been encouraged by provision of employment services to those who might be considering re-entering the labour market – for example, when the youngest child first enters school.
- *Young persons*. Benefits for young people have been restricted in the Netherlands, the United Kingdom, Australia (an announced change) and New Zealand. Furthermore, there is a greater readiness to require participation by young people in labour market programmes in order to be eligible for benefit. Such restrictions are, however, often combined with an increase in resources devoted to improving the employability of young people.

The public employment service (PES) is the main supplier of labour market services to job seekers. For whatever reason, in a substantial number of countries the PES (or its equivalent) is not felt by social assistance officers to put sufficient effort into reintegration programmes. Social assistance offices in Belgium, Ireland, the Netherlands, Norway and Sweden have started providing the services which, traditionally, were provided by the PES. Reintegration programmes financed by social assistance offices are common in all the countries listed above, and in some cases they are also providing job-broking services. There is controversy within the countries concerned about the best way of structuring relations between the employment services and social assistance offices (Pearson, 1999 forthcoming), with some favouring a split between the "purchasers" (social assistance officers or case managers) and the "providers" (the PES or other providers of employment services).

3.4. Institutional coherence

Most social policies involve *one* institution providing either services or cash benefits to clients. Social assistance is different. Several institutions are often involved in both services and cash benefits – both central and local governments; both employment and social services. Failure to co-ordinate these services results in the humiliating and disempowering passing of

clients from one office to another. Failure to ensure a coherent financial structure results in "rent-seeking" behaviour (as one institution tries to shift financial responsibility for a client to another); an unproductive over-emphasis on some activities; and under-investment in others.[2]

In many countries, the role of local governments in the delivery and sometimes the finance of social assistance is prominent. The economic case for them being involved is twofold. First local governments may be able to take local conditions into account, so they can tailor policy better to local needs. The Netherlands, for example, has given local governments significantly greater policy freedom than previously. However, local policy discretion means that equivalent people in different areas are treated differently, and this is one of the reasons why Sweden has recently reduced local discretion.

The second reason for using local governments is that financial pressures will make them enforce eligibility criteria more tightly and encourage them to invest in measures to reduce the social assistance rolls. There have been moves in the Netherlands to increase local financial autonomy. Even more dramatically, social assistance payments were fully transferred to the states in the United States, with heavy reductions in grants from the federal government if the states fail to meet targets for removing clients from the social assistance rolls. This has led to intense reintegration activity, but it is too early yet to judge whether the policy is successful in improving the labour market prospects of social assistance clients.

3.5. Conclusions

Poverty can be prevented (at least in the short run) by paying sufficient cash benefits. But cash benefits alone are not sufficient to tackle benefit dependency and social exclusion. Many countries have failed to address adequately the needs of social assistance clients for help in reintegrating into society and, in particular, into work. In part, this reflects a failure to adapt to the new social assistance caseload. Many recipients have few "problems" other than an inability to find work, requiring a major change in focus from social workers required to manage assistance benefits. It also reflects institutional failure to co-ordinate relations between assistance and employment offices, and between central and local governments.

Notes

1. Dead-weight loss arises if the employer hires subsidised programme participants that they would have hired anyway in the absence of the subsidy. Displacement refers to a reduction or crowding out of regular employment elsewhere in the economy through competition in the goods market. Finally, there is substitution when a subsidised worker taken on by an employer "replaces" a worker who would have been hired in the absence of the subsidy, with no net effect on employment in the firm.
2. One response, as recently announced in the Netherlands or New Zealand, for example, is to merge labour market and income payment services into one-stop-shops.

Chapter 6

Policy Challenges in Improving Health and Care Services

1. Introduction and main findings

Moderating the growth rate of health expenditure became a constraint on health care policy in most countries by the mid-1970s. Indeed, the need for cost-containment so dominated concerns in Member countries that it was often mistaken as a goal. More recently, questions have arisen concerning the impact of different cost-containment policies on the quality of medical care and, more generally, on the health status of the population. To resolve these problems adequately, countries are gradually reorienting their policy-making to take into account a more integrated approach to health care, simultaneously pursuing four goals: greater *equity*, more *empowerment*, increased *efficiency*, and enhanced *effectiveness*. This might be described as a new paradigm of health care. The challenge into the next millennium is to pursue simultaneously:

- reductions in persistent gaps in the *equity* of health status as they affect vulnerable groups as well as improving equity in finance and delivery of health care systems;
- greater choice and *empowerment* of patients and actors in medical services;
- achieving *efficiency* in the use of resources; and
- greater *effectiveness* in improving health outcomes.

Similar challenges also face long-term care policies. Furthermore, long-term care must ensure an appropriate balance between medical interventions and care needs. Inappropriate institutional structures can lead to unnecessarily costly systems of care.

The analytical work reviewed in this chapter points to the following policy conclusions:

- reorienting the health system so that it focuses on the needs of individuals will lead to real gains in illness prevention and treatment;
- improving patient satisfaction with the health care system engenders realistic expectations and enhances the responsibility with which various actors behave;
- developing outcome measures is essential for monitoring and assessing the impact of health policies on the national level. Both summary measures of population health status and a set of indicators more closely coupled to an intervention or series of interventions (*e.g.* the quality of care and performance indicators) are required;
- a focus on improving the quality of care through evidence-based approaches will yield greater efficiency;
- preventative and curative approaches need to be better integrated, with a greater emphasis on population health;
- policies targeted to the poor and under-served will remain largely ineffective unless the social factors which partly determine poor health status are tackled;

- equalising access to long-term care is desirable. Care needs to be rebalanced and integration achieved between institutional and community care, with a fostering of home-help networks.

2. Efficiency measures in health care systems

Pure market mechanisms do not work effectively in health care systems for a variety of reasons. The imperfect sharing of information among actors within the health care system was identified as a problem long ago, but adequate compensatory action has not been taken (Arrow, 1963; Cutler, 1996). Individuals tend to request treatment and providers offer costly treatments because insurance exists (moral hazard) and insurers try to insure only those unlikely to fall ill (adverse selection). Prices, which should play a signalling role, are distorted both because of insurance and because the real output of the interventions is often unknown. Further, individuals have limited ability to negotiate the price of medical care when they are sick, which gives excessive market power to providers.

To address these problems, governments have relied on two main types of intervention. First, they may use publicly funded programmes as a means of pooling the costs of care over a large population and controlling the overall price structure. Second, they may regulate suppliers of health care through price or quantity controls.[1] These interventions have to balance the risks of having too much state intervention which runs the risk of producing inefficient outcomes, and leaving parts of the population at risk of huge medical costs. Countries have attempted various methods of controlling costs, through regulations and altering the incentives embodied in the health-care industry.

2.1. Global measures to control costs

Price control

In a number of countries (including the United States' Medicare programme from the beginning of the 1970s, Canada, and later on, European countries), official prices of medical services have been fixed in order to slow down the overall evolution of costs. *Product-by-product price control* (the price of the reimbursable product or service is determined by the government or a public agency) is common in fee-for-service systems, where the price-per-service is set through negotiations with payers and payees. This type of system has the advantage of limiting excessive profits by service providers, who will not be paid above the reimbursement rate.

These policies have often proved effective in curbing costs in the short run. However, providers have used counter strategies in order to compensate for the adverse effect on their incomes, for example, by increasing the volume of services provided or changing the nature of the service delivered to avoid the price freeze. As new products enter the market, this scope provides for avoiding the price freeze by changing the product mix. However, these potential adverse effects can be avoided by *reference pricing* (often used in the field of pharmaceuticals) – the setting of a ceiling reimbursement price for all products or services in a given therapeutic class.

Volume control and global budgeting

OECD reports (1998*g* and *h*) show that volume-control measures are not as prevalent in Member countries as price-control measures. The oldest way of influencing supply and demand has been to *regulate supply* either of health-care professionals through admissions to medical schools, limiting or reducing the number of hospitals or hospital beds or limiting the use of high-technology equipment.

Volume control has sometimes been combined with a *global budget cap* which, in turn, implies price control as well (*e.g.* the Blüm reforms in Germany). This form of control is common for hospitals (see Box 6.1), and is used in some countries at the primary care level, by setting budgets for health clinics. Other countries control prices through a capitated payment system, whereby overall payments per patient are set. Global budget policies shield countries from unexpected price increases in their health-care sectors. However, such caps have to be coupled with incentives for providers to increase the number of services provided, as otherwise, the incentive is to minimise the level of services. Furthermore, fixed global budgets may not adapt adequately to case-mix changes or economic changes in regions. This may lead to inadequate funding for hospitals and clinics, and lead to rationing of care or queuing (see, for example, OECD, 1998*g*). Furthermore, countries rarely place global budgets on all types of services. Thus, service providers have an incentive to shift costs to uncontrolled sectors. In some cases this may be the desired effect: Chapter 2 noted that ambulatory-care expenditures are increasing as a share of total health expenditures.

2.2. Microeconomic controls

The controls listed above do not change the underlying market characteristics of health care. In the long run, use of microeconomic incentives to encourage rational decision-making and cost-consciousness may be the most effective way of reconciling costs and quality of care.

Organisational changes and gate-keeping

Gate-keeping consists of establishing a referral system, in which primary care physicians act as gate-keepers controlling entry to the specialised intensive medical institutions, which cannot be accessed by patients without referral. The OECD report (1995*e*) shows that ambulatory-care gate-keepers have played a significant role in decreasing in-patient care expenditure. The role of primary-care doctors in rationalising usage of health-care resources by regulating access to secondary or tertiary care is important.

A majority of Member countries have adopted a system, although the approach varies (Table 6.1). Some countries create financial incentives in the form of penalties on the patient or provider to restrict patients' direct access to specialists or hospitals. When the referral system is too loose, rational use of health-care resources at a second-tier level cannot be guaranteed. When the system is too tight, it poses a threat to patients through delaying necessary treatment. There is, however, no consensus on what is an "appropriate" or "inappropriate" referral.

Changes in payment systems

A more refined way of influencing incentives is to include an adjustment for *case-mix* in the payment system, such as the United States Prospective Payment System (often referred to as the Diagnostic Related Groups – DRG – system). Such a system can have a positive effect for purchasers in both controlling costs and assessing output (OECD, 1995*e*).

This system is being utilised in both countries with global budget systems, and those with fee-for-service systems. Under an overall cap on hospital expenditures, countries are transferring funds from one hospital to another based on treatment intensity (*e.g.*, Denmark, France). In countries with conventional fee-for-service systems and flat per-bed day payments, case-mix formulas are replacing these payments (*e.g.*, Austria, Korea).

Box 6.1. **Hospital funding systems**

With **block grants** (or global budgets), hospitals receive an annual budget to cover all their services. During the 1980s, this approach became the main payment method used in many "integrated" health systems, where the government is the main provider as well as funder of health services. It is found in the United Kingdom (until recent reforms), Canada, Australia, Denmark, Finland (with some direct billing of municipalities), Ireland, New Zealand, Norway and Sweden, and is also commonly used in the public hospital sectors of other systems [*e.g.* France and Spain (social security hospitals)]. In Denmark and Sweden, block grants are provided at the level of clinical departments in hospitals. Block funding provides a direct means of containing hospital spending, but provides few incentives to producers to improve efficiency, as funding is not contingent on the quantity and quality of output. Perverse incentives may arise if funding levels are set according to historical costs, or if budget savings are clawed back by the funder.

Bed-day payments provide hospitals with a flat-rate fee per occupied bed. This approach is found mainly in systems with public funding and a mixture of public and private providers [*e.g.* Germany, France (private hospitals), Austria, Belgium and Spain (private and some public hospitals)]. However, suppliers face incentives to lower patient turnover and prolong lengths of stay so that the more expensive early days (when treatment usually occurs) are offset by lower-cost days later on during recuperation. As with block grants, funding decisions do not incorporate information on relative costs across treatment methods.

Fee-for-service methods are often combined with bed-day payments. These are the principal means of paying for hospital services in Japan, some cantons in Switzerland, private clinics in many countries, and, until very recently, the United States – *i.e.*, systems with mainly private providers and multiple insurers. Specialists are usually paid on a fee-for-service basis, particularly when working outside hospitals, but also for their services in public hospitals in some cases (*e.g.* Belgium). Under this system, macro-control is weaker (requiring spending to be contained by other means), with suppliers facing incentives to raise quantity, quality and prices of services provided. In the United States, this system may have contributed to competition between suppliers on the basis of quality rather than price, and excessive diffusion of expensive technologies (Weisbrod, 1991).

The system of **payments-per-case** sets fees prospectively according to diagnosed medical conditions and standardised treatment costs. The best-known example of such a system is the Diagnostic Related Groups approach (DRGs) introduced into the US Medicare programme in 1983. Case-mix-based systems have since spread to other parts of the US medical system, and are being implemented or considered in 18 OECD countries. These methods come closer than those discussed above to being output-based payments, hence limiting suppliers' incentives to increase service volumes. They provide incentives to increase turnover (*i.e.* reducing lengths of stay), but may lead to some "unbundling" of hospital services, and there is a risk that hospitals may, where possible, "bump" patients into more highly-remunerated diagnostic groups.

