Policy Responses to Rising Autism Diagnoses in Childhood

Across the Spectrum

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ACROSS THE SPECTRUM

BETTER POLICIES FOR BETTER LIVES

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Preface

My husband and I have two children, born two years apart. Very early on, around six months old, I noticed signs in our youngest son L. that concerned me: he didn’t make much eye contact, he babbled very little, and he had strong sensory reactions, particularly to touch, which contrasted sharply with those of his older brother. Over time, other difficulties emerged: limited social interaction, limited language, and a lack of understanding of the implicit rules of everyday life. At first, my concerns were dismissed. The professionals suggested that it was a temporary developmental delay that they did not consider concerning, and implied that I was perhaps being a bit too anxious as a mother, while family members suggested I was comparing him too much to his brother. It was a very difficult time. It was ultimately thanks to a friend that we were able to get a referral to a child psychiatrist. For the first time, my observations were taken fully into account.

The diagnosis, made at the age of three after a week-long multi-disciplinary assessment at the hospital, was a turning point: autism spectrum disorder associated with attention deficit disorder, without cognitive delay. This moment was both a relief and a source of anxiety. It provided an explanation, but above all it opened up a new phase: how to organise the necessary support in practical terms? Very quickly, our daily life became structured around therapy sessions: speech therapy, psychomotor therapy, psychology, several times a week. Our schedules became increasingly busy. I adapted my professional activity to co-ordinate appointments and follow-up. This organisation is demanding, but it is essential for progress: early and regular intervention has a direct impact on development.

In everyday life, many learning processes had to be explicitly constructed. Simply brushing teeth, for example, was entirely sequenced: 1) Turn on the tap; 2) Wet the toothbrush; 3) Turn off the tap; 4) Open the toothpaste; 5) Put a small amount on the toothbrush; 6) Close the toothpaste; 7) Brush the upper teeth (front); 8) Brush the lower teeth (front); 9) Brush the teeth on the right; 10) Brush the teeth on the left; 11) Spit into the sink; 12) Rinse the mouth; 13) Rinse the toothbrush; 14) Wipe the mouth; and 15) Put the toothbrush away. This sequence was translated into: pictograms displayed on the wall; photos of our son performing each step, a two-minute visual timer, a timed song, a mirror to encourage imitation, an hourglass placed near the sink.

These aids, repeated day after day, enabled gradual learning. These actions may seem simple, but they sometimes require years of structured, repeated and patient learning. The challenge was not only about practical independence, but also social skills: responding to his name, asking for help, waiting his turn, coping with the noise of the playground, understanding the unspoken rules of social interaction.

For L., however, one of the most persistent difficulties remains his ability to form relationships outside the family circle. Despite the progress made, making friends, maintaining spontaneous relationships, understanding the implicit aspects of a conversation, and knowing how to interact naturally remain daily challenges. I remain convinced that in a more inclusive, better informed, and more open-minded society, these relationships would be easier to build because the effort to adapt would not fall solely on him.

Every step forward took time; every difficulty exposed me to the outside world, sometimes to the critical gaze of those who judge a child to be “ill-mannered”, or to those who direct reproach and contempt at the parents.

Schooling was another key focus. We chose mainstream education, convinced that learning social codes requires interaction with other children. An AESH (special needs teaching assistant) was assigned by the school, but the support modalities did not fully meet his needs. It was in this context that we were fortunate to discover the *Sur les bancs de l'école* association. Thanks to it, L was able to receive truly adapted support: an AESH recruited for their expertise with autistic children, trained and supervised weekly, and capable of creating a stable link between the family, the school and the therapists. This support ensured a more consistent and continuous provision of care. We also discovered a group of supportive and determined parents, with whom we formed genuine friendships. Mothers became essential sources of support, true warriors who would stop at nothing when it came to their children.

It is also important to point out that L.'s schooling would not have been possible without our constant involvement and daily support. Beyond the institutional arrangements, we had to provide close guidance at home, go over concepts that had not been understood, anticipate difficulties, and adapt learning methods accordingly.

To access relevant public services in France, a general assessment of a child's needs by the local authority for people with disability is required. To allow L. to be educated in a mainstream setting with the support of an assistant, nevertheless, every year again a meeting must be held with the educational team and a document be completed explaining the child's needs before the application can be submitted. Then, often with anxiety, we must wait for the renewal of the school's assistant, without which no schooling in a mainstream environment is possible.

I am aware that our journey has been made easier by financial, cultural and social resources that have enabled us to mobilise the right professionals and effectively defend our son's rights. Not all families have these levers at their disposal. For many, despite constant commitment, the outlook remains uncertain, particularly when mainstream schooling is no longer possible and specialised solutions remain insufficient.

Today, our son is 18 years old. Obtaining his baccalaureate was a major milestone and a source of immense joy, commensurate with the years of co-ordination and perseverance it represented. He is now pursuing higher education, where the issue of inclusion and, ultimately, that of professional integration, continues to be a source of concern. Our experience has led us to one conviction: behind every administrative procedure and every budgetary decision, there are people's lives. Better diagnosis, better support and better inclusion are not just a matter of technical organisation; they are a collective responsibility, supported by ambitious public policies and a shared desire to build a truly inclusive society.

Gaelle Gouarin,

mother of L.

Foreword

In the past decade, OECD countries have seen a sharp almost exponential increase in the number of children diagnosed with autism spectrum disorder (ASD). The speed of change and an associated increase in many countries in public spending for various treatments, services and supports for children with ASD, has raised concerns on the most effective and adequate policy response. These concerns are particularly strong in Israel where the increase in ASD diagnoses started a bit later but was even faster. The Ministry of Finance of Israel, therefore, turned to the OECD Secretariat, commissioning a comparative study on recent developments, services and policies in different OECD countries, and recent policy responses.

The first part of the report provides a comparison of policy approaches across 11 diverse OECD countries, including smaller and larger countries, European and non-European countries, and countries with distinct health and social protection systems. The covered countries include Australia, Canada, Denmark, Estonia, France, Germany, Israel, the Netherlands, Sweden, the United Kingdom, and the United States. As policies in Canada and the United States vary strongly by province/state, much of the information in this report refers to the province of Ontario (Canada) and the state of California (United States) – two regions with very developed programmes for children with autism.

The second part of the report zooms into five countries, Australia, Germany, Israel, the Netherlands and Sweden, digging deeper in all directions of policy and practice – data collection, diagnosing practices, policy responses, service availability and policy design – and building in-depth case studies to strengthen and deepen mutual learning. The second phase included discussions with a range of stakeholders from the five countries to get a better understanding of both regulations and policy implementation.

The purpose of this report is to provide a comparative picture across a selection of OECD countries on trends in diagnosing practices and the number of children diagnosed with ASD and on financial benefits and relevant services (education, health and social services) that are available to them. The comparison pays particular attention to differences, both within systems and across countries, between children with different levels of support needs (mild, moderate, severe), as the population diagnosed with ASD is characterised by huge unevenness – which in many ways is the general characteristic of a “spectrum”.

The report finds that the population of children diagnosed with ASD is growing in all countries, with some variation in the timing and speed of change, suggesting significant potential for mutual learning from policies and practices in other countries. It also finds that the approach of Israel is unique in many ways. In almost all countries studied, at least some assessment of needs is required for a child with ASD to be able to access financial benefits and services. Only for Israel’s Disabled Child Allowance, a diagnosis of ASD alone is sufficient for benefit access, with repercussions on many different aspects of policy.

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Furthermore, the production of this report benefitted greatly from the input and comments received from national experts, member state representatives and other stakeholders. Country experts and delegates are too many to name individually, but the authors would like to thank in particular the Department of Health, Disability and Ageing and the National Disability Insurance Agency from Australia; the German Ministry of Health; the Ministry of Education, Culture and Science and the Social Insurance Bank (*Sociale Verzekeringsbank*) in the Netherlands; the Social Security Agency (*Försäkringskassan*) and the National Board of Health and Welfare (*Socialstyrelsen*) from Sweden; and the Department for Education and the National Autism Programme at the National Health Service (NHS) in the United Kingdom.

Several non-governmental organisations and service providers also contributed generously to this report. We would like to thank the following organisations for their time, input and comments: ALUT (Israel); Bizchut (Israel); Autism Awareness Australia; Amaze (Australia); Autism Aspergers Advocacy Australia; Autism SA (Australia); Autism Canada; Eesti Autismiliit (Estonia); Autisme France; Autismus Deutschland e.V. (Germany); and Nederlandse Vereniging voor Autisme (Netherlands).

The report was prepared by a team from the OECD's Employment, Labour and Social Affairs (ELS) Directorate, under the overall co-ordination of Christopher Prinz (Employability Division) and Emily Hewlett (Health Division). Chapter 1 was prepared by Christopher Prinz in collaboration with all authors. Chapter 2 on diagnosis was prepared by Anna Victoria Perez-Lopez (Health Division) and Emily Hewlett. Chapter 3 on financial benefits and Chapter 4 on services were prepared by Valerie Kornis (Employability Division) and Christopher Prinz. The case studies (Chapters 5 through 9) were prepared by Valerie Kornis and Anna Victoria Perez-Lopez, under the supervision of Christopher Prinz and Emily Hewlett. Statistical support was provided by Dana Blumin. Administrative support was provided by Monica Meza-Essid. Communication support was provided by Natalie Corry, Charlotte Mapp and Alastair Wood from the ELS Communication team. The publication benefited from useful comments from Cecilia Mezzanotte and Lucie Cerna (Directorate for Education and Skills), Theodora Xenogiani, Head of the OECD Employability Division, Frederico Guanais, Deputy Head of the OECD Health Division, Francesca Colombo, Head of the OECD Health Division and Mark Pearson, Deputy Director of ELS. The authors would also like to thank Liora Bowers for her valuable input throughout the project and Gaelle Gouarin for providing the personal testimony for the preface.

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Note on language

This report uses the terms “autism” and “autism spectrum disorder” (or ASD) interchangeably.

- Autism is a broad term widely used in academic literature and by policymakers. It can refer to the medically diagnosed condition known as autism spectrum disorder and earlier diagnostic categories, such as pervasive developmental disorder, autistic disorder, Asperger’s Disorder, etc. It can also refer to individuals who self-identify as having autism without an official diagnosis.
- Autism spectrum disorder or ASD generally refers to a medically recognised condition as defined in diagnostic manuals, such as ICD-11 and DSM-5. It may also encompass diagnoses made under previous versions of these manuals, as well as individuals describing themselves as having the disorder.

Throughout this report, references to autism or ASD primarily concern people with a formal diagnosis and/or those receiving disability benefits related to autism. In some instances, the terms may also include individuals who report having autism in national surveys, even if they may not have an official diagnosis.

Furthermore, the report adopts person-first language, which emphasises the individual rather than defining them by a diagnosis or impairment. In contrast to identity-first language, which foregrounds the condition, person-first language places the person at the centre. Accordingly, this report uses formulations such as “a child with autism” rather than “an autistic child”.

Autism is characterised by a wide spectrum of presentations, encompassing diverse strengths, challenges and needs. For the purposes of policy analysis and cross-country comparison, this report distinguishes between different levels of support needs – mild, moderate and severe. This terminology is used as an analytical framework and does not seek to capture the full heterogeneity of experiences of children with autism or those of their families. Rather, it facilitates a structured examination of policy design and implementation across countries. Where national policies explicitly use the term “functioning”, the report adopts the same terminology in the relevant country context to ensure consistency. Such references to functioning should be understood in line with the World Health Organization’s International Classification of Functioning, Disability and Health (ICF), that is, as a measure of an individual’s performance in interaction with their environment.

The language this report uses is without prejudice to the self-identification of persons in the autism community.

Abbreviations and acronyms

Currency acronyms	
AUD	Australian dollar
CAD	Canadian dollar
DKK	Danish krone
EUR	Euro
GBP	British pound
NIS	New Israeli shekel
SEK	Swedish krona
USD	United States dollar

Standardised diagnostic instruments	
3di	Developmental, Dimensional and Diagnostic Interview
ABAS-II	Adaptive Behaviour Assessment System, Second edition
ADI-R	Autism Diagnostic Interview – Revised
ADOS (-2)	Autism Diagnostic Observation Schedule (Second edition)
AQ	Autism-Spectrum Quotient
ASQ-SE2	Ages and Stages Questionnaires SE-2
ASSQ	Autism Spectrum Screening Questionnaire
CARS	Childhood Autism Rating Scale
CAST	Childhood Autism Spectrum Test
CAT-Q	Camouflaging Autistic Traits Questionnaire
CSBS	Communication and Symbolic Behaviour Scales
DISCO	Diagnostic Interview for Social and Communication Disorders
ECA-R	*Échelle d'évaluation des comportements autistiques révisée* [Autistic behaviours evaluation scale, revised]
GARS	Gilliam Autism Rating Scale
MBAS	Marburg Assessment Scale for Asperger's Syndrome
M-CHAT	Modified Checklist for Autism in Toddlers
MHI-5	Mental Health Inventory
SCQ	Social Communication Questionnaire
SCW	South Central Wisconsin (from Group Health Co-operative of South-Central Wisconsin, GHC-SCW)
SEAS-M	Scale for the Assessment of Autism Spectrum Disorders in the Less Abled
SRS	Social Responsiveness Scale
VISK/CSBQ	*Vragenlijst voor Inventarisatie van Sociaal gedrag van Kinderen* [Children's Social Behaviour Inventory Questionnaire]
WPPSI-IV	Wechsler Preschool and Primary Scale of Intelligence, Fourth edition

International acronyms	
ABA	Applied Behaviour Analysis
ADHD	Attention Deficit/Hyperactivity Disorder

International acronyms	
AI	Artificial Intelligence
APA	American Psychiatric Association
ASD	Autism Spectrum Disorder
CDD	Childhood Disintegrative Disorder
DSM	Diagnostic and Statistical Manual
ESCAP	European Society of Child and Adolescent Psychiatry
GP	General Practitioner
HMO	Health Management Organisation
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
IEP	Individual Education Plan
LLM	Large Language Model
NDD	Neurodevelopmental Disorder
NGO	Non-governmental organisation
OCD	Obsessive-Compulsive Disorder
OECD	Organisation for Economic Co-operation and Development
PDD	Pervasive Developmental Disorder
PDD-NOS	Pervasive Developmental Disorder, Not Otherwise Specified
PPP	Purchasing Power Parity
SEN	Special Educational Needs
SES	Socio-economic Status
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

Country-specific terms

Australia	
DCLA	Disability Care Load (Child) Assessment
DCLAD	Disability Care Load (Child) Assessment Determination
ILP	Individual Learning Plan
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
QDTP	Quality Differentiated Teaching Practice
SALP	Specialised Autism Learning Programs
SDAC	Survey of Disability, Ageing and Carers
SRS	Schooling Resource Standard

Canada	
ACSD	Assistance for Children with Severe Disabilities
AISH	Assured Income for the Severely Handicapped
CDB	Child Disability Benefit
CHSCY	Canadian Health Survey on Children and Youth
CTC	Children’s Treatment Centre
DTC	Disability Tax Credit
IPP	Individualised Program Plan
MCCSS	Ministry of Children, Community and Social Services
OAP	Ontario Autism Program

PSLP	Preschool Speech and Language Program
SBRS	School-Based Rehabilitation Services
SSAH	Special Services at Home

