OECD Labour Market and Social Policy Occasional Papers
No. 32

The Growing Role of Private Social Benefits

Willem Adema,

Marcel Einerhand

https://dx.doi.org/10.1787/804013113766

OECD

Unclassified **DEELSA/ELSA/WD(98)3**

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

OLIS : 17-Apr-1998
Dist. : 21-Apr-1998

Or. Eng.

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

DEELSA/ELSA/WD(98)3
Unclassified

LABOUR MARKET AND SOCIAL POLICY - OCCASIONAL PAPERS N° 32

THE GROWING ROLE OF PRIVATE SOCIAL BENEFITS

Willem Adema and Marcel Einerhand

64464

Or. Eng.

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

OCCASIONAL PAPERS

This series is designed to make available to a wider readership selected labour market and social policy studies prepared for use within the OECD. Authorship is usually collective, but principal writers are named. The papers are generally available only in their original language -- English or French -- with a summary in the other.

Comment on the series is welcome, and should be sent to the Directorate for Education, Employment, Labour and Social Affairs, 2, rue André-Pascal, 75775 PARIS CEDEX 16, France. Additional, limited copies are available on request.

Summary

This paper contains a first analysis of trends in private social benefits within a comparative framework. There is growing interest in the role of the private sector in the provision of social support in the light of concerns about the high level of public social spending. However, up to now, methodological and measurement problems have hampered the collection of cross-country data on private social benefits.

The paper develops an appropriate methodological framework for treating this issue. It presents data on private social benefits for six countries for which such data are currently available: Denmark, Germany, the Netherlands, Sweden, the United Kingdom and the United States.

Information on trends in public and private social expenditure is drawn together and the paper discusses in more detail spending patterns in two social policy areas where private provision plays an important role: pensions and health.

Finally, the impact of the tax system is analysed, and for one year (1993), estimates on net (after-tax) total social expenditure are presented. This indicator of social effort is developed to identify that part of domestic production which is diverted towards certain recipients for social purposes.

Résumé

Cette étude fournit une première analyse des tendances de dépense sociale à caractère privé dans un cadre comparatif. Il existe un intérêt grandissant pour le rôle du secteur privé dans la fourniture d'un soutien social compte tenu du niveau élevé des dépenses sociales publiques. Toutefois, jusqu'à présent les problèmes de mesure et de méthodologie ont gêné la collecte des données internationales sur les dépenses sociales privées.

Ce document présente un cadre méthodologique approprié pour traiter ce sujet. Il donne des données sur les prestations sociales privées pour six pays pour lesquels de telles données sont actuellement disponibles : Allemagne, Danemark, Etats-Unis, Pays-Bas, Royaume-Uni, et Suède.

Ce document fournit des informations sur les tendances des dépenses sociales privées et publiques. Il permet en outre d'examiner en détail les typologies de dépenses dans les deux domaines où la prestation privée joue un rôle important : pensions et santé.

Enfin, l'incidence du système fiscal est analysée et, pour l'année 1993 sont présentées les estimations de dépenses sociales nettes (après impôt). Cet indicateur d'effort social a été développé afin d'identifier la part de la production domestique détournée en faveur de certains bénéficiaires dans un but social.

THE GROWING ROLE OF PRIVATE SOCIAL BENEFITS

THE GROWING ROLE OF PRIVATE SOCIAL BENEFITS [1]

INTRODUCTION

1. In many countries the future of the welfare state is under scrutiny. The debate focuses on the scope and role of the public sector in providing social security and highlights issues including: the changing responsibilities of the state; the market and the family; improving benefit delivery; adapting social security to a more flexible labour market; and the new challenges posed to social security provision by the emerging group of socially excluded persons. There is concern about the feasibility of maintaining a welfare state that can continue to provide for those with specific needs (OECD, 1997). In this context, policy-makers in some continental European countries frequently refer to high national levels of public social spending, particularly in comparison with other industrialised "non-continental-European" economies.

2. Because of this concern with “public social spending overload”, there is growing interest in the role of the private sector in providing social benefits (OECD, 1992 and 1996). Some countries are searching for alternative means of securing social support other than through the public delivery system. For example, recent policy initiatives concerning the provision of sickness payments in the Netherlands and the United Kingdom involved a shift from public to private provision. In such cases, governments determine benefit entitlements but leave the provision to the private sector. Furthermore, the private sector can also provide social benefits voluntarily which top-up government regulated provisions (e.g. pensions, sickness and disability benefits). Frequently these benefits are related to collective labour contracts and are subject to favourable tax treatment. This paper contributes to the discussion of public and private social provisions by drawing together information on these different ways of providing social benefits.

3. Any such discussion should ideally start with a cross-country data set that contains information on what the public and private sectors spend on social support. Gross public social expenditure is covered in the first version of the OECD social expenditure database (SOCX), which was published in 1996. OECD (1996*a*) contains detailed time-series data on gross public social expenditure and serves as the basis for our analysis.

4. Measurement and methodological problems have hampered the collection of information on private social benefits. This paper develops an appropriate framework for covering such benefits.

---

1. The authors work in the OECD and the Ministry of Social Affairs and Employment in the Netherlands respectively. The opinions expressed in this paper do not necessarily reflect those of the aforementioned institutions but are the responsibility of the authors. We would like to thank Manfred Huber, Mark Pearson, Jean-Pierre Poullier, John Martin, Peter Scherer, and Edward Whitehouse for helpful comments. Any remaining errors are the responsibility of the authors.

Section 2 gives a detailed account of definitions, methodological choices, demarcation issues and data related problems.

5. Private social expenditure programmes are discussed in Section 3. Section 4 integrates the information on gross public and gross private social expenditure, paying particular attention to trends in gross (before-tax) private social expenditure. Historical series are presented for the years 1980-1993 for six countries for which data are currently available: Denmark, Germany, the Netherlands, Sweden, the United Kingdom and the United States.

6. Adema *et al.*, 1996 extended information on gross public social expenditure by developing estimates on *net* public spending (after taxes are paid) for 1993. The impact of the tax system on private social support is discussed in Section 5. Estimates on net (after-tax) private social benefits are presented for 1993. This indicator is developed to identify what part of an economy's domestic production recipients of private social benefits draw on.

7. Section 6 integrates the information on net public and net private social benefits, by presenting indicators on net total social expenditure for 1993. Finally, Section 7 sums up the main findings of the paper.

METHODS, DEFINITIONS AND DATA

The scope of private social benefits

8. Social expenditures are defined by the OECD as:

> The provision by public and private institutions of benefits to, and financial contributions targeted at, households and individuals in order to provide support during circumstances which adversely affect their welfare, provided that the provision of the benefits and financial contributions constitutes neither a direct payment for a particular good or service nor an individual contract or transfer. Such benefits can be cash transfers, or can be the direct (in-kind) provision of goods and services. Since only benefits provided by institutions are included, transfers between households -- albeit of a social nature -- are not.

SOCX categorises benefits to provide support during circumstances which adversely affect individual welfare ("social risks") such as old-age cash benefits, sickness benefits, unemployment compensation, active labour market programmes[2], etc. (see Annex 1).

---

2. Public spending on active labour market programmes are (ALMP) is considered to be within the scope of public social expenditure as these represent the use of public funds to improve the beneficiaries' prospect of finding gainful employment. As these public expenditures also provide social and economic benefits to employers, the social and economic benefits resulting from public spending on ALMP are a joint product which cannot be separated.

9. Three broad types of financial flows are relevant to the provision of social support:

1. Benefits received by individuals or households;

2. Contributions to finance benefits to households by employers (including governments as employers), employees, and individuals;

3. Tax financing by governments of benefits received by households.

Hereafter, these financial flows will be identified separately as social benefits, social contributions and flows concerning tax financing of benefits. Public or private "social support" refers to the domain of financial flows covering financing and provision of benefits. The aggregate of publicly and privately provided social benefits received by households is also referred to as total public and private social expenditure.

10. Social benefits to households and individuals can be publicly or privately provided. In line with SOCX, social benefits are regarded as public when relevant financial flows are controlled by general government (that is central, state, and local governments, including social security funds).[3] Thus, social security contributions paid by employers to social security funds (receipts) are within the public sphere. Social benefits provided by governments to their own employees are also considered to be public. All social benefits not provided by general government are within the private domain.

11. Private social benefits can be provided by individuals, employers or non-profit organisations. They can be categorised in 2 broad groups of benefits (a summary of the relevant demarcation decisions is given in Chart 1):

Mandatory benefits

- Mandatory employer-provided social benefits to a group of employees;

- Mandatory individual private social benefits.

Voluntary benefits

- Voluntary employer-provided social benefits to a group of employees;

- Voluntary fiscally advantaged individual private social benefits;

- Social benefits provided by non-profit organisations.

Most of these benefits are provided under influence of government actions: the legislation of benefit provision or the fiscal stimulation of insurance take-up. Governments sometimes also influence the collective bargaining process. To a large extent, intervention by government determines the scope of private social support (see below). However, in some cases other benefits which are not mandatory or fiscally advantaged are also included in the domain of private social support as they are similar to those

3. Social security funds are social insurance schemes covering the community as a whole or large sections of the community that are imposed and controlled by government units (SNA, 1993, sections 8.63 and 8.64).

which are. Relevant arrangements often concern private insurance by the self-employed, or union-managed plans.

Mandatory private social benefits

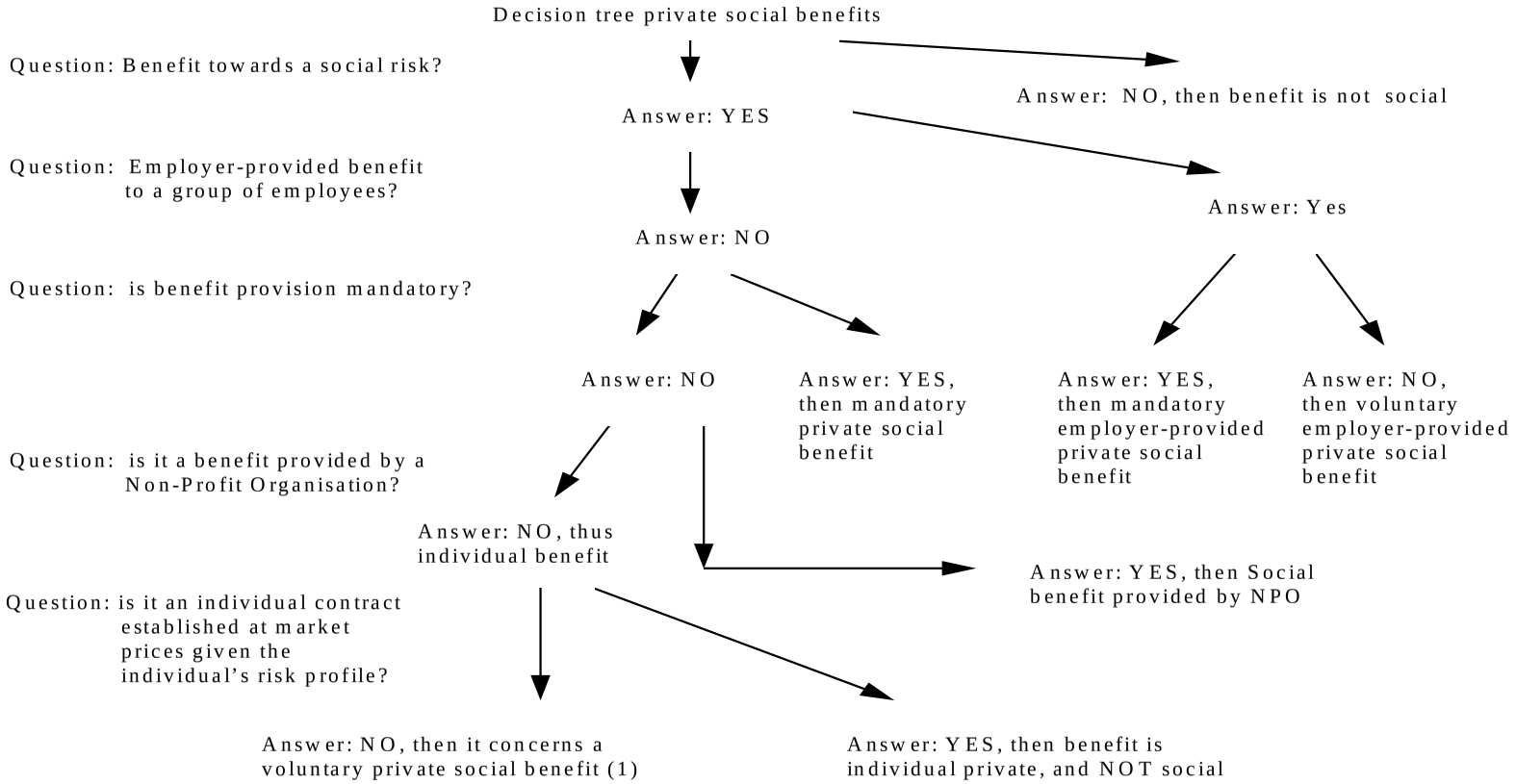
12. Employers, the self-employed and other individuals can be forced by governments to make social provisions by legal stipulations. Relevant benefits differ from public benefits in that financial flows are not channelled through the public system as defined above. Nonetheless, governments exercise control over the terms -- level, coverage and duration -- under which such private benefits are provided. For example, in Germany employers are legally required to continue wage payments at a specified rate during the initial weeks of sickness. Private social benefits are only considered as mandatory if benefit-provision by employers or individuals is statutorily enforceable. These mandatory benefits can be directly provided by employers to households, including their former and current employees (B1). The number between brackets refer to the appropriate line in Chart 2. This Chart only presents cash flows in the context of private provision of social benefits. Relevant tax items are discussed at a later stage.

13. The government can also force individuals and/or employers to make regular contributions of a specified amount (often related to the earnings of an employee) to a private fund. For example, individuals in the United Kingdom who opt out of the State Earnings Related Pension Scheme (SERPS) are forced to make guaranteed minimal pension payments towards their own personal pension plan or an occupational pension plan (line C1 in Chart 2.). Similarly, employers can be forced to make contributions to a private fund on behalf of their employees (C2). The accrued contributions will at a certain point in time lead to benefit payments to households which are derived from mandatory contributions (B2).

Voluntary private social benefits

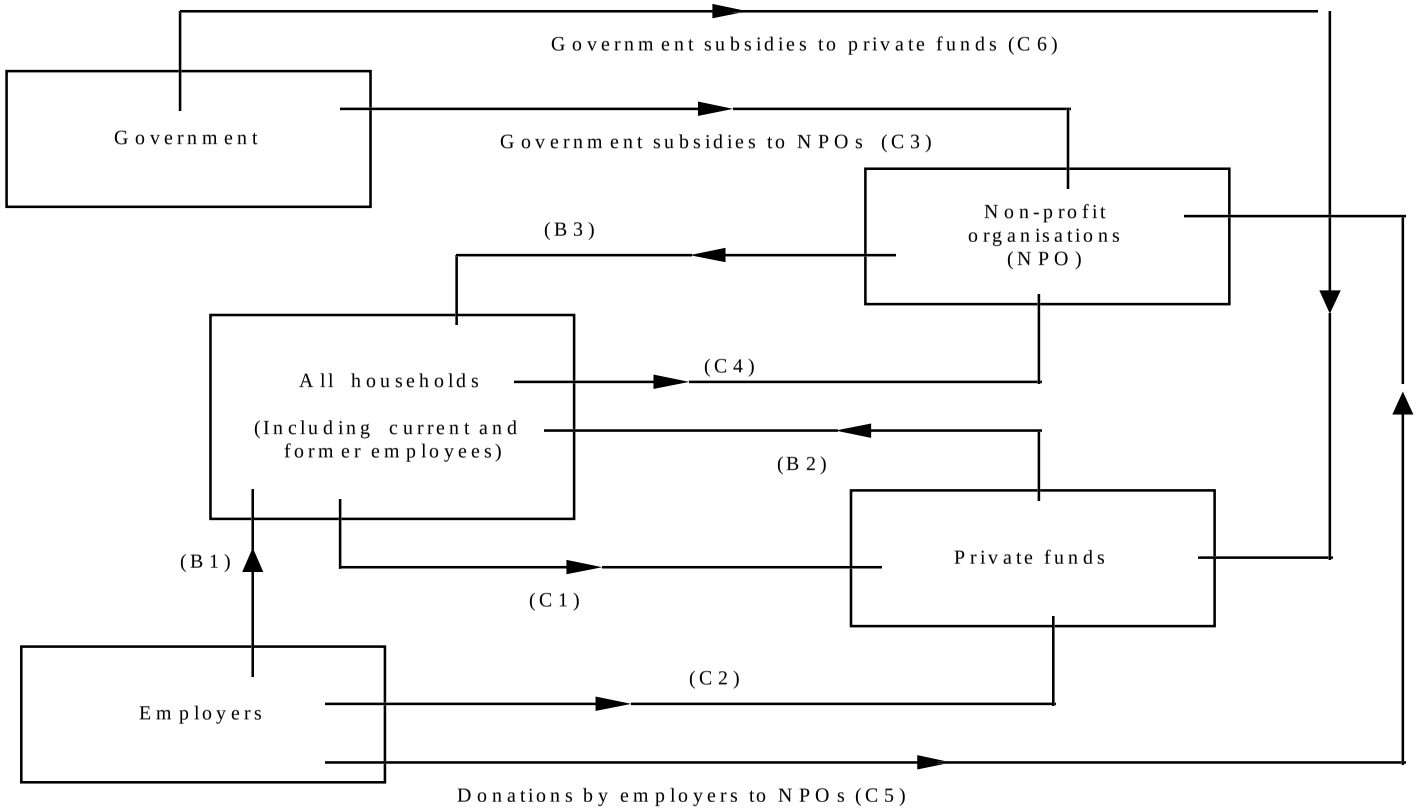
14. All social support which is not public or mandatory private is defined as *voluntary private* social support. Employers may provide social support because of stipulations in collective agreements, established at national, industry or enterprise level. Such *voluntary employer-provided private social* benefits often top up public and mandatory private benefits. Participation by employers and employees in these collective agreements is mostly voluntary, although there are borderline cases (see below). In the absence of collective agreements, employers may also provide such benefits voluntarily to their work-force or part thereof. This happens quite frequently in the United States where employers often take out group-health insurance on behalf of their employees. Such voluntary benefits often receive tax advantages. Tax advantages can also be given towards the take-up of individual private pension plans. Benefits deriving from these tax-advantaged provisions are considered to be private social benefits (see below). Thus, *voluntary private social* benefits are either provided directly to households by employers (B1) or contributions are made by self-employed persons and other individuals to private funds (C1) and employers (C2) leading to benefits being paid by private funds to households (B2).