Source: OECD (1995*e*).

Co-payments

Nearly all OECD countries have recently increased use of *cost-sharing policies*, particularly in the area of pharmaceuticals (see OECD, 1998*g*). Having consumers pay part of the cost of their care through co-payments or coinsurance makes them more aware of the cost of health care services, and encourages them to decrease unnecessary use of the system. Transferring the *full* cost of

Table 6.1. **Referral systems in OECD countries**

	Regulations	Checking	Selection
Australia	R		
Austria	R		
Belgium	X	–	–
Canada	R		
Czech Republic	X	–	–
Denmark	R(a)[1]	H	F
Finland	R(a)	X	L
France	X		
Germany	R		
Greece	R	n.a.	L
Hungary	R(a, b)[2]	G, H	L
Iceland	X		
Ireland	R		
Italy	R		
Japan	X		
Korea	R(b)	G, H	F
Luxembourg	X[3]	n.a.	F
Mexico	n.a.		
Netherlands	R[4]	[5]	F
New Zealand	R		
Norway	R	G	L
Poland	n.a.		
Portugal	R(a)	G	L
Spain	R		
Sweden	R		
Switzerland	[6]	n.a.	n.a.
Turkey	R		
United Kingdom	R		F
United States	X		

n.a.: Means no answer to question. X means no referral system in place, though there may be other means of limiting access.
1. In Denmark, Group 1 patients must register with a GP, whereas Group 2 patients have the right but not the duty to register with a GP. People under Group 2 pay higher co-payments without referral.
2. Some types of special consultation (*e.g.* gynaecology, ophthalmology, otolaryngology) can be accessed without referral.
3. Access is regulated by limiting the number of consultations.
4. Regulations are made through negotiations between providers and purchasers.
5. Purchasers have a control system.
6. Patients may choose a referral system for lower premium.

Regulations*:* regulations on access to second-tier care
R: Referral system is adopted
a) Access without referral is forbidden by law.
b) Access without referral is allowed but costs are not covered by a public system (borne by the individual patient).
Checking: checks on the appropriateness of the referral
G: Examination by GPs
H: Examination by health authorities
Selection: selection of second-tier care institutions by primary care doctors
F: Free
L: Limited

Source: OECD.

certain services to the patient has also been common. For example, many countries have changed their lists of covered pharmaceuticals, de-listing certain drugs from coverage, or have reduced coverage for certain services, such as dental or vision care. While many countries offer supplemental insurance benefits to their more vulnerable populations, the long-term effect on health outcomes of transferring the full cost of certain procedures to private individuals is yet unknown.

Competitive measures

Most health-care reforms of the past decade have introduced quasi-market mechanisms, including the separation of purchasers and providers; competition among purchasers for consumers; and competition among providers for contracts with purchasers. These types of

market mechanisms are meant to improve consumer choice, and reintroduce an element of rational decision-making into the system with an accompanying increase in efficiency. The United Kingdom implemented a GP "fundholder" system to create competition, and early data showed that efficiency in some sectors (notably elective surgery) increased and the rate of increase in fundholders' costs for drug prescribing slowed down compared to non-fundholders (OECD, 1992). However, there were also substantial increases in management costs and a perception of unfairness between patients of fundholders and non-fundholders. This has led the United Kingdom to move towards a more co-operative model.

Giving consumers the nominal power to make a choice without giving them the means to make an informed choice is unlikely to stimulate efficiency improvements. For example, the Netherlands has implemented a policy to put pressure on sickness funds to reduce their premium to attract more consumers. In reality, however, few consumers have changed funds. This may reflect a lack of information on the part of consumers.

Selection of low-risk customers by health insurance funds, so-called "cream skimming", is of concern when insurance funds start to compete. This issue has received considerable attention in the United States recently, where competition in the health-care market has actually led to decreased choice. This problem is less likely to occur in publicly controlled systems, where access and coverage rules for insurance companies level the playing field for all that enter the market. In the United Kingdom, competition amongst providers is not viewed as harmful to equity, as long as purchasers are given equitable weighted capitation funding for local populations, whether they be health authorities or sickness funds.

Performance measures may enhance competition. For example, some countries (*e.g.* Australia, New Zealand) have used benchmarking, which amounts to yardstick competition by comparison. The United Kingdom is developing a schedule of "reference costs" which will itemise the cost of individual treatments. By requiring different providers to publish their own costs on the same basis, the new arrangements will give a lever with which to tackle inefficiency.

2.3. Overall effects of measures

As countries continue to introduce macro and micro-economic measures to contain costs, and to encourage efficiency through competition measures, they should concentrate on developing quality indicators for providers that are based on outcomes (see Box 6.2). Quality measurement can have two effects. First, access to data on customer satisfaction and quality of outcomes will aid consumers in making more informed choices. As countries move towards capitated payment systems, this type of information will give providers an incentive to improve the quality of outcomes. Second, this measurement system, if coupled with incentives to concentrate on primary care and disease prevention, will aid in improving the value countries receive for their investment in health-care systems.

3. Effectiveness: the move towards outcomes-oriented policy-making

Governments are asking what they receive in return for the resources spent on medical care. The actual outcomes of the health care services which are provided to populations in Member countries are not measured by health care systems, which have traditionally focused on inputs and throughputs. A range of measures have been developed to assist policy-makers in making decisions on how to allocate existing funding to particular programmes, services, treatments, and technologies (Table 6.2)

Box 6.2. Evaluating the effects of reform: country examples of policies providing high-quality care within budget constraints

In 1992, **Canadian** Federal and Provincial Ministers of Health approved a National Strategy for Quality in Health Care. Efforts are being pursued to promote quality, appropriateness and effectiveness in health-care services through joint projects among federal, provincial and territorial governments and with national NGOs. Part of the ongoing effort has included developing a system of evaluating health-care interventions. Federal, provincial and territorial governments collaborated on primary health-care reforms in a national consultation process during 1996. Health Ministers expressed their support for innovative approaches to "first line" care. Currently, individual provincial/territorial jurisdictions are at varying stages of planning and implementing primary health-care reforms. Some initiatives include: changing physician payment methods from fee-for-service to a capitation basis, and combining or reforming these methods.

In **Finland**, a nation-wide programme has been carried out since the beginning of the 1990s to shift the balance of care by reducing institutional care and promoting ambulatory care, home-help services and other services which enable people to live in their homes as long as possible. This action programme was not intended as a cost-saving measure in the first place, rather as a measure to improve the quality of life of clients/patients, to reduce the high number of hospital beds (currently one of the highest ratio of beds to population in the OECD). However, it has prevented an immediate crisis in financing health care.

In **Ireland**, the Indicative Drug Target Scheme was introduced to address rapid increases in drug costs. This scheme provides doctors with an expenditure target based on average prescribing costs weighted on the basis of sex and age. This has slowed the increase in pharmaceutical costs. To provide incentives for physicians to comply with the targets, a portion of the savings is given back to the doctor for practice development projects. Thus, money that was spent on drugs in the past is now going towards primary care and preventive activities.

Table 6.2. **Family of health outcome/health status measures**

Range of measures	Examples of measures
Quantity of life	• Life expectancy • Standardised mortality rates • Premature mortality: potential years of life lost
Quality of life	• Measures of impairment, disability, and handicap • Measures of mental health • Health-related quality of life
Composite health measure (combining quantity and quality of life)	• QALYs • Health expectancies and DFLEs • HALEs • DALYs
Quality/Performance of the system	• Adverse events following treatment (*e.g.* hospital acquired infections); • Level of risk amenable to health care (*e.g.* blood pressure); • Patient Satisfaction; • Rates of intervention known to be effective (*e.g.* immunisation); • Avoidable mortality rates

QALYs: Quality-adjusted Life Years.
DFLEs: Disability-free Life Expextancies.
HALEs: Health-adjusted Life Expectancies.
DALYs: Disability-adjusted Life Years.
Source: OECD.

Most of these measures can be considered as generic indicators of population health status which can be attributed to a wide range of social, environmental and life-style factors as well as health care. Measures of the quality of life as well as the quantity are necessary to determine how well the health system is performing. A further set of indicators has been developed in order to assess the "performance of the medical system" where the links between medical care interventions and health have been established. These indicators focus more on establishing the quality of medical care or the level of risk amenable to health care interventions.

Across OECD countries, there is a broad agreement on the desirability of using data on outcomes information to guide policy choices, for instance, resource allocation, funding decisions, and determining the priority of health care investments. However, progress in developing agreed outcome measures has been slow, due mainly to the complexity of trying to find relevant "non-monetary outcome" measures (which can be used to quantify health gains) and the methodology underlying such measures.

Several approaches have emerged combining health-related quality of life with survival or life expectancy data in order to merge morbidity and mortality aspects into a single composite measure. The most common measure is quality-adjusted life years (QALYs), which has been used primarily in measuring the cost-effectiveness of different medical treatments. Recently, the QALY methodology has also been applied to combine mortality and morbidity experiences of a population into aggregate indices of health status such as various types of health expectancies including disability-free life expectancy, health-adjusted life expectancy, years of healthy life, and disability-adjusted life years (DALYs).

Though these measures have been developed to evaluate the effects and performance of different types of health programmes and to make comparative assessments of the health needs, there is lack of standardisation in the concepts and definitions used. The definitions of health (or lack of it) used in such measures create a wide variation in findings for the same population. Some existing measures limit the concept of health to personal characteristics, while others have adopted a broader definition including social role functions. Many of the measures rely on assessments of the values which patients or survey respondents attribute to differing states of health to adjust the life years for different interventions or programmes. However, these values themselves vary across the population.

Outcome measures have been used traditionally in clinical trials of diagnostic and therapeutic services and treatments to determine the efficacy and safety of these interventions. These studies apply the strict definition of outcome as "a measure of the attributable effect of an intervention on a health state" and their results provide some evidence for clinicians making decisions about the care of individual patients. For example, work has been done in areas such as cancer, anti-platelet drugs for cardiovascular disease, care of women during pregnancy and childbirth, and new-born infants. Evidence of effectiveness of different interventions on the clinical practice level has been used in the development of clinical practice guidelines and best-practice protocols in several countries.

On the national level, analyses of effectiveness has also been used to assist in the control of the diffusion of pharmaceuticals and new technologies. For instance, in the early 1990s, Australia and Canada incorporated effectiveness analyses into their decisions about which drugs should be included in their pharmaceutical benefit schemes.

Growing decentralisation in the management of medical services has increased the importance of accountability. Health outcome indicators can be used as a tool to monitor the performance of various actors in the system – be they regional health authorities responsible for maximising the health of the populations or providers who are contracting with the government

or insurer. Countries have begun to develop incentive and payment schemes which are tied to these outcome measures, in which suppliers of the health-care system will be paid according to what they have achieved in helping their patients.

The "quality of care delivered" has become a significant aspect of performance due to rising consumer expectations and a growing awareness of variations in practice and quality. Quality-of-care indicators monitor aspects of clinical care and quality which can highlight issues that may, in turn, have an impact on health status. Quality-of-care is defined in terms of health so that high-quality care is that which produces positive changes, or slows the decline, in health; low-quality care fails to prevent or actually accelerates a decline in a person's health. These indicators may, therefore, prove to be valuable outputs of an outcomes programme: they provide a first step towards direct indicators of the success of particular health interventions.

In reports submitted to the OECD, national experts have reported significant activity in developing these types of measures and indicators. One common type of indicator is to quantify adverse events that bring about a decline in health as a result of a health intervention, such as hospital-acquired infections, post-surgical wound infections, and other complications in surgical or obstetrical procedures. Such measures may highlight shortcomings in the process of care and stimulate improvements. Other types of quality-of-care indicators include process measures identifying rates of a health care intervention, such as immunisation rates, uptake rates of breast or cervical cancer screening.

Future development of outcome measures

Despite their desirability, there are many methodological and logistical issues to overcome before outcome measures can be applied in the policy context. National experts have made a number of recommendations to the OECD on how to overcome these problems. First, concerning the generic measures of population health status, the experts agreed that where comparability in the underlying data – particularly in disability and morbidity – was lacking, further work was needed to support current projects[2] on the harmonisation of selected components of Member countries' health interview surveys. As a second step, while monitoring the use of existing health profile and health utility instruments in the countries' health surveys, work should begin to define a *generic standard* health descriptive system as well as a *common terminology* in describing health status (*e.g.* disability and mental health). The resulting set of questions would then be included in Member countries' health surveys.

Little consensus exists at present on the most appropriate method or approach for the weighting system needed to derive a composite index of health status. Therefore, work on generic descriptions of health status should move ahead of work on the methods for and choice of a weighting system. In the interim, a simple and transparent provisional weighting system should be used. Initial work could focus on developing comparable health expectancy and health-adjusted life expectancies for cross-country comparisons.

4. Empowerment of the public

One of the structural impediments preventing efficient and effective health care is the lack of influence which patients have over the services they require or wish to receive. Doctors have long established an "authority" position in health care, with the assumption being that they know and act in the best interests of their patients. The role of patients has been passive, with little influence on treatment and little choice other than to take the advice of their doctors. This imbalance in the relationship between doctors and patients has remained the predominant model of medical practice in many OECD countries.