Denmark		
LPR	*Landspatientregisteret*	National Patient Registry
PPR	*Pædagogisk Psykologisk Rådgivning*	Pedagogical Psychological Counselling

Estonia	
SRC	Social Rehabilitation Centre

France		
AEEH	*Allocation d'éducation de l'enfant handicapé*	Education Allowance for Disabled Children
AJPP	*Allocation Journalière de Présence Parentale*	Daily Parental Presence Allowance
CAF	*Caisse d'Allocations Familiales*	Family Allowance Fund
CAMSP	*Centre d'action médico-sociale précoce*	Centre for early medico-social action
CDAPH	*Commission des droits et de l'autonomie des personnes handicapées*	Commission on the Rights and Autonomy of Persons with Disabilities
CMI	*Carte mobilité d'inclusion*	Mobility Inclusion Card
CMP	*Centre medico-pédagogique*	Medico-psychological centre
CMPP	*Centre médico-psycho-pédagogique*	Medico-psycho-pedagogical centres
CRA	*Centre de Ressources Autisme*	Autism Resources Centre
EPE	*Équipe Pluridisciplinaire d'Évaluation*	Multi-disciplinary Evaluation Team
ESS	*Équipe de Suivi de la Scolarisation*	School Monitoring Team
GEVA	*Guide d'évaluation des besoins de compensation des personnes handicapées*	Guide to assessing the needs of disabled people
GEVA-Sco	*Guide d'évaluation des besoins de compensation en matière de scolarisation*	Guide to assessing needs in education
HAS	*Haute Autorité de Santé*	Health Authority
MDPH	*Maison Départementale des Personnes Handicapées*	Department for the Disabled
PCH	*Prestation de compensation du handicap*	Disability Compensation Benefit
PCO	*Plateforme d'orientation et de co-ordination*	Co-ordination and Guidance Platform
PPS	*Projet personnalisé de scolarisation*	Individualised Education Plan
SESSAD	*Services d'Éducation Spéciale et de Soins à Domicile*	Special Education and Home Care Services
UEEA	*Unité d'enseignement en élementaire autisme*	Elementary School Autism Unit
UEMA	*Unité d'enseignement maternelle autisme*	Pre-school Autism Unit
ULIS	*Unités Localisées pour l'Inclusion Scolaire*	Local Units for School Inclusion

Germany		
AGG	*Allgemeine Gleichbehandlungsgesetz*	General Equal Treatment Act
AWMF	*Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften*	Association of the Scientific Medical Societies
BGG	*Behindertengleichstellungsgesetz*	Disability Equality Act
BTHG	*Bundesteilhabegesetz*	Federal Participation Act
SGB	*Sozialgesetzbuch*	Social Code

Israel		
ALUT	אלו”ט	Israeli Society for Autistic Children
NII	המוסד לביטוח לאומי (*Bituah Leumi*)	National Insurance Institute
RAMA	*הרשות הארצית למדידה והערכה בחינוך*	National Authority for Measurement and Evaluation in Education

the Netherlands		
CBS	*Centraal Bureau voor de Statistiek*	Central Bureau of Statistics
CIZ	*Centrum Indicatiestelling Zorg*	Centre for Indications for Care
JW	*Jeugdwet*	Youth Act
NIP	*Nederlands Instituut van Psychologen*	Dutch Institute of Psychologists
NVvP	*Nederlandse Vereniging voor Psychiatrie*	Dutch Association for Psychiatry
PGB	*Persoonsgebonden Budget*	Personal Budget
SBO	*Speciaal Basisonderwijs*	Special Primary Education
SO	*Speciaal Onderwijs*	Special Education
SVB	*Sociale Verzekeringsbank*	Social Insurance Bank
TLV	*Toelaatbaarheidsverklaring*	Declaration of Admissibility
VSO	*Voortgezet Speciaal Onderwijs*	Secondary Special Education
WGBH/CZ	*Wet gelijke behandeling op grond van handicap of chronische ziekte*	Equal Treatment on the Grounds of Disability or Chronic Illness Act
Wlz	*Wet langdurige zorg*	Long-term Care Act
Wmo	*Wet maatschappelijke ondersteuning*	Social Support Act
WsW	*Wet Werk en Bijstand*	Work and Social Assistance Act
Zvw	*Zorgverzekeringswet*	Health Insurance Act

Sweden		
LSS	*Lagen om stöd och service till vissa funktionshindrade*	Act Concerning Support and Service for Persons with Certain Functional Impairments
NBHW	*Socialstyrelsen*	National Board of Health and Welfare
SCB	*Statistiska centralbyrån*	Central Bureau of Statistics
SPSM	*Specialpedagogiska skolmyndigheten*	National Agency for Special Needs Education and Schools

United Kingdom	
APMS	Adult Psychiatric Morbidity Survey
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
EHC(P)	Education, Health & Care (Plan)
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
SENCo	Special Educational Needs Co-ordinator
SEND	Special Educational Needs and Disability
UC	Universal Credit

United States	
ADDM	Autism and Developmental Disabilities Monitoring
APA	American Psychiatric Association
CDC	Centers for Disease Control and Prevention
CDE	California Department of Education
CDSS	California Department of Social Services
DDS	Disability Determination Services
EPSDT	Early & Periodic Screening, Diagnostic & Treatment
HCBS-DD	Home and Community-Based Services for the Developmentally Disabled
IDEA	Individuals with Disabilities Education Act
IEP	Individualised Education Program
IHSS	In-Home Supportive Services
NSCH	National Survey of Children's Health
SECC	Special Education Child Count
SELPA	Special Education Local Plan Areas
SSA	Social Security Administration
SSI	Supplemental Security Income
SSP	California State Supplementary Payment

Executive summary

Autism diagnoses are rising rapidly across OECD countries, placing increasing pressure on health, education and social protection systems

Across all OECD countries reviewed in this report, the rate of ASD detection in children has risen sharply over the past decade. While prevalence estimates differ depending on data sources available, the trend is unambiguous: most countries have experienced average annual increases of 6-10%. This rapid increase reflects several factors: evolving diagnostic criteria, expanding awareness of autism, reduced stigma, earlier developmental surveillance, and broader interpretations of what constitutes the autism spectrum. As a result, demand for diagnostic assessments has grown in many countries and, in some cases, has been accompanied by rising demand for financial support and specialised services, particularly early childhood interventions and tailored educational provision.

Capacity in public diagnostic systems has not always kept pace with rising demand. Many countries report long waiting times for public diagnoses and a shortage of trained professionals. Moreover, evidence consistently shows that diagnostic systems tend to favour families with higher levels of health literacy, language proficiency and resources to navigate complex pathways. In several countries (e.g. Australia, France, Israel, the United Kingdom), waiting times and staffing shortages have driven families towards private assessments, raising concerns about accessibility and consistency. Furthermore, disparities in diagnosis rates persist across sex, socio-economic and ethnic groups: girls and women often present differently and may remain undiagnosed for longer; and children from disadvantaged families or minority backgrounds may face barriers to assessment. These inequalities highlight the importance of structured, high-quality and equitable diagnostic pathways.

Diagnostic practices have become more structured and multi-disciplinary

International diagnostic frameworks have undergone major transformations in recent decades. The consolidation of various pervasive developmental disorder subtypes into a single autism spectrum disorder category under DSM-5 and ICD-11 has broadened eligibility for diagnosis and standardised criteria across countries. These changes enable diagnosis even when symptoms become apparent later, recognise a wide range of presentations, and allow classification of different severity levels.

Diagnostic practice is now more multi-disciplinary, commonly involving developmental paediatricians, psychologists, speech-language therapists and other specialists. Standardised tools, such as ADOS-2, ADI-R, M-CHAT and 3di, enhance reliability, while diagnosis from around age two is widely considered stable when undertaken by experienced clinicians. Emerging technologies, including machine-learning tools for behavioural analysis, show promise in supporting clinical judgement, though they are not yet substitutes for professional assessment.

Countries provide a range of financial supports, but eligibility rules and generosity vary widely

Across the countries studied, financial support for families of children with ASD is provided through three main types of benefits:

- Carer allowances, recognising the reduced labour-market participation and increased caregiving responsibilities of parents.
- Disabled child allowances, providing child-centred income support to ensure adequate living standards and social inclusion.
- Additional cost allowances, covering disability-related expenses such as therapies, equipment and home adaptations.

Eligibility criteria can differ across countries. In almost all OECD countries reviewed, benefits depend on an assessment of support needs rather than diagnosis alone. The clear exceptions are Israel, where an ASD diagnosis automatically confers eligibility for the Disabled Child Allowance, and to some extent Australia, where the Carer Allowance can also be triggered by an ASD diagnosis alone (see case studies for details). Most other systems require a functioning assessment, documentation of care needs or evidence of additional costs.

Benefit levels vary substantially across countries. Countries such as Denmark and Sweden provide relatively high-value supports for children with severe care needs. Others provide more modest benefits, particularly where supports are means-tested. In most countries, children with mild support needs would typically not receive any disability-related allowance, making Israel’s automatic benefit entitlement for all children diagnosed with ASD a notable exception.

Financial support policies also influence parental employment patterns. Non-means-tested, flat-rate payments may unintentionally disincentivise employment for lower-income families, while insufficient support may compel parents to remain in employment while simultaneously lacking sufficient resources to secure external caregiving support for their child. Designing benefit systems that both safeguard family income, support labour market participation, and ensure adequate care and support for the child therefore remains a persistent policy challenge.

Services for children with ASD are extensive but differ markedly in design, intensity and allocation mechanisms

Service provision for children with ASD spans three principal systems: education, health and social services. Most countries aim to tailor supports to children’s assessed needs. These may include:

- Paramedical therapies (speech, occupational and psychotherapy);
- Individualised educational support (teaching assistants, assistive technology, adapted curricula);
- Early childhood programmes targeting developmental delays;
- Social support such as respite care, transport assistance, parent training or after-school programmes.

A key distinction across systems lies in how entitlements are allocated. In most OECD countries, needs-based allocation dominates. Therapy intensity, placement in mainstream versus special education and access to social services typically depend on a multi-disciplinary assessment rather than a diagnostic category.

Israel again stands out among the countries reviewed. Therapy hours in special education settings are standardised by diagnosis rather than individual need (e.g. a fixed number of weekly hours for all children with ASD). This simplicity facilitates planning and ensures a predictable baseline of support, but risks undermining equity: children with mild support needs may receive more services than necessary, while those with more complex needs may not receive enough.

Differences in how support is allocated are also reflected in enrolment patterns. Countries show considerable variation in the proportions of students with special educational needs (SEN) enrolled in mainstream classes, special classes, or special schools, depending on the inclusiveness of their education systems and the supports available in regular settings. While most European countries enrol children with SEN in mainstream schools predominantly, children with ASD in countries like Israel and Australia are notably more likely to be educated in special education settings.

Part I Cross-country comparison

1 Key findings

Autism diagnoses have increased significantly

It is very challenging to establish accurate estimates of the prevalence of ASD, and to compare trends, however measured, across countries and over time.

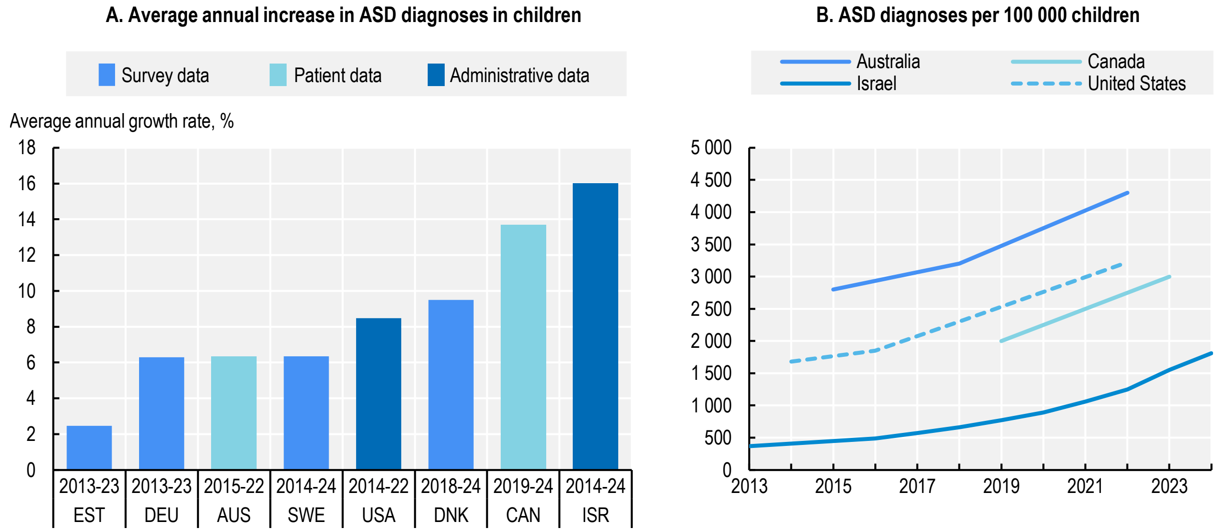
Nonetheless, the number of children diagnosed with ASD has been rising across all countries for which relevant data could be identified. Figure 1.1 attempts to provide information on trends in autism in children during the past decade. Different data reporting can be expected to be sensitive to a change in observed rates; for example, patient data is likely influenced by service capacity in the health system, while survey or administrative data could reasonably be expected to be more complete but may vary depending on the measurement instruments used. Nonetheless, the overall pattern of change shows striking similarities between countries, notably a fast growth in ASD diagnoses in children in recent years.

Figure 1.1, Panel A shows that ASD diagnoses amongst children have increased significantly everywhere, with average annual rates of growth typically around 6-10% during the past decade. Such high annual growth corresponds to between a 2.5-fold increase over a 15-year period (with a 6% annual increase) and a 4-fold increase over the same period (with a 10% annual increase). The exceptionally high annual growth in Israel corresponds to an almost 10-fold increase in 15 years.

Figure 1.1, Panel B, which excludes countries using information from patient records or health system contacts, shows that the slope of the trend curve is also surprisingly similar across countries. The data also does not seem to provide any indication yet of a halt or slowdown in the growth of autism diagnoses, as the growth has not even levelled off. Data should not be interpreted as suggesting that underlying rates of prevalence of ASD in some countries are higher than in others, but rather that all four countries are seeing similar increases in the number of children with an ASD diagnosis registered in administrative systems and/or whose carer indicates they have ASD when asked as part of a survey. Finally, the data also suggest that countries in which increases in autism diagnoses started later, such as Israel, seem to be catching up fast and might expect continued increases of considerable magnitude.

Figure 1.1. Autism diagnoses in children are increasing fast everywhere

Average annual growth in children diagnosed with ASD and rate of ASD diagnoses per 100 000 children in selected OECD countries for available age ranges


A. Average annual increase in ASD diagnoses in children

B. ASD diagnoses per 100 000 children

ASD: autism spectrum disorder.

Note: The differences in the nature of the data make comparisons between countries challenging and the figure should be interpreted with caution. Data refers to available years and the most relevant available source and indicator (survey data for Australia and Canada, administrative data for Israel and the United States, and patient records for the other countries). Data refers to children, ages 5-14 for Australia, ages 1-17 for Canada, ages 0-17 for Denmark, ages 0-14 for Estonia, ages 0-19 for Germany, ages 0-18 for Israel, ages 4-19 for the Netherlands, ages 0-19 for Sweden and children aged 8 for the United States. Panel B excludes data based on patient registers.

