

Medical Benefits for Old-Age Pensioners Under Foreign Social Security Programs

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STATUTORY protection against medical care costs is currently provided to beneficiaries of pension programs for the aged in many countries. Usually this protection is provided under the general sickness insurance or other health service programs covering currently employed workers or other population groups.

The medical benefits and services available to pensioners and their dependents and the methods used to provide them are presented here in broad outline. General practitioner and specialist care, hospitalization, essential medicines, some laboratory services, and—in certain cases—dental treatment are benefits commonly provided.

More than 65 countries now have in force some kind of statutory old-age benefit or pension system—old-age insurance, universal pensions, old-age assistance, or provident-fund program—that covers at least important segments of the population. The countries with such plans have been classified by the type of medical benefit coverage into groups that (1) cover old-age insurance beneficiaries under sickness insurance, without payment of current contributions, (2) cover old-age insurance beneficiaries under sickness insurance, but with payment of current contributions required, (3) cover all residents, including pensioners, under sickness insurance or health service, (4) allow old-age pensioners to insure voluntarily under sickness insurance, (5) cover old-age pensioners under other arrangements, and (6) exclude old-age beneficiaries from coverage of sickness insurance or have no statutory medical benefit program.

NONCONTRIBUTORY COVERAGE OF BENEFICIARIES

The countries that fall in the first group maintain both old-age insurance and general sickness insurance programs. Coverage under both programs

results, in general, from employment rather than from residence alone. Each of these countries also provides that old-age insurance beneficiaries shall be eligible for medical benefits under its sickness insurance program, without being required to pay contributions after retirement. The group includes five countries in Western Europe (Belgium, France, the Federal Republic of Germany, Italy, and Portugal); seven in Eastern Europe (Albania, Czechoslovakia, East Germany, Hungary, Poland, Rumania, and Yugoslavia); and one (Libya) in Africa.

The medical services for aged beneficiaries in these countries are, in general, the same as those for currently employed workers. Since beneficiaries do not have to contribute to sickness insurance after they retire, their medical benefits may be regarded, in effect, as supplementary benefits to which they become entitled because of their past coverage or contributions. The cost of providing medical benefits to aged beneficiaries is thus financed from past or current contributions paid by or on behalf of employed workers.

In *Belgium*, old-age insurance beneficiaries who have paid the required number of contributions, and their dependents, are eligible for medical benefits under the regular sickness and invalidity insurance program. Such benefits normally take the form of cash refunds based on a fixed national scale of fees, with a maximum of 75 percent of their expenditures for medical care. These refunds are paid to them by the mutual benefit society or public auxiliary fund with which they are enrolled. Expenditures for medical and dental care, surgery, hospitalization, drugs, nursing care, and laboratory services may be reimbursed with no limit on the duration of care. The combined sickness and invalidity insurance program for wage earners is financed from a 7-percent contribution from employer and employee (divided equally), a regular Government contribution equal to 16 percent of this contribution, and special Government subsidies.

France continues to cover old-age insurance beneficiaries, with their dependents, for medical benefits

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under the regular sickness insurance program after their coverage as active workers ceases. Benefits include general and specialist care, hospitalization, certain medicines, laboratory services, dental care, and appliances; there is no limit on duration of care. Patients pay the doctor or hospital and are then reimbursed. The reimbursement is legally equal to 80 percent of the bills that are incurred but is subject to maximums for various services, as provided in negotiated and officially approved fee schedules.

The pension and sickness insurance programs are financed from a single social insurance contribution of 6 percent of wages paid by employees and one of 14 $\frac{1}{4}$ percent paid by employers. The contributions are allocated among the various types of benefits and among the regional and local funds administering the programs, in accordance with ministerial decrees. The local funds then pay the actual re-funds to pensioners.

In the *Federal Republic of Germany*, after retirement the old-age insurance beneficiaries, and their dependents, automatically continue to be members of their sickness fund if they had had at least 52 weeks of membership in the 5 years immediately preceding their claim for a pension. The medical benefits available include at least general and specialist care, necessary hospitalization, prescribed medicines (with a small fee per prescription during the first 10 days' illness), dental care, and certain appliances. The only limit on the duration of benefits is one of 26 weeks for hospitalization.