Societal trends (greater education, easier access to information on medicine through intermediaries such as consumer journals) have put the doctor-centred approach to medical practice under pressure in some countries. Patients are calling for better-quality health care and, in particular, more say in clinical decisions (including alternative treatments).[3]

The medical case for patient empowerment is obvious. Fully-informed and involved patients are more likely to adopt necessary behavioural changes than if faced with a purely paternalistic approach. Thus, empowerment of patients is a necessary component of a prevention-oriented reform strategy. Furthermore, doctors lack knowledge of the preferences of patients, who differ in the weights they attach to different aspects of health (*e.g.* pain versus disability) and in aversion to risks. Greater influence on the selection of health-care options can therefore increase health status as perceived by the patient.

However, empowerment has consequences beyond ensuring effective treatment of individuals. A more informed population will question health policies more readily. For example, patients' associations (such as those for Alzheimer and asthma patients) have initiated a dialogue with the medical profession in order to influence the establishment of priorities in medical research and in the organisation of more appropriate therapies. The risk of institutionalising such contacts is an undesirable diversion of resources towards the more effective and influential of such groups. However, several of these initiatives have led to more effective treatment at lower expenditure (an example being the treatment of acute asthma in children). The reduction in nosocomial infection and national targets to reduce neonatal death and birth defects, may in part be due to greater patient groups raising them as important issues.

In addition to influencing medical quality, patient groups have sought to soften and humanise the environment in which medical care takes place. The Swedish reform movement insisted that patients be properly addressed in hospitals. In France, the call is for "*l'humanisation des hôpitaux*" through the elimination of dormitories in public hospitals. In the United Kingdom, fund-holding GPs have responded to rising patient expectations by refurbishing dilapidated amenities.

The response of policy-makers to patients' desires to influence decisions has varied, reflecting the different role of patients in the finance of health care. "Patient Charters" have become the norm in a majority of OECD countries at hospital and also at national level. These improve access to information, facilitate the right to opt for alternative treatment and establish greater rights of choice over medical practitioners. However, many of these developments are too new to have been evaluated yet.

5. Equity in health care

The definition of equity in health care has many facets. Here, discussion focuses on three. First, *equity in the finance of health care* implies that payments for health care should be positively related to a person's ability to pay. Second, *equity in the delivery of health care* is said to exist if people receive health care based on their need for the services and, if those who have the same level of need, are treated the same way (Van Doorslaer and Wagstaff, 1993). The third facet defines "equity" in terms of *equally good health status or health outcomes* across the population at large.

Since the 1960s, in an effort to attain equity, the majority of OECD countries have achieved the objective of nearly universal health insurance coverage of their population (Table 6.3). However, the United States and Mexico are exceptions with 46, and 69 per cent respectively of the population eligible for publicly mandated coverage for inpatient hospital care in 1995.[4] The

Table 6.3. **Percentage of the population with health care coverage in OECD countries, 1960 and 1995**

	1960	1995
Australia	100	100
Austria	78	99
Belgium	58	99
Canada	68	100
Czech Republic	100	100
Denmark	95	100
Finland	55	100
France	76.3	99.5
Germany	85	92.2
Greece	30	100
Hungary	n.a.	99
Iceland	100	100
Ireland	85	100
Italy	87	100
Japan	88	100
Korea	0	100
Luxembourg	90	100
Mexico	n.a.	69
Netherlands	71	71.8
New Zealand	100	100
Norway	100	100
Poland	n.a.	n.a.
Portugal	18	100
Spain	54	99.5
Sweden	100	100
Switzerland	74	99.5
Turkey	5.8	n.a.
United Kingdom	100	100
United States[1]	20	46

1. Does not include private health insurance coverage. With private insurance coverage, the share of persons covered rises to around 86 per cent in the most recent year.
Source: Diskette OECD Health Data 1997.

extension of health coverage in itself cannot suffice in tackling the inequities in health that still exist among population groups.

5.1. Equity in finance

An OECD report (1998*g*) showed that equity in the finance of health care remains of concern in OECD countries in two areas. First, Mexico, Turkey and the United States reported concerns about unequal health coverage in their populations. Second, many countries expressed concern about the effect of cost-sharing on equity, particularly the effects on their vulnerable populations. For example, Belgium and France reported that co-payments may be adversely affecting the ability of the poor to access care.

Those OECD countries without *universal coverage* have recently taken steps towards extending health care coverage, particularly among the uninsured. Many countries have now exempted their poor and elderly populations from cost-sharing. For example, Germany set a cap on the amount of co-payments as a proportion of income, while Finland's social welfare system assists those on lower incomes with their user fees.

Cost-sharing was originally intended to have two purposes: "*i)* to raise funds for the health care system; and *ii)* to help reduce unnecessary health spending by reducing the effect of excess use of services by creating' cost-conscious consumers'" (OECD, 1995*e*). However, studies

have shown that, to the extent that cost-sharing reduces demand for services, this reduction will happen most often to those with lower incomes, particularly since those in higher income brackets often have supplemental insurance. Many countries have therefore exempted those with low incomes, the elderly and children from cost-sharing. This is contrary to the goal of "rationalisation of usage", and leaves the first goal – revenue generation – as the only one.

Some countries provide long-term care financing based on financial need. The "spend-down limits" in the United States require an elderly person to have very few assets if he/she is to receive help through Medicaid (Sloan *et al.*, 1996). Ceilings also apply in the United Kingdom. Such measures, taken *a priori* on the basis of redistributive principles and with the objective of controlling public expenditure, can have unforeseen effects. Premature transfer of assets to children or spouses can occur to avoid loss of resources. The desire to benefit from public aid can lead to greater reliance on institutional care, which often is more likely to be funded by public sources, whereas home-help could permit less costly and more appropriate care. Intermediate options exist, which allow some protection of the assets of those in long-term care. For example, these assets may sometimes be recovered by the government, for example after the partner has deceased.

5.2. Equity in delivery

Equity in medical-care delivery exists when people can access the services they need when they need them. It is, however, not easy to measure this facet of equity. While there is information about consumption of services by different socio-economic groups, measuring the need for such services is more difficult. For example, studies based on the utilisation of services based on need (*i.e.*, illness status) may overestimate the effect of preventive care. Since people go to the doctor both when they are sick and when they are not sick, studies based on actual consumption patterns are biased.

Another method of measuring equity in service delivery is to examine the distribution of morbidity between income groups. This method generally shows that morbidity is unequally distributed, *i.e.*, it is highly concentrated among the worse off (van Doorslaer and Wagstaff, 1993). However, morbidity data are difficult to use for the purpose of measuring equity. First, measuring morbidity is difficult because it is often based on subjective perceptions and not objectively checked in health surveys. Second, as one's own medical knowledge increases, so does awareness of one's illnesses. Finally, medical data on morbidity may misrepresent its incidence, because countries which are more effective at gathering such data may appear to have higher morbidity (Sen, 1998).

There is sometimes a lack of geographical equity in health care delivery. For example, Korea, Japan, Italy and Portugal reported concerns over inequities in health care delivery systems, particularly with respect to access to care in poor and rural areas. The distribution of physicians, despite policy initiatives to distribute resources equitably across regions, is weighted towards large cities raising many barriers to accessibility. First, people in rural areas may need to travel further to visit physicians, thereby creating a physical barrier to treatment. Second, there may be a lack of choice between providers. This lack of choice means that patients have less power to question decisions made by providers.

Countries have implemented numerous measures to aid in the more effective distribution of health care resources, such as ameliorating access in rural and remote areas, and making preventive health care more accessible by delivering health screening programmes free of charge. For example, many countries have free health and preventive care for children (up to age 18 in the Nordic countries and in Germany), and free prenatal care is available in many countries.

Countries have also implemented school-based immunisation and health screening programmes to increase access and utilisation of health care for children.

The geographic dimension also plays a central role in access to long-term care – unsurprisingly, given the decentralised nature of care-giving. Recent reforms in many countries (for example, the 1992 Ädel Reform in Sweden) have often favoured greater devolution in management procedures. One of the challenges facing social policy-makers has been to ensure that decisions taken at the central level (for example, in determining block grants) do not lead to wide inequalities at the local level. In France, for example, the difference between the help given at a similar degree of dependence can vary by a factor of 10 between two regions (Joel, 1997). However, reducing such inequities is difficult *because* of the decentralisation in delivery. When long-term care is financed primarily through taxation, the financial burden is often shared, with local governments initially responsible but recompensed through block grants.

However, as explained below, achieving equity in the finance and delivery of health care may not be sufficient to reduce persistent inequalities in health status. Research shows that socio-economic and demographic factors are playing a significant role in the health status of the population, as well as environmental, behavioural and lifestyle factors (Evans *et al., 19*94).

5.3. Equity in health status

Many OECD countries believe that providing comprehensive, universal health coverage is an important step in achieving an improvement in health outcomes. Numerous country studies on the levels of health status, measured in different ways, show considerably lower health status for those with lower household income, educational level, and occupational status. Several calculations of health expectancy[5] – often based on disability or self-perceived health measurement – by socio-economic variables have shown that poorer and less educated people not only live shorter lives, but also live a greater proportion of their lives with disability or handicap (Robine *et al., 19*97). For example, in Canada, the gap in life expectancy between the richest and poorest increases from 6.3 for overall life expectancy to 14.3 years for occupational handicap-free life expectancy (Wilkins and Adams, 1983).

Countries have recently implemented a number of "targeting" programmes, aimed at decreasing inequalities in health through preventive care in school programmes and prenatal care for low-income women (see OECD, 1998*g*). In addition, many public health care policies have incorporated the targets and goals from the WHO's "Health for All" programme. It is hoped that, by setting targets for immunisation and screening programmes for individual health care providers as well as for the health care system, an improvement in the equality of health status will be achieved.

However, there is a long way to go before real progress is achieved. Many OECD countries have acknowledged that their health care systems are too focused on a curative approach. People go to the doctor when they are ill, and doctors do not encourage patients to come in for health screening and preventive care visits.

To understand this criticism further, it is important to make a distinction between a public health approach and a medical care approach. According to Lasker (1998), the medical sector tackles diseases by considering the biological mechanisms behind them, whereas the public health sector tries to identify the environmental, social and behavioural risk factors that caused such diseases to emerge, in order to develop population-based interventions to reduce those risk factors. In order to have an effective public health policy, there must be co-ordination between the two arms of medicine and public health.

A population-based approach looks at groups of people, discovers common characteristics, and targets its policies to this population based on these characteristics (see Box 6.3). This approach entails creating population-specific health promotion programmes by providing services these populations need, such as sufficient housing, education, employment, income, and nutrition; disease prevention through effective sanitation policies; monitoring disease outbreaks and taking steps to prevent them; and health education, *i.e.*, teaching people about unhealthy behaviours. By applying what it has learned through its population-based approach about the causes of disease in a specific population, this approach provides effective health screening and immunisation programmes to reduce the likelihood of individual illness.

Box 6.3. Population-based measures in OECD countries

The population-based approach moves away from concentrating on individual episodes of care. Instead, it focuses on reducing the contributing factors in *populations at risk* and developing *targeted* policies which emphasize more "care" and prevention than "cure." The populations at risk are parts of the whole population (*e.g.* those practising risky behaviour such as tobacco smoking or those people whose health needs are not adequately met – disadvantaged populations and the chronically ill).

To address this broader approach to health policy, some countries have begun to integrate their national agencies overseeing education, social services, justice, housing, and employment in work involving health policy. Development and collection of health status measures and indicators – with far more emphasis on risk factors, socio-economic factors, and environmental factors – are being used to better identify populations at risk and targets.

In **Australia,** five priority areas have been selected: cardiovascular health, cancer, injuries, diabetes and mental health. Goals and targets for these five priority areas have been specified, which will not only focus on identification of indicators and strategies for prevention, early intervention, treatment and ongoing management, but also emphasise the reduction of the level of health inequalities and strengthening intersectoral action to promote a healthy public policy.

Canada adopted the framework and strategy of a population health approach in 1994, set out in the *Report on the Health of the Canadians*. As part of this work, Health Canada will be working with other federal departments to develop tools for assessing the health impacts of their policies and programmes.

In 1994, the **New Zealand** Public Health Commission established six public health goals. Objectives, outcome indicator targets, and strategies have been prepared that will focus on the determinants of health, strategic alliances intra- and intersectorally, and strengthening of the public health infrastructure.

The **United Kingdom** 1998 White Paper established a performance framework to monitor health improvement "to reflect the overall aim of improving the general health of the population, which is influenced by many factors, reaching well beyond the NHS". For instance, using coronary heart disease as an example, the variations in death rates and risk factors (such as smoking, diet, exercise) will be monitored across different population groups such as women and ethnic minorities more closely. Development of health improvement measures will be conducted to allow for assessment of performance, beginning in 1999.