Source: Australian Bureau of Statistics (2024[1]), *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads; Statistics Canada (2025[2]), Health indicator statistics for children and youth aged 1 to 17 years, parent reported, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310094701; Social- og Boligstyrelsen (2024[3]), *Demografi – børn og unge [Demographics – Children and young people]*, https://www.social.dk/data/databank/data-om-borgere/demografi-boern-og-unge; Tervise Arengu Instituut (2024[4]), *PKH1: New and prevalent outpatient case consultations by psychiatrist by diagnosis, sex and age group*, https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__02Haigestumus__05Psyyhikahaired/PKH1.px/;, Statistisches Bundesamt (Destatis) (2025[5]), *Diagnoses of hospital inpatients*, https://www-genesis.destatis.de/datenbank/online; Socialstyrelsen (2025[6]), *Statistikdatabas för diagnoser*, https://sdb.socialstyrelsen.se/if_par/resultat.aspx; CDC (2025[7]), *Autism Data Visualization Tool*, https://www.cdc.gov/autism/data-research/autism-data-visualization-tool.html. Data for Israel was provided by national authorities.

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This paper sets out some of the contextual information around changing understanding and diagnostic criteria for ASD. Rather than examining the drivers of rising ASD prevalence, or rising ASD diagnoses, it focusses on how countries support children with ASD and their families, and on whether policies and support systems have adapted in response to increasing diagnosis rates. In this context, it is important to recognise at least three factors which influence understanding of ASD:

- First, understanding of autism has changed significantly ever since it was first recognised as a disorder in 1943. Crucially, this has meant that many different forms and types of related conditions included in earlier versions of diagnostic manuals (DSM-5, ICD-11) are now subsumed under ASD and seen as different versions of the same condition or on the same spectrum.
- Second, ASD is now detected much earlier in the life course; it is now increasingly common, and considered appropriate, to diagnose children at the age of two. The focus on the benefits of early intervention – as discussed later in this paper – can be seen as an additional incentive for diagnosis in very young children. At the same time, adult autism diagnosis is now also far more common.

- Finally, one of the biggest changes over time is an increased awareness of ASD, and falling stigma around a diagnosis of ASD, which may have led to greater diagnosis-seeking or help-seeking by persons who may be displaying signs of autism (or their carers). This shifting awareness includes understanding by the medical establishment and the general population that people with ASD can have very high cognitive abilities, and relatively less apparent functional difficulties, but still meet the criteria for a diagnosis of autism under the current DSM-5 and ICD-11 definitions.

Diagnostic practices have also changed over time, have become highly standardised across countries, and are often undertaken using standardised tools, in most cases implemented by a multi-disciplinary team. The large increase in the number of people seeking an ASD diagnosis also raises issues around the capacity of the system to provide the necessary diagnosis in a timely manner. Public systems in several countries, including Australia, Israel, France and the United Kingdom, are faced with waiting times and capacity constraints, which has led to an increase in the number of diagnoses made by private assessors who are generally paid by the person seeking a diagnosis. In turn, this has raised issues about the validity of and the equality in access to an ASD diagnosis, at least in Israel.

There is significant heterogeneity in both the level of benefits and criteria to assess entitlement to benefits and services available for children with ASD

OECD countries provide a range of support for children with ASD and their families and carers. This support includes access to financial benefits and to services for children with ASD. The level of benefit entitlement varies across countries, as do the criteria used to assess entitlement (for example, support needs of the child or employment limitations of the parent(s), or carers). In most countries, children with ASD are included under the broader policy framework for children with disability and must therefore undergo the same assessments and satisfy the same eligibility criteria as children with other disabilities. Although a formal ASD diagnosis may be required in some cases, the diagnosis alone does not automatically create benefit eligibility. The only exceptions here are Israel, where an ASD diagnosis alone entitles children to a Child Disability Allowance, and Australia's Carer Allowance.

When giving financial support for ASD some countries look only at the child's needs, while others also account for the employment impact of caring responsibilities

Financial benefits for families with children with disability, including children with ASD, can be classified into one (or sometimes several) of three categories.

- A carer allowance is a financial benefit designed to support parents or other family members who are caring for a person in need of support. Such allowances help to offset lost income from reduced working hours or withdrawal from the labour market, acknowledge the contribution of carers, and promote the provision of care within the home setting. Eight of the 11 countries covered in this report offer such a payment for children with disability (all but Canada,[1] Israel and the Netherlands).
- A disabled child allowance is a direct cash benefit provided to children with disability and their families, aimed at alleviating financial strain and fostering the child's participation and inclusion in society. Such allowances are child-focussed, considering the specific needs of the child to help ensure financial security and an adequate standard of living. Seven of the 11 countries provide some form of such an allowance (all but Australia, Denmark, Germany and Sweden).
- An additional cost allowance is a financial benefit aimed at covering specific disability-related expenses, such as specialised therapies, assistive equipment, or home adaptations. Typically, such allowances are tied to the actual additional costs incurred by the family of the child. Additional cost allowances are available in eight countries (all but Estonia, Israel, and the United States) and are often administered at the local level, by municipalities or other local authorities.

Generally, countries provide either a carer allowance or a disabled child allowance, but some – Estonia, France, the United Kingdom and California (United States) – offer both. Additional cost allowances are always offered in addition to one of the other two payments. Sweden stands out as an example of a country offering all three types of payments – its Assistance Allowance has elements of both a carer allowance and disabled child allowance – and the United Kingdom stands out as an example of a country offering two different disabled child allowances, one of them means-tested.

Entitlements vary hugely across countries but generally increase, often sharply, with the level of support the child needs. In most countries, with the notable exception of Israel, families with a child with mild support needs are not entitled to any payment, while payments for families with a child with severe support needs can reach several thousand USD (PPP) per month. Some payments are means-tested, thus, targeted to low-income families; others are paid at a fixed rate irrespective of family income, thus, providing the same payment for every child with the same level of needs; and others are paid as a fraction of the parents' earnings, thus, following an insurance principle. In some countries, therefore, lower-income families will be more likely to prefer caregiving over employment, as the benefit they are entitled to provides a financial incentive to stop working, while in countries with insufficient carer allowances, families are more likely to prefer staying employed and hiring a caregiver, where possible.

Data in Table 1.1 attempt to measure and compare the level of financial support (excluding in-kind benefits) available for a two-parent household with a 12-year-old child formally diagnosed with ASD and each parent employed and earning the national average monthly wage. Calculations refer to three levels of support needs, assumed to imply a necessary corresponding reduction in working hours of one parent to care for the child. The estimates exclude additional costs allowances and, therefore, underestimate the financial package in countries which offer such payments.

Table 1.1. Financial benefit entitlements vary hugely by country and levels of support needs

Monthly payment in USD (PPP) for three levels of support needs and corresponding reduction in working hours

	Mild support needs (no working hours reduction of either parent required)	Moderate support needs (50% working hours reduction of one parent required)	Severe support needs (100% working hours reduction of one parent required)
Australia	896	1 452	2 577
Canada (Ontario)	554	1 516	3 259
Denmark	0	3 240	5 719
Estonia	0	229	417
France	0	806	1 393
Germany	0	473	1 091
Israel	1 004	1 004	1 888
Netherlands	0	1 623	3 622
Sweden	0	695	7 258
United Kingdom	0	166	892
United States (California)	0	0	0

PPP = purchasing power parities.
Note: The assumed reference family is a two-parent household with a 12-year-old child formally diagnosed with ASD, in which both parents earn the national average monthly wage. Average full-time wages of 2023. Includes only carer allowances and disabled child allowances (except for Canada and Australia). For detailed country-specific information and assumptions, see Table 3.4.
Source: OECD (2025[8]), *Annual Purchasing Power Parities and exchange rates* (dataset), https://data-explorer.oecd.org/s/3sp. OECD (2025[9]), *Average annual wages* (dataset), https://data-explorer.oecd.org/s/3sq. Compilation of OECD material.

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ASD support for children is provided through the education, health and disability-service systems, each with different entitlement approaches

Financial benefits alone provide only a partial picture of the support that families can receive. As children with ASD can benefit from a wide array of paramedical therapies such as speech therapy, occupational therapy and psychotherapy, as well as special support for education, the way in which these supports are organised and funded plays a key role in the overall support package for families. By and large, countries provide services for children with ASD through three main pathways.

- Education system: most countries provide significant tailored education supports and therapies integrated into school services, sometimes without needing a formal medical diagnosis.
- Health system: most countries provide therapies through the public health system, often uncapped; the use of such services usually requires a medical referral.
- Disability-specific programmes: some countries, especially Australia and Canada (Ontario), also provide tailored services through disability schemes, based on a disability assessment.

Even more than for financial benefits, the provision of services is generally linked with an assessment of individual needs. Standardisation and regulation of these needs assessments vary. France uses a structured guide and multi-disciplinary teams for in-depth evaluations; Denmark, Germany and Sweden equally emphasise in-person evaluations. Canada (Ontario), Israel and the United States (California) rely on formal diagnoses as gatekeeping mechanisms, even if services are tailored to individual needs.

In many countries, medical diagnoses are not required to access special educational services, though they may be necessary for placement in an ASD-specific setting. ASD-specific schools exist in a few countries, e.g. in Australia, but they are rare and often private. Generally, countries vary in the extent to which they emphasise special schools, special classes within mainstream schools, or full inclusion in mainstream classrooms for children with ASD. These differences largely reflect each country's overall approach to educating children with disabilities and special educational needs. Parents in most countries have a considerable say in the choice of school setting and may prefer special settings for children with severe support needs because these environments often offer more intensive individual support and a higher concentration of specialist expertise among teaching staff.

Most countries tailor therapy hours to the child's individual needs, with no formal upper limit (other than the constraints of the capacity of the healthcare system). Ontario (Canada) and Australia differ from this insofar as they allocate budgets based on assessed needs, thereby indirectly influencing therapy hours. Israel again is a unique case as it standardises therapy hours based on diagnosis. Recognising the importance of very early support, many countries also offer early childhood intervention, such as California's Early Start Programme and Ontario's Preschool Speech and Language Program, and similar programmes in European countries. Israel also has a dedicated Early Childhood Program offering (up to) 14 hours of therapy per week for each child with ASD aged 0-6, again based on diagnosis alone (see Chapter 7 for details).

Social services also play a key role in the lives of children with autism and their families, amongst others, by supporting children's well-being and autonomy and by alleviating the care responsibilities of parents. Some of the social services offered by the countries reviewed include free transportation to and from school or therapy, family counselling, specialised after-school activities, and respite care.

Significant variability in design of and entitlement to ASD services and support makes cross-country comparison challenging

Estimating and comparing across countries the financial value of the overall service package or, for that matter, the total support package including benefits and services, is impossible, unfortunately, for several reasons. First, in most OECD countries what a family can get will depend entirely on the child's needs.

Paramedical therapies which are in most countries offered and paid by the healthcare system are generally uncapped – children can receive as much as they need, only limited by therapy capacity, waiting times and parents' availability to arrange sessions – and any estimate of the total cost would simply reflect the assumptions made. Second, where families access general disability support or even mainstream services, the number of families with a child with ASD supported through these services is often unknown. This is, naturally, especially the case in countries and for services that do not require an ASD diagnosis. Third, with a few exceptions, countries simply do not collect information at a level of detail that would allow preparing meaningful estimates.

Accordingly, any assessment of the value of the countries' total support package can only be qualitative. A key finding is that in most countries the total cost of services for children with ASD and mild support needs will be limited. These children will often be integrated in mainstream classes and receive services mostly through the health system, if any therapies are needed, with limited need for extra services by the education system. On the contrary, children with high support needs could potentially receive multiple services from both the health and the education system, often without an upper limit. This general assessment in particular holds for the European countries covered in this report in which a diagnosis itself has no impact on the services a child and its family can receive. This is slightly different in Israel, Australia, and Canada (Ontario), where systems either set formal upper limits on services or allocate children a defined budget for support. However, also in these countries, children with medium-to-high support needs and an ASD diagnosis and/or a disability status will receive rather generous support.

Israel, again, is a notable exception among the countries covered in this report. In Israel, children with ASD are entitled to a fixed number of therapies per week (e.g. three hours in special education settings for ages 7-18) on account of their ASD diagnosis and irrespective of their actual assessed support needs. This renders a situation likely in which children with mild support needs might receive more services than systems in other countries would assess as being necessary, while children with severe support needs may be under-served. This adds to a benefit system which also pays a Child Disability Allowance to children based on an ASD diagnosis alone, making a strong case for a shift in attention from children with mild support needs to those with severe support needs.

Conclusions

- The number of children with ASD diagnosis has increased in all countries where data is available. Despite important differences in the types of data that can be used to measure and compare trends in autism diagnoses between countries, overall growth and speed of change over time are very similar across countries.
- Growing ASD awareness and better identification opens the possibility to offer services to more people needing support. The increasingly younger age at identification allows countries to offer early childhood support which has the potential to improve abilities and functioning sustainably.
- Financial benefits vary greatly across countries even for children with similar support needs. In most countries, children with mild support needs will rarely receive any benefits, and entitlements generally increase sharply with the level of needs. In some countries, families can receive several thousands of USD per month, to compensate reduced working and increased caring time.
- Countries differ in the type of payments they offer, which can be focussed on the child, on the carer or on the extra costs that occur, or a combination of all or some of these parameters, and in the degree to which these benefits are targeted through fixed-rate or means-tested payments.
- Services and therapies for children with ASD are offered through three channels predominantly, the education system, the health system, and specific disability programmes. In nearly all countries, access is determined through a needs-based assessment, ensuring support can be tailored flexibly

to each child. Diagnosis plays a role in services offered by the health system but no or only a limited role for education supports.

- Therapies provided by health systems are generally uncapped but capacity constraints and waiting times are frequent in healthcare systems of all countries. Capacity constraints also arise for the provision of an ASD diagnosis, in turn implying a growing role for the private market and, thus, a growing need for guidance, supervision and public control.
- Overall, ASD tools and policies across OECD countries demonstrate a big shift away from a purely medical approach, except in Israel, and a strong focus on children's actual needs and functioning. Disability assessment across OECD countries could learn from this shift.
- While the number of young people with an ASD diagnosis has increased fast, much of this increase seems to be on the mild-support-needs side of the spectrum. It is, therefore, unlikely that the increase in disability benefit claims of young people observed in many OECD countries is driven by increases in ASD diagnoses, except for Israel, where disability payments for children with ASD are not contingent upon a support needs assessment.
- In view of the ongoing shift in all OECD countries towards ASD diagnoses and provision of ASD services very early in life, it is surprising how little is known about the impact of early supports on social and economic outcomes later in life. Countries could make efforts to evaluate functioning, skills, and well-being of children diagnosed with ASD over their lifetime, from diagnosis to early adulthood. This could be done by following a representative population cohort over time, with due consideration to ethical and privacy concerns for the people involved.
- More generally, too little is known about what type and combination of services and supports make the biggest difference for children diagnosed with ASD. In times of growing demand for services, and tight healthcare budgets, more rigorous evaluations are needed to ensure children can access the most effective and cost-effective service package with the best therapeutic outcomes.

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Note

[1] Canada's Employment Insurance Caregiver Benefit is designed to provide temporary income replacement to individuals who must take time off work to care for a critically ill or injured family member, including a child, adult, or person requiring end-of-life care – e.g. a maximum of 35 weeks for children. It does not cover disability as such or ongoing caregiving needs related to stable, chronic conditions.