Chart 1. The scope of private social benefits



(1) Individual insurance contracts towards a social risk taken out with mutual benefit societies, by members of a specific occupation, and by groups of employees managed by a union are within the scope of private social support: through risk-sharing, this type of "group insurance" is likely to ensure that the individual contributions are not fully determined by the individual risk-profile at going market prices.

Chart 2. Private social support: benefits and contributions



Benefits: B1: Mandatory and voluntary private social benefits by employers to households, including former and current employees; B2: mandatory and voluntary private social benefits to all household by private funds; B3: social benefits by NPOs to all households.
Contributions: C1: Mandatory and voluntary social contributions to private funds by households; C2: Mandatory and voluntary social contributions to private funds by employers; C3: Government subsidies to NPOs; C4 Donations by households to NPOs; C5: Donations by employers to NPOs; C6: Government subsidies to private funds.

15. Private social benefits can also be provided by Non-Profit Organisations (NPOs). Organisations such as the Red Cross or the Salvation Army provide benefits to people who for one reason or another do not receive sufficient support through the national social protection system, such as the homeless, drug-addicts, and other people with a multitude of social problems (OECD, 1998, *forthcoming*). The benefits provided by such institutions are captured by flow (B3), while the institutions receive donations and subsidies from households, employers and government (C3, C4 and C5). Sometimes governments subsidise private funds: a cash flow captured by (C6).

16. The data presented in this paper concern estimates on benefits and tax advantages towards the provision of private benefits (see below): flows (B1 to B3); not on contributions (C1 to C6).

Demarcation issues

17. The methodological issues which arise when defining the domain of social support come even more to the fore in the context of private social support than when only the public domain is concerned (OECD, 1996*a*). The scope of private social support is determined by the purpose of benefits (support towards circumstances which adversely affect the welfare of the individuals concerned); their collective character; and government intervention through legal and fiscal regulations. The factors determining the scope of private social support establish the distinction between:

- remuneration and private social benefits (relevant in the context of employment-related benefits);

- private social benefits and private non-social benefits.

These demarcation issues are particularly important for cross-country analysis, where, apart from measurement issues, comparability is affected by significant variation in institutional arrangements across countries. Therefore, demarcation must be done with care, otherwise the analysis might lead to inappropriate conclusions.

Remuneration and private social benefits

18. The first demarcation issue concerns the distinction between social benefits and wage-payments. Social benefits do not include remuneration (wages and salaries) for work, as it does not cover market transactions, i.e., payments in return for the simultaneous provision of services of equivalent value. Employer costs such as allowances for transport costs, holiday pay, etc. are part of remuneration in this sense.[4] Employers may also directly provide in-work benefits to an individual employee on an individual and voluntary basis. This may be done to attract or keep high quality labour and reduce firm adjustment costs (Nickell, 1986). Those payments which do not concern a group of employees are not regarded as social.. For example, an employer may contribute to the pension provision for a particular employee independently of what other employees may receive. Such payments are not regarded as social contributions as they are made on an individual and voluntary basis.

4. The domain of social support does also not include contributions by employers to tax-advantaged saving plans with a limited contract period. Because of the favourable tax regime in comparison to wage payment, such saving plans in the Netherlands gained significant popularity.

19. In contrast, collectively provided *employer-provided* benefits such as sickness payments are included in social support, as are old-age pensions to former employees (Chart 1). Thus, the collectively provided benefits towards a social risk by employers on a voluntary basis are here always regarded as within the scope of private social support, even though some of these benefits (e.g. sickness benefits) are not tax-advantaged.

Private social benefits and private non-social benefits

20. Take-up of individual insurance, even if it is against a "social" risk is a matter for the persons covered, and premiums are based on the individual preferences and the individual "risk profile". Therefore, in contrast to collective arrangements, individual arrangements are generally not regarded as social support. For example, individuals may make their own pension arrangements or take up health insurance packages or life-insurance policies. Such individual contracts, where contributions and the ensuing benefits are determined by market prices and the individual risk profile, are here considered as "individual private" and are outside the social domain.[5] In theory this benchmark provides a clear distinction between what is social and what is not. In practice, however, this distinction is not that easily made.

21. Governments can -- and often do -- stimulate take-up of individual policies through the tax-system. In these cases, the take-up decision is not fully determined by the individual risk-profile (the same holds for social benefits derived from collective agreements or taken out by employers on a collective basis). Hence, premiums are not fully determined by market prices. As such there is a high degree of similarity between these arrangements and mandatory individual arrangements. In a methodological context we have therefore taken the view that if, and only if, the individual-risk profile fully determines insurance take-up the relevant benefits are not within the social domain.

22. To illustrate the point, consider the case where the government fiscally stimulates individual pension provision at a digressive rate:

- for an individual to pay his/her first 1000 units in to his/her individual pension plan, the government provides a fiscal deduction of 200 units;
- for the second 1000 units paid in by the individual the government provides a fiscal deduction of 100 units;
- there is no fiscal stimulus regarding any contribution over and above the 2000 units threshold.

23. The governments fiscal "subsidy" (or revenue foregone) is considered social if it was intended to serve a social purpose.[6] These tax breaks for social purposes are here regarded as being within the scope

---

5. Life-insurance policies have a clear social purpose when such policies are paid out to survivors. However, in practice such policies are often marketed as a savings instrument (such policies can also be linked to individual mortgage-policies). Generally, pay-outs of life-insurance policies take place at the moment of policy-expiration rather than in case of death. Separate data on the "survivors component" are not available and therefore all benefit payments and relevant tax-expenditures have been omitted from the analysis.

6. Fiscal measures to stimulate savings in general or savings by specific groups such as young persons are not considered as tax breaks for social purposes.

of public social support (see below). The relevant private benefit payments are considered social if they were not fully determined by the individual risk profile at going market prices. Thus, the pension payments accruing to contributions up to the "threshold-level" will be regarded as social.[7] Pension payments accruing to contributions paid in over and above the threshold level are not deemed social. In practice, however, such a neat categorisation is often impossible to apply: the data do simply not allow for it. Inevitably, sometimes arbitrary choices were made, and where appropriate these will be mentioned in the text.

24. Sometimes self-employed individuals belonging to the same occupation insure themselves within an occupational framework against social risks. Similarly, groups of employees can take out insurance, possibly under union-management. Governments often mandate or fiscally stimulate relevant provisions, but it is possible that such arrangements which are based on individual contracts are completely voluntary without government intervention as described above. Nonetheless, through risk-sharing, this type of "group insurance" is likely to ensure that the individual contributions are not fully determined by the individual risk-profile at going market prices. This also applies to individual insurance through a mutual benefit society. Therefore, payments towards social risks by relevant institutions are regarded as within the scope of voluntary private social support.

Data sources

25. As there presently is no complete data-set on private social benefits across the OECD area, therefore use had to be made a variety of sources:

- Data on benefit payments were taken from the following national sources: for Sweden (Konjunkturinstitutet, 1995); the USA (Kerns, 1994, 1994*a*, 1995 and 1997 and 1997*a*, and SSA, 1995 and 1996); and data published by EUROSTAT, (1992, 1993, 1995, and 1996*a*) for all other countries.

- Data on private health care benefits are taken from OECD *Health Data* (OECD, (1996*b*).

- Comparable data on benefits provided by non-profit institutions is presently not available for all six countries. Where possible the importance of such benefits will be indicated.

- Data on public social benefits (see section 5 and Annex 1) have been taken from the OECD Social Expenditure database (SOCX).

- Information on the impact of tax-systems on public and mandatory private social benefits has been taken from Adema, *et al.* (1996).

- Data on Gross Domestic Product (GDP) has been taken from the Analytical Data Base as maintained by the OECD.[8]

---

7. This is different from the methodology developed by EUROSTAT with regard to social protection in Europe (EUROSTAT, 1996). According to that methodology, the fiscally simulated individual pension arrangements, such as prevalent in Canada and the United States, would not be considered to be within the scope of social protection.

8. The GDP data used in this paper account for differences in reporting years. For example, the recording period for public social benefit payments in the Unites States matches the financial year (October to

- Policy considerations regarding education are outside the scope of this analysis. OECD (1995) contains detailed information on spending on education through both the public and the private provision channels.

- Data on individual private benefits are presently not comprehensive enough to analyse relevant trends in a cross-country framework.

26. Given the variety of sources it is inevitable that the data-set is not fully consistent. Overall, the quality coverage of data on private social benefits is considered lower than data on publicly provided social benefits. This is particularly so when central recording of private benefits is not stipulated. For example, employers often do not have to report their actual spending on continued wage payments to their employees in case of sickness. Sometimes, the aggregate value of such benefits received by households can be estimated by using information in Labour Costs Surveys.

PRIVATE SOCIAL PROVISIONS: PROGRAMMES AND BENEFITS

27. This section discusses the various private social expenditure programmes in the six countries studied. Each sub-section concentrates on the situation in one year: 1993. There is some overlap with the discussion of mandatory private benefits in Adema, *et al.*, 1996. However, a comprehensive discussion of private social benefits warrants an extensive discussion of these mandatory payments to households.

Mandatory private social benefits

28. *Mandatory private* benefits are defined as those benefits which economic agents (often employers) are legally obliged to provide or are benefits derived from private insurance arrangements which economic agents are enforced to take up. Governments exercise control over the terms -- level, coverage and duration -- under which such private benefits are provided, but regulations can vary from programme to programme.

29. *Mandatory private* benefits mainly concern continued wage payments in case of absence from work because of sickness or benefits relating to occupational accidents when private insurance is required. In Denmark, Sweden and Germany[9] and the United Kingdom, the government has mandated employers to pay sickness benefit for a specific period of time.[10] In 1993, the UK government reimbursed employers up to 80 per cent of the sick pay they paid out (Statutory Sick Pay). This part can be regarded as public

---

September), whereas the recording period for private social benefit payments concerns the calendar year. Data on GDP match the relevant recording period. These differences have also been taken into account when calculating total (public and private) social expenditure as a percentage of GDP.

9. Throughout, Germany refers to the Federal Republic of Germany after the unification of Germany and western Germany refers to the Federal Republic of Germany before the unification of Germany.

10. The benefit data for Denmark may include payments which are voluntary, however, the magnitude of such benefits is deemed relatively small.

social support, whereas the remainder is categorised as mandatory private benefits and amount to 0.03 percentage points of GDP. In the United States, 6 jurisdictions had mandated Temporary Disability Insurance Programmes (TDI), with benefits payable when a claimant is unable to perform regular work because of a mental or physical condition (Kerns, 1994*b*). Some of the TDI benefits go through public funds, recorded as public social benefits. The relevant mandated benefit payments through private insurance funds amounted to 0.01 per cent of GDP in 1993.

30. The Danish occupational injury programme, operated through private insurers, tops up public sickness and invalidity benefits. Estimates on the value of these benefit payments indicate that such amounts to around 0.16 per cent of GDP. This aggregate includes benefits provided by the government to its own employees, which are estimated to make up 10 per cent of all benefits.[11] Workers' compensation in the United States is covers government and private employees when they are injured in connection with their jobs. Spending relates to cash and medical benefits. Although relevant laws are in force across the United States, individual States and other jurisdictions have discretionary powers regarding coverage and insurance method. In only eight jurisdictions are employers not allowed to be insured by commercial insurance companies. In four jurisdictions employers are required to take up insurance with a state-insurance fund or to self-insure (if they can prove their financial ability to carry their own risk). In four other jurisdictions only take-up through a state-fund is permitted.[12] Payments through state funds are regarded as public and amounted to 0.17 per cent of GDP in 1993 (recorded in SOCX). Other benefits ensuing from the workers' compensation laws are regarded as *mandatory private*: 0.46 per cent of GDP in 1993 (see also the section on private social health benefits below).

31. *Mandatory private* social benefits are most significant in Germany indicating the reliance of government on the private sector to provide sickness benefits (Table 1), while such benefits in the USA are predominantly voluntary or concern public employees (Kerns, 1994*b*, p. 89). Only a small part of payments made in the context of the TDI-programme is *mandatory private*. Mandatory sickness payments in Europe are more prevalent. The magnitude of aggregate benefit payments is also related to the length of time for which such payments are due: relevant totals in Germany are significantly higher than for Denmark and Sweden. The period of time during which the employer is mandated to provide sickness benefits in Germany is 6 weeks, as compared with up to 2 weeks in both Nordic countries.

32. Among the six countries considered here, the United Kingdom is the only country with *mandatory pension benefits* (see below). These benefits are expected to increase because of the growing coverage of private pension arrangements. (Table 1 does not account for the impact of recent legislative reforms concerning the provision of sickness benefits in the Netherlands and the United Kingdom. These reforms took place after 1993 and will increase the magnitude of spending on mandatory private benefits in both countries.)

33. In practice, an unambiguous categorisation of *mandatory private* social benefits is hard to achieve. This is particularly so when benefits do not concern direct payments from employer to employee such as sickness benefits but are derived from mandatory social contributions. In this case, benefit payment in year t, B(t), is related to contributions in previous years, C(t - n), and the rate of return on investment income, I(t-n):

$$B(t) = F [\Sigma (C(t-n), I(t-n))]$$

---

11. This information was provided by the Danish government department supervising the implementation of the Occupational Injury Act (Arbejdsskadestyrelsen).

12. In 18 jurisdictions state funds compete with commercial insurers (SSA, 1995).

The total amount of contributions (C) paid to a particular arrangement over the years can be sum of different types of contributions: mandatory contributions (Cm); collectively induced contributions (Cc); fiscally advantaged individual contributions (Cf); and individual private contributions which are not fiscally advantaged (Ci). Consequently, in any particular year:

$$C = Cm + Cc + Cf + Ci.$$

Thus, benefit payments in year x can be related to four types of contributions made over previous years and the relative importance of the different types of contributions can shift from year to year.

34. Often, data on benefit payments only records aggregate payments (Bx) and does not facilitate separate identification of payments due to different types of contributions (Cm, Cc, Cf, Ci). For example, data on pensions paid by all private pension plans in the United Kingdom in 1993 do not separately identify payments derived from mandatory contributions. Occupational pension programmes in the UK are allowed to opt out of the State Earnings-Related Pension Scheme (SERPS), conditional on the provision of a guaranteed minimum pension to the employee which is based on the individual's life time earnings (Dilnot *et al.*, 1994). The aggregate pension benefits by Occupational pension plans in the UK amounted to about 2.1 percentage points of GDP in 1993. This includes *mandatory* payments (based on Cm) and pension payments which are not "contracted out", i.e., *voluntary* employer-provided benefits (based on Cc and possibly Cf and Ci). Data on payments derived from the different types of contributions is not directly available. Estimates on pension payments based on mandatory contributions indicate that such disbursements amounted to around 0.21 per cent of GDP in 1993 (Box 1 and Table 1).

35. The institutional practice of "administrative extension" of agreements between employers and employees establishes a particular case in the context of mandatory private social benefits. In the Netherlands, for example, initially voluntary collective agreements which also cover pension stipulations are often enforced on a whole industry by government stipulations, i.e. "administrative extension". In this case, the data do not separate the payments made by employers who were part to the initial voluntary agreement and those employers on whom the terms of the agreement were enforced. The relevant benefits are categorised as "*voluntary private* social benefits" for three reasons: first, the Dutch authorities do not have any influence on the terms agreed in the initial collective agreement: second, the authorities can only use the tool of administrative extension on request of the parties concerned; third, most of the companies and employers involved were party to the voluntary initial agreement. This is clearly a borderline case with many voluntary elements and relevant benefits are therefore difficult to compare directly with the mandatory benefits as discussed above. However, in as much as the government uses the tool of administrative extension there is a mandatory component. Therefore, the relevant benefit payments are presented as a memorandum item in table 2. These benefits are included in relevant benefit totals on "*voluntary private* social benefits" (see below).

Table 1. Mandatory private social benefits by social policy area, as a percentage of GDP at market prices, 1993

	Denmark	Germany	Netherlands	Sweden	United Kingdom	United States
Old age cash benefits (a)					0.21	
Disability cash benefits						
Occupational injury and disease (b)	0.16					0.25
Sickness benefits (c)	0.43	1.31		0.62	0.03	0.01
Services for the elderly and disabled						
Survivors (d)						0.02
Family cash benefits (e)		0.08				
Family services						
Active labour market programmes						
Unemployment						
Health (f)						0.19
Housing						
Other contingencies						
Total	0.61	1.39		0.62	0.23	0.47
Memorandum item: Pensions (g)			0.60			

(a) Sources: *United Kingdom*: Own calculations, see Box 1, based on EUROSTAT (1996), Digest of Statistics on Social Protection in Europe, *Old Age and Survivors, An Update*, Brussels-Luxembourg, and DSS (1994), *Social Security Statistics 1994*, London.

(b) Sources *Denmark*: information from the Government department supervising the implementation of the Occupational Injury legislation (Arbejdsskadestyrelsen); *United States*: own computations based on SSA (1995), *Annual Statistical Supplement to the Social Security Bulletin*, Washington DC. The data on workers compensation concern cash benefits on disability and survivors and medical benefits through private funds. The data on workers compensation benefits are published disaggregated by way of funding (public or private) or by social policy area (disability, survivors and health). The relevant cross tabulations (e.g., survivors benefits by private funds) were made by the authors, and are not the responsibility of the SSA.

(c) Sources: *Denmark and Sweden*: NOSOSCO (1995), *Social Security in the Nordic Countries, Scope, Expenditure and Financing 1993*, Nordic Social-Statistical Committee, Copenhagen; *Germany*: Data kindly provided by the Federal Ministry of Labour and Social Affairs; *United Kingdom*: own calculations based on EUROSTAT (1994), Digest on Social Protection in Europe, *Sickness*, Brussels-Luxembourg; United States; Kerns (1994*b*), "Protection Against Income Loss During the First 6 Months of Illness or Injury", *Social Security Bulletin*, Vol. 57, No. 3., pp. 88-92, Washington, DC; Kerns (1995), "Role of the Private Sector in Financing Social Welfare Programs, 1972-92", *Social Security Bulletin*, Vol. 58, No. 1., pp. 66-73, Washington, DC; Kerns (1997*a*), "Cash benefits for Short-term Sickness, 1970-1994", *Social Security Bulletin*, vol. 60, No. 1, pp. 49-53, Washington DC. The benefits under Sickness benefits include mandatory temporary disability payments through private funds.