For the services rendered to their members, the sickness funds make direct payments to doctors (on a capitation basis), hospitals, and pharmacies with which they have contracts. The funds receive from the appropriate pension institution a contribution for each pensioner covered by the fund that is equal to two-thirds of the contribution payable for actively employed members (computed on the basis of 85–100 percent of their average wages). Any difference between such contributions and outlays by the sickness funds for medical care for pensioners must be met from contributions received from actively employed members and their employers, each of whom currently pay about 4.8 percent of wages, on the average.

In *Italy*, old-age insurance beneficiaries continue, with members of their family, to be eligible for medical benefits under the regular sickness insurance program after they retire. Benefits include

general and specialist care, hospitalization, 50 percent of the cost of dental care, and treatment at a spa. The normal maximum duration of such care is 180 days, but this limit is removed when the pensioner suffers from one of various specified diseases common to old age. Medical services are normally provided by doctors, hospitals, and pharmacies under contract with and paid directly by the National Sickness Insurance Institute or other fund with which a worker was affiliated before retiring.

Pensioners do not contribute after retirement to the cost of their medical protection. This cost is usually borne by the National Social Insurance Institute, which administers the pension program; its revenues are derived from a 7-percent employee contribution, a 14-percent employer contribution, and a 7-percent Government subsidy. A special pension equalization fund handles the financing of medical benefits for pensioners.

Persons receiving pensions from approved welfare funds in *Portugal* were made eligible to receive medical benefits from them as well, on the same conditions as active workers, by a ministerial order of September 1960. The funds in question are required to provide general and specialist care, hospitalization for general surgery, and medicines. Patients bear up to 30 percent of the cost of hospitalization and 25 percent of the cost of medicines. Some funds and various federations of funds in the larger population centers operate their own clinics, which provide medical services directly to patients. Elsewhere, services are provided by physicians under contract with a fund or in public institutions.

Sickness insurance benefits, including medical care, are financed from employer and employee contributions. Each fund fixes its own contribution rates, sometimes through collective agreements; usually the employee rate is about 1 percent of wages and the employer rate about 3.3 percent.

In the seven countries in *Eastern Europe* that do not require contributions after retirement, old-age pensioners and their dependents are, in general, entitled to medical benefits on the same basis as currently employed workers. Services are usually provided through a public clinic or other facility. Typically, all social security benefits in these countries—cash or medical—are financed mainly from a single combined contribution payable by every employing enterprise. There is thus, in effect, a pooling of pension and sickness insurance funds. In *Yugoslavia*, pensioners may receive prescribed medicines entirely without cost. Currently insured

workers, however, receive only 30 percent of the cost of such medicines.

In *Libya* the social insurance law makes the same medical benefits available to pensioners as to currently insured workers. Provision of benefits to family members has, however, been deferred by regulation. Pensioners do not pay contributions after they retire. Benefits include general practitioner care, in-patient specialist care, out-patient specialist care where available, hospitalization, and essential medical supplies. Medical benefits are provided by dispensaries and pharmacies operated by the National Social Insurance Institution and by doctors of the Provincial health services and Provincial hospitals, which are reimbursed by the Institution.

The cost of medical benefits for pensioners is financed from current contributions to the medical benefit program as a whole. These contributions are 1.6 percent of wages for employees and 2.5 percent for employers.

CONTRIBUTORY COVERAGE OF BENEFICIARIES

In some countries, old-age insurance beneficiaries are automatically entitled to medical benefits under the regular sickness insurance program but must pay a special contribution for such protection after they retire. The countries in which this is the practice are Austria, Bolivia, Chile, Greece, Luxembourg, Mexico, Nicaragua, Panama, Paraguay, and Spain.

In *Austria* the insurance institutions that administer pensions withhold 1.0–2.5 percent from each old-age benefit paid (a minimum of 6 schillings a month (\$0.23)) for sickness insurance coverage. The institutions, in turn, pay an amount equal to 8 percent of their total pension expenditure to the sick funds with which their pensioners are affiliated.

Pensioners are entitled to receive from these funds the full range of medical services available under the regular sickness insurance program, including medical treatment, hospitalization, and medicines. The only restriction on the duration of services is a 26-week limit on hospitalization, which may be extended in some circumstances to 52 weeks. Medical services are ordinarily provided by doctors under contract with the sickness funds, and in dispensaries and hospitals belonging to the funds or with which they have a contract. Doctors and hospitals are usually paid directly by the funds, the former on a capitation basis.