If the fact of being poor contributes to lower health status, then health care must become more than medical care provision. For example, policy-makers should encourage health care commissioners/physicians to undertake a broader range of activities, such as referring patients for income and housing assistance. Countries should work to match providers and public health promotion with specific populations, and recognise that those who are not accessing services may be facing other barriers than availability. If the services are offered, for example, by providers who have nothing in common with those who are being served, this may create reluctant patients. In the United States, states who wish to change their Medicaid programmes are obliged to ensure that the health care providers with whom they contract are able to speak the language of the low-income populations they serve, or else provide translation services. This may lead to a culturally appropriate approach to facilitating access for disadvantaged population groups.

One possible drawback is that there can be a large opportunity cost associated with pursuing a policy of equalising health beyond equity of delivery and access. If there are unequal initial endowments in health and the law of diminishing returns applies, there will come a point after which directing more resources at low health status groups will reduce the total sum of health gains to society. The problem with such a strategy in universal systems, especially those with tightly capped expenditure, is that they are likely to impose sacrifices on the middle classes who pay for the bulk of the cost.

6. Care provision for the frail elderly

In most countries, the share of the population aged over 65 in institutions varies between 5 and 7 per cent (Table 6.4). This share does not appear to have grown dramatically in recent years; rather, the increase in numbers in institutional care has been driven by the increasing number of elderly in the population (indeed, age-adjusted rates of institutionalisation have fallen in some countries). The amenities available to the elderly differ both within and across countries. Between residences which are almost like hotels, with medical care available only in case of emergency, and nursing homes offering the full range of medical care, there is a whole gamut of establishments (Pacolet, 1997). In Japan and the Netherlands and, to a lesser extent in France, hospitals provide residential care on a *de facto* basis.

The average annual cost of institutionalisation appears to be between one and one and a half times average annual GDP per capita; this sum exceeds the resources of most of those requiring care. Home help is accessible to between 5 and 17 per cent of the population according to the country. Its cost is very variable, ranging from one tenth to one half of average per capita income. In countries with developed care systems, most of those who are severely disabled receive some sort of help, either at home or in an institution (OECD, 1994*b* and 1996*b*).

6.1. Future demand for long-term care

Total spending on long-term care in a *typical* OECD country is estimated at under 1.5 per cent of GDP. In contrast to health expenses, the main factors driving changes in long-term care costs are demographic and epidemiological factors. Total long-term care costs depend above all on the evolution of longevity and future health status. Several studies have examined the potential impact of the dynamic of disability on elderly populations. Manton *et al.* (1997), for example, show that reductions in the extent of disability apparently lead to a relatively optimistic perspective on future rates of dependence. This improvement is sufficient to maintain a constant ratio between the population requiring help and the population aged 18 to 64, through to 2028. This is a substantially different picture to that obtained from previous studies

Table 6.4. **Comparisons of care systems**

	Estimated total spending on LTC (1992-95)	Estimated public spending on LTC (1992-95)	Share of population aged 65 and over in institutions	Share of population aged 65 and over receiving formal help at home	Share of private beds among institutions	Share of spending towards institutions in total public spending on long-term care
	% GDP[1]	% GDP[1]	% of total[2]	% of total[3]	% of total[2]	% of total[4]
Australia	0.90	0.73	6.8	11.7	26	73
Austria	1.4	n.a.	4.9	24	n.a.	n.a.
Belgium	1.21	0.66	6.4	4.5	49	53
Canada	1.08	0.76	6.2 to 7.5	17	38	67
Denmark	n.a.	2.24	7	20.3	n.a.	80
Finland	1.12	0.89	5.3 to 7.6	14	12	86
France	n.a.	0.50	6.5	6.1	32	59
Germany	n.a.	0.82	6.8	9.6	33	48
Greece	0.17*	n.a.	n.a.	n.a.	n.a.	n.a.
Ireland	0.86*	n.a.	5	3.5	47	n.a.
Italy	0.58*	n.a.	3.9	3.0	33	n.a.
Japan[5]	n.a.	0.15/0.62	6.0 (3.0 NH)[6]	5	n.a.	n.a.
Netherlands	2.70	1.80	8.8 (2.7 NH)[6]	12	n.a.	76
Norway	≅ 2.80	2.80	6.6	17	10	63
Portugal	0.39*	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	0.56*	n.a.	2.8	2	n.a.	n.a.
Sweden	≅ 2.7	2.7	8.7	11.2	n.a.	n.a.
Switzerland	0.75*	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	1.30	1.00	5.1	5.5	44	70
United States	1.32	0.70	5.7	16	100	67

n.a.: Data not available.

1. Long-term care spending refers to the care needed to help older persons leading an independant life, at home or in an institution. It excludes informal help. For home care, it should include all home care services, including district nurses services, excluding medical visits. For institutions, it includes all the costs related to care and lodging, including help for all self-care activities, but excluding medical costs. Definitions across countries are not always totally homogenous as information was provided from two different sources. Most of the information was derived from Pacolet (1997) and other national sources (see Table 1.8 for sources). In addition, for other countries mentioned by*, data is derived from Markus Schneider *et al.* (1994), *Gesundheitssysteme im internationalen vergleich,* BASYS. Data refer to the years 1992-94 as supplied by the authors.
2. Estimates may vary according to the concept chosen for institutions (sheltered housing, hotels for the elderly, medical homes). Normally, the concept described should include only staffed homes. For Denmark the concept of older persons refer mostly to over 67. Additional details and country specific data can be found in Jacobzone (1999 forthcoming).
3. Proportion of older persons receiving formal help at home, including district nursing, and help with activities of daily living.
4. This shows the proportion of public funding devoted to institutions as opposed to supporting help in a community setting.
5. 0.15 corresponds to present spending for care to the older person in 1995 (not including hospitalisation costs) while 0.62 correspond to the additional spending involved by the current long-term care insurance adjusted with the 1995 population.
6. Some of the residential accommodation is provided within hospitals. Data refers to nursing homes *stricto sensu.*

(Wiener *et al.*, 1994). Work by the OECD Secretariat (Jacobzone *et al.*, 1998) shows that the potential effects of ageing could be compensated in part by a relative improvement in the health status of the elderly population. Even though the effects are not as strong as those of Manton *et al.* (1997), the growth in expenses would be slightly more rapid than assumed GDP growth.

6.2. Providing adequate incentives for care access and use

Long-term care policies are implemented via a complex interaction of three actors: the family, the market and the state. Private or public formal care is a partial substitute for care provided in the family. Families will try to use least-cost (both financially, but also taking into account convenience) forms of care even if this leads to higher total social cost. For example, they may ask for institutional care if co-payments are lower for this type of care. In most cases, behaviour takes relative prices into account, with a high preference for remaining in their own home.

In Canada (Carrière and Pelletier, 1995) and Belgium (Crevitts and de Donder, 1995), empirical results show that age, marital status, income and availability of aid play an important role in the demand for institutional care. The presence of children reduces the probability of having recourse to institutional aid (Dick *et al.*, 1992). The effects of age and the presence or absence of a spouse have similar effects in Germany and the United States (Himes *et al.*, 1997). Use of institutional care can also be influenced by care providers, who may attempt to maximise their activity or size, even if this is to the detriment of their patients. Furthermore, the presence of public help to those needing institutionalisation can also put the market for institutional aid in a situation of excess demand, as has been shown in the case of the United States (Reschovsky, 1996).

It is necessary to consider ways of achieving a better balance and a better integration of care. Social authorities and health care institutions often work side-by-side without a proper interface to meet the individual's real need. Services provided under a medicalized setting are often more expensive. This difficulty is particularly acute where both types of services are run in a different institutional setting, which occurs in a large number of Member countries, such as the United Kingdom, Hungary, France, Canada or Italy (see OECD, 1998*g*). The introduction of a unified social insurance scheme seems to have helped in limiting this problem in Germany.

Studies show that a switch to community care will not result in large cost savings. A review of American studies (Jacobzone, 1999 forthcoming) shows that the eventual result is roughly revenue neutral. Two factors explain this result. First, the demand for services in the home appears to be quite elastic (Lagergren, 1997). Second, the cost of help depends mainly on the degree of incapacity, not the institutional setting (Browne *et al.*, 1995). A person who is highly dependent will result in similar costs whether he/she is helped at home or in an institution. This implies that rebalancing care between institutional forms should be pursued only while tailoring care more closely to need, reserving institutional care for those with the greatest needs.

More efficient financing, whether within a fiscal or insurance-based framework, requires output indicators for the care delivered. The RUG (Resource Utilisation Groups) scales developed in the United States are starting to be used in other countries for pricing long-term care (Ikegami *et al.*, 1994). In Germany and France, standard scales of disability have been developed for determining entitlement to a home care allowance according to the degree of disability.

6.3. Integration with other social policies

Countries are experimenting with a variety of flexible financing arrangements. In some cases, greater individual flexibility in choice of care delivery is being considered through the

medium of individual saving accounts. On the other hand, the United States is experimenting with consolidation of financing. The PACE programme addresses the needs of long-term care clients by offering a comprehensive service package to continue living at home. In contrast, other countries have chosen to expand their social protection system. In Germany and Japan, formal systems of long-term care insurance have been put in place with dedicated financing and specific services. In Norway and Sweden and, more recently, in Austria, a public long-term care provision system has been established.

Given the complexity of the problems posed by care for the dependent elderly, most reforms will necessitate partnerships at various levels – public/private and central/local. These partnerships can be concluded between care institutions and the bodies financing them at local level, and between public systems of funding and care institutions. They may also involve negotiations between the various levels of government, between central government which provides the funding, and the local authorities that most often manage care systems. They may also result in devolution, to promote local responsibility with unified management and individual follow up of the older person using "case-management techniques".

Whenever it is possible, the prospect of allowing pooling of resources between sickness insurance and pension systems, whether public or private, should be evaluated, even if institutional boundaries often make it difficult. If a person becomes dependent, his health needs and daily life will be transformed. The system of transfers should therefore allow for substitutions according to needs at a certain point in time. Some patients arrange to receive acute medical care which is covered by sickness insurance, while home care or long-term care is not covered, although the latter are both less costly and more appropriate to real needs.

Notes

1. In reality, the two actions will work together. The public system will in itself have an effect on the price and quantity of health care provision, as it pools the risk over a larger population.
2. Such work is already being carried out by the WHO EUROHIS project which over the next three years will be supported by EC BIOMED 2 programme.
3. In the case of the United States, these principles have been developed within the judicial arena rather than through initiatives of the executive, in particular through the pursuit of claims for medical malpractice.
4. About 40 per cent of the population in the United States is covered under some form of non-compulsory health insurance, usually employer-sponsored tax-privileged schemes. Employer-sponsored schemes limit adverse selection and allow for lower premia than under individual schemes.
5. More discussion on the measure of health expectancies can be found in Chapter 1.

Chapter 7

Conclusion: Much Has Been Done, More Needs Doing

The main pressures driving social policy outlined earlier in this report are well-understood in most OECD Member countries. The general directions of necessary reforms – helping people to work; population-based health care; a better balance between health and long-term care – are also not seriously contentious (although, of course, countries differ in how best to achieve these objectives). Despite this consensus on objectives, however, there remain real differences in the extent to which countries have altered their policies accordingly. This section reviews some of the main obstacles to implementing the necessary reforms and how examples of successful reforms have overcome them.

1. Managing equity and efficiency trade-offs

The OECD report (1998*g*) revealed many cases of apparent tension between equity and efficiency objectives. For example, many OECD countries want to reduce the extent of social exclusion and poverty in their country at the same time as they want to keep strict control on the extent of social expenditures, and enhance incentives for working-age people, in particular, to work. Similar concerns arise with respect to service provision. The preceding chapter revealed a strong case on equity grounds for a shift in public resources devoted to health care to address the persistent differences in health status across different population groups. But to do so raises at least the possibility that the causes of poor health are so intractable that bigger improvements in overall health status can be achieved by allocating funds to other, less disadvantaged but more easily treated groups.

There are few examples of direct reductions in the generosity of social security provisions because of these concerns about equity. Where there have been reductions, they have been in the areas of public retirement pensions, and to a lesser extent, of unemployment insurance. The reductions in public retirement pensions have primarily been concentrated on the second-tier earnings-related pensions – with the largest effects often on those who would have contributed the most. The first tier of pension provision, which seeks to provide an adequate level of support for all aged people who qualify, has generally been unaffected, reflecting its predominant poverty-alleviation objective. A number of countries have reduced the generosity or duration of unemployment insurance benefits but have left unemployment assistance and social assistance benefits largely intact.

Some countries have been seeking to improve the generosity and coverage of their pension provision as part of the processes associated with economic development (*e.g.*, a number of eastern European countries in transition, Greece), while there have also been increases to the flat-rate benefits available in Australia and Ireland.

In contrast to the general reluctance to reduce benefit levels, there has been a much greater willingness to tighten programme eligibility. Greater attention is being placed on ensuring that potential recipients satisfy the core criteria of disability, sickness and unemployment. There are risks if these measures are taken to extremes as overly rigorous and inflexible rules can lead to people in need being excluded from assistance – contrary to the objective of many countries to reduce the incidence of social exclusion. It is noticeable that there is very little information available in countries on what happens to those excluded from benefits.