(d) Source *United States*: see note (b).

(e) Source *Germany*: Data kindly provided by the Federal Ministry of Labour and Social Affairs.

(f) Source *United States*: see note (b).

(g) Source *The Netherlands*: See, EUROSTAT (1996), Digest of Statistics on Social Protection in Europe, *Old Age and Survivors: An Update*, Brussels-Luxembourg. Spending on benefits concerning the social policy areas of old-age cash benefits and survivors benefits through private industry-wide pension funds amounted to 0.56 percent of GDP in 1993. Relevant benefit payments concerning specific groups of self-employed professionals amounted to 0.04 percent of GDP in 1993.

Box 1 The UK pension system

B1. Coverage of the basic public pension provision in the UK is almost universal. Entitlement is linked to having a sufficient "National Insurance" contributions record whereas benefits are paid at a flat-rate. Persons earning more than the lower earnings level for national insurance contributions are also by default members of SERPS (the State Earnings-Related Pension Scheme) as well as the basic pension provision. Complications arise because both employees and employers can opt out of these pension plans.

B2. When SERPS was set up, existing occupational pension programmes were allowed to contract out of SERPS under the condition that they guarantee a minimum pension (GMP), thereby foregoing benefits from SERPS equal to GMP (since 1986 employers are also allowed to operate a contracted-out defined contribution plan). Furthermore, the national insurance contributions of both employers and employees are reduced: the "contracted-out rebate". The legally-required employer contributions to a contracted-out occupational fund would be the actuarially necessary contribution to fund the GMP. However, since this contribution is never calculated separately, it equals the minimum contribution which an employer claiming the "contracted-out rebate" must make to his occupational fund. Similarly, the pension payments by occupational pension programmes contain a legally-required element.

B3. Since 1988, individuals have also been able to opt out of SERPS and the occupational pension programmes (which until 1986 were predominantly made compulsory by employers for all their employees), so as to set up their own personal pension plan (PPP). As before, the individual foregoes the benefit paid by SERPS equal to the GMP. However, there is no condition that the PPP has to pay a GMP: the individual has to pay a guaranteed minimum *contribution* into his PPP. This minimum contribution (GMC) equals the "contracted-out rebate". The pensions paid out of a PPP contain a part which is due to legally-required contributions, and its level is assumed to be equivalent to the guaranteed minimum pension (GMP). This is thought of as a mandatory private pension benefit. Thus, for benefits paid out of PPPs a distinction has to be made between the GMC and the individual contributions over and above the GMC. This case is not yet relevant as pensions paid to beneficiaries due to PPPs will not materialise until 2002.

B4. Information on what part of total contracted-out occupational pensions represents the GMP is not readily available and has to be estimated. The relevant estimates are based on information regarding the relation between SERPS and the GMP. Most employees are contracted out of SERPS as long as they receive an occupational pension which at least equals the GMP. However, the prevailing SERPS and GMP rules have led to a situation wherein the GMP is not the same as equivalent SERPS pensions due to different accrual rates and different indexation mechanisms regarding benefits and the lower earnings limit. Therefore, GMP will nearly always be less than SERPS (for those who have contracted out the Notional SERPS entitlement is calculated) and as the government makes up the difference ("Net SERPS"), even those who are contracted out of SERPS will still receive SERPS.

B5. Individuals who have opted out of SERPS and taken up a PPP will not receive a GMP but receive an annuity bought with the proceeds of the GMC and associated property income (= additional contributions). This amount should be equivalent to the GMP.

B6. In both cases the government will pay to those who have contracted out of SERPS the difference between the notional SERPS entitlement and the GMP paid by contracted out occupational pension plans: Net SERPS. Net SERPS is thus calculated assuming that the individual was contracted in. So: GMP = Notional SERPS - Net SERPS.

B7. Notional SERPS, Net SERPS and the GMP are calculated by multiplying the number of recipients by the average pension amount (annuities received by holders of PPPs are zero until 2002). For example for 1993: pensions paid by contracted out occupational pension plans was 13.5 billion pounds; Notional SERPS was 2.93 billion pounds; Net SERPS 1.69 billion pounds (this is a public social benefit) and the GMP amounted to 1.32 billion pounds (categorised as a mandatory private social benefit). Source: DSS (1994).

Voluntary private social benefits

36. *Voluntary private* social benefits concerns those private benefits that are delivered outside the public delivery system and whose provision is not legally stipulated. Thus, all non-mandatory private social benefits are defined as voluntary private social benefits. That is not taken to mean that government does not affect the provision of voluntary private benefits. However, the extent to which public influence prevails varies from programme to programme. The government can affect the provision of voluntary private benefits through the tax system. Tax advantages often apply to private pension plans, but can also concern health insurance (Gruber and Poterba, 1995). These tax breaks for social purposes concern both employer-provided plans and individual insurance policies. Public support for charitable organisations can take the form of tax concessions and public funding of their activities.

37. Pensions (old-age cash benefits and survivors pensions) and health insurance involve the largest aggregate benefit payments. Other examples of private social benefits concern severance pay, supplementary unemployment compensation, sickness benefit, child care, or maternity pay (parental leave).

38. Voluntary employer-provided private benefits in Europe are often based on collective agreements between employers and unions. Such labour contracts that stipulate social benefits can apply nationally, by sector or industry, or at enterprise level. *Voluntary private* social benefits also covers benefits provided by individual employers to all their employees, or specific sub-groups of employees (e.g., white collar workers), even though such arrangements are not part of a collective agreement.

Voluntary private social pension benefits

39. In countries where state pensions guarantee a flat rate minimum pension (e.g., Denmark, the Netherlands, Sweden and the United Kingdom), companies may provide additional (earnings-related) pension provisions. Such pension plans are often tax-advantaged, and are of considerable importance in the Netherlands and the United Kingdom. These countries have relatively high private pension payments, except for Denmark where supplemental earnings-related benefits are partly incorporated in separate public benefits (ATP). The public pension system in Germany is also earnings-related and generates -- for those with a sufficient number of contribution years -- a relatively high net pension compared to earnings. This reduces the need for additional provisions. The United States Social Security is also earnings related, but the ratio of public benefits to previous earnings is less generous than in Germany. This leads to comparatively high take-up of private pensions in the US (Employment Benefit Research Institute, 1995, p. 219, and Bundesministerium für Arbeit und Sozialordnung, 1994, p. 255). The *voluntary private* pension plan benefits in the US include all employment-related defined benefit and defined contribution plans and private pension plans with life-insurance companies (Kerns, 1997*b*). These pension benefits concern pre-retirement payments as well as disability or survivor payments as stipulated by the provisions of employment-related pension plans. The relevant disbursements are presented in Table 2.

40. Private pensions are important in the United States where benefit payments amounted to 2.4 per cent of GDP in 1993 and the Netherlands and the United Kingdom (around 2.6 per cent of GDP in that year).[13] The pension payments in the Netherlands and the United Kingdom are employer-provided pensions related to collective agreements and/or occupational pension plans. The private pension benefits

13. In Sweden, spending relative to GDP is high in comparison to the 1980s (1.63 per cent of GDP in 1993 compared to 1.25 percent of GDP in the 1980s). This is explained by the decline in GDP in the beginning of the 1990s.

in the US include payments out of employer-provided defined benefit and defined contribution plans (e.g., "401(k) type plans") and tax-advantaged individual plans: Individual Retirement Accounts and Keogh-plans (see below). Total disbursements through Keogh-plans and individual retirement accounts amounted to $ 800 million in 1991, and constituted only a small part of total private pension plan disbursements: $ 174 452 million in 1994 (Kerns, 1997*b*, p. 59).

Private social health benefits

41. The magnitude of private social health benefits is partly related to the limited coverage of public provisions. In the United States there is no universal public health insurance programme for employees in the private sector. Stimulated by fiscal measures, employers often provide health care coverage for their employees, leaving individual take-up as the only alternative. In contrast, Denmark, Sweden and the United Kingdom operate health care insurance systems that cover the entire population. The Netherlands operates a public system that covers only workers (and social security benefit-recipients) below a certain income level. The self-employed and around one-third of all employees are not insured publicly but may take out private health insurance. In Germany the public system covers about 92 per cent of the population, and about 7 percent has private cover (OECD, 1996*b*). In Germany and the Netherlands, about 1 per cent of the population is not covered by public or private health insurers. In the United States in 1993, 25.6 per cent of the population is covered by public insurance (predominantly Medicaid and Medicare); 69 per cent of the population is covered by private insurance (of which 83 per cent is through employers); and 16 per cent of the population has no health insurance (EBRI, 1995, p. 238).

42. The information in Table 2 includes estimates on private social health care benefits: that part of private benefits which is accounted for by private insurance as financed by employer and employee contributions. In line with the methodological framework developed above, individual private benefits are not social, and therefore not included in the totals. For example, those costs for the individual on medical products that are not reimbursed by an insurer are *individual private*, i.e., not social. At present there is no comprehensive data set on private social health benefits.[14] Therefore, we had to rely on estimates. OECD *Health Data* includes information on total private health care benefits: including the *individual private* component. Schneider *et al.* (1995) presents disaggregated information for several years in the 1980-1992 period on the financing of health care, and identifies those health care components which are publicly financed, financed through employer and employee contributions to private health insurance funds, and financed by the individual. The information on the magnitude of the individually financed component of health care has been used by subtraction to estimate the private social health benefit component in total private health consumption.[15] The estimates on "private social health benefits" are presented in Table 2.

---

14. There is growing interest in the private component of health care. The Dutch Ministry of Health Welfare and Sports has initiated a study on health care data. This study has not been completed yet, and presently available data only concern private expenditure in the context of "intramural health care" (van Mosseveld and van Son, 1996). See also van den Berg et al. (1997).

15. The OECD *Health Data* cover individualised and collective goods and services while Schneider *et al.* (1995) only cover individualised goods and services. Therefore, applying indicators on the financing of health care from the latter source to expenditure data according to OECD *Health Data* may somewhat overestimate the individually financed component in total private health care. Nonetheless, the estimate used here for the Unites States is supported by other findings. Our estimate indicates that the individual private health component amounts to 32.8 per cent of total private health benefits in 1992. Kerns (1994b, p. 88) reports that individual consumers in the United States paid 34.2 per cent of private health care cost in 1991.

43. The relatively high aggregate private health benefits in the United States are also related to high overall health care costs. Per capita health consumption expressed in US dollars are about twice as high in the United States as in the other countries (EBRI, 1995, p. 674, and OECD 1996*c*). These relatively high health care costs are related to a variety of interacting factors: relatively high factor costs (high wages and the use of modern and expensive technology); a relatively commodious package of goods and services provided; and relatively high operating costs of the US health system. The relatively high operating costs are due to institutional aspects: advertisement costs which are non-existent in public systems; the impact of limited cost-sharing and cross-subsidisation between enterprises or industries; the absence of public intermediaries negotiating between health care providers and those financing the system (employers and individuals). Unlike their counterparts in European countries, medical doctors in the USA are not faced by a monopsony buyer of their services. More detailed analysis of the comparative costs of the US health care can be found in McKinsey (1996) and Schieber, Poullier and Greenwald (1994).

Other voluntary employment-related private social benefits

44. Information on benefits in social policy areas other than old-age cash benefits and health is less comprehensive. The survivors and disability cash benefits in Table 2 are provided in the context of company- and industry-wide pension plans or concern plans for specific occupational groups or the self-employed. Voluntary disability cash benefits in the United States are paid to long-term (over six months) disabled workers in the private sector. However, it is not always possible to separate these benefits from old-age cash benefits. Therefore, cross-country comparisons for these broad policy areas are of limited value.

45. These "other" *voluntary private* social benefits in Table 2 concern: sickness benefits; supplementary unemployment benefits; and some family cash benefits. The *voluntary* sickness benefits in the Netherlands and the United Kingdom concern payments which top up *public* and *mandatory private* provisions. Until the recent "privatisation", public sickness benefits in the Netherlands amounted to 70 per cent of the going wage (equivalent to the level of the present mandatory sickness benefits). Labour contracts in most industries however require the employer to pay the remaining 30 per cent. Swedish employers topped-up sickness benefits by 10 percent of the wage until 1992 when the sickness benefit system was changed. However, subsequent changes in the system (e.g., the introduction of one waiting day prior to receipt of sickness benefit) have again stimulated supplemental payments by employers. For both Denmark and Sweden no information is available on the costs of the topping-up of *public* (or *mandatory private*) benefits by employers. In Germany topping-up of mandatory benefits was of relatively minor importance in 1993 (Statistisches Bundesamt, 1995, p. 26) as publicly mandated benefits frequently compensate the loss of income for the full 100 per cent. Public sickness benefit arrangements are uncommon in the United States, although the government as an employer and a few jurisdictions operate public sickness benefits. Also, the private sickness programmes operated by employers are of relatively minor importance (US Department of Commerce, 1995, p. 386). *Voluntary* sickness benefits in the US are usually in the form of group benefits to workers in the private sector employment (voluntary group or self-insurance and sick leave).

Table 2. Voluntary private social benefits by social policy area, in percentages of GDP at market prices, 1993

	Denmark	Germany	Netherlands	Sweden	United Kingdom	United States
Old age cash benefits (a)	0.50	0.68	2.07	1.63	1.90	2.39
Disability cash benefits (b)		0.05	0.04			0.05
Occupational injury and disease						
Sickness benefits (c, 1)			0.35		0.82	0.23
Services for elderly and disabled						
Survivors (d)		0.04	0.53		0.51	
Family cash benefits (e)		0.06				
Family services						
Active labour market programmes						
Unemployment (f)						0.01
Health (g)	0.12	0.66	1.34	0.09	0.33	5.15
Housing						
Other contingencies						
Total	0.62	1.49	4.33	1.72	3.57	7.81
Total (excluding health)	0.50	0.82	2.99	1.63	3.24	2.66

(1) No aggregate information available for *Denmark, Germany and Sweden* on supplemental employer benefits for topping-up mandatory and/or public sickness benefits.

(a) *Sources*: *Denmark, Germany, the Netherlands, and the United Kingdom*: EUROSTAT (1996), Digest of Statistics on Social Protection in Europe*, Old Age and Survivors: An Update*, Brussels-Luxembourg; *Sweden*: Konjunkturinstitutet (1995), *Konjunkturlaget*, December, Stockholm; *United States*: SSA (1995, and 1996), *Annual Statistical Supplement to the Social Security Bulletin*, Washington, DC. Estimates on payments through "Keogh-plans" and "Individual retirement accounts" for the year 1993 are based on Kerns (1997*b*), "Private Social Welfare Expenditures, 1972-1994", *Social Security Bulletin*, vol. 60, no. 1., pp. 54-60, Washington, DC.

(b) *Sources*: Estimates on Disability cash benefits for *Germany* and *the Netherlands* are based on EUROSTAT (1992), Digest of Statistics on Social Protection in Europe, Volume 2: *Invalidity/Disability*, Brussels-Luxembourg; *United States*: SSA (1995).

(c) *Sources*: Estimates on Sickness benefits for *the Netherlands* and the *United Kingdom*, EUROSTAT (1995), Digest of Statistics on Social Protection in Europe, Volume 5: *Sickness*, Brussels-Luxembourg; *United States*: estimates on sickness payments (excluding mandatory and public TDI payments) are based on Kerns (1994b), "Protection Against Income Loss During the First 6 Months of Illness or Injury", *Social Security Bulletin*, vol. 57, no. 3., pp. 88-92, Washington, DC, and Kerns (1997*a*), "Cash benefits for Short-term Sickness, 1970-1994", *Social Security Bulletin*, vol. 60, no. 1, pp. 49-53, Washington DC. For data on private sickness benefits see Kerns (1997*a*) and US Department of Commerce (1995), *Statistical Abstract of the United States, the National Data Book*, 115th edition, Washington, DC.

(d) *Source*: *Germany, the Netherlands, and the United Kingdom*: EUROSTAT (1996), Digest of Statistics on Social Protection in Europe*, Old Age and Survivors: An Update*, Brussels-Luxembourg

(e) *Source*: *Germany*: Data kindly provided by the Federal Ministry of Labour and Social Affairs.

(f) *Source*: *United States*: SSA (1995, and 1996).

(g) For all countries, estimates on private social health benefits are based on OECD (1996*c*), *Health Data 1996*, Paris, and Schneider, *et al.* (1995), *Gesundheitssysteme im Internationalen Vergleich*, Augsburg.

46. Family cash benefits in Germany concern family allowances paid by employers to workers with children. In the United States, employers can pay supplemental unemployment benefits. For example, under certain conditions workers in the auto industry are entitled to supplemental benefits paid for by the employer.

47. The "emerging benefits" or "work and family benefits" are of growing importance in the United States (Commission on Leave, 1996, and US Merit System Protection Board, 1991). These benefits are based on the notion that employers should assist their employees in meeting their personal needs and obligations while becoming or remaining a productive member of the work-force. For example, the incidence of unpaid paternity leave in medium and large establishment more than tripled from 1988 to 1993 (Bureau of Labor Statistics, 1996). However, comprehensive data on the private parental benefits (OECD, 1995*c*, chapter 5), child care, but also severance pay, is presently not available.

Benefits provided by non-profit organisations

48. Apart from the *voluntary* benefits as discussed above, non-profit organisations (NPOs) also give social support in the context of helping the poor, provision of houses and other social services. Governments often stimulate such activities through direct funding and through tax concessions. In Germany for example, the non-profit sector draws more than half of its revenue from the public sector (Salamon *et al.*, 1996). 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 United Kingdom Inland Revenue to be worth over £1 billion (Williams, 1997). Private sector enterprises can also be significant contributors to NPOs: total corporate support in the United Kingdom was valued at £275 million (Pharoah, 1997). There is increasing interest in the role of NPOs as a complement to the public authorities in providing community services. Unfortunately, comprehensive data on these forms of voluntary private social benefits that are consistent with SOCX are not available from national authorities. Available information suggests that voluntary benefits in the field of social services and housing provided by NPOs do not concern huge amounts (Table 3). However, these data abstract from the value of time of volunteers which could be considerable.