2

Diagnosing autism in children and adolescents

This chapter presents the evolution of autism diagnosis and diagnostic criteria, by looking at the two main diagnostic manuals used internationally and how their definition of autism has changed over time. The chapter also looks at how diagnostic practices have evolved, through the introduction of standardised diagnostic instruments, guidelines and regulations, and lower age at diagnosis for children. The chapter also presents growing rates of autism diagnoses across countries, as well as literature exploring the reasons behind this growth. Different diagnosis rates across population groups, such as for girls and women, groups with different socio-economic status, and ethnic and racial minorities are also discussed.

In Brief

Diagnosing autism: Trends and challenges

Autism diagnosis has undergone a profound transformation. Once considered a rare condition and classified under childhood schizophrenia, autism is now recognised as a common neurodevelopmental disorder with highly diverse presentations. The shift from fragmented subtypes to a single spectrum in the two main diagnostic manuals, DSM and ICD, reflects this broader understanding and has shaped diagnostic practices worldwide.

Diagnosis today is more structured and multi-disciplinary, combining clinical observation with caregiver input and standardised tools. These changes have helped identify autism earlier, though many children are still diagnosed late, often after entering school. Early diagnosis remains critical, as timely intervention can significantly improve developmental outcomes.

Autism diagnoses have risen sharply across OECD countries. This increase does not necessarily mean autism is becoming more common; rather, it reflects evolving criteria, greater awareness, and reduced stigma. Expanding the spectrum has brought into view individuals who might previously have gone unnoticed, including girls and women, whose symptoms often differ from those of boys and are harder to detect. Socio-economic and cultural factors also shape access to diagnosis, with disadvantaged families and minority groups facing persistent barriers.

National guidelines play a central role in promoting consistency and quality. Most OECD countries recommend multi-disciplinary assessments and the use of DSM-5 or ICD-11 criteria, with the NICE guidelines developed in the United Kingdom widely regarded as best practice.

The evolution of autism diagnosis: From schizophrenia to autism spectrum disorder

Autism is a neurodevelopmental disorder (NDD), a condition with onset in the early developmental period, described by impairments in social communication and characterised by restricted, repetitive behaviours. Autism was first recognised by Kenner (1943[1]), who used the term "early infantile autism" to describe the disorder and highlight the fact that early symptoms were already evident in infancy. The two internationally recognised diagnostic manuals, the American Psychiatric Association's "Diagnostic and Statistical Manual" (DSM) and the World Health Organization's "International Classification of Diseases" (ICD) first set out criteria for autism in 1977 (ICD-9) and 1980 (DSM-III), respectively (APA, 1980[2]; WHO, 1977[3]).

Autism-like behaviours were long considered to be a type of childhood schizophrenia by both the DSM (DSM-I, 1952 and DSM-II, 1968) and the ICD (ICD-9, 1977) (see Table A A.1). In 1980, the third edition of the DSM (DSM-III, 1980) classified "infantile autism" as separate from schizophrenia for the first time, listing "infantile autism" as a subtype of pervasive developmental disorder (PDD) (APA, 1980[2]). However, the ICD continued to consider autism as a type of schizophrenia for over a decade, until the publication of the 10th revision (ICD-10) in 1992 (WHO, 1992[4]).

For about three decades, from the 1980s to the 2010s, autism was classified under pervasive developmental disorder, i.e. a type of severe, early developmental disorder characterised by delays and distortions in the development of social skills, cognition and communication. The DSM-III (1980) defined four subtypes of PDD (see Table A A.2) including infantile autism and childhood-onset PDD, with onset before and after 30 months of age respectively, as well as atypical PDD (an autism-like condition) and residual infantile autism (APA, 1980[2]). The ICD-10 (1992) included a total of eight subtypes (see Table A A.2) including childhood autism and atypical autism, similar to the DSM-III but also other forms of autism, including Asperger syndrome, other and unspecified PDD, as well as other disorders such as Rett syndrome, other childhood disintegrative disorder, etc. (WHO, 1992[4]).

The fourth edition of the DSM (DSM-IV, 1994) included five subtypes (see Table A A.2) – excluding overactive disorder associated with mental retardation and “stereotyped movements” (repetitive, non-functional motor behaviours that are commonly observed in youth with autism, e.g. arm flapping, hand flapping, rocking back and forth), and combining other and unspecified PDD under PDD-not otherwise specified (PDD-NOS), which included atypical autism (APA, 1994[5]).

These subtypes were almost the same as those included in the ICD-10, a sign of efforts to streamline disorders between the two diagnostic manuals. Consistency between the two diagnostic manuals contributed to the development of standardised assessment methods and facilitating research, which in turn lead to a dramatic increase in the number of scientific publications on autism. In addition, the focus of DSM-IV and ICD-10 on consistent application of diagnostic criteria across functional levels contributed to increased awareness of severe social and communicational impairments in cognitively more able individuals, increasing access to services for this population group (Volkmar and McPartland, 2014[6]).

Progressively, from the publication of the DSM-IV (1994) onwards, clinicians started referring to three of the subtypes of PDD in the DSM-IV: autistic disorder, Asperger’s syndrome and PDD-NOS; as autism spectrum disorder (ASD) (see Table A A.3). Instead of referring to autism under three different clinical disorders, autism started to be considered as more of a spectrum with all three disorders part of the same clinical condition, but with differing levels of severity. Asperger’s and PDD-NOS were considered milder versions of autism, while autistic disorder was seen as a more severe version (Tsai, 2014[7]).

In 2013, autism spectrum disorder was included in the fifth edition of the DSM (DSM-5, 2013). The DSM-5 also dropped the subtypes (Asperger’s, PDD-NOS, and others) that had appeared in previous editions (APA, 2013[8]). Almost a decade later the ICD followed with the 11th revision (ICD-11, 2019), which also replaced the previous subtypes by introducing ASD (WHO, 2019[9]).

Diagnostic criteria between the DSM-IV and the DSM-5 differ quite significantly, suggesting an important shift in practice when it comes to diagnosing autism (see Table 2.1). This change was similar between the ICD-10 and the ICD-11. Other than the shift from PDD to ASD, the diagnostic domains were also slightly modified, grouping impairments in social interaction and impairment in communication together, reducing the diagnostic domains from three to two. Another important change between the DSM-IV/ICD-10 and the DSM-5/ICD-11 was the required age of onset for diagnosing the disorder. While the DSM-IV and the ICD-10 required that the age of onset be no later than 3 years of age, the DSM-5 and the ICD-11 were more permissive, allowing for diagnosing even if symptoms do not become apparent until later, when “social demands exceed limited capacities” (APA, 2013[8]; WHO, 2019[9]) (see Table 2.1).

Table 2.1. Comparison of autism diagnostic criteria in DSM-IV and DSM-5

		DSM-IV (1994)	**DSM-5 (2013)**
Diagnosis name		Pervasive Developmental Disorders (PDD)	Autism spectrum disorder (ASD)
Subtypes		• Autistic Disorder • Rett's Disorder[1] • Childhood Disintegrative Disorder (CDD), • Asperger's Disorder, • Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS)	No separate subtypes, Autistic Disorder, Asperger's Disorder and PDD-NOS was merged under ASD. Rett's disorder and CDD were classified elsewhere.
Diagnostic domains		1. Impairment in social interaction 2. Impairments in communication 3. Restricted repetitive and stereotyped[2] patterns of behaviour, interests, and activities *A total of six (or more) items from the three domains are necessary to establish a diagnosis, with at least two from the first domain and one each from domains 2 and 3.*	1. Deficits in social communication and social interaction 2. Restricted, repetitive patterns of behaviour, interests, or activities *All criteria from domain 1 need to be met to establish diagnosis, and at least two criteria from domain 2 need to be met.*
Diagnostic criteria	Diagnostic domain: Social and communication deficits	Social interaction deficits: • Lack of eye contact, facial expression, body postures, and gestures to regulate social interaction • Failure to develop peer relationships • Lack of showing, bringing, or pointing out objects of interest • Lack of social/emotional reciprocity Communication deficits: • Language delay (or total lack of) • Difficulty to initiate/sustain conversation • Stereotyped/repetitive/ idiosyncratic language • Lack of imaginative/social imitative play	• Deficits in social-emotional reciprocity e.g. abnormal social approach, failure of back-and-forth conversation, reduced sharing of interests/emotions/affect, failure to initiate/respond to social interactions • Deficits in nonverbal communicative behaviours e.g. poorly integrated verbal/nonverbal communication, abnormalities in eye contact and body language, deficits in understanding/use of gestures • Deficits in developing, maintaining, and understanding relationships e.g. difficulties in adjusting behaviour to social contexts, in imaginative play, in making friends
	Diagnostic domain: Repetitive behaviour and interests	• Stereotyped and restricted patterns of interest • Rigid routines/rituals • Stereotyped/repetitive motor mannerisms • Persistent preoccupation with part or objects	• Stereotyped/repetitive motor movements, speech or use of objects • Insistence on sameness, rigid routines/rituals • Highly restricted, fixated interests • Hyper- or hypo-reactivity to sensory input
Language impairments		Language delay is a key diagnostic criterion.	Language delay is no longer required for diagnosis.
Age of onset		Symptoms must appear before age 3.	Symptoms must be present in the early developmental period (but may not become fully apparent until social demands exceed capacity or may be masked by learned strategies).
Severity levels		No severity levels.	Level 1: requiring support Level 2: requiring substantial support Level 3: requiring very substantial support
Co-morbidities		Co-morbid diagnoses of ADHD (Stereotypic Movement Disorder) were not possible.	Allows co-diagnosis with ADHD.

ADHD = Attention deficit/hyperactivity disorder

Note: 1. The DSM-IV-TR (2000) classified Rett's disorder as a separate genetic disorder, distinct from PDD (APA, 2000[10]). 2. Stereotypical movements refer to repetitive, non-functional motor behaviours that are commonly observed in youth with autism e.g. arm flapping, hand flapping, rocking back and forth (Olson, Bishop and Thurm, 2024[11]).

Source: American Psychiatric Association (1994[5]), *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, https://doi.org/10.1176/appi.books.9780890420614.dsm-iv; American Psychiatric Association (2013[8]), *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596.

In 2022, the DSM published a text-revision to the DSM-5 (DSM-5-TR). This edition did not change the core diagnostic criteria for ASD but put more focus on different presentations of symptoms depending on cultural context and sex. The DSM-5-TR also included a more explicit recognition of ASD and co-occurring conditions such as attention-deficit/hyperactivity disorder (ADHD), anxiety, and intellectual disabilities (APA, 2022[12]).

Co-diagnosis of ASD with Stereotypic Movement Disorder (ADHD in the DSM-IV-TR and onwards, 2000) was not possible under the DSM-IV but it became possible to co-diagnose ADHD under the DSM-5. ADHD is now recognised as one of the most common co-occurring conditions with ASD, affecting on average 28% of children with autism and even higher among older children and adolescents (Lai et al., 2019[13]).

Evolving diagnostic practices for ASD have contributed to growing rates

Understanding of autism and diagnostic criteria for the disorder has changed considerably in the past 70 years. Until around 20 years ago, autism was considered to be a rare developmental disorder, generally accompanied by some level of intellectual disability (Constantino and Charman, 2016[14]). Now, autism is understood as a very common neurodevelopmental disorder, with very heterogenous presentations, hence the introduction of the term "spectrum" (Mottron and Bzdok, 2020[15]; Zeidan et al., 2022[16]).

Autism diagnosis in children usually relies on two main sources of information: description by parents or caregivers of the child's development, and observation of the child's behaviour by a professional or professionals (CDC, 2024[17]), as recommended by the DSM-5 (APA, 2013[8]). A typical diagnostic process is described more in detail in Box 2.1.

Box 2.1. Diagnosing autism in children

Autism, like other neurodevelopmental conditions, is diagnosed through a series of structured observations and interactions to determine whether an individual meets the criteria for diagnosis. Screening and diagnostic practices do vary between countries (see "Diagnostic guidelines and regulations"), but there are some clear similarities in terms of overall approach.

1) Screening for autism in primary care

Screening for autism often begins in primary care settings, often during routine check-ups with a general practitioner or paediatrician. This may be done systematically for all children – as recommended by the American Academy of Paediatrics – or prompted by concerns from parents, healthcare, or childcare/educational providers when developmental milestones are not met.

Several screening tools are available to help identify children who may need further assessment. Commonly used tools include:

- Ages and Stages Questionnaires SE-2 (ASQ-SE2);
- Communication and Symbolic Behaviour Scales (CSBS);
- Modified Checklist for Autism in Toddlers (M-CHAT);
- Childhood Autism Spectrum Test (CAST).

Among these, the M-CHAT and CAST are the most widely used. These relatively brief questionnaires (23 and 38 items, respectively) are completed by the child's caregiver(s) or the paediatrician and help determine whether further diagnostic evaluation is needed.

2) Multi-disciplinary assessment in specialist care

If screening indicates a likelihood of autism, the child may be referred to a specialist or a specialist multi-disciplinary team for a comprehensive diagnostic assessment. The evaluation focusses primarily on two areas:

- Difficulties with social communication and interaction
- Repetitive behaviours, restricted interests, or activities

To ensure a thorough understanding of the child's functioning, observations should ideally take place across multiple settings, such as at home, at school, or at kindergarten.

The diagnostic assessment may include:

- Autism-specific tools that support behavioural observation, such as the Autism Diagnostic Observation Schedule – Second Edition (ADOS-2), or the Childhood Autism Rating Scale, Second edition (CARS-2); and diagnostic tools that are based on parent and/or caregiver interview, such as the Autism Diagnostic Interview – Revised (ADI-R) or the Developmental, Dimensional and Diagnostic Interview (3di).
- Cognitive and adaptive functioning assessments to evaluate general cognitive abilities and adaptive behaviours, and to identify possible co-occurring intellectual disability.
- Communication and language evaluation to assess language development and functional communication skills, and screen for co-occurring language disorders.
- Physical and medical examination including e.g. vision and hearing checks, growth measurements (height, weight, head circumference), and screening for conditions such as epilepsy or sleep, feeding, and gastrointestinal problems, etc.
- Behavioural and mental health assessment to identify co-occurring psychiatric or behavioural conditions such as anxiety, mood disorders, ADHD, OCD, tic disorders, or conduct problems.
- Developmental history gathered through interviews with parents and input from teachers or other caregivers.

The diagnostic team may include:

- A clinician trained in autism diagnosis, such as a child psychiatrist, a developmental psychologist, a developmental paediatrician, or a paediatric neurologist.
- A speech and language therapist, to assess social communication skills.
- An occupational therapist and/or a physiotherapist, to evaluate motor skills and functional abilities.
- Other professionals, such as a social worker, may assess family dynamics and support needs to ensure an appropriate environment for the child.