An improved analytical framework may help policy-making more generally. Those who advocate reductions in benefit levels do not usually do so on the grounds that a wider income distribution is desirable, but that the long-term effects of improving employment incentives and reducing fraud would be to increase income from work, potentially narrowing the income distribution. This distinction between short and long-term effects is fraught with difficulties – not least, the possibility that reducing the income of the most vulnerable in society can contribute to their exclusion from society and the labour market. But there is considerable danger that in the absence of an adequate framework for assessing outcomes, solutions designed only to produce short-term equity improvements will be selected.

2. Taking greater account of policy interactions

One means of achieving greater cost-effectiveness in policy responses is through fully understanding and exploiting the many interactions between social outcomes, and the ripple effect some social policies can have in contributing to a number of policy goals.

Examples of some of these interactions between social policies include:

- better employment outcomes, higher incomes and suitable housing contribute to better health outcomes of the population;
- better employment outcomes for the working-age population will generally lead to a higher level of retirement income;
- better standards of living across the population, especially nutrition and housing during formative years, contribute to a healthier and longer life, improving the prospects for potential workforce activity; and
- the long-term care arrangements for elderly people may influence the available housing stock for the younger population, and the housing and income position of people approaching older ages may constrain their long-term care choices.

With the complexity of modern social programmes, responsibilities for oversight and management of social policy are split across a number of Ministers and ministries/agencies. To this can be added the potential involvement of two or more levels of government, as well as the potential involvement of non-government organisations and private sector providers (as in the retirement pension and health care sectors).

But whilst the potential gains in co-ordination of different groups are denied by no one, effective exploitation of the gains from policy integration has sometimes remained elusive. Examples of policy successes include:

- As outlined in Chapter 5, a number of countries have sought to tackle social exclusion through more effective combining of minimum income payments, promotion of labour market integration and services (both of health care and personal services). Two approaches have been followed with some success. One has involved painstaking development of common objectives by different institutions, for example through the Poverty Report process in Belgium (OECD, 1998*d*). This has been used to identify gaps

in policy coverage and inconsistent policies across different governmental levels, and to agree on appropriate policy responses. The second approach is to focus overall responsibility on one body, which then purchases appropriate services from providers across different bodies.

- Long-term care for the elderly is another policy focus of some OECD countries which necessarily brings together health care, social services and accommodation arrangements. Different levels of government are often involved, as is the non-profit sector. The intensity of service must be matched to the needs of the individuals and yet must be responsive to changes in needs over time. Again, successful responses have usually involved either a co-ordinator of services (*e.g.* with care networks co-ordinated by local GPs or by an 'aged care-co-ordination team') or else intensive efforts to bring the policies and processes of different actors into line.

- Taking appropriate account of policy interactions is a central problem in moving from the provision of health care to the promotion of health. Although in theory it is easy to imagine situations where a given amount of money would produce better long-term health outcomes were it spent on services *other* than health (*e.g.* accommodation), freeing-up budgets to be spent in such a way remains very difficult to accomplish. The Swedish FINSAM experiment (see Box 7.1) provides one example where an experiment was implemented with some success. However, whereas the extent to which budgets are fungible at the local level remains limited, there have been moves to take health consequences of other policies into account at an earlier stage in the policy design and implementation process, through intergovernmental working parties and "health impact statements" about policy developments.

- The links between employment policy (often a national responsibility) and disability rehabilitation (often administered and financed locally) give rise to cost-shifting and gaps in coverage.

Box 7.1. **The Swedish FINSAM experiment**

The Swedish FINSAM experiment gave five counties (and municipalities within these counties) joint responsibility for sickness benefits and reimbursements for rehabilitation. The counties could allocate *social insurance* funds to measures aimed at reducing the demand for cash assistance by reducing incapacity rates and stimulating rehabilitation. It therefore involved the co-ordination of health, social insurance and local social services.

The official report on the experiment suggests that it yielded savings in social insurance payments (not only sickness benefits but also the disability pensions to which sick people would have become entitled) which were 154 million SEK larger than the increased amounts spent on rehabilitation measures between 1993 and 1995. These savings amounted to around 9 per cent of the relevant social insurance costs. The incapacity rate in the experimental areas fell by 2.5 per cent between 1993 and 1995, compared with an increase of the average Swedish incapacity rate of 2.1 per cent. Effects on health expenditures proved more difficult to assess. It seems that there may have been some limited cost savings.

These success stories suggest that the achievement of policy coherence will be aided by a number of distinct processes:

- clear elucidation of the major policy goal desired to be achieved;
- agreement between the major players and community acceptance of the importance of success in achieving the desired goals;
- either:
  - shared understanding of the respective roles and responsibilities of the different agencies as they contribute towards achieving the policy goal; or
  - clear responsibility for policy implementation to be located with one institution, which usually is given flexibility in allocation of financial resources;
- scope for adjustment of policy responses.

3. Reopening social contracts

Very strong public expectations about the nature and level of public provision can make it difficult to achieve radical changes in social programmes. Some social provisions may have been accumulated over many years as a direct substitute for higher private earnings, and diminution of social benefits may lead to greater wage pressure as workers seek to replace any reduction in their "social wage".

Some reasons for the willingness of some countries to introduce policy reforms are well-known and beyond the control of Social Policy Ministers. For example, crises in public finance helped overcome resistance to revisions of social security in New Zealand and Sweden, and pensions reform in many countries have been sold on the basis of an impending old-age crisis. In other cases, apparently radical changes (such as the increased use of co-payments in health services in Nordic countries) must be understood in a wider context (such as the rise in living standards of the elderly population).

Tripartite negotiations over social programmes exert considerable influence in a number of countries (such as Sweden, Norway, Austria). In countries with minority governments, this can provide a mechanism for building consensus for policy changes. At the same time, a dominant role for the social partners in the development of social policy carries significant risk that policies will reflect the needs and aspirations of the members of these organisations (the "insiders"), with much less attention given to the requirements of those outside of existing employment arrangements (the "outsiders"). In these situations, there is greater responsibility on the government sector to play the role of the "honest broker" and fully represent the interests of the unemployed, those who are socially excluded, and future generations who will inherit the structure and financing burden of prevailing social institutions.

4. Utilising the potential of the private, not-for-profit, and voluntary sectors

Governments under pressure to do more with less can make more effective use of the networks and skills of non-government organisations. Some governments are already increasingly outsourcing some activities previously undertaken in the public sector to the private and not-for-profit sector, to benefit from cost-efficiencies and competitive tendering.

Private social expenditure is more significant in a number of areas, such as health and retirement pensions, as some people seek improved quality of provision over and above that which is available from the public system (Adema and Einerhand, 1998; Esping-Anderson,

1997). In some social policy areas – such as health and education – there can be considerable competition between the public and private sectors (such as in the United States).[1] In the provision of sickness benefits in some countries, reduced public provision during the initial stages of illness has been accompanied by an expectation that employers would provide protection – producing not only lower public costs but also changed incentives for employers to ensure their workplaces are safe, healthy environments and have mechanisms to reduce the level of absenteeism. Private sector organisations may be able to generate higher corporate donations for their work than a corresponding public social welfare organisation, and some of their business contacts may be particularly useful in establishing work opportunities for those who are jobless.

The quality of regulation has become increasingly important in the context of greater reliance on private, not-for-profit and voluntary sectors to deliver social programmes, as a means of providing some form of external accountability. This may involve codes of practice and professional standards expected of non-government agencies, such as those providing health care and long-term care services. In other cases, such as private retirement pensions, extensive regulatory and supervisory mechanisms should be in place, reflecting the scale and importance of the investments for the well-being of the contributors.

5. Constructive public sector reform, devolution and decentralisation[2]

Citizens are demanding more diversified and sophisticated services from government. Meanwhile, public debt and fiscal imbalances limit governments' room to manoeuvre. One option to cope with those difficulties is enhancing the role of private, non-profit, and voluntary sectors, as discussed in the previous section. More generally, a closer focus on *results* in terms of efficiency, effectiveness and quality of service tailored to the needs of the general public as clients, is a major element in public service reform.

This approach has been seen in health care reform, for example, where a majority of the OECD countries now have national commissions on quality standards, and several countries are beginning to develop "consumer bills of rights". Commitment to public standards of services (*e.g.* the Citizens Charter in the United Kingdom) can provide a yardstick for judging performance and managing public expectations as well as greater transparency of performance. These trends also seem to have been a catalyst for the replacement of highly centralised hierarchical structures with devolved/decentralised management environments.

Some progress has been achieved in making governments more client-oriented in several areas, such as access to governmental services, transparency of operations and decision-making, and provision of grievance procedures to provide a feedback mechanism for government services. In the social protection area, a separation between agencies providing services and policy development, can focus the energies of the former on the improvement of services (*e.g.*, in Australia, New Zealand and the United Kingdom). However, the formal separation of policy-making and policy execution functions has some risk that policy becomes out of touch with realities unless mechanisms for providing feedback from operations are strengthened. One-stop shops have been pursued in some countries as a means of achieving greater integration of services, including across levels of government.

Another distinct trend is towards "devolution" and/or "decentralisation" which aims at more efficient and effective public administration, though its process and extent differs. Here, "devolution" refers to the shift of responsibilities within the central government, whereas decentralisation refers to the shift of responsibilities to local levels of governments.

Table 7.1. **Devolution measures in selected fields and in selected countries**

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
Australia		*Administrative arrangements* • State and territorial governments generally have authority in service provision as a whole *Funding responsibilities* • Shared by all levels of governments (and non-governmental sectors)	*Administrative arrangements* • Provision of services: overall by local governments, a small number of residential care by state governments *Funding responsibilities* • Mainly state governments (along with the Commonwealth government)		• A compulsory private pension scheme
Austria	• Social assistance legislation (by each *Länder*)	*Administrative arrangements* • Länders generally have authority in service provision as a whole *Funding responsibilities* • Social Insurance Scheme (federal) covers the most of the population	*Administrative arrangements* • *Länder* governments are responsible for granting social service benefits *Funding responsibilities* • Possible supplementary benefits (for long-term care) by the *Länder* governments		
Belgium	• Granting access • Additional payments when necessary	*Administrative arrangements* • Shared by regional governments (hospital accreditation, etc.) and Communities (primary prevention, etc.)	*Administrative arrangements* • Shared by regional governments (institution accreditation, etc.) and Communities (primary prevention, etc.) • Public Social Assistance Centres		• Private non-profit sickness funds take a significant role in funding health care (risk-pooling is done by the government)
Canada	• Decides benefits and eligibility criteria (no national standard)	*Administrative arrangements* • Provincial and territorial governments have authority in service provision as a whole *Funding responsibilities* • Provinces and territorial governments have individual health insurance schemes (though largely funded by general taxation) with federal support subject to plans' compliance with principles in Canada Health Act	*Administrative arrangements* • Provincial and territorial governments have authority in service provision as a whole, with nationally set standard of administration *Funding responsibilities* • Provinces and territorial governments have individual health insurance schemes (though largely funded by general taxation) with federal support • There is a trend toward shifting responsibilities (both administrative and financial) to local authorities		• Promoting private pension schemes

Table 7.1. **Devolution measures in selected fields and in selected countries** *(cont.)*

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
Czech Republic	• Provides benefits on behalf of the central government • Limited responsibility: discretion along with national regulations		*Administrative arrangements* • The role of local governments in providing services is expanding, according to the shrinking share of the central government *Funding responsibilities* • Communities, towns and district authorities finance the services, getting lump-sum grants from the central government		• A scheme of voluntary supplementary pension
Denmark	• Cost of cash assistance is split 50/50 between central and local authorities	*Administrative arrangements* • Managed by the county governments *Funding responsibilities* • Health care reimbursement scheme at county level, funded by block grant from the central government along with county taxes	*Administrative arrangements* • Municipalities have a responsibility for providing long-term care *Funding responsibilities* • Municipalities have a responsibility for funding long-term care		• A compulsory private pension scheme
Finland	• Provides living allowances (subsidised by the central government, but the local authorities create their own practices) • Broad equality across the country with some regional differences	*Administrative arrangements* • Municipalities have active role in planning, as well as primary care services, etc. *Funding responsibilities* • The system is funded by municipal taxes (along with federal taxes that are allocated according to some formula)	*Administrative arrangements* • Local governments: monitoring and developments of services • Municipalities: organising necessary care *Funding responsibilities* • Local authorities finance about half of the total cost		• Gradual implementation of private pension schemes
France			*Administrative arrangements* • The *département,* which is the second level of the local government, has authority to social assistance for the elderly and other service recipients		
Germany	• The central government and local governments bear increased costs	*Administrative arrangements* • Regulations diffuse through state and local level of governments, along with the federal government • *Länder* government subsidise hospitals for developing infrastructure	*Administrative arrangements* • *Länder* government subsidise for developing infrastructure • Municipalities are responsible for the persons in need of long-term care *Funding responsibilities* • The social assistance scheme finances cost which cannot be covered by the long-term care insurance		• Private pension promoted with legislation. Further expansion wanted Funding for health care services (also largely long-term care services) are conducted by autonomous sickness funds

Table 7.1. **Devolution measures in selected fields and in selected countries** *(cont.)*