Table 3. Selected benefits and revenues of NPOs, as per cent of GDP at market prices, 1990

	Germany	United Kingdom	United States
Social services			
Benefits	0.90	0.55	0.65
Revenue (of which):	0.90	0.60	0.63
- publicly funded	0.83	0.26	0.51
Housing			
Benefits	0.43	0.20	0.12
Revenue (of which):	0.43	0.35	0.11
- publicly funded	0.29	0.22	0.04

Source: Salamon *et al.,* (1996). Social services comprises child, youth and family welfare services; services for the elderly; services for the handicapped; emergency and relief services; and income support and maintenance. Housing covers expenditures on development and maintenance of housing, and benefits by organisations providing housing search and related assistance.

TRENDS IN TOTAL SOCIAL EXPENDITURE

49. Having set out the information on private social benefits, information on both public and private social benefits can be drawn together to analyse trends in total social expenditure (total social benefit payments). Historical series on both public and private social expenditure are presented in Annex 1. Although, the public and private delivery systems are not fully complementary -- in particular the degree of wealth distribution is likely to differ among private and public systems -- the magnitude of both systems is not independent of each other. In countries characterised by comprehensive coverage of the social insurance system there is often less need for private coverage. Also, private social benefits provided as a result of collective agreements -- sometimes the government as a direct partner in the negotiations influences the outcome -- often serve to top-up *public* or *mandatory private* benefits. Individuals may have more incentives to take up private insurance in the absence of public and collective arrangements, but this also depends on the risk profile of the individual concerned.

50. During the 1980s and the beginning of the 1990s **public social expenditure** has been considerably higher in the Nordic countries and countries in the continental part of western Europe than in Anglo-Saxon countries, particularly the United States. Public social expenditure as a percentage of GDP is growing steadily in most countries, with the exception of Germany and the United Kingdom where the public social expenditure to GDP ratio declined during the second part of the 1980s.

Trends in private social expenditure

51. Private social expenditure as related to GDP is indeed relatively small in Denmark and Sweden, although Sweden in particular experienced a significant increase of such benefit payments during the beginning of the 1990s. This increase was related to the introduction of mandatory employer-provided sickness benefits -- as in Denmark -- and the overall decline in GDP. In fact, *private mandatory* benefit payments has risen in all countries except Germany, where mandatory sickness benefits declined from 1981 to 1982 (Annex 1).

52. **Mandatory private benefits** existed in three of the six examined countries in 1980 (United States, Denmark and Germany). For the United States this reflects the private element in Workers Compensation. For Germany mandatory benefits mainly concern continued wage payments during the first weeks of sickness. In Denmark employers were also mandated to pay relatively low sickness benefits (separate information on relevant benefits is not available for 1980). Since 1994 Danish employers have been mandated to pay the full wage to all employees during the first 2 weeks of sickness. The other countries introduced mandatory benefits after 1980. Sweden and the United Kingdom also introduced mandatory sickness payments by employers. When Statutory Sick Pay (SSP) was first introduced in the United Kingdom, employers were fully reimbursed for the costs incurred. In the beginning of the 1990s, reimbursement was reduced to 80 per cent of sick-payments (In 1994, reimbursement was abolished altogether, which is not reflected in the data). The role of mandatory private benefits therefore seems to be increasing in most of the countries examined (Table 4). Nonetheless, mandatory benefits are small compared to public benefits.

Table 4. Gross public and private social expenditure (benefit payments) as a percentage of GDP at market prices, 1980-1993

DENMARK	1980	1985	1990	1993
Public social expenditure	**27.63**	**26.47**	**28.25**	**30.51**
Private social non-health	0.25	0.32	0.47	1.09
of which:				
mandatory	0.00	0.00	0.00	0.59
voluntary	0.25	0.32	0.47	0.50
Private social health (1)	0.04	0.05	0.09	0.12
Private social expenditure	**0.29**	**0.37**	**0.56**	**1.21**
Total social expenditure	**27.92**	**26.84**	**28.81**	**31.72**
Private expenditure share(2)	1.04	1.38	1.94	3.81

SWEDEN	1980	1985	1990	1993
Public social expenditure	**30.42**	**31.64**	**32.62**	**38.25**
Private social non-health	1.20	1.20	1.30	2.25
of which:				
mandatory	0.00	0.00	0.00	0.62
voluntary	1.20	1.20	1.30	1.63
Private social health (1)	0.07	0.07	0.10	0.09
Private social expenditure	**1.27**	**1.27**	**1.40**	**2.34**
Total social expenditure	**31.69**	**32.91**	**34.02**	**40.59**
Private expenditure share(2)	4.01	3.86	4.12	5.76

GERMANY (3)	1980	1985	1990	1993
Public social expenditure	**24.98**	**25.51**	**23.83**	**28.66**
Private social non-health	2.27	2.18	2.29	2.22
of which:				
mandatory	1.66	1.39	1.41	1.39
voluntary	0.61	0.79	0.88	0.83
Private social health (1)	0.56	0.60	0.65	0.66
Private social expenditure	**2.83**	**2.78**	**2.94**	**2.88**
Total social expenditure	**27.81**	**28.29**	**26.77**	**31.54**
Private expenditure share(2)	10.16	9.83	11.00	9.13

UNITED KINGDOM	1980	1985	1990	1993
Public social expenditure	**18.32**	**21.04**	**19.78**	**23.41**
Private social non-health	1.95	2.87	3.15	3.47
of which:				
mandatory	0.00	0.04	0.13	0.23
voluntary	1.95	2.83	3.02	3.24
Private social health (1)	0.14	0.22	0.28	0.33
Private social expenditure	**2.09**	**3.09**	**3.43**	**3.80**
Total social expenditure	**20.41**	**24.13**	**23.21**	**27.21**
Private expenditure share(2)	10.24	12.81	14.78	13.97

NETHERLANDS	1980	1985	1990	1993
Public social expenditure	**28.77**	**28.95**	**29.23**	**30.64**
Private non-health	1.27	1.78	2.46	2.99
of which:				
mandatory	0.00	0.00	0.00	0.00
voluntary	1.27	1.78	2.46	2.99
Private social health (1,4)	N/A	N/A	1.40	1.34
Private social benefits	**1.27**	**1.78**	**3.86**	**4.33**
Total social expenditure	**30.04**	**30.73**	**33.09**	**34.97**
Private expenditure share(2)			11.67	12.38

UNITED STATES	1980	1985	1990	1993
Public social expenditure	**12.51**	**12.63**	**13.50**	**15.04**
Private non-health	1.82	2.83	2.95	2.94
of which:				
mandatory	0.24	0.27	0.32	0.28
voluntary	1.58	2.56	2.63	2.66
Private social health (5)	3.05	3.89	4.84	5.34
Private social expenditure	**4.85**	**6.72**	**7.79**	**8.28**
Total social expenditure	**17.54**	**19.46**	**21.37**	**23.47**
Private expenditure share(2)	28.01	37.01	36.60	35.51

Sources: See notes to Tables 1 and 2.

(1) These are voluntary private social health benefits.

(2) Private expenditure share: the ratio of private social expenditure to total social expenditure.

(3) Break in series because of the reunification of Germany.

(4) Break in series as estimates on private social health benefits cannot be made for the years up to 1988.

(5) Includes medical component of workers' compensation benefits. The value of such benefits increased from 0.08 per cent of GDP in 1980 to 0.2 percent of GDP in 1990. In 1993 benefit payments amounted to almost 0.19 per cent of GDP (see Annex 1).

53. **Voluntary non-health related private social expenditure** has been growing steadily in all countries (Table 4). Across the board, this growth was driven by upward trends in private social pension benefits. The increase in private social pension benefits is generally related to the maturing of occupational pension programmes, whereas one of the causes of the relatively strong growth of private non-health benefits in the Netherlands was the introduction and extension of early retirement programmes during the 1980s. During 1980-1993, private non-health benefits increased particularly in the Netherlands, the United Kingdom and the United States. In 1980, private old-age cash benefits amounted to 18 per cent of all old-age pensions paid out in the United States (Table A1.2, Annex 1). By 1993, this share had increased by 10 percentage points. During the 1980-1993 period, the proportion of private old-age cash benefits in total old-age cash benefits rose from 15 to 27 per cent in the United Kingdom and from 12 to 23 per cent in the Netherlands.

54. Some of the tax-advantaged private pension plans in the Unites States were established in the beginning of the 1980s. These plans reflected US tax-policies to increase retirement savings among particular groups of the population[16]: Keogh-plans (for the self-employed); individual retirement accounts (for individuals/households); and defined contribution plans such as the 401(k)type plans (employers establish these plans for their employees). The growth of the 401(k) type plans in particular, has contributed to the increase in coverage of defined contributions plans at the expense of defined benefit plans (Table 5).

Table 5. Magnitude of private employer-provided pension plans in the United States, billions of US $ (1)

	1980	1985	1990
Total Assets	**564**	**1 253**	**1 674**
Defined benefit plans	401	826	962
Defined contribution plans	162	427	712
of which 401 (k) plans	-	144	385
Total Contributions	**66**	**95**	**99**
Defined benefit plans	43	42	23
Defined contribution plans	24	53	76
of which 401 (k) plans		24	49
Total Benefits	**35**	**102**	**129**
Defined benefit plans	22	54	66
Defined contribution plans	13	47	63
of which 401 (k) plans		16	32

Source EBRI (1995), *The EBRI Databook on Employee Benefits*, Employee Benefit Research Institute, Washington, DC.

(1) The data presented here do not concern individual tax-advantaged pension plans such as the individual retirement accounts or Keogh-plans.

16. Recent evidence suggests little substitution between these pension plans and other forms of personal saving (Poterba, Venti, and Wise, 1995). This supports the notion that fiscal incentives can attract "new saving" for social purposes, in this case the provision for retirement.

55. The future relevance of individual tax advantaged pension plans is not fully reflected in the benefit data: contributions to these pension programmes are currently much greater than payments to recipients. For example, in 1990 pension benefits paid out of individual retirement accounts amounted to $ 143 million (Kerns, 1997), while contributions amounted to $ 87 billion in that year (EBRI, 1995). The increase in contributions made to individual retirement accounts is primarily due to "rollover contributions" from employment-based plans: in 1990 82 per cent of all contributions to individual retirement accounts were of this nature.

56. **Private social health expenditure** in Germany and the United Kingdom only shows a modest increase over the years, while there is no clear discernible upward trend concerning these benefits in the Netherlands. In contrast, the high and increasing private social benefit payments in the United States are mainly driven by the sharp increase in high private social health benefits: an increase of 2.3 percentage points of GDP over a 13 year period. The growth rate of public and private per capita health care expenditure is higher in the United States than in any other OECD country (Schieber, Poullier and Greenwald, 1994). Health care prices in the United States have increased rapidly relative to overall prices. This relatively high level of excess health care inflation is a dominant driving force for the increasing total social health expenditure to GDP-ratio. Over the entire period of observation, the share of private social health benefits in total social health expenditure has been around 49 per cent (Annex 1, Table A1.2).

57. It is difficult to discern a clear relationship between public expenditure *growth* and private expenditure *growth* for the period 1980-1993. An increase in public expenditure does not lead to a decrease in private expenditure, while decreasing or stable public budgets do not automatically lead to increasing private expenditure.

Accounting for private benefits: convergence of gross total social expenditure levels

58. Total (public and private) social expenditure levels relative to GDP indicate that Sweden (41 percentage points) and the Netherlands (35 percentage points) are the biggest "social spenders". However, accounting for private social benefits has a converging effect on total social expenditure levels across countries (Table 6). The standard deviation in 1993 of total social expenditure levels across countries (5.96) is 24 percent lower than the standard deviation of public social expenditure levels (7.84).

59. Across the six countries, there has been little convergence in public expenditure levels over time. The standard deviation of public expenditure levels for all countries increased, but that is mainly due to the Swedish "outlier" in 1993. Because of the adverse demand shock at that time, GDP was relatively low with high public unemployment related social expenditure. The standard deviation for public social expenditure for all countries, excluding Sweden, declined marginally form 1980 to 1993 (see notes Table 6).

60. Table 6 also presents "relative expenditure ratios" which compare social expenditure levels across countries with expenditure levels in the United States as the base value. The "relative *public* expenditure ratio"[17] declined over time for Denmark, Germany and the Netherlands, while it increased for Sweden and the United Kingdom.

17. Relative public social expenditure ratio: [(public social expenditure level Country X) / (public social expenditure level United States) * 100 per cent].

61. Over time, "relative *total* social expenditure ratios" -- total (public + private) social expenditure levels in an individual county compared to total social expenditure in the United States -- declined for all countries but the United Kingdom. The standard deviation of total (public + private) social expenditure levels decreased when the Swedish social expenditure level is not included: almost 18 per cent. Thus, total social expenditure across countries seem to converge over time, with relatively high growth rates of private social health benefits in the United States as the main driving force.

Table 6. Convergence of gross expenditure levels 1980 and 1993, in percentage of GDP at market prices

Year	Item	Denmark	Germany (1)	Netherlands (2)	Sweden	United Kingdom	United States	Standard deviation (3)
1980	Public social expenditure	27.63	24.98	28.77	30.42	18.32	12.51	6.96 (6.87)
	Relative public social expenditure ratio (4)	2.21	2.00	2.30	2.43	1.46	1.00	
	Ranking (5)	3	4	2	1	5	6	
	Total social expenditure	27.92	28.11	30.04	31.69	20.41	17.54	5.65 (5.48)
	Relative public social expenditure ratio (4)	1.59	1.60	1.71	1.81	1.16	1.00	
	Ranking (5)	4	3	2	1	5	6	
1993	Public social expenditure	30.51	28.66	30.64	38.25	23.41	15.04	7.84 (6.62)
	Relative total social expenditure ratio (6)	2.03	1.91	2.04	2.54	1.56	1.00	
	Ranking (5)	3	4	2	1	5	6	
	Total social expenditure	31.72	31.75	34.97	40.59	27.21	23.47	5.96 (4.50)
	Relative total social expenditure ratio (6)	1.35	1.35	1.49	1.73	1.16	1.00	
	Ranking (5)	3	3	2	1	5	6	

(1) Data for 1980 and 1993 are not directly comparable due to the reunification of Germany.

(2) For the Netherlands, there is no estimate available on the magnitude of private social health benefits for 1980. Hence, the 1980 observation on total social expenditure for the Netherlands underestimates expenditure levels in comparison to the values for the other countries. Were the relevant estimate available, expenditure levels in the Netherlands for 1980 are expected to have been very close to that of total gross social expenditure in Sweden.

(3) The first number concerns the standard deviation for expenditure levels for all six countries. The number in-between brackets refers to the standard deviation in expenditure levels for all countries but Sweden. This figure has been calculated to account for the adverse position of the Swedish economy in the cycle in 1993 (relatively low GDP levels, and high public unemployment related social expenditure).

(4) Relative public social expenditure ratio: (public social expenditure level Country X) / (public social expenditure level United States) * 100 per cent.

(5) Ranking: top-down ranking of countries by expenditure levels.

(6) Relative total social expenditure ratio: (total social expenditure level Country X) / (total social expenditure level United States) * 100 per cent.

NET VOLUNTARY PRIVATE SOCIAL BENEFITS

62. The public and private social benefit data analysed above concern gross benefit payments for the selected countries and are not corrected for the impact of the tax system. Moreover, these differences in tax systems can be significant across countries. Tax systems determine the degree to which *gross* expenditure levels differ from *net* (after tax) expenditure levels. Governments sometimes levy direct taxation on benefit income while levying indirect taxation on the consumption by benefit-recipients. Moreover, governments aim to stimulate the take-up of private provisions by giving tax breaks for social purposes.[18] Adema *et al.* (1996) discusses in detail how these issues affect measurement of net public social expenditure and net mandatory private social expenditure.[19] These adjustments will not be discussed here, but a summary is presented in Annex 2.

63. The focus of this section is the net value of *voluntary private* social benefits. Because of direct and indirect taxation of the relevant benefits the *net* value of voluntary private social benefits is different from *gross* voluntary private social benefits. Relevant adjustments only concern cash benefits, and leave the value of in-kind provisions unaltered.

Brief overview of adjustments

64. The impact of the tax system on the value of *voluntary private* benefits concerns two issues:

1. Households, may have to pay direct taxes and social security contributions on the private cash transfers with a social purpose they receive (Chart 3, line T1).

   Deduction of the value of direct taxation from gross voluntary private social benefits leads to net cash voluntary private social expenditure. Cash transfers can be taxed at a zero, reduced or standard rate and the two former cases lead to "revenue foregone" of a specific value and constitute "tax expenditures". This sort of tax relief is equivalent to a variation in direct taxation of benefit income and is thus accounted for under direct taxation (line T1). In order to avoid double counting, such tax expenditures are not considered under tax breaks for social purposes.

2. Households pay indirect tax on goods and services which they consume out of income from voluntary private social benefits (Chart 3, line T2).

   Deducting the value of indirect taxation from what recipients of private benefits receive in cash gives net direct voluntary private social expenditure. This indicator measures the net value of voluntary private social benefits received by households.

---

18. Tax breaks for social purposes are what is defined as "social fiscal measures" in Adema *et al.* (1996).

19. For earlier work in this field, see Einerhand *et al.* (1995).

65. Governments also use the tax system to pursue social policy objectives. Rather than mandating private benefits, governments can aim to stimulate the take-up of private provisions by giving tax advantages to households, including employees (TB1), employers (TB2), private funds (TB3), and Non-profit organisations (TB4) -- see Chart 3. These tax breaks for social purposes (TBSPs) are here regarded as a cost to the public budget and discussed in more detail in section 5.3.

66. There are other items of taxation relevant to the provision of private benefits. For example, employers may also have to pay tax or social security contributions on the benefits they provide to employees (S1). Comprehensive information on the magnitude of this and similar tax items is not available. Therefore, these items have been ignored in the present analysis.