ADHD = Attention-deficit/hyperactivity disorder; OCD = Obsessive-compulsive disorder.
Note: The exact diagnostic process may vary according to country and clinical practice.
Source: American Academy of Pediatrics Committee on Children with Disabilities Autism Subcommittee (2025[18]), *How Is Autism Diagnosed?*, https://www.healthychildren.org/English/health-issues/conditions/Autism/Pages/Diagnosing-Autism.aspx; Autism SA (n.d.[19]), *The diagnostic process*, https://autismsa.org.au/autism-diagnosis/autism-diagnosis-process/the-diagnostic-process/; eMentalHealth.ca (n.d.[20]), *Screening Tool: Autism spectrum disorder*, https://www.ementalhealth.ca/index.php?m=survey&ID=61; Barthélémy et al. (2019[21]), *People with Autism Spectrum Disorder: Identification, Understanding, Intervention – Third edition*, https://www.autismeurope.org/wp-content/uploads/2019/09/People-with-Autism-Spectrum-Disorder.-Identification-Understanding-Intervention_compressed.pdf.pdf; Mayo Clinic (2025[22]), *Autism spectrum disorder*, https://www.mayoclinic.org/diseases-conditions/autism-spectrum-disorder/diagnosis-treatment/drc-20352934.

Age at diagnosis has been going down

Numerous studies have demonstrated that intensive, early intervention programmes can help improve the cognitive and language abilities, as well as adaptive behaviour in children with ASD, possibly due to higher neuroplasticity (the capacity of the nervous system to modify itself, both functionally and structurally, in response to experience, e.g. injury) earlier in life (Daniels and Mandell, 2013[23]). Evidence suggesting that early intervention can contribute to improved outcomes has likely contributed to diagnoses of ASD at younger ages (Constantino and Charman, 2016[14]; Hus and Segal, 2021[24]).

A study by Daniels and Mandell (2013[23]) reviewing literature on autism diagnoses between 1990 and 2012 found that the mean age at diagnosis for ASD ranged from 38 to 120 months globally, with a decrease in age at diagnosis over time, although most people with autism tend to get diagnosed once they enter the education system. According to a more recent study from the United Kingdom, this is especially the case if emotional and behavioural difficulties overlap with autism, with the age of diagnosis at 8-14 years of age (Mandy et al., 2022[25]). The same paper found that only a third of the study participants were diagnosed with autism by age 7, as reported by parents (Mandy et al., 2022[25]).

Similar findings were observed in Western Australia, where a population-based cohort-study by Nassar et al. (2009[26]) found that for children born in the early 1990s, the prevalence of autism was highest for children aged 4-5, whereas for the cohort born in the mid-1990s, prevalence was highest for 2-3 year-olds.

A follow-up to the study by Daniels and Mandell (2013[23]) reviewed studies published between 2012-2019 and found that the reported mean age at diagnosis is 60.5 months, ranging between 31 and 235 months (van ’t Hof et al., 2020[27]). A subgroup analysis focussing on studies including children aged 10 years or younger found that the mean age of diagnosis was at 43 months on average, ranging between 31 and 75 months (van ’t Hof et al., 2020[27]). The results of this meta-analysis show that continuous efforts are being made in various countries to lower the age at diagnosis, but many children are still diagnosed quite late, well after they reach school-age (van ’t Hof et al., 2020[27]).

Diagnosis in children as young as two years of age is relatively stable, i.e. it is unlikely to change over time, especially if diagnosis is done by a multi-disciplinary team of experienced clinicians (Constantino and Charman, 2016[14]). According to research, an autism diagnosis can be reliably set as of 24 months of age (Daniels and Mandell, 2013[23]). Although diagnosis is possible in children as young as 18 months old, these diagnoses tend to be less stable, as there can be overlap with other disorders and conditions (especially other NDDs), as well as difficulty in assessing the extent of impairment in social functioning (Constantino and Charman, 2016[14]).

Standardised diagnostic tools are increasingly being used for assessments

Diagnosis of autism in the last two decades has benefited from the development of standardised measures in the form of screening and diagnostic instruments to measure the symptoms of ASD, developed at the end of the 20th and at beginning of the 21st century.

These diagnostic tools can be in the form of a checklist questionnaire to screen and rapidly assess symptom severity, the most known and widely validated tools being the Autism Diagnostic Interview, Revised (ADI-R) and the Developmental, Dimensional and Diagnostic Interview (3di). Standardised instruments can also be in the form of observational measures, such as the Autism Diagnostic Observation Schedule, second edition (ADOS-2), which together with the ADI-R is the best studied diagnostic instrument, and is often seen as the “gold standard” for diagnosing autism (Constantino and Charman, 2016[14]; Zeidan et al., 2022[16]; Zwaigenbaum and Penner, 2018[28]; Wolff and Piven, 2021[29]).

It is important to note that the utility of these tools is contingent on the expertise and level of training of the professionals administering them (Zeidan et al., 2022[16]). There has been a growing recognition of the limits of the clinician standard and tools for diagnosing ASD (Constantino and Charman, 2016[14]). A study by Roman-Urrestarazu et al. (2021[30]) found that standardised procedures, protocols, and diagnostic tools and instruments used by clinical teams are inconsistent in diagnosing autism in children, especially when it comes to racial and ethnic minorities.

Standardised diagnostic tools are an important part of the diagnostic process but should be used in addition to information gathered from other sources and observations by a clinician trained specifically in autism. International NGO and advocacy group Autism Europe suggests that ideally all members of the multi-disciplinary assessment team should have autism-specific training but even if that is not possible, diagnosis should not rely on a single standardised diagnostic tool alone: “A valid diagnosis depends on expert clinical judgement based on information gathered from all relevant sources” (Barthélémy et al., 2019[21]).

New technology-enabled procedures for ASD diagnosis are currently being tested. Some AI applications, especially large language models (LLMs), have shown promise in supporting diagnostic processes. While still in its infancy, research suggests that AI has the potential to support autism diagnosis with a high degree of accuracy, although ethics and equity concerns will need to be considered to progress the introduction of AI diagnosis in public services. One study, for instance, used video-based AI to detect “stereotypical” motor movements in children with autism with over 90% accuracy (Barami et al., 2024[31]). Other studies have explored the use of AI in early diagnosis before the age of 3 (Bussu et al., 2018[32]), distinguishing between autism and ADHD (Duda et al., 2016[33]), and identifying atypical facial expressions and motor patterns (Liu, Li and Yi, 2016[34]; Li et al., 2017[35]; Anzulewicz, Sobota and Delafield-Butt, 2016[36]). More recent work has focussed on leveraging large language and deep learning models to reduce clinician bias and improve identification across the autism spectrum, though these models require large, diverse datasets and integration with electronic health records to reach their full potential (Stanley et al., 2025[37]; Sheik Abdullah et al., 2025[38]; Ibadi and Lakizadeh, 2025[39]). An Israeli longitudinal study also found that automatic prediction models can achieve high accuracy in early prediction of ASD (Amit et al., 2024[40]).

Pressure on diagnostic services is increasing

Growing awareness of autism has contributed to an increase in the number of referrals from primary care doctors, and growing demands for accessing diagnostic services (Russell et al., 2021[41]; Monteiro et al., 2015[42]). However, half of those referred do not end up having ASD, according to Monteiro et al. (2015[42]).

Frequent co-morbidity of ASD with other NDDs makes diagnosing ASD in children a complicated task. According to Monteiro et al. (2015[42]), 40-55% of those diagnosed with ASD also have intellectual disability, and 29% of those referred to an ASD diagnosis ended up receiving an ADHD diagnosis instead. A more recent study – based on data from the CDC’s autism and Developmental Disabilities Monitoring Network (ADDM) – found that out of those diagnosed with ASD, 32% had co-occurring intellectual disability, and 59% did not (Shenouda et al., 2023[43]). In Germany, an analysis done by *Handelskrankenkasse* – a health insurance fund providing statutory health insurance – found that more than half (53.6%) of all individuals with autism spectrum disorder had at least on other co-occurring psychiatric disorder, such as ADHD (33.1%) or anxiety disorder (24.6%) (Nymbach, 2023[44]), complicating early identification and diagnosing,

Better developmental-behavioural training is necessary for primary healthcare providers to improve access to diagnostic and early intervention services for those with ASD (Monteiro et al., 2015[42]). Specialised autism training programmes for primary care physicians have been associated with positive changes in the knowledge and self-efficacy of physician’s care of patients with autism (Clarke and Fung, 2022[45]).

The WHO and UNICEF recommend well-care visits for children and adolescents in the form of regular check-up by healthcare providers to monitor health growth, development and well-being of children notably in the first two decades of their lives. Most countries already recommend universal or routine healthcare contacts, for antenatal, childbirth and postnatal care, as well as vaccinations. Well-care visits provide a critical platform for early identification of conditions such as autism, and developmental surveillance, and have the potential to reduce pressure on diagnostic services (WHO/UNICEF, 2023[46]). In line with these recommendations, Israel has a wide network of primary healthcare centres called *Tipat Halav* (טיפת חלב, meaning "drop of milk") that provide postnatal and early childhood care. The majority of children in Israel go to these centres for regular check-ups, notably to make sure that they are meeting the appropriate developmental milestones. These centres and well-care visits are central to early screening for autism.

Trends in autism diagnosis and prevalence are showing an upward trend

Global ASD prevalence is estimated at 1-2% with relative consistency across international studies, making autism one of the most common neurodevelopmental disorders (Mandy et al., 2022[25]; Zwaigenbaum and Penner, 2018[28]). In the past 20 years, the number of people diagnosed with ASD has been increasing globally. Currently, it is unclear whether the increase in the number of people diagnosed with autism over the past 20-30 years point to a "real" increase in the prevalence of autism, or rather an increase in the number of people diagnosed with the disorder. An increased rate of diagnosis will have been influenced by increased awareness of ASD, falling stigma around ASD, and changes to definition of autism as a disorder (see previous discussion).

Diagnosis rates and prevalence estimates are difficult to compare across countries

It is important to distinguish between autism prevalence estimates and diagnostic rates. Prevalence refers to the estimated proportion of people with a disease or condition in the overall population. Prevalence rates can be estimated through a population survey, or assumptions based on other indicators such as rate of diagnosis of a condition or contact with health services. True prevalence should seek to capture the actual proportion of persons with a condition in the population, regardless of whether they have been diagnosed or not. Diagnostic rate, by contrast, refers to the actual number of individuals diagnosed with a condition in a given population. Rate of diagnosis may be captured through clinical records, or surveys where respondents are asked whether they have received a diagnosis of autism.

A range of academic literature seeks to give an estimated prevalence for the rate of autism in the population. Most of the literature identified for this paper relies at least in part on rates of diagnosis (for example, recorded diagnoses or parent-reported diagnoses); such "prevalence" estimates can be expected to be influenced at least to a degree by trends in diagnostic practice for autism. Similarly, certain countries rely on diagnosis data to estimate "prevalence". For instance, Canada has estimated "prevalence" rates for autism going back to 2000, gathered in the Canadian Chronic Disease Surveillance System. However, this database uses data from public hospital discharges and physician billing claims, making the "prevalence" susceptible to changes in diagnostic practices.

Several systematic and meta-analyses have explored ASD prevalence in the population. These studies point to variations in estimations between countries, and over time, with a general trend towards an increase in measured autism prevalence globally. Zeidan et al. (2022[16]) reviewed prevalence estimates worldwide in the period up to 2021, and found an approximate rate of diagnosis of autism in children of 1%. A systematic review and meta-analysis by Salari et al. (2022[47]) found an average global ASD prevalence rate of 0.6%, ranging from 1.7% in Australia, 1% in America and Africa, to 0.5% in Europe and 0.4% in Asia, with large variability in sample size and number of studies per continent. A mixed-effects meta-analysis by Talantseva et al. (2023[48]) established a global prevalence estimate of 0.72%. Similar regional estimates were found in both the study by Talantseva et al. (2023[48]) and Salari et al. (2022[47]), as well as a clear trend in which higher income countries tended to report higher prevalence estimates, which was suggested as being associated with better detection of autism in wealthier countries (Talantseva et al., 2023[48]). This study also found that estimates were higher in prevalence studies that used records-review surveillance rather than other designs (i.e. studies that have a trained expert review a range of clinical and educational information obtained in routine practice, rather than only information from health insurance or administrative databases).

National-level prevalence estimates have been established through a range of different methods. For example, in the United States the Autism and Developmental Disabilities Monitoring (ADDM) Network is an active surveillance system that provides estimates of ASD amongst 8-year-olds in 11 sites (Baio et al., 2018[49]; Shaw et al., 2025[50]). This approach has two phases: review of evaluations by service providers in the community (record review) which includes a wide variety of data sources from general paediatric health clinics to specialised programmes, and a second phase of review of all extracted information by experienced clinicians to determine ASD case status. The latest wave of this study, for 2022, found ASD prevalence to be 31.2 per 1 000 children aged 8 years, ranging from 9.7 in Texas to 53.1 in California.

According to a study on autism diagnosis rates in patient health records and insurance claims in the United States between 2011 and 2022, the diagnosis rate increased almost threefold during the study period among 5-8 year-olds (from 2.3 per 1 000 in 2011 to 6.3 per 1 000 in 2022), and between four- and fivefold among 26-34 year-olds. The increase was also greater for women than for men. Among children, the relative increase was greater in ethnic minority groups compared to those identifying as White (Grosvenor et al., 2024[51]), suggesting that hitherto underdiagnosed populations are catching up.

Autism rates in selected OECD countries vary but show similar trends

While comparisons across countries are challenging with markedly different approaches to estimate autism trends, it is clear for all countries that the number of ASD diagnoses has been increasing (Figure 2.1). Countries take different approaches to estimating the rate of autism in their populations. For example:

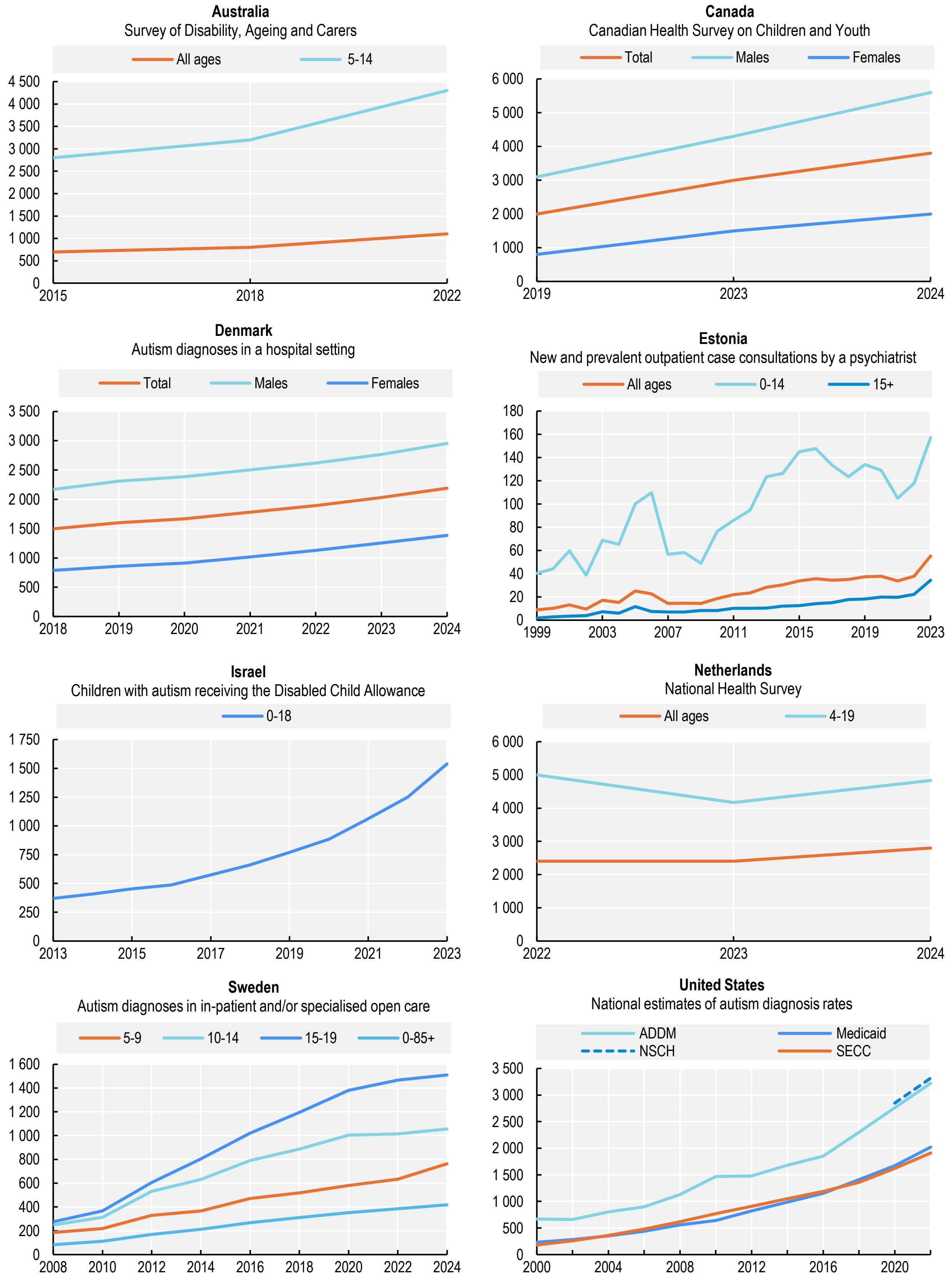
- Australia, Canada and the Netherlands undertake surveys of key populations to capture self-reported rates of ASD.
    - In Australia, respondents are asked whether they have a long-term health condition but not whether they have a diagnosis of the condition.
    - In Canada, the person most knowledgeable about the child or youth (usually a parent) reports on the child or youth’s diagnosed autism status.
    - In the Netherlands, the National Health Survey only started to record data on autism in 2022 making comparisons over time challenging. The data show important fluctuation in the 3-year period for which data is available, probably related more to measurement bias than a real change in prevalence. Data also identify very high rates of autism, though influenced by both a self-reporting bias and the inclusion of suspected cases of autism.
- Denmark and Sweden have a national patient registry that records diagnoses of autism established in the health system. Similarly, Estonia and Germany do not collect national prevalence data, but information is available on inpatient and/or outpatient hospital consultations – these measures can be used to give an indication of the rate of health system contacts for persons with an autism diagnosis. Data for Germany is excluded from Figure 2.1, as the only data available concerns main medical diagnosis for inpatient hospitalisations. Since autism by its nature does not require hospital care, this data is not considered representative enough to be included.
- In Israel, data on children diagnosed with ASD who receive state-funded services are collected by different agencies but are not consolidated into a single national registry. The most reliable data source is the National Insurance Institute’s registry of children eligible for the Disabled Child Allowance. This allowance is granted to all children diagnosed with ASD, regardless of their level of support needs, thereby strengthening the assumption that a very high share of those diagnosed are captured in this database.

- The United Kingdom measure ASD prevalence among the adult population through their Adult Psychiatric Morbidity Survey. Since this survey data is quite different from what other survey data show, this data is not shown in Figure 2.1 (see Box 2.2 for more details).
- In the United States, several different data sources exist that have been used to estimate national ASD prevalence. The most-commonly referred data is gathered by the ADDM Network, which reviews a range of records from the health and educational systems in a select number of states.

There are different patterns between countries, which may reflect the measure used to understand autism rates. For example, in Estonia (and Germany), where contacts with the health system are used to identify ASD cases, there was a clear inflection around 2020-2021 which is likely attributable to the COVID-19 crisis.

Figure 2.1. The rate of ASD is growing across OECD countries, and for all identifiable measures

Per 100 000 in each category



Australia
Survey of Disability, Ageing and Carers

Canada
Canadian Health Survey on Children and Youth

Denmark
Autism diagnoses in a hospital setting

Estonia
New and prevalent outpatient case consultations by a psychiatrist

Israel
Children with autism receiving the Disabled Child Allowance

Netherlands
National Health Survey

Sweden
Autism diagnoses in in-patient and/or specialised open care

United States
National estimates of autism diagnosis rates

ADDM: autism and developmental disabilities monitoring; ASD: autism spectrum disorder; NSCH: National Survey of Children's Health; SECC: Special Education Child Count.

Note:

Australia: Respondents are asked whether they have a long-term health condition which has lasted for 6 months or more, autism being one of the conditions they can report.

Canada: Data cover children aged 1-17 with autism. Parents are asked whether their child was diagnosed with autism/autism spectrum, autistic disorder, Asperger's disorder or pervasive developmental disorder.

Denmark: OECD calculations based on data from the National Patient Registry (*Landspatientregistret*, LPR), which captures new and previously (up to 5 years) made diagnoses (Danish ICD-10-equivalent codes for F84, including F84.0, F84.1, F84.5, F848 and F84.9) for children and adolescents (0-17).

Estonia: OECD calculations based on data from the National Institute for Health Development (*Tervise Arengu Instituut*), which captures new and prevalent outpatient case consultations by a psychiatrist by diagnosis (F84).

Israel: Any child between the age of 91 days and 18 years and 3 months with an autism diagnosis who benefits from the disabled child allowance.

Netherlands: OECD calculations based on data from the Dutch Central Bureau of Statistics (*Centraal Bureau voor de Statistiek*, CBS). Respondents are asked if they or their child has one or more chronic disorder (for 6 months or longer), autism spectrum disorder (until 2023, the question included Asperger's syndrome and pervasive developmental disorder not otherwise specified) being one of the disorders they can report.

Sweden: Diagnoses of pervasive developmental disorders (F84) in inpatient and/or specialised open care as the number of patients per 100 000 habitants.

United States: ADDM Network data is collected from health and/or education records of 8-year-old children to estimate the number of 8-year-old children with ASD. The sites do not collect nationally representative data. Medicaid data shows administrative claims reported by states to the Centers for Medicare and Medicaid Services. Data represents children aged 3-17 who receive Medicaid benefits. Data from 2014 and 2015 are excluded due to data quality issues for diagnosis codes. Data from the National Survey of Children's Health (NSCH) is collected annually through a cross-sectional address-based survey that collects information on the health and well-being of children aged 0-17 years. Special Education Child Count refers to administrative data collected by the U.S. Department of Education, reporting the number of children.

Source: Australian Bureau of Statistics (2024[52]), *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads; Statistics Canada (2025[53]), Health indicator statistics for children and youth aged 1 to 17 years, parent reported, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310094701; Social- og Boligstyrelsen (2024[54]), *Demografi – børn og unge [Demographics – Children and young people]*, https://www.social.dk/data/databank/data-om-borgere/demografi-boern-og-unge; Tervise Arengu Instituut (2024[55]), *PKH1: New and prevalent outpatient case consultations by psychiatrist by diagnosis, sex and age group*, https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas_02Haigestumus_05Psyyhikahaired/PKH1.px/; CBS (2025[56]), *Health and healthcare; personal characteristics* https://opendata.cbs.nl/#/CBS/en/dataset/85454ENG/table?searchKeywords=health; Socialstyrelsen (2025[57]), *Statistikdatabas för diagnoser*, https://sdb.socialstyrelsen.se/if_par/resultat.aspx; CDC (2025[58]), *Autism Data Visualization Tool*, https://www.cdc.gov/autism/data-research/autism-data-visualization-tool.html. Data for Israel was provided by national authorities.

StatLink https://stat.link/n4yav0

Box 2.2. England collects prevalence data through the Adult Psychiatric Morbidity Survey

Every 10 years or so, the United Kingdom's National Health Service (NHS) conducts the Adult Psychiatric Morbidity Survey (APMS) among the adult population (aged 16 and over). These surveys provide a series of data on both treated and untreated psychiatric disorders in England:

- Adult Psychiatric Morbidity in England – 2007, Results of a household survey
- Adult Psychiatric Morbidity Survey: Survey of Mental Health and Well-being, England, 2014
- Adult Psychiatric Morbidity Survey: Survey of Mental Health and Well-being, England, 2023/24

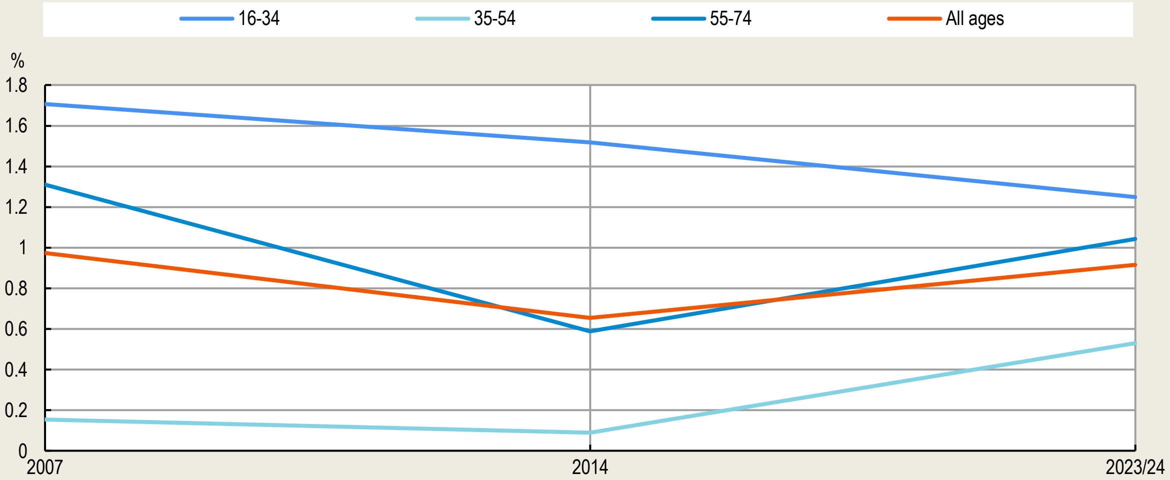
Autism prevalence is typically estimated through a detailed validation assessment. This means that, contrary to population-level surveys in other countries which measure self-reported autism (such as the Survey of Disability and Carers in Australia, the Canadian Health Survey on Children and Youth and the Dutch National Health Survey), England's APMS measures the real prevalence. Prevalence in the APMS is estimated through the following steps:

- In the phase-one interview, autism is screened using an adapted version of the 20-item Autism Spectrum Quotient (AQ-20).
- In the phase-two interview, a full examination is carried out with a subset of participants by clinically trained interviewers using the Autism Diagnostic Observation Schedule (ADOS-2).
- ADOS-2 results are weighted to generate a prevalence estimate for the general population.

According to APMS data, prevalence levels of autism have remained quite stable over time, at around 1% (Figure 2.2). Age-specific data show a slight decline in those aged 16-34 (from 1.7% in 2007 to 1.2% in 2023/24) and a slight increase in those aged 35-54 (from 0.2% in 2007 to 0.5% in 2023/24).

Figure 2.2. Autism prevalence has remained relatively stable over time, at around 1%

The true prevalence of autism in the United Kingdom by broad age group, 2007, 2014 and 2023/24



ADOS: Autism Diagnostic Observation Schedule.

Note: Autism prevalence is estimated based on the profile of ADOS-examined autism amongst adults (16+) living in private households.

Source: NHS (2025[59]), *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Well-being, England, 2023/4*, https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder.

StatLink https://stat.link/afb6oi

Table 2.2 provides an overview of ASD diagnoses per 100 000 population in ten OECD countries and the indicators on which these rates are based on. The nature of the indicator influences how sensitive the measure is to change and how large an increase is expected to be seen. For example, a comprehensive population survey in a population where ASD diagnoses are increasing significantly captures a bigger increase than data that captures inpatient hospitalisation which remains rare among people with autism.

Table 2.2. Rates of detected autism vary considerably across countries and measurements used

People with ASD in the overall population, selected OECD countries, latest available year

Country	Rate per 100 000	Year	Data source	Indicator
Australia	1 100	2022	Survey of Disability, Ageing and Carers (SDAC)	Number of persons with autism (self-reported)
Canada	3 800	2024	Canadian Health Survey on Children and Youth (CHSCY)	Number of persons with autism (self-reported or by person most knowledgeable of the child)
Denmark	1 345	2024	National Patient Registry (LPR)	Number of people diagnosed with autism in a hospital setting
Estonia	55	2023	National Institute for Health Development	New and prevalent outpatient case consultations
Germany	5.5	2023	Federal Statistical Office	Autism as the main diagnosis of hospital inpatients
Israel	1 820	2024	Provided by national authorities	Number of children diagnosed with ASD receiving the Disabled Child's Allowance
Netherlands	2 800	2024	National Health Survey	Number of persons with autism (self-reported)
Sweden	418	2024	National Board of Health and Welfare	Number of persons diagnosed with ASD in inpatient and/or specialised open care
England (UK)	900	2023/24	Adult Psychiatric Morbidity Survey	Estimated prevalence of autism among the adult population.
United States	3 220	2022	Centers for Disease Control and Prevention (CDC), ADDM Network[1]	Number of 8-year-old children diagnosed with ASD in selected Network sites.

ADDM: autism and developmental disabilities monitoring; ASD: autism spectrum disorder; LPR: *Landspatientregistret* (National Patient Registry).

Note: Calculated by the OECD. 1. ADDM Network data is collected from health and/or education records of 8-year-old children to estimate the number of 8-year-old children with ASD. The sites do not collect nationally representative data.

Source: Australian Bureau of Statistics (2024[52]), *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads; Statistics Canada (2025[53]), Health indicator statistics for children and youth aged 1 to 17 years, parent reported, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310094701; Social- og Boligstyrelsen (2024[60]), *Data om borgere [Data on citizens]*, https://www.social.dk/data/databank; Tervise Arengu Instituut (2024[55]), *PKH1: New and prevalent outpatient case consultations by psychiatrist by diagnosis, sex and age group*, https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__02Haigestumus__05Psyyhikahaired/PKH1.px/; Statistisches Bundesamt (Destatis) (2025[61]), *Diagnoses of hospital inpatients*, https://www-genesis.destatis.de/datenbank/online; CBS (2025[56]), *Health and healthcare; personal characteristics* https://opendata.cbs.nl/#/CBS/en/dataset/85454ENG/table?searchKeywords=health; Socialstyrelsen (2025[57]), *Statistikdatabas för diagnoser*, https://sdb.socialstyrelsen.se/if_par/resultat.aspx; NHS (2025[59]), *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Well-being, England, 2023/4*, https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder; CDC (2025[58]), *Autism Data Visualization Tool*, https://www.cdc.gov/autism/data-research/autism-data-visualization-tool.html. Data for Israel was provided by national authorities.

StatLink https://stat.link/p8h2of

Changes in autism diagnosis rates

The growth in rates of ASD might be explained by a range of factors, some of which have already been mentioned, such as:

- changes in diagnostic criteria (from subtypes of PDD to understanding the disorder as a spectrum);
- changes in diagnostic practices (e.g. a lower age at diagnosis);

- more accurate diagnostic tools (development of standardised measures);
- better understanding of the disorder (growing literature around genetic and environmental causes of autism, better diagnosis in girls and adults); and
- growing awareness around autism and other neurodevelopmental disorders (NDDs), thanks to the neurodiversity movement.