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
Greece	• May improve the programme through additional services		*Administrative arrangements* *Funding responsibilities* • Shift of the role of care and funding borne by the state to municipal and prefectural bodies Open Care Centres		
Hungary	• May increase the rate, which is covered by national budget/taxpayers	*Administrative arrangements* • Local governments administer most hospitals and outpatient clinics	*Administrative arrangements* • Local governments mostly provide the care		• New pension schemes include a portion managed by private sector
Iceland		*Administrative arrangements* • Eight medical areas with health councils administer health affairs *Funding responsibilities* • In 1992, local governments funded 20% of the total cost			
Ireland		*Administrative arrangements* • Eight Health Boards provide health care services *Funding responsibilities* • National funds are allocated to the health boards	*Administrative arrangements* *Funding responsibilities* • Health boards provide and finance long-term care services	• Possibility of transferring administration of rent/mortgage supplements, currently administered under supplementary welfare allowance scheme to local authorities, is being considered	• Promoting private pension schemes
Italy	• Assistance lies within the exclusive realm of local authorities in both regions and towns/cities • *The central government is considering a national standard and funding for minimum benefits*	*Administrative arrangements* • The Local Health Units (USLs) administer public hospitals and make contracts with other providers *Funding responsibilities* • USLs pay for services by physicians registered with them • Responsibility for overall expenditures is shared by the region, the USL Directorates, the Hospital Agency Directorate	*Administrative arrangements* *Funding responsibilities* • The Local Health Units: for organising the care and for managing related finances		

Table 7.1. **Devolution measures in selected fields and in selected countries** *(cont.)*

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
Japan	• The cost is shared by central and local governments on a 3:1 basis	*Administrative arrangements* • Public health centres run by prefectures and some municipalities	*Administrative arrangements* • Municipalities are taking a primary role in terms of long-term care • The role of policy planning is shared by prefectures and municipalities, as well as the central government *Funding responsibilities* • Prefectures provide subsidies for home care, day care centres, etc.		• Promoting private pension schemes
Korea	• The cost is shared on a 50:50 basis	*Administrative arrangements* • Public health centres are run by provinces and municipalitites *Funding responsibilities* • Central and local governments share the total cost			• Private pension schemes
Luxembourg	• Applications to social assistance are made to Social Assistance Offices in small municipalities (provisional or advanced payments can be made, but final decision is left to the National Solidarity Fund.) 10% of the costs are borne by local governments				
Mexico				• Shift of housing responsibilities to state governments	• A new compulsory private pension scheme
Netherlands					• Promoting private pension schemes

Table 7.1. **Devolution measures in selected fields and in selected countries** *(cont.)*

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
New Zealand		*Administrative arrangements* *Funding responsibilities* • Health Funding Authorities purchases from service providers (they are funded by the government)			• Promoting private pension schemes (without tax concessions) • The recent cut of basic entitlement to social assistance increased the role of voluntary welfare groups (for in-kind benefits)
Norway	• Generally has own guidelines with the final amount left to the discretion of social services. Also has financial responsibilities. (National guidelines also exist on the sort of expenses which should be covered.)	*Administrative arrangements* • Counties administer hospitals *Funding responsibilities* • In 1997, 35% was financed by counties, 55% by the central government • Countries fund institutional care and home care services as well as hospital services	*Administrative arrangements* *Funding responsibilities* • Municipalities have a primary legal responsibility for arranging and financing community based as well as institution based assistance. (They are funded by local taxes and block grants from the central government.)		
Poland	• Seeking greater corporations between national government, local governments and NGOs (balance between ensuring essential benefits and decentralised and autonomous local social assistance)	*Administrative arrangements* • 49 voidvoships provide regional planning and oversee 400 ZOZs (health and social care centres) *Funding responsibilities* • Voidvoships are funded by the Finance Ministry directly, co-ordinated by the Ministry of Health and Social Welfare. Voidvoships fund ZOZs	*Administrative arrangements* • *Gmina*: providing nursing services, etc.(as their own responsibility), as well as paying various benefits (as delegated by the central government with necessary grants) *Funding responsibilities* • Social services are funded by the central government and each *Gmina*, though health services are mostly from the central government	• Increased role of *Gminas* in establishing local housing policy	• A new pension scheme includes private schemes as the third tier
Portugal		*Administrative arrangements* • Within the system of National Health Services, five regions administer the health care system (local health centres, co-ordination with hospitals) *Funding responsibilities* • Funded by taxation (direct taxation or through grants from the central government)	*Administrative arrangements* • National Health Services *Funding responsibilities* • Funded by taxation (direct taxation or through grants from the central government)		

Table 7.1. **Devolution measures in selected fields and in selected countries** *(cont.)*

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
Slovak Republic			*Administrative arrangements* • Municipalities to provide the assistance to the elderly within the social care settings (the cost is largely funded by the central government)		• Legalised private pension schemes
Spain		*Administrative arrangements* • Regional health services (within a national system)			
Sweden	• National standards as guidance to municipal bodies, but benefit levels can vary across the country • *National initiative to set some equalities in benefits* • Funding for the benefits are largely by local incomes taxes, but with block grants from the central government	*Administrative arrangements* • County councils and three municipalities (outside the councils) are responsible for in-patients care, outpatient care, etc. Some other areas such as environmental health are under the charge of municipalities *Funding responsibilities* • County councils (municipalities in some cases) collect taxes (70% of the whole cost)	*Administrative arrangements* *Funding responsibilities* • Municipalities are responsible for supplying and financing the care needs of the elderly (with the help of the central government in the form of general government grants)	• *From 1994, State bears full cost of housing allowances and responsibility for administration given to local social insurance offices*	
Switzerland	• Benefits and eligibility requirements vary from canton to canton, as well as within a canton • *Initiatives to set minimum level of benefits nationally* • Costs are borne by cantons and communes	*Administrative arrangements* • Cantons: health services, preventative care, etc. *Funding responsibilities* • Cantons can contribute to the compulsory health insurance system to lower the contribution rates (with federal support)	*Administrative arrangements* • Cantons or communes: elderly, home care, etc. *Funding responsibilities* • Cantonal or communal benefits are paid only after it is confirmed that the all the insurance schemes (health, old-age, disability, etc.) are not available to a sufficient extent		
Turkey		*Administrative arrangements* • Generally, services are administered at village level			• Considering encouraging greater private pensions

Table 7.1. **Devolution measures in selected fields and in selected countries** *(cont.)*

	Role of local authorities in social assistance	Role of local authorities in health care services	Role of local authorities in long-term care services	Other shift of roles to local authorities	Devolution to private sectors
United Kingdom		*Administrative arrangements* *Funding responsibilities* • Regional health authorities administer and fund family health service and provide funds to District health authorities, who fund hospitals	*Administrative arrangements* • Local authorities are the prime commissioners of care. They can also operate as providers • The local municipalities are responsible for arranging social care services *Funding responsibilities* • Local authorities are subsidised by the central government for providing long-term care. They can increase the funding for the services by their own discretion		• Promoting private pension schemes
United States	• No national standards for temporary assistance to needy families, Medicaid, most housing assistances, etc. • Significant variations across states and local governments	*Administrative arrangements* • Policies made at many levels of state and local governments along with the federal government *Funding responsibilities* • Medicaid and child care: funded by taxation, with a shared financial responsibilities with the federal government	*Administrative arrangements* • Policies made at many levels of state and local governments along with the federal government *Funding responsibilities* • Medicaid: funded by taxation, with a shared financial responsibilities with the federal government		• Promoting private pension schemes

Note: Statements with italicised words indicates that they describe the opposite directions against devolution.

Within the health and welfare sectors, there are many examples of decentralisation of social programmes (see Table 7.1 and OECD, 1997*g*). The growing importance of means-tested social assistance in the broad schema of social security (see Chapter 5), necessarily introduces greater emphasis on local control and responsibility given the way social assistance is structured in a number of OECD countries (OECD, 1998*g*).[3] Greater regional responsibility is also being introduced with housing assistance in Mexico and Poland, and Ireland is also actively considering this shift in responsibilities from the national government to the regional level. In the Ädel Reform in Sweden (1992), management of long-term care institutions and day-care facilities was shifted from county councils to municipalities, with the possibility of a further shift of authority from counties to municipalities of visiting nurse services or other medical care services. Responsibility of funding care for the elderly in county hospitals has been shifted from the counties to municipalities (OECD, 1998*g*).

The Personal Responsibility and Work Opportunities Act of 1996 in the United States transferred more responsibility to the states for welfare provision. In exchange for accepting a fixed block grant per year, states were given much more flexibility and freedom to determine eligibility of recipients and how to administer the benefits. Additionally, states themselves could devolve responsibility by contracting with private companies for a broad range of services, including eligibility determination and work retraining programmes. The United States has also been devolving responsibility for Medicaid. In return for accepting a five-year budget neutrality "cap" on federal and state expenditures on Medicaid, states may have the freedom to broaden eligibility guidelines to cover more uninsured people, and experiment with fixed budgetary payment systems under Medicaid, such as capitation rates to Health Maintenance Organisations.

Decentralisation of authority can be accompanied by very complicated financial arrangements, hampering the real autonomy of the local level of the government in policy decision-making. Fixed block grants for services are one way of devolving responsibility and decision-making authority to the local level. As the block grant is no longer an entitlement, the incentive for the local government to shift costs to the central government is minimised as they will not receive additional payments or matching funds for increased expenditures. Several countries provide fixed block grants to local governments to supplement local revenue-raising powers, who then administer health care services.

However, block funding can also have potential pitfalls. Greater local autonomy can weaken policy coherence across the country and lead to differential minimum standards of public provision. While administering public health programmes at the local level enhances a locality's ability to react quickly to public health epidemics and to adopt their educational programmes to a smaller population, such adaptability brings with it the price of perhaps insufficient co-ordination and integrity of programme policy on a national level.

6. Adapting to family developments

As noted in Chapter 1, there have been many very significant changes to family arrangements which have implications for social policy. Some governments are torn between a desire to encourage greater female labour force participation and concerns that this may reduce the care available to children. The result is inconsistent policy signals. For example, lone parents may not be required to look for work, but may be encouraged to do so. Child-care benefits may be paid if children are in formal care but not in informal care.

The desire for greater economic independence of women and increased household living standards, improved education levels and growth of service sector employment have all contributed to increasing female participation in paid work. The increasing precariousness of

employment among males, as well as the increasing precariousness of marriage, is also encouraging women to get paid work as a form of economic insurance for households and themselves. These employment gains for women have not been evenly shared, with many lone parents still reliant upon social security rather than employment for their main form of income.

Of particular concern is the high rate of poverty among (predominantly female) lone-parent families. Countries have embarked upon three strategies to reduce poverty rates of lone-parent households: improving financial incentives to get work (including limitations on welfare provision), increasing employment prospects through active measures specifically designed for lone parents and increasing attention on compliance with child-support liabilities. The most recent limitations on welfare for lone parents (*e.g.*, in the United States and Norway) are largely untested at this stage, although the restriction introduced in Australia just over ten years ago to reduce the age of qualifying child (to under 16 years) is now well accepted. While most Nordic countries do not provide categorical income support for lone parents, they instead provide them with other measures, such as child care and parental benefits, to assist them to combine family responsibilities with labour market activity. Many countries are devoting considerable resources to improving the compliance of absent parents with their child-support obligations, but success is very mixed. The role taken by some governments as provider of last resort may encourage absent parents to default on their obligations, although the intention of government is to assist lone parents through such an approach.

Much more attention and government expenditure has been given to increasing child-care opportunities, but most countries still have a serious shortage of places for very young children, and outside of school hours care for slightly older children is still developing in many countries. Informal care arrangements are, to varying extents, filling the breach (as well as providing lower cost alternatives). The expansion of parental benefits may enable some parents to care for their very young children at home. While the take-up of parental leave by fathers is increasing, it remains relatively low. Some countries show increasing policy sophistication in the way they deal with the work-family interface, with increased leave from work when children are sick and some examples where pension rights continue to accumulate (albeit in a limited sense) when the mother is temporarily absent from paid work to care for a young child. The pension rights of a former spouse in the circumstances of marriage dissolution are starting to receive attention in some countries – they may be particularly vulnerable to poverty in older age if they are not properly protected and treated fairly in property settlements.

Preventative measures are receiving insufficient attention. Improved family planning and sex education has contributed to reduced teenage pregnancies in many countries. Interventions in early childhood development can have significant positive impacts on personal and educational development – conversely a deficiency in early childhood development can contribute to ongoing problems throughout the life course. Good nutrition, proper shelter and a stable family environment also produce significant benefits for the health and general well-being of the population. Family counselling and conflict resolution measures can reduce the incidence of relationship breakdown. Neglecting the traditional role of personal social service providers in supporting families can also have long term consequences.

7. Realism about the effects of globalisation on social protection

Globalisation is often seen as a threat to systems of social protection. Competitive pressures, it is argued, will mean that producers in high social protection jurisdictions will lose out to their competitors from locations with lower social standards and therefore lower costs, forcing them to either reduce social protection in the current environment or relocate if they do not

wish to be forced out of business. Globalisation could then lead to a "race to the bottom", as countries reduce social protection in order to preserve employment.