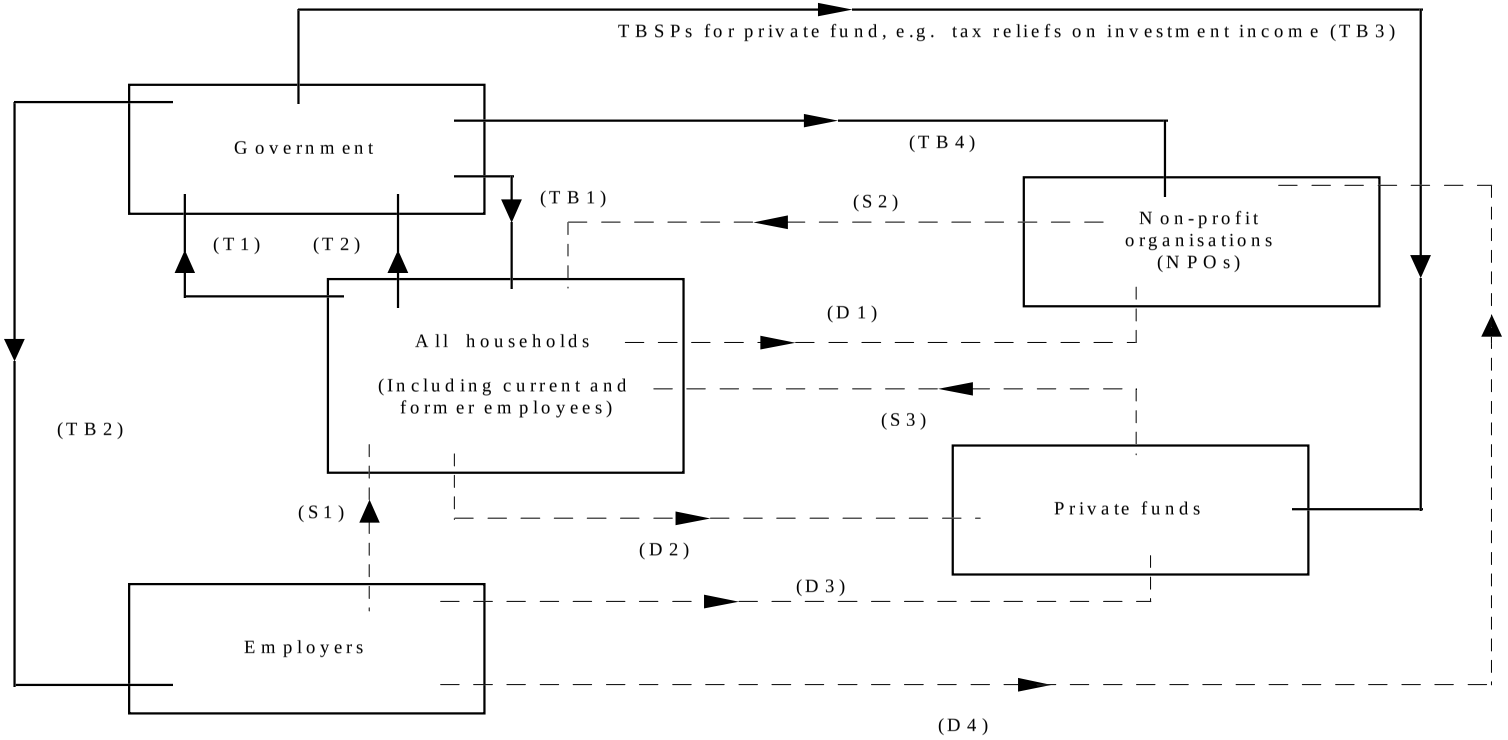
67. To facilitate cross-country comparisons gross expenditure indicators are related to GDP at market prices – the most frequently used indicator which includes the value of indirect taxation. The "voluntary private social expenditure indicators" developed here aim to measure the net value of such expenditure, and by doing so, they account for the value of indirect taxation on the consumption of benefit income. These indicators are therefore related to GDP at factor costs – a measure which does not include the value of indirect taxation (Adema, 1997).[20]

Measuring net voluntary private social benefits

68. The first step in the adjustment process concerns the identification of direct taxes and social security contributions paid over *voluntary private* social benefits. Sometimes this information can be directly obtained from actual tax records. This is the most reliable source of information. Alternatively, information can be derived from microsimulation models. These models include detailed information on both the incomes received by households and their taxation. The models can be used to generate "average itemised tax rates" (AITR), e.g., average tax paid on private pension income. Subsequently, these tax rates are applied to the gross benefit payments.

20. GDP at market prices captures gross expenditure on the final uses of domestic supply of goods and services at purchasers' values; indirect taxes also form a substantial part of GDP at market prices. But net social spending also accounts for the value of indirect taxes which are levied by the government on benefit income. Thus, there is a case for adjusting the denominator (GDP) to account for the value of indirect taxes. Hence, the net social expenditure indicators are related to GDP at factor cost which does not include the value of indirect taxation and government subsidies to private enterprises and public corporations.

Chart 3. The tax-system and private social benefits



Tax flows relevant to calculations (unbroken lines): (T1): income tax paid by households over private social benefit income; (T2): indirect taxes paid by households in receipt of private social benefits; (TB1): TBSPs to households, e.g. aimed to stimulate take-up of individual pension plans; (TB2): TBSPs to employers, e.g. aimed to stimulate take-up of collective health insurance; (TB3): TBSPs to private funds, e.g. tax reliefs on investment income; (TB4): TBSPs to NPOs, tax relief for charitable organisations. Donations to NPOs by households (D1) and employers (D4) may be subject to tax relief (recorded under TB1 and TB2). Similarly, contributions by households (D2) and employers (D3) to private funds can be subject to tax-advantages (recorded under TB1 and TB2).

Other tax items on private social benefits (dashed lines): Employer-provisions to households may not be taxed at source or at a reduced rate (S1); Benefits provided by NPOs (S2) and private funds (S3) to households may not be taxed at source or at a reduced rate. The amount of tax paid by employers, NPOs and private funds relevant to the provision of benefits is not recorded here.

69. There are two broad groups of *voluntary private* cash transfers which are subject to **direct taxation**: sickness benefits and pensions. Voluntary sickness benefits are continued wage payments provided by employers to employees who are absent of work because of illness. Thus, the tax-treatment of such payments is similar to tax rules concerning income from work. In the absence of detailed information on the tax paid over voluntary sickness benefits by benefit recipients, the average tax rate applicable to the earnings of the Average Production Worker (APW) is used as the correction factor.[21]

70. This adjustment method cannot be used with regard to the other main *voluntary private* social cash benefit: pensions. In most countries these are subject to tax rules which are different -- often favourable -- from the standard tax rates. For estimates on taxes paid on pension benefits use could be made of detailed accounts obtained from the Inland Revenue in the United Kingdom, and information published by the Internal Revenue Service in the United States (IRS, 1997). Information on average tax rates for private pensions was given by the Ministry of Economic Affairs for Denmark, the Ministry of Social Affairs and Employment for the Netherlands and the Swedish Ministry of Finance. No estimates are directly available for Germany. However, on basis of available institutional information the average itemised tax-rate on private pensions in Germany is estimated to be 8.6 per cent.[22] Deduction of the value of direct taxation from gross private expenditures leads to net cash voluntary private social expenditure (p2). The number in-between brackets refers to the appropriate line in Table 7.

71. Concerning the **indirect taxation** of private benefit income, the approach followed here is to calculate an average implicit indirect tax rate based on aggregate data available for all countries (OECD, 1995). It is calculated as the ratio of revenue from general consumption taxes and excise to a broad consumption tax base (private consumption and government consumption minus government wages). Multiplying net cash direct public social expenditure with the minimum indirect tax rate leads to net current voluntary private social expenditure (p3).

72. The net value of private social benefits, net current private social expenditure (p4), is obtained by adding net voluntary private social expenditure to net mandatory private social expenditure (the latter is presented as a memorandum item Table 7). This is an indicator of the net value of total private social benefit payments.

---

21. The average itemised tax rate on voluntary sickness benefits was estimated by calculating a tax rate for an Average Production Worker (APW) which is the average of the tax-rate for earnings of a single person and a single earner in a household consisting of 2 adults and 2 children (OECD, 1995*c*). For the latter category all child benefits were disregarded in calculating the relevant tax rates, as they are already accounted for in direct tax rates on public family benefits.

22. There are 4 ways through which private enterprises provide old-age cash benefits in Germany: direct insurance (group-life insurance); pension funds; support funds and book reserves of the company. Benefits out of direct insurance and pension funds are predominantly tax-free. Only the assumed interest content of an annuity is taxable (27 per cent of the pension paid to a person aged 65). Benefits paid out of support funds and book-reserves are taxed as earned income subject to special allowances. About one-third of all pension benefits are paid through book reserves or support funds. Generally, all gross pension income is subject to a health insurance contribution of 6.7 per cent of gross pension income (Bundesministerium für Arbeit und Sozialordnung, 1995). Thus, the minimum average tax rate on private pension income is 6.7 while the maximum is 1/3 of the average tax rate on earnings of an APW: 10.5 per cent. For our calculations we have therefore assumed an average tax rate of 8.6 per cent. Errors resulting form this estimation method are likely to be small: direct taxation of the pension benefits amounts to about 0.07 per cent of GDP at factor cost.

73. It is clear from Table 7, that the United States has by far the largest percentage of GDP devoted to net private social benefit amongst the six countries considered here: 8.3 per cent of GDP at factor cost. Net private social benefits is also significant in the Netherlands and the United Kingdom; around 3.4 percentage points of GDP at factor cost in both countries. The net value of non-health related private benefits is largest in the United Kingdom (3 percent of GDP at factor cost). The net value of private non-health related benefits in the Netherlands is significantly lower (see Table 2) as such benefits are taxed rather heavily in the Netherlands.

Table 7. Net voluntary private social expenditure as a percentage of GDP at factor cost, 1993

	Item	Denmark	Germany	Netherlands	Sweden	United Kingdom	United States
p1	**Gross voluntary private social expenditure**	**0.72**	**1.69**	**4.81**	**1.91**	**4.15**	**8.22**
-	Direct taxes and social contributions paid on transfers	0.20	0.10	1.05	0.72	0.51	0.26
p2	Net cash voluntary private social expenditure	0.52	1.59	3.76	1.19	3.64	7.95
-	Indirect taxes	0.08	0.14	0.35	0.21	0.45	0.14
p3	Net direct voluntary private social expenditure	0.44	1.45	3.41	0.97	3.19	7.82
p4	**Net current private social expenditure (p3+pm)**	**0.78**	**2.35**	**3.41**	**1.36**	**3.39**	**8.34**
	Memorandum items						
pm	**Net current mandatory private social expenditure**	**0.33**	**0.90**	**-**	**0.39**	**0.20**	**0.53**
	Net current private non-health social expenditure	0.63	1.61	1.92	1.26	3.02	2.76

" - " item does not exist.

Sources: For direct taxation and voluntary private social expenditure: *Denmark*: information provided by the Ministry of Economic Affairs; *Germany*: own calculations; *the Netherlands* and *Sweden*, Ministry of Finance; *the United Kingdom*: information provided by the Inland Revenue; *the United States*: IRS (1997), *Individual Income Tax Returns: Income and Tax Items for 1993,* Internal Revenue Service (US Department of the Treasury), Internet: http://www.irs.ustreas.gov/prod/tax_stats/index.html. For indirect taxation and voluntary private social benefits: OECD (1995), Revenue Statistics of OECD Member Countries, 1965-1994, Paris. For mandatory private social benefits: see Table 9.

Government measures aiming to stimulate take-up of private social provisions

74. Governments can pursue social policy objectives through the tax system by giving tax advantages which are grouped under **tax breaks for social purposes**. The TBSPs are here considered as a cost to public budgets and estimates on their value are presented in Table 8. TBSPs are defined as:

> "those reductions, exemptions, deductions or postponements of taxes, which: *a)* perform the same policy function as transfer payments which, if they existed, would be classified as social benefits; or *b)* are aimed at stimulating private provision of benefits".

Tax allowances which mirror the effects of a cash benefit can be substantial (Table 8 and Annex 2). For example, in Germany the value of tax allowances for families with children amounted to almost DM 21 billion in 1993. Nonetheless, the TBSPs which are similar to public cash benefits to households are not relevant to our discussion on *voluntary private* social benefits, as they do affect the provision of such benefit.

75. The TBSPs which are aimed at stimulating take-up of private provision can be categorised in two broad groups:

76. **Tax-breaks for pensions**. The appropriate methodology concerning calculating the value of these TBSPs towards funded programmes is arguable (see Annex 3). Therefore, the treatment of these TBSPs is limited and relevant estimates are only presented as memorandum items in Table 8. However, for the United Kingdom and the United States information is available which reflects the cost to public budgets -- on a cash basis -- of the current tax system in the current financial year on tax breaks on contributions. The available data indicate that public costs on these TBSPs aimed at private pension take-up can be significant: in the United Kingdom tax relief for personal and occupational pension programmes and the contracted-out rebate of National Insurance contributions amounts to 3.1 per cent of GDP at factor cost in 1993.

77. **TBSPs on "current" private social benefits**. These tax-breaks include favourable tax treatment of benefits provided by NPOs or donations by households and employers to NPOs. For example, tax concessions on donations to NPOs amounts to about $ 13 billion in the USA in 1993. Such TBSPs are equivalent to financing the provision of benefits by NPOs. Similarly, TBSPs can be aimed at stimulating take-up of private medical insurance. In the United States the value of tax advantages concerning employer contributions to medical insurance premiums and medical care is significant and amounted to 0.75 per cent of GDP at factor cost in 1993. In the United Kingdom, tax relief for private medical insurance premiums for those aged 60 and over was introduced in 1990-91. The cost for that fiscal year was £40 million, assuming an increase in take-up in the region of 10 per cent as a result of the new relief (HM Treasury 1989), and rose to about £80 million in 1993. Nonetheless, its value is only 0.01 per cent of GDP at factor cost in 1993.

Table 8. Tax breaks for social purposes as a percentage of GDP at factor cost, 1993 (1)

Item	Denmark	Germany	Netherlands	Sweden	United Kingdom	United States
TBSPs similar to cash benefits	0.09	0.88	0.09	N/A	0.40	0.24
TBSPs on pensions	N/A	0.09	N/A	0.22	3.13	0.93
TBSPs towards current private social benefits	N/A	N/A	N/A	N/A	0.01	1.01
Total TBSPs	0.09	0.98	0.09	0.22	3.55	2.18

"N/A" data are not available

(1) The coverage of data on TBSPs is limited for Denmark, Germany, the Netherlands and Sweden. Therefore, the value of TBSPs given for these countries cannot be directly compared with information available on the United Kingdom and the United States.

Source: Adema *et al.* (1996), "Net Public Social Expenditure" , Labour Market and Social Policy Occasional papers, no. 19, OECD, Paris and Annex 3.

NET TOTAL SOCIAL EXPENDITURE

78. The development of the *net voluntary private* social expenditure indicators facilitate an integration with indicators on *net public* and *net mandatory private* social expenditure to derive estimates on *net total social expenditure*. This indicator is developed to identify that part of an economy's domestic production recipients of social benefits lay claim to.

79. Adema *et al.* (1996) presents estimates on net public and net mandatory private social expenditure, and these indicators are reproduced in Table 9 (Annex 2). The information in Table 9 gives a step-by-step account of the value of the adjustments concerned. The resulting indicator is net total social expenditure (11). It has been calculated by adding net current public social expenditure (4), net current mandatory private social expenditure (7) and net current voluntary private social expenditure (10). However, as noted above, some TBSPs which are recorded under net current public social expenditure are tantamount to financing private social benefits (see Table 8: TBSPs towards current private social benefits). Simply adding net current to net private social expenditure would establish a double counting. Therefore, the value of TBSPs towards current private social benefits has been ignored while calculating net current total social expenditure. For example, the value of TBSPs towards contributions to employer-provided health insurance is regarded as financing private health insurance and the value of these tax-advantages has been ignored for the calculation of net current total social expenditure.[23]

80. The upshot of these calculations is a marked convergence of social expenditure levels across countries. Sweden remains the biggest social spender. However, how robust this result is remains to be tested for future years when Swedish GDP figures relate to a more favourable position in the cycle than for 1993. The net social expenditure totals for Denmark, Germany, the Netherlands and the United Kingdom are approximately within a range of 2 percentage points of GDP at factor cost. Furthermore, the ranking between the four other European countries changes, with Germany now "leading" this group. Total expenditure levels in the United States (25.3 per cent of GDP at factor cost) are only just below expenditure levels in European countries. If data on the value of TBSPs to private pensions had been available for all countries, it is likely that British, Dutch and US net total expenditure levels would further increase relative to the other countries.

81. The convergence of aggregate expenditure levels is driven by two factors: including private social benefits and the impact of the tax system. The impact of the tax system leads to a drop in the standard deviation of total social expenditure levels from 6.8 (gross total expenditure) to 3.2 (net total expenditure). The tax system is also has an "equalising" effect on social expenditure in European countries: a decline in the standard deviation from 5.0 (gross total expenditure) to 2.7 (net total expenditure).

82. Including private social benefits is particularly important for convergence of expenditure levels in the United States vis-à-vis European countries. The standard deviation of net total expenditure is 3.2 compared to a standard deviation of net public expenditure of 5.0. A main factor in this is the increasing magnitude of private social health benefits, as indicated by a standard deviation of 4.2 of net current total non-health benefit payments across countries.

---

23. The value of tax concessions to NPOs is also recorded under net current public social expenditure. If benefit payments by NPOs were included in the expenditure totals in Table 8, the value of relevant tax concessions would also have to be ignored in order to avoid double counting.