A Swedish study by Lundstörm et al. (2015[62]) found that while the number of clinically diagnosed individuals with ASD increased substantially in a 10-year period between 1993 and 2002, the measured level of autism symptoms actually remained stable. Similarly, a follow-up study by Arvidsson et al. (2018[63]) found that, while more autism diagnoses were made with time, this was due to a drop in the threshold of autism symptoms necessary for a diagnosis, rather than an increase in autistic symptoms in the population.

A study from the United Kingdom (Russell et al., 2021[41]) found that the increase in the rate of autism diagnosis was higher in adults and in females, coherent with the hypothesis that expanding the autism spectrum – as was done through the DSM-5 and the ICD-11 – has allowed for the inclusion of more cognitively able individuals as well as of differently presenting persons who might have gone unnoticed previously, such as women (see "Girls and women"). Accordingly, changes in identification and recording of ASD diagnoses may lead to changes in prevalence rates (Russell et al., 2021[41]).

Growing autism awareness might also be contributing to the growing rates of autism. Since the beginning of the millennium, there has been growing awareness of neurodevelopmental disorders among the population, particularly autism and ADHD. The global neurodiversity movement, advocating for people with brains different from what is considered "typical" developmentally, also called "neurodiversity", has pushed towards destigmatisation of conditions such as autism and ADHD which may have led to increased diagnosis-seeking. For instance, there has been an increased awareness of ASD in females related to expanded representation in social media, in addition to improved diagnosing tools and training programmes (Grosvenor et al., 2024[51]).

A range of research into the possible causes of autism exists, and some seeks to understand whether the underlying prevalence of autism has been increasing alongside the growth in rates of autism diagnosis. Most studies fall into two categories: genetic studies and environmental studies (Box 2.3). Current research is also focussing on identifying critical developmental windows (particularly the pre- and perinatal periods) to better understand how biological and environmental factors shape neurodevelopmental trajectories in autism (Barthélémy et al., 2019[21]).

Box 2.3. Numerous studies have investigated the causes of autism

Studies seeking to understand the causes of autism tend to focus on genetic and epigenetic factors, potential environmental exposures, and the interactions between genes and the environment.

Genetic research

Research over the past few decades has established that genetic factors play a major role in the development of autism, with heritability estimates consistently high. While no single mutation accounts for most cases, some genetic variants have been found to contribute to autism susceptibility in up to 40% of cases – many of which are also associated with other neurodevelopmental or psychiatric conditions such as epilepsy, ADHD, schizophrenia, and intellectual disability (Constantino and Charman, 2016[14]).

Genome-wide techniques have identified hundreds of potentially important genetic loci – i.e. a specific, physical area on a chromosome – with evidence suggesting that both inherited and new mutations may contribute to autism risk (Barthélémy et al., 2019[21]). Some cases of autism are associated with specific genetic syndromes, such as Fragile X, neurofibromatosis, and tuberous sclerosis, as well as other chromosomal rearrangements detectable by genetic testing (Barthélémy et al., 2019[21]). The clinical heterogeneity of autism suggests that multiple genes and mechanisms are involved, and many findings require cautious interpretation.

Environmental research

In addition to genetic susceptibility, environmental factors and gene-environment interactions are believed to play a role in autism risk, although the exact causal pathways remain unclear. Potential environmental risk factors include advanced parental age (particularly paternal), prenatal exposure to toxins (such as mercury, lead, polychlorinated biphenyls, or valproic acid), nutritional deficiencies (e.g. vitamin D), birth complications, and prematurity (Sealey et al., 2016[64]; Grabrucker, 2013[65]; Wu et al., 2016[66]; Barthélémy et al., 2019[21]). However, while many associations have been observed, clear causal mechanisms have not yet been established, and this area of research remains in its early stages (Grabrucker, 2013[65]; Modabbernia, Velthorst and Reichenberg, 2017[67]).

Source: Constantino and Charman (2016[14]), *Diagnosis of autism spectrum disorder: reconciling the syndrome, its diverse origins, and variation in expression*, https://doi.org/10.1016/s1474-4422(15)00151-9; Barthélémy et al. (2019[21]), *People with Autism Spectrum Disorder: Identification, Understanding, Intervention – Third edition*, https://www.autismeurope.org/wp-content/uploads/2019/09/People-with-Autism-Spectrum-Disorder.-Identification-Understanding-Intervention_compressed.pdf.pdf; Sealey et al. (2016[64]), *Environmental factors in the development of autism spectrum disorders*, https://doi.org/10.1016/j.envint.2015.12.021; Grabrucker (2013[65]), *Environmental factors in autism*, https://doi.org/10.3389/fpsyt.2012.00118; Wu et al. (2016[66]), *Advanced parental age and autism risk in children: a systematic review and meta-analysis*, https://doi.org/10.1111/acps.12666; Modabbernia, Velthorst and Reichenberg (2017[67]), *Environmental risk factors for autism: an evidence-based review of systematic reviews and meta-analyses*, https://doi.org/10.1186/s13229-017-0121-4.

Diagnosis rates vary across different population groups

Girls and women are diagnosed less with autism

Historically autism has been viewed primarily as a “male disorder.” Boys have tended to be diagnosed with ASD at rates four to six times higher than girls (a ratio of 4-6:1). However, more recent studies suggest that the gender gap is smaller than previously thought, with updated estimates placing the male-to-female diagnostic ratio closer to 2-3:1 (Duvekot et al., 2016[68]; Hamdani et al., 2023[69]; Lockwood Estrin et al., 2020[70]). This shift reflects a growing awareness amongst medical professionals that autism has likely been underdiagnosed in girls and women. Similar findings have also been reported for ADHD (Duvekot et al., 2016[68]).

One likely reason for the historically lower rate of diagnosis of autism in females is that diagnostic criteria have traditionally been based on how autism presents in males, especially young boys. It is now better understood that autism can manifest differently in girls and women (Gould, 2017[71]; Hamdani et al., 2023[69]). Studies have shown that girls and women are more likely to internalise their difficulties, leading to symptoms associated with anxiety and/or depressive disorders, whereas boys are more likely to show externalised (and sometimes disruptive) symptoms, making autism more “noticeable” in boys (Duvekot et al., 2016[68]). This can result in autistic traits going unnoticed in girls, or being attributed to other mental health issues, or learning difficulties, especially at a younger age (Hamdani et al., 2023[69]). Lockwood Estrin et al. (2020[70]) suggest that in many cases, girls under age 21 must display more severe behavioural or cognitive difficulties than boys to be considered for diagnosis: “for females to be diagnosed using existing criteria, their observable characteristics must be exaggerated to score sufficiently to warrant a diagnosis”.

Girls are also more prone to “masking” or “camouflaging” their autistic traits, i.e. adapting their behaviour in social settings to conform with peers, which makes their challenges less visible to teachers, clinicians, and even family members. These subtler presentations are more likely to emerge or be recognised during adolescence and young adulthood, when social interactions become increasingly complex (Gould, 2017[71]; Hamdani et al., 2023[69]; Lockwood Estrin et al., 2020[70]).

Girls with autism are less likely to be diagnosed with autism than boys, and when they are, they tend to be diagnosed later, which can delay access to needed supports and interventions (Duvekot et al., 2016[68]; Hamdani et al., 2023[69]).

In recognition of these differences, characteristics of what is sometimes referred to as a female “phenotype” of autism have been included in the DSM-5-TR, including reference to “masking” and to special interests being more similar to peers than for boys (APA, 2022[12]). However, standardised instruments often referred to as “gold standards” such as the ADOS-2 or the ADI-R may still not accurately capture autistic traits in girls, particularly in relation to social interests or repetitive behaviours. For example, a girl with autism with restricted interest in e.g. animals or dolls, may appear more typical and socially acceptable, whereas a boy’s interests with autism e.g. in train timetables or mechanical systems, may raise more clinical concern. Likewise, girls may be less likely to engage in “stereotyped” behaviours such as lining up toys, which are key diagnostic indicators in many tools (Gould, 2017[71]; Duvekot et al., 2016[68]). In response, new diagnostic approaches are being developed. These include the Camouflaging Autistic Traits Questionnaire (CAT-Q) developed by Hull et al. (2019[72]), and a checklist of compensation strategies proposed by Livingston et al. (2020[73]), both designed to better identify autism in girls and women (Lockwood Estrin et al., 2020[70]).

Socio-economic status has an impact on diagnostic access and outcomes

The relationship between socio-economic status (SES) and autism diagnosis is complex and varies across countries. In many contexts, access to healthcare, awareness of autism symptoms, and parental education can influence when and whether a child receives an autism diagnosis.

In the United States, children from higher-income families are more likely to be diagnosed with autism and more likely to receive a diagnosis at a younger age than children from middle- or low-income families. This disparity is likely due to differences in access to healthcare and associated diagnostic tools, as wealthier families often have better access to specialised services, earlier screening, and higher-quality care. Parental education may also play a role, as more educated parents often have higher levels of autism awareness and are better equipped to navigate the healthcare system and advocate for their child’s needs (Thomas et al., 2011[74]; Durkin et al., 2010[75]). Similarly, in the United Kingdom, studies found lower autism diagnosis rates among children of mothers with lower educational attainment – 0.7% compared to 1.5% for children whose mothers had at least a high school education – possibly due to reduced awareness of developmental signs (Kelly et al., 2017[76]).

However, more recent evidence suggests that the pattern may be shifting. A large-scale UK study found that autism prevalence was higher among children from lower SES backgrounds, with an average national prevalence of 1.8%, albeit with important regional differences (Roman-Urrestarazu et al., 2021[30]). Similar trends have been observed in other European countries, suggesting that socio-economic disadvantage may be associated with higher underlying risk, possibly due to increased exposure to environmental stressors – e.g. heavy metal and air-pollution exposure is more common in low-income neighbourhoods – or other social determinants of health (Lyall, Schmidt and Hertz-Picciotto, 2014[77]; Volk et al., 2011[78]; Volk et al., 2014[79]; Wu et al., 2024[80]).

Public health policies and health system structures play a role in shaping diagnostic patterns. In Sweden, where children undergo routine developmental screening and where healthcare tends to be highly accessible regardless of income level, children from lower-income families and those with parents in manual occupations had a slightly higher risk of getting an ASD diagnosis – 1.4% compared to 1% for children with parents from higher SES – a reversal of the pattern observed in the United States (Rai et al., 2012[81]). The availability of free and standardised diagnostic pathways likely facilitates earlier and more equitable identification of autism across socio-economic groups.

Diagnostic patterns in France seem like those in Sweden. A study of eight-year-olds in South-Western France (Haute-Garonne) found that children from more socially deprived backgrounds, single-parent households, and immigrant families had the highest autism prevalence, particularly when associated with intellectual disability (Delobel-Ayoub et al., 2015[82]). However, these results should be interpreted with caution, as France does not collect prevalence data systematically. Since 2018, France has made efforts to collect better data under their national autism and neurodevelopmental strategy (Box 4.2). A 2022 analysis was able to use data from the national health data system in France. The study found that the proportion of patients with autism aged 0-17 in medical-administrative databases living in adverse social conditions, gradually rose from 29% in 2010 to 42.4% in 2022 (Ponnou et al., 2025[83]). Another study on the prevalence of ASD in France (Haute-Garonne, Isère, Savoie and Haute-Savoie territories), based on data from the child disability database, found that there has been a significant drop in the proportion of children with autism with co-morbid intellectual disability (Delobel-Ayoub et al., 2020[84]).

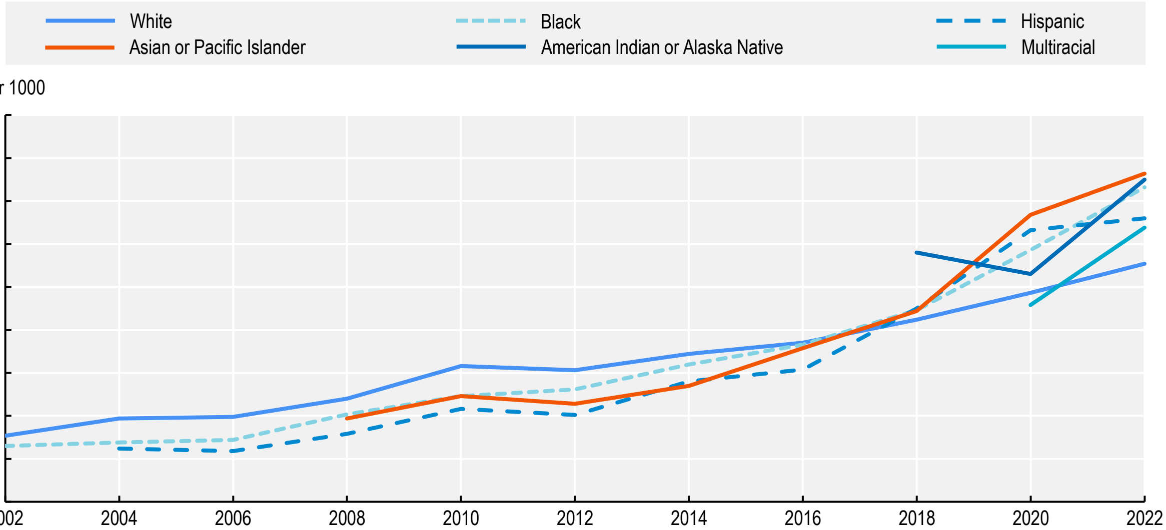
Race and ethnicity may also affect ASD diagnosis rates

The relationship between race and ethnicity, and autism diagnosis is shaped by a range of social, cultural, and systemic factors. In many countries, children from racial or ethnic minority groups appear to face delays in diagnosis, possibly due to cultural stigma and unequal access to healthcare. There is also evidence of diagnostic bias, where clinicians may interpret similar behaviours differently across racial or cultural groups.

In the United States, autism prevalence differs across racial and ethnic groups, with findings varying by state. In 2022, estimated prevalence was 32.2 per 1 000 children on average, ranging from 14.3 per 1 000 in Texas to 53.1 per 1 000 in California (CDC, 2025[58]). Data from the ADDM Network sites show that prevalence has increased across all racial and ethnic groups, with a notable shift in the mid-2010s, likely related to raising awareness in some population groups. Until 2016, children identified as “White” had the highest estimated autism prevalence; by 2022, however, they had the lowest prevalence of all racial and ethnic groups (Figure 2.3). Despite this shift, disparities remain in diagnostic patterns. For instance, in the United States, Black children are more likely to be diagnosed with co-morbid intellectual disability than Hispanic or White children, which might be a reflection of diagnostic bias (Zeidan et al., 2022[16]).

Figure 2.3. In the United States, disadvantaged groups now show higher ASD prevalence

ASD prevalence in the United States by race and ethnicity, 2002-2022



ADDM: autism and developmental disabilities monitoring, ASD: autism spectrum disorder.
Note: Estimate is based on ADDM Network data. ADDM data is not representative for each state.
Source: CDC (2025[58]), *Autism Data Visualization Tool*, https://www.cdc.gov/autism/data-research/autism-data-visualization-tool.html.