Globalisation certainly does have an impact on systems of social protection, but its effects are more subtle than this unduly alarmist perspective would imply.

Dislocation of production. Greater global competition will result in job losses in some industries, as well as gains in others. If job losses led to destitution, it would be unsurprising if global competition was resisted. However, social protection systems can ensure that those who lose their jobs are insured against loss of all their income during the period while they search for a new job. Social policies also have a role to assist displaced workers to readjust to the new labour market opportunities. Thus, one effect of globalisation could be to *increase* the demand for social protection.[4] A modern, efficiently administered welfare state can reduce resistance to change and new working practices, enhancing the attractiveness of the country concerned as a business location. Conversely, failure to maintain adequate and effective systems of social protection would leave countries vulnerable to protectionist pressures.

Increased labour costs. More intense competition exposes differences in production costs. However, as noted in Chapter 2, there is no consensus as to whether higher social protection charges inevitably lead to generally higher labour costs (although the possibility of adverse effects on those with low earnings capacity is widely accepted). Furthermore, by analogy, a study of labour standards in general concluded that there was little evidence that failure to respect core worker rights led to a competitive advantage (OECD, 1996*i*). Were a government to try to reduce labour costs by reducing the extent of publicly provided social protection, success would depend on the response of workers and employers. For example, shifting responsibilities (and costs) directly onto employers would have no direct effect – although social contributions to government would fall, their overall labour costs would not. Similarly, if workers were left with responsibility for making their own arrangements, but succeeded in being compensated through increased wages for any reduction in social protection, there would once again be no effect. Publicly-managed programmes can provide efficient, and low-cost, social protection. Globalisation is an additional reason to structure social protection efficiently, but not necessarily a rationale to reduce the level of protection.

Comparative advantage in the labour market. The exact causes of the decline in relative demand for low-skilled labour outlined in Chapter 1 are open to question, but one hypothesis is that it is due to competition from low labour cost countries. The available evidence suggests that such an effect, if it exists, is likely to be very small.[5] However, some observers argue that it is not possible to disentangle the effects of globalisation from other factors, such as the introduction of new technologies. Whatever the reason, countries are faced with the dilemma of how to deal with a group which is not benefiting from general increases in prosperity caused by increased trade and technological developments. Social protection policies need to be reoriented towards meeting the needs of this group.

Financing welfare. As noted in Chapter 2, globalisation makes some tax bases more mobile and less easy to tax. Furthermore, the burden of labour taxes will fall more heavily on workers if globalisation erodes the economic rents previously earned by capital. Labour taxation in turn can distort the labour market. Hence, regardless of the need for it, social protection may become more difficult to finance through the tax and social security contributions systems.

There is no inevitable connection between globalisation and less social protection. But failure to assist those who are adversely affected by competition risks – in particular, the unskilled – can lead to an increase in protectionist sentiment. A more useful blueprint for reform would be to recognise that globalisation reinforces the need for some social protection. There is a

need for flexibility, to focus on the new emerging needs for protection, and to deliver such protection in the most efficient manner.[6]

8. Emphasising the economic function of social protection

Social protection is about more than the sum of the transfers and services which it provides. When this essential point is lost in the policy debate, it is unsurprising that policy inertia arises. If public debate is reduced to discussions only about who gains or loses from a particular reform, rather than whether the reform helps to meet the ultimate goals of public policy, the line-up of those who are for and against the changes is pre-programmed from the start.

Many social policy measures have a simple and clear objective: to protect the vulnerable and ensure that those in need have adequate resources. Basic pensions for the elderly, last-resource assistance for the destitute, basic health care facilities, support for the severely handicapped and social services for children at risk need little justification: they represent the use of public resources to protect basic human dignity.

But social protection has a broader role than poverty prevention, vital though that is. It helps bind economies and societies together in the following ways:

- *Social policies are vital determinants of the rate of employment.* Social benefits are often conditional on job-search activity; social benefits can support families in their balancing of caring and paid work; health status of the population is a key determinant of who is able to work; by insuring against events which lead to loss of earnings, social insurance makes work in general more attractive.
- *There are costs to exclusion.* If people are excluded from society, they cannot fully contribute either in the labour market or in systems of family and social support.
- *Change is resisted.* Taking advantage of new opportunities requires risk-taking. But most people are risk-averse. Some form of income security can, for example, help in making the risk attached to long-term investments in lifelong learning attractive, as well as reduce protectionist sentiments. Social protection helps limit the potential downside risks of change, thereby promoting development.
- *Inequality can have costs.* Few would seriously dispute the proposition that wide disparities in income and high rates of poverty impose costs on society in terms of threats to property and the measures taken to contain these threats. Furthermore, trust in personal and economic relationships, dense networks of community organisations and wide participation by citizens have been identified as factors potentially contributing to economic growth. Growth in disparities in incomes can threaten this consensus.

These disparate observations do have a common theme: that effective social protection can promote not just equity objectives of public policy, but also the desire for material improvements in living standards. It is easy to ignore the positive aspects of social policy in favour of overly-emphasising the very real danger that *inappropriate* social policies can harm growth. Selling the broad vision of what the social protection system is for – performing socially desirable activities as well as not only helping individuals and families avoid poverty, but also assisting them to achieve their potential through appropriate services and cash assistance when in need – is a necessary part of social protection reforms.

9. Will reforms take place?

Ageing; labour market changes; public budget constraints; gender equity; citizens demanding more effective public services; technological and scientific advances: most of the social and

economic developments taking place at the end of the 1990s and which seem likely to persist into the next decade have consequences for social policy. The impression inevitably given by a report outlining current and possible future challenges and directions for reform is that there are dire problems; governments are not doing enough; circumstances are likely to get worse, rather than better. It is appropriate in the last section of this report to focus on whether such an impression is justified.

In some countries, the ability of governments to respond to social needs is now somewhat greater than it was a few years ago. The reasons for this cautious optimism are based on three broad developments:

The labour market has improved

In a few countries, the rate of unemployment has fallen. This is true of Ireland, the Netherlands, New Zealand, the United Kingdom and the United States (and tentatively, because the improvements have been more recent, Australia and Denmark). The gains go beyond the obvious effects on unemployment benefits. There is some reason to believe that reliance on other benefits, less closely related to unemployment, may also have fallen or the rate of growth of spending on such benefits contained. This is true, for example, of social assistance (or welfare) payments in many of these countries. The rate of inflow into invalidity benefits in the Netherlands has fallen.

Yet, as consideration of these countries shows, the improvement of the labour market is far from being an answer to all social problems. The rate of inflow into invalidity benefits in New Zealand and the United Kingdom continues to be cause for concern. Furthermore, as noted in Chapter 1, there has been a growth in the number of workless households, even in some of these countries where unemployment has fallen. The employment gains, however welcome, still leave families reliant on public support.

Public finances have improved

In many countries, the social policy agenda for the past ten years has been driven by the state of the public finances. There have been seemingly endless efforts to cut or curb the growth in spending programmes in order to contain public sector budget deficits.

In some cases, the result of financial stringency has been a failure to address social needs. Introduction of employment-oriented social policies, for example, have been inhibited because although they hold out the prospect of long-term gains as the structure of the labour market is altered, in the short term they are expensive.

However, the moves towards more innovative delivery mechanisms, the greater focus on efficiency and the decentralisation and devolution of expenditures also often have their origin in cost-containment measures. The focus on budgetary problems has pushed “value for money” issues to the centre of the debate on social policy, with a greater focus on “outcomes”.

Public finances are now in a much healthier state. Whether this will free up sufficient resources to tackle some of the issues which have recently been neglected is yet to be seen, but the legacy of the years of attempts to get around the constraint on public spending is a wider range of policy options.

There is a greater willingness to innovate

Not so many years ago, use of the term “policy paralysis” would not have been unreasonable in describing social (although not health) policy developments. Whilst the problems with

existing structures were acknowledged, the inability to gain sufficient social acceptance of reform was fatalistically accepted. This is no longer the case, with a wave of recent reforms having been undertaken. Under the pressure of fiscal constraints, pension systems have been reformed in many countries, but there have also been innovations in unemployment benefit systems and care of the frail elderly. Reform of health care systems has continued.

But no country can be said to have yet responded to the reform agenda in full. Even in those countries where employment is somewhat higher than before and budget deficits are at acceptable levels, the case for continuing reform remains strong. Indeed, the case for tackling the more intractable social problems (such as the problems of the low skilled, and the socially excluded) is stronger when broad economic developments are favourable:

- An improving labour market is an important element in making a more active social policy more effective. For example, tighter controls on invalidity benefits (as in the Netherlands) may be easier to enforce when there is a greater chance that someone who has been refused invalidity benefits will find work. How much of the sharp reduction in welfare rolls recently in the United States should be considered as being due to the reform and how much to the general improvement in the labour market is (as yet) unclear, but may also be an irrelevant question – the greater stress on job-search and provision of child-care facilities would not have proved so effective if the economy had not been generating many job opportunities.
- Similarly, if governments do not address the problems of exclusion when public finances are in good shape, the only possible conclusion is that this is seen as either an inevitable or an acceptable feature of modern societies.

Resistance to changing social protection arrangements was motivated by a concern that with so many other social and economic changes taking place, some reliable system of social protection was necessary. However, examples of successful reforms can help unlock other reforms. There appears to be an acceptance in many countries that, far from being politically dangerous, social policy reform may be a vote-winner.

Notes

1. Australia is currently experimenting with a competitive market for employment services, in association with a change to the nature of its public employment service to ensure it competes on even terms with private and not-for-profit agencies.
2. The conceptual basis of this section draws heavily from OECD (1995*b*).
3. The decentralised nature of social assistance in Sweden, Switzerland, Poland and Italy is being modified, to some extent, by the introduction (or possible introduction) of common national standards for social assistance.
4. Rodrik (1997) has claimed that there is empirical evidence for such an effect. In particular, he presents evidence that the greater is the product of the openness of an economy (as proxied by the sum of exports and imports as a percentage of GDP) and the variation in the terms of trade, the greater has been the growth in social expenditure. See also Report of the Director-General of the ILO to the 85th International Labour Conference in 1997.
5. See OECD (1997*a*) for a review of the available evidence.
6. Reductions in social protection may also run foul of international obligations. International Labour Organisation (ILO) conventions provide a minimum standard by which countries can assess their national law, as well as creating binding obligations for the countries which ratify them. In the European environment, the Treaty of Maastricht stipulates that the European Community shall promote "… a high level of employment and of social protection, the raising of the standard of living and quality of life, and economic and social cohesion and solidarity among Member States", complemented by a recommendation adopted on 27 July 1992 which called for greater convergence of social protection objectives and policies among Member States (CEC, 1994).

Annex

Press Communiqué of Social Affairs Ministers 23-24 June 1998

The OECD's Employment, Labour and Social Affairs Committee met at Ministerial level to discuss Social and Health Policies from 23-24 June 1998, chaired by the Honorable Donna E. Shalala, Secretary of Health and Human Services of the United States. The Vice-Presidents were Mrs. Sinikka Mönkäre, Minister of Social Affairs and Health of Finland and Mr. Junichiro Koizumi, Minister of Health and Welfare of Japan.

The meeting was preceded by consultations with the Business and Industry Advisory Committee and the Trade Union Advisory Committee to the OECD.

Main conclusions of the meeting

Ministers agreed:

- that structural reform of social and health care systems should achieve greater equity and efficiency of social protection systems;
- to promote employment-oriented social policies to combat poverty, inequality and exclusion;
- to ensure the best possible start for children by promoting early childhood development and family-friendly policies which would help families balance work and caring responsibilities, and by improving employment opportunities for those parents without work;
- to promote a healthier population by focusing on more prevention and the broader factors contributing to health improvements and by tackling persistent inequalities in health status;
- that an "active ageing" strategy should encourage and enable people to lead productive lives in society and the economy as they age;
- that necessary reforms of retirement pension systems should not be delayed, so that they provide adequate income support while ensuring their long-term sustainability;
- to co-ordinate the roles of health and social care systems so they provide appropriate and integrated care for those with long-term needs;
- to promote an appropriate balance in rights, responsibilities and opportunities between government, at its various levels, and individuals, families, social partners and communities; and
- to support the elaboration of effective instruments for monitoring and evaluating programme outcomes, and to develop internationally-comparable social indicators.

Social policies can claim many achievements...

Effective social policy and health care are an integral part of economic development, enhancing the growth potential of economies and facilitating economic adjustment. The incidence and extent of poverty

among the elderly have fallen over time as pension systems have matured. Unemployment, sickness, and disability do not automatically lead to severe social and financial hardship as a result of the measures now in place which provide income security and increased opportunities to participate in society. The unemployed and other persons at risk of unemployment are helped to obtain new jobs through active labour market programmes. Income and services support helps with the extra costs and responsibilities facing families raising children. Much longer life expectancy and increased disability-free life expectancy has been achieved as a result of improvements in medical treatments and expansion of health-care coverage, together with higher standards of living, housing and nutrition.