In *Bolivia*, each old-age pensioner continues to have coverage for himself and his family under sickness insurance, and 5 percent is deducted from his pension for that purpose. Medical benefits include general and special medical care, hospitalization, medicines, and dental care. These are provided for a maximum of 26 weeks in any 12-month period and sometimes up to 52 weeks if there is a reasonable chance of recovery within that time. Medical services are usually provided by dispensaries and other facilities operated by the National Social Security Fund.

In *Chile* all pensioners under the social insurance system for wage earners have 5 percent of their pension withheld by law. In return, they are entitled to medical care under the National Health Service as long as their pensioner status continues. Such care includes the services of doctors and dentists, medicines, and 85 percent of the cost of hospitalization. The services are usually furnished directly to patients through dispensaries and hospitals of the National Health Service.

In *Greece*, old-age insurance beneficiaries have 4 percent of their pensions deducted for medical care benefits (though a 4-percent increase in pensions was granted in October 1960 to offset this charge). They and their dependents are entitled to receive medical services in dispensaries and hospitals operated by the Central Social Insurance Institution or in facilities of the special occupational fund with which they were previously affiliated. The services are the same as those available to active insured workers covered by sickness insurance and include medical treatment, medicines, and hospitalization, with no limit on duration.

Patients pay up to 20 percent of the cost of medicines provided, a fee for each prescription given by a doctor, and various flat charges for other services. The sickness insurance program as a whole is financed from employee contributions of 3¼ percent of wages and employer contributions of 6¼ percent.

Luxembourg requires old-age insurance beneficiaries to pay 2.6 percent of their monthly pension to the sickness fund with which they were previously affiliated. The pension institutions paying the benefits must also contribute an amount equal to 1.3 percent of their pension expenditure to the funds concerned.

Beneficiaries are thereby eligible on the same basis as employed members of the sickness funds for medical benefits, including general and specialist

care, hospitalization, laboratory services, dental care, and 75–85 percent of the cost of medicines. Surgeons, hospitals, and druggists are generally paid directly by the sickness funds, on a fee-for-service basis. For other types of medical care, most funds use a partial reimbursement system.

In *Mexico*, entitlement to medical benefits under sickness insurance also extends to old-age insurance beneficiaries and their family members. Pensioners pay $2\frac{1}{4}$ percent of their pension for this coverage—the proportion of wages that employed workers pay for sickness insurance. The Mexican Social Insurance Institute contributes an additional $4\frac{1}{2}$ percent of the pension amount, corresponding to the employer contribution for active workers.

Care is provided mainly through clinics, hospitals, and pharmacies operated by the Institute, though some use is made of contract doctors in rural areas. Services include surgery, hospitalization, and medicines, as well as general care. Duration is usually limited to 52 weeks but may be extended to 72 weeks if recovery is considered likely within that time.

The social security law of *Nicaragua* provides that old-age pensioners shall continue to be eligible for medical benefits under sickness insurance. This law currently is operative only in the Managua urban area but is to be extended gradually to other regions. Pensioners must pay $4\frac{1}{2}$ percent of their pensions for the medical protection, and the Government pays an additional $1\frac{1}{2}$ percent.

Medical services are provided in dispensaries and other facilities of the National Social Security Institute or in public or private establishments with which it has contracts. Services include medical attendance, hospitalization, laboratory services, and various medicines.

In *Panama*, persons receiving old-age insurance benefits under the social insurance program must pay 4 percent of their pensions toward the cost of continued coverage under the medical benefit provisions. They are eligible for the same health services as actively employed workers. By voluntarily paying an additional 5 percent of their pension, they can secure medical protection for the members of their family as well.

Medical services are usually provided in the larger cities through dispensaries and other facilities of the Social Insurance Fund, including a new social insurance hospital. Where Fund facilities are not available, patients may be reimbursed for part or all of the cost of care obtained privately.

Old-age insurance beneficiaries in *Paraguay* must pay 5 percent of their pensions toward continued coverage under sickness insurance—the same percentage as currently employed workers pay of their wages. They and their dependents are entitled to free medical services in clinics and hospitals operated by the Social Insurance Institute. The services include general and specialist medical treatment, hospitalization, laboratory services, pharmaceuticals, and some dental care. Medical benefits are provided for a maximum of 26 weeks for one illness (52 weeks in special cases).