Table 9. Net total social expenditure as a percentage of GDP at factor cost, 1993

		Denmark	Germany	Nether-lands	Sweden	United Kingdom	United States	St.dev. all 6 (1)	St.dev. Eur 5 (2)
1	Gross public social expenditure	35.25	32.48	34.02	42.38	26.91	16.31	*8.85*	*5.57*
-	Direct taxes and social contributions paid on transfers	4.52	2.91	6.51	5.88	0.68	0.08		
2	Net cash public social expenditure	30.73	29.57	27.52	36.50	26.23	16.23		
-	Indirect taxes	4.47	3.28	2.75	4.10	2.61	0.52		
3	Net direct public social expenditure	26.26	26.29	24.77	32.39	23.62	15.71		
+	TBSPs excluding TBSPs on pensions (3)	0.09	0.88	0.09	0.00	0.30	1.25		
4	**Net current public social expenditure**	**26.35**	**27.17**	**24.86**	**32.39**	**23.92**	**16.96**	*5.03*	*3.30*
5	Gross mandatory private social expenditure	0.69	1.57	-	0.69	0.27	0.55	*0.48*	*0.55*
-	Direct taxes and social contributions paid on transfers	0.25	0.49	-	0.20	0.03	0.00		
6	Net cash mandatory private social expenditure	0.44	1.08	-	0.49	0.24	0.54		
-	Indirect taxes	0.11	0.18	-	0.10	0.03	0.02		
7	**Net current mandatory private social expenditure**	**0.33**	**0.90**	**-**	**0.39**	**0.20**	**0.53**	***0.26***	***0.30***
8	Gross voluntary private social expenditure	0.72	1.69	4.81	1.91	4.15	8.22	*2.75*	*1.74*
-	Direct taxes and social contributions paid on transfers	0.20	0.10	1.05	0.72	0.51	0.26		
9	Net cash voluntary private social expenditure	0.52	1.59	3.76	1.19	3.64	7.95		
-	Indirect taxes	0.08	0.14	0.35	0.21	0.45	0.14		
10	**Net current voluntary private social expenditure**	**0.44**	**1.45**	**3.41**	**0.97**	**3.19**	**7.82**	*2.70*	*1.34*
11	**Net current private social expenditure (7+10)**	**0.78**	**2.35**	**3.41**	**1.36**	**3.39**	**8.34**	*2.70*	*1.19*
12	**Net current total social expenditure (4+11)** (4)	**27.13**	**29.52**	**28.20**	**33.76**	**27.31**	**24.24**	*3.17*	*2.73*
	Memorandum items								
	Gross total social expenditure	36.65	35.75	38.83	44.98	31.32	25.07	*6.76*	*4.99*
	Net current total non-health social expenditure	20.50	21.14	18.96	26.59	20.33	13.57	*4.18*	*2.95*
	TBSPs on pensions	N/A	0.09	N/A	0.22	3.13	0.93		

(1) Standard deviation of expenditure levels for all 6 countries.

(2) Standard deviation of expenditure levels for all 6 countries except the USA.

(3) These TBSPs include the value of TBSPs which are similar to cash benefits, e.g., tax allowances towards families with children and TBSPs aimed at stimulating "current" private social benefits, e.g., tax concessions to NPOs and towards donations to NPOs and tax advantages towards private health insurance.

(4) In order to avoid double counting, the value of TBSPs which are tantamount to financing private social benefits included under line 8, e.g. private health insurance, has been ignored for the calculation of net current total social expenditure. Therefore, net current total social expenditure is not equivalent to adding the values in lines 4, and 11 for the United Kingdom and the United States.

Sources: For estimates on public and mandatory private social expenditure: Adema *et al.* (1996), and Adema, W. (1997); for estimates on net voluntary private social expenditure, see the notes to Table 7.

CONCLUDING REMARKS

83. This paper develops a framework to account for private social benefits across countries, and this facilitates a comprehensive analysis of total (public and private) social expenditure. This study also extends an existing framework for considering adjustments to data on gross social expenditure which allow conclusions to be drawn about the net (after tax) value of private social benefits.

84. Both these area of social statistics are under development, and this initial study is affected by inevitable data limitations. Data on private social benefits is particularly limited concerning employer-provided family benefits such as paternity leave and the private provision of child care facilities, social benefits by non-profit organisations, whereas estimates had to be used on the magnitude of private social health benefits.

85. Measurement of the impact of the tax system is subject to the following limitations:

- Adjustments for indirect taxation are necessarily approximate and vary in quality across countries;

- Adjustments on indirect taxation are highly dependent on assumptions, but as argued by Adema *et al.* (1996), the relative ordering of countries remains unchanged under different assumptions.

- Methodological and data problems affect the measurement of tax breaks for social purposes, in particular for tax concessions towards pensions.

86. Nonetheless, it seems implausible to suggest that these limitations make the results generated in this study invalid. Private social family benefits are small in comparison to private social health and pension benefits, and although the public costs of TBSPs can be significant, their magnitude remains small in comparison with direct benefit payments. Therefore, the following general conclusions can be drawn:

- Private social pension benefits are of growing importance particularly in the United States, the Netherlands, and the United Kingdom, and in these countries, the fiscal promotion of such programmes institute significant costs to the public budget. Maturation of private pension systems, demographic trends and increased reliance on private pension provisions contribute to this upward trend;

- The most important social policy areas in terms of *voluntary private* social benefits are old-age cash benefits and health, while *mandatory private* social benefits often concerns the continued payment of wages in case of illness;

- Accounting for private social benefits and the impact of the tax system on social expenditure has an equalising effect on expenditure levels across the six countries studied.

87. The apparently large differences in gross direct public social expenditure levels are related to the variety in which governments pursue social objectives by mandating of fiscally stimulating private provisions. Observations on social expenditure levels across countries which do not account for private social benefits and the impact of the tax system could well be seriously misleading.

88. In many OECD countries the role of the state, employers, non-profit organisations and individual regarding the provision of social benefits is under debate. This debate encapsulates questions on the responsibility of the different actors, which of the actor is best equipped for the provision of social benefits, and the extent to which competition should be introduced in the provision of social benefits. Although this paper does not directly address these issues, the ongoing debate on the role of the private sector in providing social support will generate a growing need for comprehensive and up to date information on private social benefits.

BIBLIOGRAPHY

ADEMA, W. (1993), *The Beveridge Curve and Institutional Arrangements*, D. Phil. thesis, St. Edmund Hall, University of Oxford, Oxford.

ADEMA, W. (1997), "What do countries really spend on social policies? A Comparative Note, *OECD Economic Studies*, No. 28, 1997/I, OECD, Paris.

ADEMA, W., M. EINERHAND, B. EKLIND, J. LOTZ, and M. PEARSON (1996), "Net Public Social Expenditure", Labour Market and Social Policy Occasional Paper, No. 19., Paris.

BERG, E. van den, C.J.P.M van MOSSEVELD, R. REZVANI, and J. SMIT (1997), "Eigen Betalingen in de Zorg", 1990-1994, *Maandbericht Gezondheidsstatistiek*, 97/1, pp. 15-22.

BUNDESMINISTERIUM FÜR ARBEIT UND SOZIALORDNUNG (1994), *Übersicht über das Sozialrecht*, Bonn.

BUNDESMINISTERIUM FÜR ARBEIT UND SOZIALORDNUNG (1995), "Alterssicherung in Deutschland 1992", *Forschungsbericht BMA*, no. 244/Z, January, Munich.

BUREAU OF LABOR STATISTICS (1996), *Employee Benefits Survey*, Internet: http://stats.bls.gov:80/ebshome.htm

COMMISSION ON LEAVE (1996), *A Workable Balance: Report to Congress on Family and Medical Leave Practices*, US Department of Labour (the Women's Bureau), Washington, DC.

DSS (1994), *Social Security Statistics 1994*, Department of Social Security, HMSO, London.

EBRI (1995), *EBRI Databook on Employee Benefits*, third edition, Employee Benefit Research Institute, Washington, DC

ERHVERVMINISTERIET, FINANSMINISTERIET, SKATTEMINISTERIET, ØKONOMIEMINISTERIET (1996), *Skatteudgifter i Danmark*, Copenhagen.

EINERHAND, M., M. KERKLAAN, H. METZ, E. SIEGELAAR, and M. VLIEGENTHART (1995), *Sociale Zekerheid: Stelsels en Regelingen in Enkele Europese Landen*, Ministerie van Sociale Zaken en Werkgelegenheid, the Hague.

EUROSTAT (1992), *Digest of Statistics on Social Protection in Europe, Volume 2: Invalidity/Disability*, Brussels-Luxembourg.

EUROSTAT (1993), *Digest of Statistics on Social Protection in Europe, Volume 4: Family*, Brussels-Luxembourg.

EUROSTAT (1995), *Digest of Statistics on Social Protection in Europe, Volume 5: Sickness*. Brussels-Luxembourg.

EUROSTAT (1996), *ESSPROS Manual*, Brussels-Luxembourg.

EUROSTAT (1996*a*), *Digest of Statistics on Social Protection in Europe, Old Age and Survivors: An Update*, Brussels-Luxembourg.

FEDERAL MINISTRY OF LABOUR AND SOCIAL AFFAIRS (1994), *Social Security in Germany, Expenditure and Revenue 1960 - 1993*, Bonn.

HM TREASURY (1989), *Financial Statement and Budget report 1989-90*, HMSO, London.

IRS (1997), *Individual Income Tax Returns: Income and Tax Items for 1993*, Internal Revenue Service (US Department of the Treasury), Internet: http://www.irs.ustreas.gov/prod/tax_stats/index.html.

GRUBER , J. and J.M. POTERBA (1995), *Tax Subsidies to Employer-Provided Health Insurance*, NBER Working Papers no. 5147, National Bureau of Economic Research, Cambridge MA.

KERNS, W.L. (1994), "Private Social Welfare Expenditures, 1972-1991", *Social Security Bulletin*, vol. 57, No. 1, pp. 87-95, Washington DC.

KERNS, W. L. (1994*a*), "Protection Against Income Loss During the First 6 Months of Illness or Injury", *Social Security Bulletin*, Vol. 57, No. 3., pp. 88-92, Washington, DC.

KERNS, W. L. (1995), "Role of the Private Sector in Financing Social Welfare Programs, 1972-92", *Social Security Bulletin*, Vol. 58, No. 1., pp. 66-73, Washington, DC.

KERNS, W.L. (1997), "Cash benefits for Short-term Sickness, 1970-1994", *Social Security Bulletin*, vol. 60, No. 1, pp. 49-53, Washington DC.

KERNS, W. L. (1997*a*), "Private Social Welfare Expenditures, 1972-1994", *Social Security Bulletin*, Vol. 60, No. 1., pp. 54-60, Washington, DC .

KONJUNKTURINTITUTET (1995), *Konjunkturlaget*, December, Stockholm.

McKINSEY and COMPANY (1996), *Comparative Care Costs in Germany, the United Kingdom and the United States*, Washington DC.

MOSSEVELD, C.J.P.M. van and P. van SON (1996), *International Comparison of Health Care Data, Phase 1: Intramural Health Care*, Centraal Bureau voor de Statistiek (Statistics Netherlands), Voorburg/Heerlen.

NICKELL, S.J. (1986), Dynamic Models of Labour Demand, in O. ASCHENFELTER and R. LAYARD (eds.), *Handbook of Labor Economics*, Vol. 1., North-Holland, Amsterdam.

OECD (1992), *Private Pensions and Public Policy*, Paris.

OECD (1995), *Education at a Glance*, Paris.

OECD (1995*b*), *Employment Outlook*, Paris.

OECD (1995*c*), *The Tax/Benefit Position of Production Workers, 1991-1994*, Paris.

OECD (1996), *Ageing in OECD Countries, a Critical Policy Challenge*, Social Policy Studies no. 20, Paris.

OECD (1996*a*), "Social Expenditure Statistics of OECD Member States - Provisional Version", Labour Market and Social Policy Occasional Paper, No. 17., Paris.

OECD (1996*b*), *Health Data 1996*, Paris.

OECD (1996*d*), *Tax Expenditures: Recent Experiences*, Paris.

OECD (1997), *Family, Market and Community: Equity and Efficiency in Social Policy*, Social Policy Studies, No 21, Paris.

OECD (1998), *The Battle against Exclusion: Social Assistance in Belgium, the Czech Republic, the Netherlands and Norway*, Paris, *forthcoming*.

OECD (1998*a*), *Taxes, Benefits and Incentives*, Paris, *forthcoming*.

POTERBA, J.M., S.F. VENTI and D.A. WISE (1995), *The Effects of Special Saving Programmes on Saving and Wealth*, NBER Working Papers no. 5287, National Bureau of Economic Research, Cambridge MA.

PHAROAH, C. (1997) (ed.), *Dimensions of the Voluntary Sector: key facts, figures, analysis and trends*, Charities Aid Foundation, Kent, United Kingdom.

SALAMON, L. M., H.K. ANHEIER, W. SOKOLOWSKI and ASSOCIATES (1996), *The Emerging Sector: A Statistical Supplement*, Baltimore, The Johns Hopkins Institute for Policy Studies.

SCHIEBER, G.J., J-P. POULLIER and L.M. GREENWALD (1994), "Datawatch: Health System Performance in OECD Countries, 1980-1992", *Health Affairs*, Fall 1994, pp. 100-12.

SCHNEIDER, M., P. BIENE-DIETRICH, M. GABABYI, U., HOFMANN, U., M. HUBER, A. KÖSE and J.H. SOMMER (1995), Gesundheitssysteme im Internationalen Vergleich (ausgabe 1994), Beratungsgesellschaft für Angewandte Systemforschung (BASYS), Augsburg.

SNA (1993), *System of National Accounts 1993*, CEC-EUROSTAT, IMF, OECD, UN and the World Bank, Brussels/Luxembourg, New York, Paris, Washington, DC

SSA (1995), *Annual Statistical Supplement 1995*, to the Social Security Bulletin, (Social Security Administration), Washington, DC.

SSA (1996), *Social Security Programs Around the World 1995*, (Social Security Administration), Washington, DC.

SSA (1996*a*), *Annual Statistical Supplement 1996*, to the Social Security Bulletin, (Social Security Administration), Washington, DC.

STATISTISCHES BUNDESAMT (1995), *Löhne und Gehälter, Arbeitskostenerhebungen 1992*, Fachserie 16, Heft 1, Wiesbaden.

US DEPARTMENT of COMMERCE (1995), *Statistical Abstract of the United States, the National Data Book*, 115th Edition, Washington, DC.

US OFFICE of MANAGEMENT and BUDGET (1994), *Analytical Perspectives, Budget of the United States Government, Fiscal Year 1995*, Government Printing Office, Washington DC.

WILLIAMS, S. (1997), "The cost of UK tax reliefs in favour of charities" in C. Pharoah (1997) (ed.), *Dimensions of the Voluntary Sector: key facts, figures, analysis and trends*, Charities Aid Foundation, Kent, United Kingdom.

ANNEX 1 HISTORICAL EXPENDITURE SERIES BY BROAD SOCIAL POLICY AREA

A1. In general, changes in social expenditure as a percentage of GDP can be related to: the inception or abolition of social expenditure programmes; changes in the number of beneficiaries to a programme; the phase of the business cycle; and changes in the demographic composition of a population. Demographic factors play a significant part in determining, among other things, pension payments. At present, the baby-boom generation is supporting the retired population. However, at the outset of the forthcoming millennium this generation will start to retire. Thus, the retired population relative to the population of working-age will grow significantly. Concurrently, life expectancy is increasing. These two factors will exert increasing pressure on prevailing pension systems, and have already led to considerable debate on the financing of such systems (OECD, 1996 and 1997).

A2. Many welfare provisions in western Europe were introduced in the 1960s. The subsequent widening of entitlement conditions and/or relaxation of the application of administrative rules, often led to a considerable expansion of the number of beneficiaries and benefits. For example, there was a particularly sharp increase in the number of recipients of invalidity/disability benefit in the Netherlands over the years 1975 to 1980 and in the United Kingdom after 1983 (Adema, 1993).

A3. Fluctuations of aggregate demand can cause considerable short-term variation in public social expenditure on unemployment compensation and to a lesser extent active labour market programmes (ALMP). The automatic budget effects ensuing from such cyclical fluctuations can be quite powerful and are most evident in Sweden: public social expenditure as a percentage of GDP increased by more than 6 percentage points from 1989 to 1993.

General notes

Data on public social benefits have been taken form the OECD Social Expenditure database (SOCX). At present SOCX covers public expenditure for the period 1980-1993 grouped across the following social policy areas: old-age cash benefits; disability cash benefits; occupational injury and disease; sickness benefits; services for the elderly and disabled; survivors; family cash benefits; family services; active labour market policies (ALMP); unemployment compensation; housing benefits; public health expenditure; and other contingencies (*e.g.*, cash benefits to those on low income). Expenditures on housing subsidies that are not directly provided to the beneficiary are not included. See, OECD (1996*a*), for more detail. Data on private social benefits have been taken from various sources which are comprehensively listed in the notes to Tables 1 and 2.

The category "Old age" includes SOCX-categories old-age cash benefits and survivors; "Disability" includes SOCX-categories disability cash benefits and occupational injury and disease; "Sickness" includes SOCX-categories sickness benefits and family cash benefits (maternity benefits); "Other" includes all other SOCX-categories except "Health" which is listed separately.

Note to the tables on Denmark and Sweden

Benefits in the "Old age" category only includes survivors cash benefits and old age cash benefits but not services. These benefits are included in the category "other". The public provision of services to those over 65 years of age is particularly important in Denmark and Sweden (in 1993 expenditure amounted to 2.3 and 3.8 per cent of GDP respectively). Therefore, the Danish and Swedish benefits data in the old age category do not reflect the total public effort concerning the provision for retirement.