… but many challenges also loom large

Despite some evident successes, there is a widespread perception in many countries that the Welfare State is in crisis. This is exaggerated but social policy and health care systems are currently facing major challenges and further reforms are needed:

- High and persistent unemployment remains a central preoccupation for many OECD countries. Too many people of working age are reliant upon welfare support for long periods, and there are significant risks that this will be transmitted to future generations.
- The growth of social exclusion in many OECD countries – and, in some countries, the persistence of extreme poverty and high income inequality – is of great concern. Income support alone is not a sufficient response: improved access to education, training, employment experience, housing and health care, the full exercise of citizenship, and other social services is needed too.
- Families are coming under increasing strain as evidenced by high rates of family break-up, growth in the number of lone-parent families, longer average dependency of children and concerns that children, as well as frail and invalid relatives, receive proper care.
- Despite improvements in medical technology and the expansion of health-care coverage, there remain persistent differences in health status within populations in OECD countries.
- Population ageing in OECD countries will reduce the prospective increase in overall living standards, with concerns about increasing social expenditures and the adequacy of provision for the elderly.
- Fiscal consolidation continues to have a significant influence on social and health policy. To meet this goal and to sustain social provisions in the long term, most governments have imposed tight constraints on social expenditures which account for a large share of public spending.

… and investments for the future are required

In order to address these challenges adequately, structural reform of social and health care systems should aim to achieve greater equity and efficiency of social protection systems, thus enhancing economic development. Social expenditures can be an investment in the future when they enhance the growth potential of the economy as well as ensure that individuals and families are provided with suitable assistance to maximise their potential and contribute fully to society. Co-ordination between different agencies and levels of government is a necessary condition to achieve these goals efficiently.

Employment-oriented social policies are part of the answer…

Ministers agreed that social policies can best respond to some of these challenges by helping to maximise paid employment. Under such an employment-oriented strategy, a high priority attaches to reducing the number of households with no adult in paid employment. Favourable economic and employment conditions, as well as effective active labour market policies, will help in achieving this goal. It also requires minimising work disincentives arising from the interaction of tax and social security systems, especially as they impact on those with low incomes. Some countries have been experimenting with in-work benefits (particularly for families), improved incentives for social security recipients to take up part-time work and continued entitlement to selected social benefits for a limited time once a person enters work. An employment-oriented social policy also means trying to limit any adverse impact that the financing of social programmes has on job creation. In recognition of this, a number of countries have

recently reduced social security contributions and other non-wage labour costs, particularly for the low paid. Ministers recognised that more information is required on the effectiveness and consequences of these alternative approaches to implementing an employment-oriented social policy and called upon the OECD to devote a high priority to this task.

An employment-oriented social policy also implies tighter administration of sickness, disability, lone-parent and early retirement benefits which, in some OECD countries, have come to be used as an alternative to unemployment benefits. While those unable to work must continue to receive adequate support, public policy should seek to foster employability. Social protection requires a suitable balance between cash benefits, social services and support for labour market integration. Ministers supported the initiative launched by the Canadian authorities to determine how best to integrate people with disabilities into the labour market, and encouraged the OECD to pursue work in this field.

… supported by more family-friendly social policies

Profound social changes are having major impacts on families. Increased labour force participation of women has provided them with greater economic independence and security. In some countries, this has been supported by improved access to child-care opportunities, enhanced maternity and parental benefits and greater flexibility in working arrangements to help men and women balance work and family responsibilities. Social programmes may need to adapt further so they respond to and support family structures.

Ministers recognise the key importance of the family unit in nurturing, caring and supporting members of society. Social programmes play a valuable role to assist the family in carrying out its many purposes as well as intervening, as appropriate, when family structures dissolve or act in destructive ways. Early childhood development is crucial in establishing a sound basis for further learning, with potentially substantial benefits especially for children from disadvantaged families. Women play a special role as formal and informal caregivers predominantly in family settings, as well as being recipients of care, and social policy needs to respond to their specific situation.

Ministers agreed that public policy must respond to the needs of the many families with dependent children with no adult in work, where there are major concerns over the consequences of long-term welfare dependency. As noted above, in-work benefits are one possible response to the poor work incentives faced by many unemployed families, but countries may also need to adjust the means-testing of social assistance in order to improve incentives for all adults to seek work. Family-friendly policies, including improved access to affordable and quality child care, access to parental leave, greater flexibility in work arrangements and training opportunities can provide the key to better employment opportunities for families with young children, especially lone parents. More reliable systems of child-support payments from the absent parent would also help reduce poverty among lone-parent families.

Health outcomes must be further improved…

Ministers agreed that the focus of health policy reform should be on improving health outcomes, within the context of ongoing efforts to improve cost-effectiveness. Choices need to be made about the best ways to use health expenditures; and such choices require better understanding of the relative cost-effectiveness of different medical interventions, technologies, preventative programmes and population health approaches in achieving health improvements. Greater empowerment of patients, *e.g.* through improved education and greater access to information on the effectiveness of alternative treatments, can contribute to improved health outcomes, balanced by some cost-sharing, where this is appropriate, by patients who can afford to pay. Ministers recognised that programme assessment and evaluation need to be improved, so that providers, patients and governments can make the best decisions, and encouraged the OECD to pursue work in this area.

… and reducing inequities in health status is a high priority

Despite tangible improvements in the average health status of the population, there is evidence for some countries that those who are socially and economically disadvantaged have a widening disparity of health status compared with the rest of the population. Effective health-care access for the disadvan-

taged remains important and should be improved where there are deficiencies. But provision of medical care alone will not solve these inequities in health status, as social, environmental, behavioural and cultural factors also influence health outcomes. Tackling health inequities requires co-ordinated cross-sectoral programmes.

Maintaining prosperity in an ageing society is a key goal

Many OECD countries are expecting rapidly ageing populations, especially from around the year 2010 onwards, as a result of increasing longevity and declining birth rates. While ageing populations reflect positive outcomes from improved living standards and greater choice and control over family formation, they will also put strains on social and health-care programmes, as well as living standards in the absence of continued productivity growth. Ministers, like their colleagues at the recent meeting of the OECD Council at Ministerial level on 27-28 April 1998, welcomed the report "Maintaining Prosperity in an Ageing Society" which proposes principles for interrelated reforms in many areas of social, economic and financial policy.

The policy principles outlined in the report are useful for OECD countries to meet the challenges and opportunities of ageing populations, through supporting active ageing, improving incentives and opportunities to work longer, reforming retirement pension systems and ensuring cost-effective health and long-term care provision. Ministers agreed to take these principles into account when designing reform strategies and monitoring progress.

Pursuit of an "active ageing strategy" will help…

Ministers agreed that societies must foster a climate conducive to "active ageing", expanding and encouraging the capacity of people, as they grow older, to lead productive lives in the society and economy, through paid work and unpaid activities like voluntarism and family caregiving. People should have increased choices in the way they spend time over the course of their life – in learning, in work, in leisure and in care-giving – which will benefit individuals and society. Reforms may be necessary to remove constraints on these lifetime choices and promote an increased range of opportunities for people as they age, through policies such as life-long learning or medical interventions that help people maintain autonomy. Ministers requested that the OECD identify elements of an active ageing strategy.

… encouraging people to work longer and be more active

One of the main OECD recommendations is that, in order to cope with the fiscal and other challenges posed by ageing populations, it will be necessary to encourage and enable those who are able to work longer, to do so. This requires a coherent set of policy measures providing appropriate financial incentives for people to work beyond current actual retirement ages in most OECD countries. Existing financial incentives for early retirement should be withdrawn or scaled back significantly, and longer working life rewarded by pension systems. Access to alternative social benefits such as disability pensions and sickness benefits should be limited to those who genuinely qualify. Policies to improve the employability of workers as they age, via lifelong learning, promotion of occupational health and other activities of maintaining work ability, as well as targeted labour market measures, supported by positive attitudes of employers towards older workers and more flexible working arrangements, will also be needed to complement changes to social security systems. Ministers affirmed their commitment to work with their colleagues in related Ministries and the social partners to achieve the goals of active ageing.

In a number of countries, there are indications of improving health status and declining disability rates, on average, among older people which open up many opportunities for them to contribute to society. Ministers looked forward to the International Year of Older Persons in 1999 as one opportunity to remove the false stereotype of older people as generally inactive.

Necessary reform of pension systems should not be delayed…

Ministers noted that some countries have already introduced reforms to public pension systems in anticipation of the pressures they will face as a result of population ageing. These pressures are leading to greater reliance on other forms of retirement income provision to complement public pensions, both

through individual acquisition of assets and through the development of other forms of pension provision, including occupational and personal pensions, and other retirement savings vehicles. Multi-tiered pension systems, with a continuing important role for public pensions, can reduce financial risks, and provide individuals with greater choice over the level of retirement income which they want. Proper planning will also enable assurance of adequate assistance for those with limited incomes and assets through improvements, where necessary, in the basic public pension system.

Ministers agreed that reforms would give future governments greater flexibility to respond to new emerging social issues, otherwise there is a real risk that retirement pensions will crowd-out alternative expenditures which have a higher social priority. Reforms need to also ensure intergenerational equity, so there is a balance of burden-sharing between generations. To secure retirement income systems, necessary reforms should not be delayed so that the unavoidable transitional phase is largely completed before population ageing peaks in the 2010-2035 period for most OECD countries. Ministers urged the OECD to devote a high priority to elaborating criteria and instruments suitable for monitoring systems of retirement income provision in Member countries and evaluating the effects of reforms, where appropriate through country reviews.

… and the interface between long-term care and health care must be improved

Long-term care is a high priority in countries preparing for growing populations of elderly people. One encouraging trend is that opportunities for domiciliary and community care are increasing, supporting the desired independence of older people with improved local support services. Nevertheless, for some older people, long-term institutional care will be required. Ministers agreed on the importance of developing affordable and cost-effective approaches to meeting long-term care needs in ways that facilitate choice and control by individuals over their own lives.

Ministers agreed that the interface between health services and long-term care needs further attention to ensure people are provided with the most appropriate and cost-effective forms of care. Problems are more likely to arise where individuals require both residential care and substantial health care, and responsibilities are split within or across governments. Some worthwhile reforms include merging of services for the elderly under the one administration or establishing closer co-operation between sectors, removing financial incentives for individuals to access inappropriate forms of care and properly controlling access to the two sectors.

Ministers noted that health spending need not rise dramatically if there is confirmation of older people experiencing improved health status. Nonetheless, health-care treatments are changing previously fatal conditions to chronic conditions. Ensuring a higher priority to the development of better treatments for the specific health problems of older people (such as dementia), improved health education and preventative measures could be cost-effective. Comprehensive population health approaches may also produce substantial benefits for the health outcomes of new generations.

Achieving policies for a caring world

Ministers stressed the importance of sharing national experiences and knowledge in social and health policy areas, as proposed by Mr. Hashimoto, the Prime Minister of Japan, in his “Initiative for a Caring World”. The background documentation prepared for this conference shows that considerable social policy and health reforms have been undertaken in recent years. Nevertheless, discussions over the past one and a half days have revealed that the policy reform process is far from complete.

OECD countries face many challenges in reorienting social and health policies to the needs of their societies as they move into the 21st century. Some of these challenges, such as ageing populations, are well known and can be anticipated; others, such as trends in international migration, are more difficult to predict. But economic and social structures are forever changing and not all challenges can be foreseen. A truly “caring world” is one in which social and health policies adapt and respond sensitively to the opportunities and needs of individuals and their families, while remaining sustainable, and empower them to develop their full potential and contribute fully to society.

Social policies involve striking a balance between dignified self-reliance and social solidarity, and a rebalancing of roles and responsibilities is underway in many OECD countries. One of the predominant themes underlying most recent reforms is that individuals are increasingly expected to take as much responsibility for their lives as is possible. The OECD's reviews of social assistance show there has been a clear move in some countries to foster integration into the labour market of those receiving benefits, especially young people and lone parents. In some OECD countries, employers are being asked to take on a greater role in social care (for example, in provision of sickness benefits). Families and communities are increasing their responsibilities, in terms of financial provision in response to reduced government provision, and expanding informal services. With any major change, the support of the community and social partners can assist in achieving the necessary reforms designed to improve efficiency as well as greater equity between generations and groups within society.

Greater OECD effort is required to monitor and evaluate social and health policy

Many recent reforms of social security and health programmes have been introduced in response to social and demographic challenges as well as fiscal consolidation pressures. Unfortunately, relatively little is known about the outcomes of these changes. Ministers recognised that more effort should be devoted to assessing the effects of policy reforms and called on the OECD to devote a high priority to this task.

Ministers agreed that the availability of suitable social and health indicators would provide a valuable tool to assist in any comparison of the results of social programmes across countries. An improved base of information about the population, available on a comparative cross-country basis, would support this effort. Ministers gave a high priority to developing a comparable set of such indicators and supported OECD work in this area, emphasising in particular continued OECD development of health outcome indicators.

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OECD PUBLICATIONS, 2, rue André-Pascal, 75775 PARIS CEDEX 16
PRINTED IN FRANCE
(81 1999 01 1 P) ISBN 92-64-17007-3 – No. 50487 1999