In *Spain*, old-age pensioners and their dependents are covered for medical care under the sickness insurance program. They must pay 2 percent of their pension for this coverage, which is the percentage of wages payable by currently employed workers. Employers contribute at the rate of 5 percent of payroll.

Benefits include the services of general practitioners and specialists, medicines, and hospitalization. Services are available for 39 weeks in a year, or in special circumstances for 52 weeks, except that hospitalization is limited to 12 weeks. They are provided through medical establishments operated by the National Welfare Institute or by doctors with whom the Institute has contracts and whom it pays on a capitation basis. Pensioners under the extensive system of mutual benefit societies are also eligible for medical benefits in addition to their pension.

COVERAGE OF ALL RESIDENTS

Some countries maintain comprehensive programs of medical care, which by law apply in general to all residents. Old-age pensioners are covered under all these programs, but their coverage is usually based on residence alone, rather than on special status as a pensioner. The countries that provide this broad coverage are *Australia*, *Bulgaria*, *Iceland*, *New Zealand*, *Norway*, *Sweden*, the *Union of Soviet Socialist Republics*, and the *United Kingdom*.

In the *United Kingdom*, the *Soviet Union*, and *Bulgaria*, old-age benefits are provided on an insurance basis, but medical care services are, in principle, available to every resident without regard to insurance or beneficiary status. These services, including doctors' services, hospitalization, and drugs, are provided directly to the population,

within the limits of available facilities, through a national health service or public health system rather than on a reimbursement basis. In the United Kingdom, services are provided by doctors and druggists, who are under contract with and paid directly by the National Health Service, and by public hospitals; doctors are usually paid on a capitation basis. In the other two countries, medical treatment is provided by salaried doctors employed in public medical establishments.

Services in these three countries are financed in large measure from general revenues, except for limited cost-sharing by patients for some medicines or other items. In the United Kingdom, however, a small national health service contribution of 2-3 shillings a week (28-42 cents) is also payable by active workers and their employers but not by pensioners.

The health benefits program of *New Zealand* also covers all residents, including the aged recipients of universal superannuation benefits and of age benefits based on an income test. Doctors, druggists, and hospitals receive payments for services rendered from a public "social security fund"; payments to doctors are generally made on a fee-for-service basis. Both payments to doctors and to private hospitals are at fixed rates. If these rates do not cover the gross fee or charge, the patient must pay the difference directly.

Like the cash social security benefits, health benefits are financed mainly through special earmarked taxes on income of individuals and corporations. The remainder comes from general revenues.

In *Australia*, an old-age pension is payable to every aged citizen whose income and property are below specified levels. All recipients of this pension are automatically entitled under a "pensioner medical service" to free general practitioner care in the office or at home, free medicines prescribed by a doctor, and a hospital benefit of 36 shillings (\$4) for each day of hospitalization. Payment is made by the Department of Health directly to the doctor, druggist, or hospital. All residents not eligible for pensioners' medical benefits may receive instead a hospital benefit of 8 shillings a day; they may obtain most prescribed medicines at a cost of 5 shillings per prescription.

In addition, about 70 percent of the population are contributory members of more than 100 voluntary benefit organizations that refund up to 90 percent of doctors' bills and pay an additional hospital benefit of 10-60 shillings a day. The Government

pays a subsidy to these organizations; the maximum payment is 50 percent of their outlays. All Government expenditures for medical benefits are financed from general revenues exclusively.

In *Sweden*, all adult residents, including old-age pensioners, are compulsorily covered under the national health insurance program. This program is financed from contributions by insured persons and employers and from Government subsidies, but pensioners are excused from contributing.

Medical benefits include refunds of up to 75 percent of the cost of fees paid to doctors, subject to maximums fixed in a fee schedule; the cost of hospitalization in a ward of a public hospital; free medicines for some chronic diseases and other medicines at half price; and limited dental care. Duration of benefits is unlimited, except that hospitalization is provided to pensioners for only 6 months and to other persons for up to 2 years.