Table A1.1 Social benefits by provision-type and broad social policy area, as a percentage of GDP market prices

Denmark	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Public														
Old age	6.13	6.17	6.14	6.08	6.00	5.95	5.80	5.92	6.18	6.51	6.55	6.74	6.75	6.78
Disability	1.96	1.95	1.95	1.97	1.85	1.85	1.91	1.85	1.90	1.91	1.87	1.90	1.86	1.85
Sickness	3.21	2.84	2.62	2.16	2.06	2.10	2.13	2.50	2.94	2.72	2.77	2.65	2.72	2.35
Health	5.80	5.80	5.82	5.57	5.38	5.30	5.12	5.31	5.48	5.40	5.31	5.45	5.57	5.62
Other	10.53	11.08	11.62	12.84	12.09	11.27	10.79	10.96	11.36	11.82	11.74	12.40	12.99	13.77
Total	27.63	27.85	28.15	28.62	27.38	26.47	25.75	26.54	27.86	28.37	28.25	29.14	29.90	30.51
Mandatory private														
Old age														
Disability														0.16
Sickness (1)														0.43
Health														
Other														
Total														0.59
Voluntary private														
Old age	0.25	0.25	0.26	0.30	0.30	0.32	0.42	0.42	0.42	0.49	0.47	0.48	0.46	0.50
Disability														
Sickness														
Health	0.04	0.04	0.04	0.05	0.05	0.05	0.06	0.07	0.08	0.08	0.09	0.1	0.12	0.12
Other														
Total	1.25	1.27	1.26	1.29	1.28	1.30	1.29	1.41	1.49	1.58	1.62	1.62	1.64	1.68
Public plus Private														
Old age	6.38	6.42	6.4	6.38	6.3	6.27	6.22	6.34	6.6	7	7.02	7.22	7.21	7.28
Disability	1.96	1.95	1.95	1.97	1.85	1.85	1.91	1.85	1.9	1.91	1.87	1.9	1.86	2.14
Sickness	3.21	2.84	2.62	2.16	2.06	2.1	2.13	2.5	2.94	2.72	2.77	2.65	2.72	2.78
Health	5.84	5.84	5.86	5.62	5.43	5.35	5.18	5.38	5.56	5.48	5.4	5.55	5.69	5.74
Other	10.53	11.08	11.62	12.84	12.09	11.27	10.79	10.96	11.36	11.82	11.74	12.4	12.99	13.77
Total social expenditure	27.92	28.14	28.45	28.97	27.73	26.84	26.23	27.03	28.36	28.94	28.81	29.72	30.48	31.72

Separate data on mandatory sickness payments are not available until 1993, until then relevant benefits are included under “public”.

Table A1.1 (cont.) Social expenditure by provision-type and broad social policy area, as a percentage of GDP market prices

Germany (1.)	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Public														
Old age	11.45	11.51	11.68	11.36	11.16	11.00	10.73	10.86	10.77	10.59	10.18	10.31	10.74	11.23
Disability	2.74	2.80	2.89	2.83	2.86	2.80	2.71	2.68	2.56	2.48	2.39	2.46	2.49	2.62
Sickness	2.36	2.37	2.12	1.90	1.75	1.67	1.71	1.76	1.72	1.66	1.62	1.84	1.84	1.80
Health	6.32	6.53	6.39	6.23	6.33	6.39	6.34	6.37	6.53	6.00	5.94	6.58	6.91	6.79
Other	2.10	2.66	3.12	3.08	2.84	3.65	3.75	3.97	4.04	3.84	3.70	5.00	5.59	6.21
Total	24.98	25.87	26.20	25.40	24.92	25.51	25.24	25.64	25.62	24.58	23.83	26.19	27.57	28.66
Mandatory private														
Old age														
Disability														
Sickness	1.66	1.56	1.36	1.34	1.34	1.39	1.43	1.46	1.38	1.39	1.41	1.45	1.43	1.39
Health														
Other														
Total	1.66	1.56	1.36	1.34	1.34	1.39	1.43	1.46	1.38	1.39	1.41	1.45	1.43	1.39
Voluntary private														
Old age	0.53	0.56	0.59	0.63	0.64	0.69	0.73	0.75	0.77	0.79	0.78	0.71	0.71	0.72
Disability	0.04	0.05	0.05	0.05	0.05	0.06	0.06	0.06	0.06	0.06	0.06	0.05	0.05	0.05
Sickness	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.05	0.04	0.04	0.05	0.05	0.06
Health	0.56	0.57	0.58	0.59	0.59	0.6	0.61	0.61	0.62	0.64	0.65	0.67	0.66	0.66
Other														
Total	1.17	1.22	1.26	1.31	1.32	1.39	1.44	1.46	1.5	1.53	1.53	1.48	1.47	1.49
Public plus Private														
Old age	11.98	12.07	12.27	11.99	11.8	11.69	11.46	11.61	11.54	11.38	10.96	11.02	11.45	11.95
Disability	2.78	2.85	2.94	2.88	2.91	2.86	2.77	2.74	2.62	2.54	2.45	2.51	2.54	2.67
Sickness	4.06	3.97	3.52	3.28	3.13	3.10	3.18	3.26	3.15	3.09	3.07	3.34	3.32	3.25
Health	6.88	7.1	6.97	6.82	6.92	6.99	6.95	6.98	7.15	6.64	6.59	7.25	7.57	7.45
Other	2.1	2.66	3.12	3.08	2.84	3.65	3.75	3.97	4.04	3.84	3.7	5	5.59	6.21
Total social expenditure	27.81	28.65	28.82	28.05	27.58	28.29	28.11	28.56	28.50	27.50	26.77	29.12	30.47	31.54

Data for 1991-1993 concern the Federal Republic of Germany after unification, data on preceding years concern the Federal Republic of Germany before unification.

Table A1.1 (cont.) Social expenditure by provision-type and broad social policy area, as a percentage of GDP market prices

Netherlands	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Public														
Old age	7.96	7.95	8.22	8.12	7.90	7.90	8.02	8.22	8.22	8.09	8.73	8.63	8.65	8.66
Disability	4.62	4.71	4.87	4.75	4.65	4.35	4.30	4.42	4.37	4.23	4.59	4.65	4.65	4.65
Sickness	5.32	5.02	4.87	4.57	4.36	4.13	4.04	3.72	3.72	3.68	4.03	3.71	3.88	3.90
Health	5.92	6.09	6.31	6.23	6.05	5.91	5.77	5.97	5.85	6.05	6.05	6.36	6.83	7.04
Other	4.95	5.81	6.93	7.62	7.21	6.65	6.50	6.53	6.32	6.03	5.84	5.84	5.97	6.39
Total	28.77	29.58	31.20	31.31	30.16	28.95	28.62	28.85	28.48	28.09	29.23	29.19	29.98	30.64
Mandatory private (1.)														
Old age														
Disability														
Sickness														
Health														
Other														
Total														
Voluntary private														
Old age	1.03	1.14	1.28	1.38	1.5	1.54	1.72	1.87	1.95	2.02	2.14	2.28	2.44	2.6
Disability	0.03	0.03	0.03	0.03	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Sickness	0.21	0.19	0.18	0.17	0.17	0.2	0.2	0.2	0.24	0.29	0.28	0.29	0.31	0.35
Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.45	1.41	1.4	1.52	1.31	1.34
Other														
Total	1.27	1.36	1.49	1.58	1.71	1.78	1.96	2.11	3.68	3.76	3.86	4.13	4.1	4.33
Public plus Private														
Old age	8.99	9.09	9.5	9.5	9.4	9.44	9.74	10.09	10.17	10.11	10.87	10.91	11.09	11.26
Disability	4.65	4.74	4.9	4.78	4.69	4.39	4.34	4.46	4.41	4.27	4.63	4.69	4.69	4.69
Sickness	5.53	5.21	5.05	4.74	4.53	4.33	4.24	3.92	3.96	3.97	4.31	4	4.19	4.25
Health	5.92	6.09	6.31	6.23	6.05	5.91	5.77	5.97	7.3	7.46	7.45	7.88	8.14	8.38
Other	4.95	5.81	6.93	7.62	7.21	6.65	6.5	6.53	6.32	6.03	5.84	5.84	5.97	6.39
Total social expenditure	30.04	30.94	32.69	32.89	31.87	30.73	30.58	30.96	32.16	31.85	33.09	33.32	34.08	34.97

Pension-benefits paid under "administrative extension" are grouped under voluntary benefits. No estimates available on private social health benefits prior to 1988.

Table A1.1 (cont.) Social expenditure by provision-type and broad social policy area, as a percentage of GDP market prices

Sweden	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Public														
Old age	8.03	8.60	8.64	8.80	8.45	8.61	8.77	8.71	8.76	8.77	8.74	9.22	9.99	10.29
Disability	2.18	2.34	2.30	2.35	2.23	2.28	2.39	2.50	2.72	2.82	2.86	3.01	3.24	3.35
Sickness	4.24	4.08	3.90	3.68	3.56	4.01	4.05	4.30	4.86	4.82	4.87	4.82	4.05	3.86
Health	8.67	8.73	8.82	8.72	8.55	8.01	7.73	7.75	7.63	7.68	7.71	7.46	6.46	6.38
Other	7.29	7.59	7.92	8.39	7.87	8.73	8.81	8.65	8.51	7.72	8.43	10.30	13.27	14.36
Total	30.42	31.33	31.58	31.94	30.65	31.64	31.74	31.91	32.48	31.80	32.62	34.81	37.02	38.25
Mandatory private														
Old age														
Disability														
Sickness													0.31	0.62
Health														
Other														
Total													0.31	0.62
Voluntary private														
Old age	1.2	1.21	1.26	1.25	1.23	1.2	1.2	1.38	1.37	1.36	1.3	1.78	1.62	1.63
Disability														
Sickness														
Health	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.1	0.08	0.09	0.09
Other														
Total	1.27	1.28	1.33	1.32	1.3	1.27	1.27	1.45	1.44	1.43	1.4	1.86	1.71	1.72
Public plus Private														
Old age	9.23	9.81	9.9	10.05	9.68	9.81	9.97	10.09	10.13	10.13	10.04	11	11.61	11.92
Disability	2.18	2.34	2.3	2.35	2.23	2.28	2.39	2.5	2.72	2.82	2.86	3.01	3.24	3.35
Sickness	4.24	4.08	3.9	3.68	3.56	4.01	4.05	4.3	4.86	4.82	4.87	4.82	4.36	4.48
Health	8.74	8.8	8.89	8.79	8.62	8.08	7.8	7.82	7.7	7.75	7.81	7.54	6.55	6.47
Other	7.29	7.59	7.92	8.39	7.87	8.73	8.81	8.65	8.51	7.72	8.43	10.3	13.27	14.36
Total social expenditure	31.69	32.61	32.91	33.26	31.95	32.91	33.01	33.36	33.92	33.23	34.02	36.67	39.04	40.59

Table A1.1 (cont.) Social expenditure by provision-type and broad social policy area, as a percentage of GDP market prices

United Kingdom	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Public														
Old age	6.82	7.31	7.45	7.38	7.36	7.08	7.11	6.80	6.32	6.21	6.49	6.91	7.14	7.15
Disability	1.09	1.17	1.23	1.29	1.36	1.38	1.46	1.49	1.51	1.54	1.68	1.76	1.99	2.16
Sickness	2.07	2.18	2.12	2.14	2.15	2.09	2.03	1.95	1.95	1.91	1.90	1.85	2.02	1.99
Health	4.89	5.13	4.93	5.14	5.05	4.90	4.88	4.81	4.74	4.78	4.99	5.37	5.78	5.75
Other	3.44	4.07	4.49	4.96	5.26	5.58	5.78	5.39	4.60	4.35	4.72	5.15	5.89	6.36
Total	18.32	19.85	20.22	20.91	21.18	21.04	21.26	20.43	19.12	18.79	19.78	21.04	22.82	23.41
Mandatory private														
Old age					0.02	0.04	0.06	0.07	0.08	0.09	0.13	0.15	0.18	0.21
Disability														
Sickness												0.03	0.03	0.03
Health														
Other														
Total					0.02	0.04	0.06	0.07	0.08	0.09	0.13	0.18	0.21	0.23
Voluntary private														
Old age	1.24	1.47	1.69	1.77	1.91	2.00	2.07	2.23	2.10	2.14	2.22	2.31	2.39	2.42
Disability	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sickness	0.71	0.77	0.71	0.87	0.86	0.83	0.90	0.87	0.83	0.81	0.80	0.81	0.82	0.82
Health	0.14	0.15	0.17	0.19	0.21	0.22	0.24	0.25	0.27	0.27	0.28	0.31	0.33	0.33
Other														
Total	2.09	2.39	2.57	2.83	2.98	3.05	3.21	3.35	3.2	3.22	3.3	3.43	3.54	3.57
Public plus Private														
Old age	8.06	8.78	9.14	9.15	9.29	9.12	9.24	9.1	8.5	8.44	8.84	9.37	9.71	9.78
Disability	1.09	1.17	1.23	1.29	1.36	1.38	1.46	1.49	1.51	1.54	1.68	1.76	1.99	2.16
Sickness	2.78	2.95	2.83	3.01	3.01	2.92	2.93	2.82	2.78	2.72	2.7	2.69	2.87	2.84
Health	5.03	5.28	5.1	5.33	5.26	5.12	5.12	5.06	5.01	5.05	5.27	5.68	6.11	6.08
Other	3.44	4.07	4.49	4.96	5.26	5.58	5.78	5.39	4.6	4.35	4.72	5.15	5.89	6.36
Total social expenditure	20.41	22.24	22.79	23.74	24.18	24.13	24.53	23.85	22.4	22.1	23.21	24.65	26.57	27.21

Table A1.1 (cont.) Social expenditure by provision-type and broad social policy area, as a percentage of GDP market prices

United States	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Public														
Old age	5.74	6.23	6.34	6.17	6.05	6.01	5.99	5.82	5.70	5.74	5.95	6.14	6.11	6.10
Disability	1.06	1.13	1.06	0.97	0.94	0.93	0.95	0.91	0.89	0.89	0.94	1.09	1.06	1.10
Sickness	0.62	0.61	0.59	0.56	0.56	0.56	0.40	0.40	0.42	0.42	0.45	0.54	0.54	0.54
Health	3.44	3.77	3.93	3.86	3.90	3.99	4.12	4.18	4.23	4.44	4.85	5.21	5.51	5.67
Other	1.66	1.64	1.54	1.64	1.23	1.15	1.39	1.34	1.30	1.23	1.32	1.48	1.74	1.64
Total	12.51	13.39	13.46	13.21	12.67	12.63	12.85	12.64	12.53	12.72	13.50	14.46	14.95	15.04
Mandatory private														
Old age	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Disability	0.19	0.20	0.20	0.19	0.21	0.22	0.23	0.24	0.25	0.26	0.28	0.29	0.28	0.25
Sickness	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.01	0.02	0.01	0.01	0.01
Health	0.08	0.10	0.10	0.11	0.11	0.13	0.14	0.15	0.16	0.18	0.20	0.21	0.21	0.19
Other														
Total	0.32	0.34	0.36	0.34	0.36	0.39	0.41	0.43	0.45	0.48	0.52	0.54	0.53	0.48
Voluntary private														
Old age	1.23	1.35	1.58	1.75	1.87	2.26	2.66	2.43	2.33	2.49	2.36	2.33	2.45	2.39
Disability	0.05	0.04	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05
Sickness	0.26	0.28	0.27	0.26	0.25	0.24	0.23	0.24	0.24	0.24	0.22	0.21	0.21	0.21
Health	2.97	3.13	3.29	3.44	3.60	3.76	3.87	3.98	4.08	4.29	4.64	4.83	5.07	5.15
Other	0.03	0.03	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.02	0.01	0.01
Total	4.55	4.83	5.21	5.50	5.78	6.32	6.82	6.71	6.71	7.08	7.27	7.44	7.80	7.81
Public plus Private														
Old age	7.00	7.61	7.95	7.95	7.95	8.30	8.68	8.27	8.05	8.25	8.33	8.49	8.58	8.51
Disability	1.30	1.37	1.31	1.21	1.20	1.20	1.23	1.20	1.19	1.20	1.27	1.43	1.39	1.40
Sickness	0.90	0.91	0.88	0.84	0.83	0.82	0.65	0.66	0.68	0.67	0.69	0.76	0.76	0.76
Health	6.49	7.00	7.32	7.41	7.61	7.88	8.13	8.31	8.47	8.91	9.69	10.25	10.79	11.01
Other	1.69	1.67	1.56	1.65	1.24	1.16	1.40	1.35	1.31	1.24	1.33	1.50	1.75	1.65
Total social expenditure	17.38	18.57	19.02	19.06	18.82	19.35	20.09	19.78	19.69	20.27	21.29	22.43	23.27	23.32

Table A1.2 Social expenditure by type of provision as proportion of total expenditure

DENMARK	1980	1985	1990	1993
Category	Public share in total social expenditure			
Old-age cash benefits	96.1	94.9	93.3	93.1
Disability	100	100	100	93.5
Sickness	100	100	100	84.5
Health	99.3	99.1	98.3	97.9
Other	100	100	100	100
Total public share	**99.0**	**98.6**	**98.1**	**96.2**
	Private share in total social expenditure			
Old-age cash benefits	3.9	5.1	6.7	6.9
Disability	-	-	-	6.5
Sickness	-	-	-	15.5
Health	0.7	0.9	1.7	2.1
Other	-	-	-	-
Total private share	**1.0**	**1.4**	**1.9**	**3.8**

SWEDEN	1980	1985	1990	1993
Category	Public share in total social expenditure			
Old-age cash benefits	87.0	87.8	87.1	86.3
Disability	100	100	100	100
Sickness	100	100	100	86.2
Health	99.2	99.1	98.7	98.6
Other	100	100	100	100
Total public share	**96.0**	**96.1**	**95.9**	**94.2**
	Private share in total social expenditure			
Old-age cash benefits	13.0	12.2	13.0	13.7
Disability	-	-	-	-
Sickness	-	-	-	13.8
Health	0.8	0.9	1.3	1.4
Other	-	-	-	-
Total private share	**4.0**	**3.9**	**4.1**	**5.7**

GERMANY	1980	1985	1990	1993
Category	Public share in total social expenditure			
Old-age cash benefits	95.6	94.1	92.9	94.0
Disability	98.6	97.9	97.6	98.1
Sickness	58.2	53.9	52.7	55.4
Health	91.9	91.4	90.1	91.1
Other	100	100	100	100
Total public share	89.9	90.2	89.0	90.9
	Private share in total social expenditure			
Old-age cash benefits	4.4	5.9	7.1	6.0
Disability	1.4	2.1	2.5	1.9
Sickness	41.8	46.2	47.3	44.6
Health	8.1	8.6	9.9	8.9
Other	-	-	-	-
Total private share	10.2	9.8	11.0	9.2

UNITED KINGDOM	1980	1985	1990	1993
Category	Public share in total social expenditure			
Old-age cash benefits	84.6	77.6	73.4	73.1
Disability	100	100	100	100
Sickness	74.5	71.6	70.4	70.1
Health	97.2	95.7	94.7	94.6
Other	100	100	100	100
Total public share	89.7	87.2	85.2	86.0
	Private share in total social expenditure			
Old-age cash benefits	15.4	22.4	26.6	26.9
Disability	-	-	-	-
Sickness	25.5	28.4	29.6	29.9
Health	2.8	4.3	5.3	5.4
Other	-	-	-	-
Total private share	10.2	12.8	14.8	14.0

NETHERLANDS	1980	1985	1990	1993
Category	Public share in total social expenditure			
Old-age cash benefits	88.5	83.7	80.3	76.9
Disability	99.4	99.1	99.1	99.2
Sickness	96.2	95.4	93.5	91.7
Health	N/A	N/A	81.2	84.0
Other	100	100	100	100
Total public share	N/A	N/A	88.3	87.6
	Private share in total social expenditure			
Old-age cash benefits	11.5	16.3	19.7	23.1
Disability	0.7	0.9	0.9	0.9
Sickness	3.8	4.6	6.5	8.2
Health	N/A	N/A	18.8	16.0
Other	-	-	-	-
Total private share	4.2	5.8	11.7	12.4

UNITED STATES	1980	1985	1990	1993
Category	Public share in total social expenditure			
Old-age cash benefits	82.0	72.4	71.5	71.7
Disability	81.5	77.5	74.0	78.6
Sickness	68.6	68.1	65.4	70.8
Health	53.0	50.6	50.1	51.1
Other	98.2	99.1	99.3	99.4
Total public share	72.0	65.3	63.4	64.5
	Private share in total social expenditure			
Old-age cash benefits	18.0	27.6	28.5	28.3
Disability	18.5	22.5	26.0	21.4
Sickness	31.4	31.9	34.6	29.2
Health	47.0	49.4	50.0	48.5
Other	1.8	0.9	0.8	0.6
Total private share	28.0	34.7	36.6	35.5

"N/A": data not available; " - " not applicable

ANNEX 2 MEASURING NET PUBLIC AND NET MANDATORY PRIVATE SOCIAL EXPENDITURE

A1. Gross public social expenditure reflect budgetary resource allocation by different levels of government and social security funds. However, for two main reasons these data may sometimes fail to reflect the true public "social effort" of a country. First, the budget does not fully account for the impact of relevant fiscal arrangements. In this context, account should be taken of: tax advantages for social purposes (*e.g.* child tax allowances); direct taxation of benefit income; and indirect taxation of consumption by benefit-recipients. Often governments claw back more money through direct and indirect taxation of benefit income than the value of tax breaks for social purposes. Hence, net public expenditure is often less than gross public expenditure.