In *Norway*, which pays a pension to every aged resident, all family heads, including pensioners, must belong to a private or public local insurance fund furnishing medical as well as cash benefits. The funds derive part of their income from members' contributions, but low-income pensioners are exempt from this requirement. Employers contribute to the funds, which also receive subsidies from the National Government and from local governments equal to one-fifth and one-fourth of members' contributions, respectively.

Medical benefits provided to members by the funds include 66-75 percent of the cost of doctors' fees, dental care, and transportation; free hospitalization in public hospitals; and specified essential medicines and laboratory services. Some funds make direct payments, according to a fee schedule, to doctors with whom they have a contract; patients pay the balance, if any, of the fee. Other funds reimburse the patient.

Iceland pays old-age pensions to citizens on the basis of an income test. All residents, including pensioners, must become members of one of the sickness funds, which are financed from members' contributions and Government subsidies equal to one-third of such contributions. Contributions on behalf of pensioners, however, are paid to the funds by the State Social Security Institute. These take the form of an annual lump sum equal to 4 percent of all pensions paid by the fund in the preceding year.

The sickness funds contract with doctors and hospitals for the provision of services to their mem-

bers and pay them directly for such services. Medical benefits include general medical care, hospitalization, 50-100 percent of the cost of various medicines, and X-rays. Some funds also pay for the cost of specialist care, other laboratory services, and transportation.

VOLUNTARY COVERAGE OF PENSIONERS

In a few countries—Denmark, the Netherlands, Peru, and Switzerland—old-age pensioners are permitted to insure themselves voluntarily under the public sickness insurance program. They are required, in all cases, to pay a contribution if they wish to avail themselves of this privilege.

In *Denmark*, recipients of national old-age pensions, like all other residents with low or moderate incomes, may decide for themselves whether or not to become active members of one of the numerous sick clubs. Those who elect active membership receive from their club certain statutory benefits, including general practitioner care, hospitalization in a public hospital, home nursing, and 75 percent of the cost of essential medicines. Some clubs voluntarily provide additional benefits, such as specialist care, dental care, 75 percent of the cost of less important medicines, care in a convalescent home, and appliances. There is no limit on the duration of services. Care is ordinarily provided by doctors and hospitals under contract with and paid directly by the clubs; the doctors are usually paid through the capitation method.

The contributions payable to the Danish clubs by pensioners who are active members vary somewhat but average about 4 crowns a month (\$0.58). In addition to membership fees, the clubs receive subsidies from the national and local governments covering about 30 percent of their expenditure. These payments include 5 crowns a year per active member; 25 percent of the cost of medical treatment, home nursing, and dental care; a 50-percent reduction in hospital charges in public hospitals; 75 percent of the cost of chronic care; the full cost of certain essential medicines and transportation; and payment of the contributions of needy members.

The *Netherlands* has a somewhat similar plan. Recipients of the quasi-universal old-age pensions may join one of the approved sickness funds voluntarily, if their income does not exceed 3,590 guilders a year (\$1,002). Their contributions of 0.92 guilders or 1.84 guilders a week (\$0.25 or

\$0.50), depending upon annual income, meet one-fourth and one-half of the cost. Fifty percent of the remaining cost is covered by a Government subsidy, and the remainder from a general equalization fund set up under the sickness insurance program.

Benefits provided by the sickness funds include medical treatment, laboratory services, medicines, hospitalization, and appliances. Services are normally provided by doctors, druggists, and hospitals under contract with and paid directly by the sickness funds; doctors are usually paid on a capitation basis.

In *Peru*, pensioners under the two social insurance systems (one for wage earners and one for salaried employees) may choose, when they retire from employment, whether to continue to be covered for medical benefits under the sickness insurance provisions. If they elect to continue coverage, they must pay a contribution equal to 4 percent of their pension. Medical services are ordinarily provided through clinics and hospitals operated by the National Social Insurance Fund or the Salaried Employees' Social Insurance Fund.

Other revenues of the two social insurance programs include employee and employer contributions and, in the wage earners' program, a Government contribution as well.

Sickness insurance in *Switzerland* is voluntary in some Cantons but compulsory in all or parts of others. More than three-fourths of the population now belong to public and private sickness insurance funds, which number about 1,100. An old-age insurance beneficiary, like any other resident, may become a member of one of these funds voluntarily unless the fund imposes an age limit, which it may do under the Federal law. About 85 percent of the revenues of the sickness insurance funds, on the average, comes from members' contributions. The remainder consists of Government subsidies.