A2. For various reasons, including to reduce aggregate budget allocations, governments sometimes choose to secure social support outside the public delivery system, while concurrently keeping control over the modalities of support through regulatory means. These mandatory private social benefits are also subject to direct and indirect taxation, thus their net value is likely to differ from gross indicators.

Direct taxes and social security contributions on transfers.

A3. Government budgets contain information on gross expenditure related to transfers. In some OECD countries almost all 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, received annual unemployment benefits of Gld 39 504 and paid Gld 13 037 in income taxes and social security contributions (OECD, 1998*a*, *forthcoming*). From the government perspective, net expenditure is often likely to be more relevant than gross expenditure and gives a better impression of the resources being reallocated to benefit recipients. One step in the measurement of government effort is the deduction of direct taxation and social security contributions from the gross expenditure totals to arrive at net cash direct public social expenditure (2). (The number between brackets refers to the appropriate line in Table 8.)

A4. Correction for the taxes and social security contributions paid on social transfers not only facilitates international comparisons but also gives a better impression of effort over time. For example, in 1994 old-age cash benefits and social assistance benefits became taxable in Denmark. Simultaneously, social assistance benefits were raised to preserve their net value unchanged which led to an increase in gross expenditure of about DKr 5 billion, and a similar decrease in tax expenditures. Also, specific tax allowances for pensioners were abolished while benefits were increased by an equivalent amount: gross expenditures increased by about DKr 16 billion (Erhvervsministeriet *et al.* 1996). In both cases, net government expenditure was unaffected, but gross benefit payments increased significantly. This example illustrates how failure to adjust for the influence of the tax system can lead to an inaccurate view of public social expenditure.

A5. For the Germany, the United Kingdom and the United States, the value of direct taxation of social transfers can be obtained directly from national sources. This is the most reliable source of information. For Denmark, the Netherlands and Sweden, use had to be made of information derived from microsimulation models. These models include detailed information on both the incomes received by households and their taxation. The models can be used to generate "average itemised tax rates" (AITR), *e.g.* average tax paid on public pension income. Subsequently, these tax rates were applied to the gross expenditure data.

A6. Benefit income can be taxed at a zero rate, a reduced rate or at the rate applicable to other income. In the parlance of public finance, the two first cases lead to "revenue foregone" of a specific value and constitute "tax expenditures". This sort of tax relief is accounted for by making the adjustment for direct taxation. For example, income tax exemptions for those receiving "Industrial Disablement Benefit" in the United Kingdom are accounted for while establishing the amount of direct taxes paid over benefit income. So, in order to avoid double counting, the estimated value of this particular tax advantage (OECD, 1996*b*) is not included in the calculations concerning tax breaks for social purposes (see below).

Indirect taxes

A7. Cash transfers made in the context of social expenditure are generally used by recipients to finance consumption of goods and services. For example, in 1993 excise tax on the consumption of beer amounted to 2.2 billion pounds in the United Kingdom (OECD, 1995). Calculating the flow back in indirect tax receipts to the Exchequer generated by cash transfers and deducting it from net cash direct social expenditure gives a measure of net direct public social expenditure (3).

A8. An objection to similar treatment of direct and indirect taxes is that, unlike with direct taxes, there is nothing inevitable about indirect taxes: people can avoid them, either by purchasing untaxed or low-taxed goods or not purchasing anything. However, non-consumption is not a viable option, and the argument relating to the composition of consumption is also flawed. It is true that there is nothing inevitable about consumption of cigarettes and alcohol which are highly taxed in most OECD countries, but continued purchase of such goods out of benefit income reflects a judgement by the recipient on the worth of such consumption. Depending on their preferences, benefit recipients have to pay indirect taxes in order to maximise the utility from their consumption of benefit income. It is an irrelevant argument that they could pay less if they consumed a different bundle of goods, as this bundle would bring them a lower level of utility.

A9. Furthermore, in practice policymakers have recognised the link between indirect taxation and the position of those with low incomes or receiving benefit income. The extension of the VAT base to cover domestic fuel in the United Kingdom in 1993, for example, was accompanied by changes in benefit payments (particularly to the elderly) to compensate them for the reduction in the real value of the benefits. Similarly, when the Goods and Services Tax was introduced in Canada in 1991, a non-wastable tax credit was introduced to compensate those on low incomes for the regressive effects of the tax.

A10. The approach followed here is to calculate an average implicit indirect tax rate based on aggregate data available for all countries (OECD, 1995). It is calculated as the ratio of revenue from general consumption taxes and excise to a broad consumption tax base (private consumption and government consumption minus government wages). Multiplying net cash direct public social expenditure with the minimum indirect tax rate leads to net direct public social expenditure (3).

A11. In principle, it would have been desirable to allow for different expenditure patterns between income groups by using data sets on household expenditure patterns. The detailed information in such surveys theoretically facilitates the calculation of implicit indirect tax rates by group of beneficiaries. Unfortunately, data sets of this type are not readily available for all countries. Moreover, consumption surveys suggest tax payments which are well below actual tax receipts. Alternatively, a broader definition of indirect taxes (covering also customs duties and additional taxes on the use of goods such as licences for motor vehicles) and a smaller consumption base (just covering private consumption) could have been used to calculate the implicit indirect tax rate. However, Adema *et al*. (1996) find that the method described above appears to produce the least misleading results. The chosen methodology may also be criticised for implicitly assuming that benefit recipients do not save but consume all their benefit income. However, the marginal propensity to consume out of this type of benefit income is probably close to 1, so that resulting errors are likely to be very small.

Tax breaks for social purposes

A12. Many governments of OECD countries pursue social policy objectives through the tax system. Two main types of such measures can be distinguished. One is reduced taxation on particular sources of income or types of household. For example, old age pensions could be taxed at a zero or reduced rate which would lead to "revenue foregone" of a specific value and constitute "tax expenditures". As noted above, this sort of tax relief is equivalent to a variation in direct taxation of benefit income and has already been accounted for in the section on direct taxation. Thus, in order to avoid double counting, such tax expenditures are not considered here.

A13. The second group of tax measures with social effects are those which can be seen as replacing cash benefits or stimulating the provision of private benefits (*e.g.* tax advantages for the provision of private child-care facilities). These are termed tax breaks for social purposes and defined as: "those reductions, exemptions, deductions or postponements of taxes, which: *a)* perform the same policy function as transfer payments which, if they existed, would be classified as social benefits; or *b)* are aimed at stimulating private provision of benefits". The value of such tax expenditures is added to net direct public expenditure to obtain an indicator of net current public social expenditure (4).

A14. 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 (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 provisions, such as tax advantages granted to employer contributions to health insurance programmes. For example, in the United States the value of tax advantages concerning employer contributions to medical insurance premiums and medical care amounted to 0.75 per cent of GDP in 1993.

A15. The nature of certain tax measures illustrates the relationship between direct cash transfers and tax breaks for social purposes. Consider the "Earned Income Tax Credit" (EITC) in the United States. In 1993, the cost of this programme amounted to about $13.2 billion, of which $10.8 billion concerned tax credits exceeding tax liabilities of recipients. These "refundable" tax credits constitute direct transfer payments from the government to the recipient and, as such, relevant benefit payments are included in SOCX. The value of the remaining tax credits is taken into account in the calculations on tax breaks for social purposes.

A16. In order to ensure comparability with the direct expenditures, a cash rather than an accruals basis is used for calculating the value of the relevant tax breaks for social purposes. The data have been taken

from national sources. Tax breaks for social purposes often concern medical expenditures, particularly in the United States, but there is a wide variety across countries. For example, there are tax breaks towards housing for older people (Denmark), specific tax breaks for low income groups (Germany, the Netherlands), tax breaks for lone parent families (the United Kingdom, the Netherlands) and tax breaks concerning severance pay (the United Kingdom) and supplementary unemployment benefits (the United States). Moreover, many countries have various tax breaks related to pension saving (Annex 3).

Mandatory private social benefits

A17. As with public social expenditure, gross mandatory private social expenditure (5) is also subject to adjustment for direct and indirect taxation. The revenue of direct taxation of mandatory private social transfers was obtained from national sources for the United States, Germany and the United Kingdom. For Denmark and Sweden use had to made of microsimulation models. The average itemised tax rates (AITR) for public sickness benefits and occupational injury payments were applied to the relevant benefits in Denmark, whereas for Sweden the AITR for public sickness benefits was applied to aggregate payments concerning employer-provided sick pay. Concerning indirect taxation, the implicit indirect tax rate, described above, was applied to the mandatory private benefits after direct tax, leading to net current mandatory private social expenditure (7).

ANNEX 3 TAX BREAKS ON PENSIONS

A1 Tax breaks for social purposes encompass measures aimed at stimulating private pension take-up, e.g. tax exemptions for contributions to private pensions. However, such tax breaks on occupational and individual pension programmes are difficult to deal with, both conceptually and in practical terms, because such programmes are aimed at yielding benefits in the future: taxation occurs at, and tax reliefs are given at, various stages of what is a form of contractual savings. Uncertainties about how to treat such programmes arise because their tax treatment needs to be considered in three different areas:

- Contributions to programmes could be by employers or employees, out of taxed or untaxed income;

- The funds which invest the pension contributions on behalf of those contributing could be taxed or untaxed;

- The payment of pension or annuity or lump-sum benefits at the end of the contributions period could be taxed or untaxed.

A2. Due to the complexity of calculations arising from these issues, there is no comparable data set available on the value of tax breaks for pensions. For the United Kingdom and the United States there is some data available on the cost to public budgets -- on a cash basis -- of the current tax system in the current financial year on tax breaks on pension contributions. These data abstract from the effects the current tax system may have on revenues in future years.

Table A2.1 Value of tax breaks on pensions, 1993 (cash basis)

United Kingdom (fiscal year 1993/1994)	Pound Sterling(mln.)	In per cent of GDP fc
Relief for occupational pension schemes	7400	1.33
Relief for contributions to personal pensions	1600	0.29
Incentive for personal pensions and new contracted-out occupational programmes	810	0.15
Contracted-out rebate for occupational programmes and personal pensions plans (National Insurance contributions)	7600	1.37
Total		3.13
United States (fiscal year 1992/1993)	Dollars (mln)	
Net exclusion of pension contributions and savings (1, 2):		
Employer plans	49430	0.78
Individual retirement accounts	5720	0.09
Keogh plans	3245	0.05
Total		0.92

(1) Only federal taxes are considered.

(2) For the United States, public expenditure on the net exclusion of pension contributions to individual retirement accounts and Keogh plans is expected to amount to $ 76.6 billion in 1997 (EBRI, 1995).

Sources: *United Kingdom*: OECD (1996), Tax Expenditures: Recent Experiences, Paris; *United States*: United States Office of Management and Budget (1994), *Analytical Perspectives, Budget of the United States Government, Fiscal Year 1995*, Government Printing Office, Washington DC.

LABOUR MARKET AND SOCIAL POLICY OCCASIONAL PAPERS

Most recent releases are:

No. 31 *KEY EMPLOYMENT POLICY CHALLENGES FACED BY OECD COUNTRIES (1998) - OECD SUBMISSION TO THE G8 GROWTH, EMPLOYABILITY AND INCLUSION CONFERENCE,* London, 21-22 February 1998

No. 30 *PRIVATE PENSIONS IN OECD COUNTRIES - FRANCE* (1997) Emmanuel Reynaud (*available in French*)

No. 29 *OECD SUBMISSION TO THE UK LOW PAY MISSION* (1997)

No. 28 *OECD SUBMISSION TO THE IRISH NATIONAL MINIMUM WAGE COMMISSION* (1997)

No. 27 *CHILDCARE AND ELDERLY CARE: WHAT OCCUPATIONAL OPPORTUNITIES FOR WOMEN?* (1997) (Susan Christopherson)

No. 26 *THE CONCENTRATION OF WOMEN'S EMPLOYMENT AND RELATIVE OCCUPATIONAL PAY: A STATISTICAL FRAMEWORK FOR COMPARATIVE ANALYSIS* (1997) (Damian Grimshaw and Jill Rubery)

No. 25 *MAKING THE PUBLIC EMPLOYMENT SERVICE MORE EFFECTIVE THROUGH THE INTRODUCTION OF MARKET SIGNALS* (1997) (Robert G. Fay)

No. 24 *TRENDS IN SECRETARIAL OCCUPATIONS IN SELECTED COUNTRIES (1980-95)* (Hilary Steedman) (1997)

No. 23 *PRIVATE PENSIONS IN OECD COUNTRIES - AUSTRALIA* (1997) (Hazel Bateman and John Piggott)

No. 22 *THE DEFINITION OF PART-TIME WORK FOR THE PURPOSE OF INTERNATIONAL COMPARISONS* (1997) (Alois van Bastelaer, Eurostat; Georges Lemaître, OECD; Pascal Marianna, OECD) *(available in French)*

No. 21 *PRIVATE PENSIONS IN OECD COUNTRIES - THE UNITED KINGDOM* (1997) (E. Philip Davis)

No. 20 *OCCUPATIONAL CLASSIFICATION (ISCO-88): CONCEPTS, METHODS, RELIABILITY, VALIDITY AND CROSS-NATIONAL COMPARABILITY* (1997) (Peter Elias)

No. 19 *NET PUBLIC SOCIAL EXPENDITURE* (1996) (Willem Adema, Marcel Einerhand, Bengt Eklind, Jórgen Lotz and Mark Pearson)

No. 18 *ENHANCING THE EFFECTIVENESS OF ACTIVE LABOUR MARKET POLICIES: EVIDENCE FROM PROGRAMME EVALUATIONS IN OECD COUNTRIES* (1996) (Robert G. Fay)

A complete list of available papers can be found on the internet site: *http://www.oecd.org/els/papers/papers.htm,* through which recent papers can be accessed directly. To receive a paper copy of this list or any particular papers, please send your name, organisation and full address to: Labour Market and Social Policy Occasional Papers
Directorate for Education, Employment, Labour and Social Affairs
OECD, 2, rue André-Pascal, 75775 PARIS CEDEX 16, FRANCE

Mailing List for free of charge Labour Market and Social Policy Occasional Papers
Please include the following name on the mailing list:
(**write in capitals**)

Name ----------

Organisation ----------

Address ----------

RECENT OECD PUBLICATIONS IN THIS FIELD INCLUDE:

"OECD SOCIAL POLICY STUDIES" SERIES

No. 21 *FAMILY, MARKET AND COMMUNITY: EQUITY AND EFFICIENCY IN SOCIAL POLICY* (1997)

No. 20 *AGEING IN OECD COUNTRIES: A CRITICAL POLICY CHALLENGE* (1996)

No. 19 *CARING FOR FRAIL ELDERLY PEOPLE: POLICIES IN EVOLUTION* (1996)

No. 18 *INCOME DISTRIBUTION IN OECD COUNTRIES* (1995)

HEALTH POLICY STUDIES

No. 8 *HEALTH CARE REFORM: THE WILL TO CHANGE* (1996)

No. 7 *NEW DIRECTIONS IN HEALTH CARE POLICY* (1995)

No. 6 *INTERNAL MARKETS IN THE MAKING: HEALTH SYSTEMS IN CANADA, ICELAND AND UNITED KINGDOM* (1995)

MISCELLANEOUS

OECD HEALTH DATA (1997)
available in English or French on diskettes (Windows 3.11) or CD-ROM (Windows 95/NT or 3.11).

THE BATTLE AGAINST EXCLUSION
Social Assistance in Australia, Finland, Sweden and the United Kingdom (1998)

OECD EMPLOYMENT OUTLOOK July 1997 (published annually)

THE OECD *JOBS STRATEGY:*
Making Work Pay: Taxation, Benefits, Employment and Unemployment (1997)

THE OECD *JOBS STRATEGY:*
Enhancing the Effectiveness of Active Labour Market Policies (1996)

TRENDS IN INTERNATIONAL MIGRATION: CONTINUOUS REPORTING SYSTEM ON MIGRATION (SOPEMI) (1995)

For a full list, consult the OECD On-Line Bookstore on: http://www.oecd.org or write for a free written catalogue to the following address:

OECD Publications Service
2, rue André-Pascal, 75775 PARIS CEDEX 16
or to the OECD Distributor in your country