Benefits are required by Federal law to cover at least 75 percent of the cost of medical treatment and of specified medicines. Many funds pay up to 90 percent of the cost of medical treatment, however, as well as a part of the cost of hospitalization, dental care, additional medicines, appliances, etc. The funds generally pay doctors directly for their services to members, on a fee-for-service basis.

OTHER TYPES OF COVERAGE

Ireland provides old-age insurance benefits to aged persons. Its Department of Health also

furnishes free general practitioner care, hospital and specialist services, and necessary medicines to all persons, including pensioners, whose income is less than 800 pounds a year (\$2,240) or who are medically needy. In the latter group are those persons who are unable to procure the services from their own resources. The services are usually furnished by dispensaries and hospitals of the county and city health authorities.

Canada, which pays a universal old-age pension to all aged residents, has a system of hospitalization insurance under which the Provinces establish their own programs and receive in turn a national subsidy covering about half the cost. These programs cover all residents of the Province concerned, including old-age pensioners. Benefits include standard ward hospital care, necessary nursing, in-patient diagnostic and laboratory services and drugs, operating-room facilities, and limited diagnostic out-patient services. There is some variation among the Provinces, however, in the exact range of services. The Provinces meet their share of the cost in various ways—from premium payments by the insured, sales taxes, general revenue, or a combination of these.

Japan has two separate systems of health insurance. The compulsory health insurance system applies to currently employed workers of firms with five or more employees in industry and commerce; it does not cover old-age insurance beneficiaries. The other system (national health insurance) applies compulsorily to all residents not otherwise covered, including pensioners. In a number of areas,

clinics and hospitals are operated by municipal health insurance funds under the latter system, for direct provision of care to their members. In other areas, medical benefits are furnished on a reimbursable basis. Services are financed by members' contributions, which sometimes take the form of a municipal health tax, and by Government subsidies.

COVERAGE NOT AVAILABLE

In eight countries that have both an old-age benefit program and a sickness insurance program providing medical benefits, the latter program does not cover old-age beneficiaries. These countries are Brazil, Colombia, Costa Rica, the Dominican Republic, Guinea,¹ and Turkey.

Nineteen countries have an old-age pension or benefit program for at least a significant number of the employees in private industry but have no general statutory program providing medical benefits either for pensioners or for other persons. The countries in this group include Argentina, Ceylon, China (Nationalist), China (Communist), Congo (Leopoldville), Cuba, Cyprus, Finland, Iraq, Israel,² the Ivory Coast, Malaya, Morocco, Nigeria, the Philippines, South Africa, United Arab Republic, Upper Volta, and Uruguay.

¹ India has a provident-fund system paying only a lump-sum benefit upon retirement.

² Israel has an extensive system of voluntary health insurance that covers about three-fourths of the population, including a large number of pensioners.

Notes and Brief Reports

Workmen's Compensation Payments and Costs, 1961*

Although there was a leveling off of employment during the year, payments—both cash and medical—made under workmen's compensation programs in 1961 continued to rise at almost the same pace as in the preceding year. The total of \$1,362 million paid out under the State and Federal laws represented a 5.7-percent advance from the 1960 aggregate

* Prepared in the Division of Program Research by Alfred M. Skolnik and Julius W. Hobson. Annual estimates of workmen's compensation payments in recent years appeared in the December or January issues of the *Bulletin*. A summary article appeared in the *Bulletin* for June 1962.

of \$1,288 million. The 1960 rise was 6.5 percent. In the recession years of 1954 and 1958, however, increases of only 4.2 percent and 4.7 percent were registered.

The performance of workmen's compensation in 1961 is even more unusual in view of the decline in disabling work injuries. The rate dropped, the Bureau of Labor Statistics reported, from 30.4 per 1,000 workers in 1960 to 30.1 per 1,000.

Apparently influential in pushing benefit payments to new heights were (1) an increase of 3 percent in average wages, to which cash benefits are related; (2) an advance of 3 percent in medical care prices, according to the consumer price index of the Bureau of Labor Statistics; and (3) liberalization of State workmen's compensation laws.

A rough indication of the higher wages to be com-