StatLink https://stat.link/j0r4zm

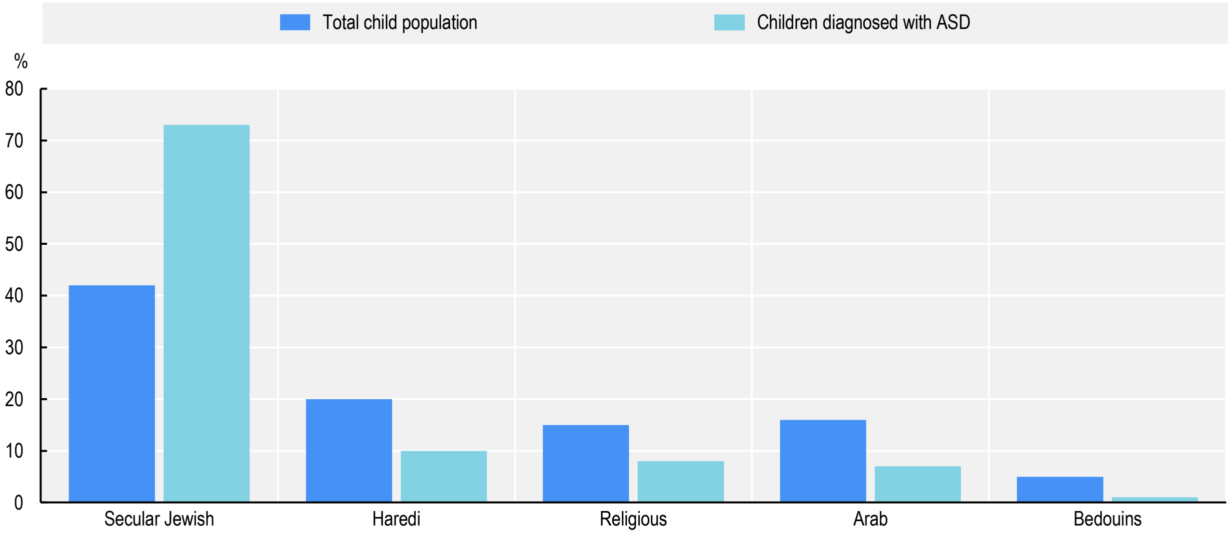
In Europe, patterns differ. In the United Kingdom, recent national studies have found higher autism prevalence rates among children from ethnic minority and immigrant backgrounds. A 2021 study using school census data reported the highest autism prevalence among Black pupils, while also showing that children who spoke English as an additional language or faced socio-economic disadvantage were more likely to be diagnosed as having autism (Roman-Urrestarazu et al., 2021[30]). A follow-up study in 2022 found that Asian, Black, and Chinese girls were significantly less likely to be diagnosed than White girls. The authors suggest there may be underdiagnosis among minority ethnic girls due to language barriers, cultural stigma, and limited access to services (Roman-Urrestarazu et al., 2022[85]).

In France, a population-based study found that autism with intellectual disability was more common in areas with higher concentrations of immigrants, as well as in areas marked by social deprivation, such as higher unemployment and lower educational attainment. No such pattern was found for autism without intellectual disability, suggesting that severe or visible cases may be more likely to be identified in disadvantaged and immigrant communities (Delobel-Ayoub et al., 2015[82]).

In Israel, autism diagnosis rates are notably lower among children from certain minority population groups, including Bedouins, Israeli Arabs and – to a lesser extent – Haredi Jews (a branch of Orthodox Judaism characterised by the strict interpretation of religious sources and traditions), who represent 5%, 16% and 20% of the child population, respectively. Recent national data on the participation in the special education system show that 73% of diagnosed children are from the "Secular Jewish" population, which makes up only 42% of all children. By contrast, only 10% of diagnosed children are Haredi Jew, 7% are Arab and 1% are Bedouin (Figure 2.4). However, special education data are not representative of the entire population, as families have many and different reasons for sending their child to a regular school or a special school. Due to language and cultural reasons, children issued from minority ethnic populations (Haredi Jews, Arabs, Bedouins) may be less likely to go into the special education system, even if they have an autism diagnosis, compared to children from the majority Jewish population. Indirect estimates derived from district data suggest large underdiagnosing in neighbourhoods with a large Arab population but not in neighbourhoods with a large Haredi population. A recent study based on district data from the National Insurance Institute found that Jewish children residing in predominantly Haredi neighbourhoods became eligible for the Disabled Child Allowance (an allowance given to all Israeli children with an ASD diagnosis) significantly later (on average at 4.7 years) than Jewish children from non-Haredi neighbourhoods (on average at 2.7 years) (Silverman, Amit and Sadaka, 2026[86]).

Figure 2.4. The secular population in Israel seems to have the highest ASD diagnosis rate

Distribution across ethnic and religious groups in the total child population and among children in the special education system diagnosed with ASD, 2024



ASD: autism spectrum disorder.
Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/undktr

Diagnostic guidelines and regulations are key for accurate autism assessments

Most OECD countries have a national guideline for health professionals on the diagnosis of autism, including recommendations around the diagnosing professional(s), the diagnostic criteria to be applied (e.g. DSM-5 or ICD-11), and the diagnostic tools to be used, such as the ADOS or the ADI-R (see Table A B.1). Guidelines may highlight that these diagnostic instruments should be used in addition to a clinician's observation and do not replace a full autism assessment, such as the National Guideline for the assessment and diagnosis of autism in Australia (Goodall et al., 2023[87]), France's Best Practice Guideline for autism diagnosis and assessment (HAS, 2018[88]), Germany's S3 guideline (the most rigorous type of medical guideline in Germany) for ASD diagnosis (AWMF, 2016[89]), the Dutch Guideline for the diagnosis and treatment of ASD in children and adolescents (NVvP, 2009[90]), as well as the United Kingdom's NICE guideline (NICE, 2011[91]) (see Box 2.4 for more details).

Box 2.4. The United Kingdom's NICE guidelines are considered international best practice

The National Institute for Health and Care Excellence (NICE) in the United Kingdom has issued comprehensive guidelines on the diagnosis and treatment of autism, as well as recommendations on the support for children and adults with autism. These guidelines are renowned internationally and have been used as a source for similar guidelines in many other OECD countries.

Development of NICE guidelines follows a rigorous process

NICE guidelines are developed following a rigorous pre-defined process. Topics are chosen based on referral from a national organisation, e.g. the National Health Service. Scoping is done in consultation with relevant stakeholders. The guideline is developed by reviewing the latest evidence, considering costs on the provision of services based on the guidelines and developing recommendations. Finally, a committee of professionals, care providers and service users consider the evidence and produce recommendations. Published guidelines are reviewed and updated regularly if needed (NICE, 2025[92]).

Currently, NICE has three clinical guidelines on autism:

- **Autism spectrum disorder in under 19s: recognition, referral and diagnosis (CG128)**. First published in 2011, last updated in 2017 and last reviewed in 2021 this guideline covers the first steps that lead up to the diagnosis of ASD in children and young people (NICE, 2011[91]).
- **Autism spectrum disorder in under 19s: support and management (CG170)**. First published in 2013, last updated in 2021 and last reviewed in 2025, the guideline covers the different ways health and social care professionals can provide support, treatment and help for children and young people with autism and their families (NICE, 2013[93]).
- **Autism spectrum disorder in adults: diagnosis and management (CG142)**. First published in 2012, last updated in 2021 and last reviewed in 2025, this guideline covers diagnosis and management of suspected or confirmed ASD in adults. It aims to improve access to health and social services and improved experience of care for people with autism (NICE, 2012[94]).

International guidelines are often inspired by NICE

NICE guidelines have achieved broad international recognition. Many OECD countries have cited NICE guidelines in their own policies or developed guidelines aligning closely with NICE's recommendations.

- In 2016, **Australia** published a report on good practices for support to pre-school children with ASD and their families and carers. The NICE 2013 guidelines on support and management of autism for under 19s served as a basis (CG170) (Roberts and Williams, 2016[95]).
- In 2019, **Canada's** Paediatric Society published a position paper on "Standards of diagnostic assessment for autism spectrum disorder". The 2011 NICE guidelines (Clinical Guideline 128) on recognition, referral and diagnosis of ASD in children and adolescents were one of the main guidelines reviewed (Brian, Zwaigenbaum and Ip, 2019[96]).
- **France**'s *Haute Autorité de Santé* (HAS) published a guideline on good practice on intervention and life trajectory of children and adolescents with ASD. The 2011 NICE guidelines (CG128) was one of the guidelines considered for the recommendations (HAS, 2023[97]).
- **Germany**'s S3 autism guidelines cite NICE guidelines (CG128, CG142 and CG170) as "methodologically excellent" and as the main source for the S3 guideline (AWMF, 2016[89]).
- For the **Netherlands**' clinical guidelines on ASD in children and youth, the NICE 2011 guideline (CG128) is one of the two main sources (NVvP, 2025[98]).

Source: NICE (2025[92]), *How we develop NICE guidelines*, https://www.nice.org.uk/what-nice-does/our-guidance/about-nice-guidelines/how-we-develop-nice-guidelines; NICE (2011[91]), *Autism spectrum disorder in under 19s: recognition, referral and diagnosis*, www.nice.org.uk/guidance/cg128; NICE (2013[93]). *Autism spectrum disorder in under 19s: support and management*, https://www.nice.org.uk/guidance/cg170; NICE (2012[94]), *Autism spectrum disorder in adults: diagnosis and management*, https://www.nice.org.uk/guidance/cg142; Roberts and Williams (2016[95]), *Autism spectrum disorder: Evidence-based/evidence-informed good practice for support provided to preschool children, their families and carers*, https://www.ndis.gov.au/media/863/download; Brian, Zwaigenbaum and Ip (2019[96]), *Standards of diagnostic assessment for autism spectrum disorder*, https://doi.org/10.1093/pch/pxz117; HAS (2023[97]), *Trouble du spectre de l'autisme (TSA): interventions et parcours de vie de l'enfant et de l'adolescent* – Note de cadrage, https://www.has-sante.fr/jcms/p_3448980/fr/trouble-du-spectre-de-l-autisme-tsa-interventions-et-parcours-de-vie-de-l-enfant-et-de-l-adolescent-note-de-cadrage; AWMF (2016[89]), *S3-Leitlinie Autismus-Spektrum-Störungen im Kindes-, Jugend- und Erwachsenenalter, Teil 1: Diagnostik, [S3 Guideline for Autism Spectrum Disorders in Childhood, Adolescence, and Adulthood. Part 1: Diagnostics]*, https://register.awmf.org/assets/guidelines/028_D_G_f_Kinder-_und_Jugendpsychiatrie_und_-psychotherapie/028-018l_S3_Autism_spectrum_disorders_in_childhood__adolescence_and_adulthood_2021-09_abgelaufen.pdf.

The assessment process recommended by national guidelines usually includes two steps: an assessment of needs and functioning combined with a medical evaluation, and a diagnostic assessment (see Table A B.1). The first part usually includes information on developmental history of the child, a cognitive and/or intelligence assessment, assessment of adaptive skills, assessment of language and communication level, and assessment of psycho-motor capabilities. The medical evaluation usually includes screening for hearing and visual disorders, detailed family medical history, and a clinical paediatric exam including e.g. weight, height and head circumference measurement. The diagnostic assessment usually includes two kinds of measures: an observational measure using tools, such as the ADOS, and a questionnaire filled out by the parent or caregiver, such as the ADI-R.

Most countries also suggest that the assessment be administered by at least two, or ideally a team of multi-disciplinary professionals, in line with the recommendations in the DSM-5 (APA, 2013[8]); this is the case for example for Australia, Canada, France, Germany, the Netherlands, Sweden and the United Kingdom. It may also be suggested that these professionals are trained specifically in administering a neurodevelopmental or an autism assessment (see Table A B.1). The growing demand for diagnostic assessments has made it difficult in many countries (e.g. France, the United Kingdom) to ensure that appropriately trained multi-disciplinary teams conduct the assessments. Although the Danish Health Authority's clinical guidelines also mention the need for a specialist assessment, the guideline mainly focusses on treatment and different intervention options and has few details on the diagnostic and assessment process. Interestingly, the Danish guideline is also the only one that includes measuring parental well-being as part of the assessment process (Sundhedsstyrelsen, 2021[99]).

Israel is the only country reviewed in this report where autism assessment for children is not issued as a guideline or a set of recommendations by a public health institution. Instead, diagnosing professionals must follow the assessment process set out in Circular n°15 of 2013 of the Ministry of Health (Ministry of Health, 2013[100]). The Circular includes information about professionals that can diagnose autism, diagnostic criteria, what kind of assessments should be included in the diagnostic process, as well as recommended assessment tools (see Table A B.1). Other legal instruments exist in several OECD countries. In 2014, France issued an "Instruction on the national framework for detection, diagnosis and early interventions for children with autism or other pervasive developmental disorders provided for in the autism plan", but this doesn't go into detail about the diagnostic process and focusses on laying the ground for a national autism framework instead (Ministère des affaires sociales et de la santé, 2014[101]). Similarly, in 2023 Canada's *Federal Framework on Autism Spectrum Disorder Act* received Royal Assent, i.e. formal approval from the governor to become law – requiring the development of a federal framework on autism spectrum disorder. However, this Act does not set out diagnostic guidelines (Minister of Justice, 2023[102]). The 2024 *Framework for Autism in Canada* includes a measure to advance opportunities to develop and update national guidelines for screening, diagnosis and services (Public Health Agency of Canada, 2024[103]).

Although these guidelines are key for diagnosing ASD, they become especially relevant for countries that require a valid ASD diagnosis to access disability benefits. Requirements for diagnosis to access a disability scheme may or may not be in line with national guidelines. For instance, in Canada, the Canadian Paediatric Society's guidelines allow for three different approaches when it comes to diagnosis, but some provinces only accept diagnosis made by an interdisciplinary or multi-disciplinary team (Approach 3) to access specialised services and benefits (Brian, Zwaigenbaum and Ip, 2019[96]).

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3

Financial benefits for children with autism spectrum disorder

This chapter provides a comparative overview of the allowances available to children with ASD and their families across 11 OECD countries. It begins by outlining the range of government supports – carer allowances, disabled child allowances, and additional cost allowances – and explains how these types of benefits differ in purpose. The chapter then examines how countries assess eligibility, highlighting the central role of support needs assessments, the varying weight given to medical diagnoses, and the diversity of administrative practices across systems. Special attention is given to Israel's diagnosis-based model, which uniquely links benefit levels to medical conditions, in contrast to the needs-based approaches prevalent elsewhere. The chapter also reviews the substantial cross-country variation in benefit generosity, the use of means-testing, and the ways in which allowances interact with caregivers' employment decisions. Finally, it discusses provisions that apply specifically to children with ASD, including Ontario's Autism Program and certain features of Australia's NDIS.

In Brief

Financial support for families of children with autism

Governments across OECD countries provide a mix of allowances and benefits to respond to the financial challenges families raising a child with autism are facing. Available benefits can include carer allowances to compensate for lost earnings, child disability allowances to ensure an adequate standard of living, and additional cost allowances to cover disability-related expenses such as therapies or home adaptations. While all countries reviewed offer some form of financial assistance, or even combine some of these payments, approaches differ markedly in design, generosity, and eligibility criteria.

Most countries base eligibility on an assessment of the child's support needs rather than on diagnosis alone. Israel and Australia are the notable exceptions: a formal autism diagnosis automatically entitles a child to a 100% rate of Israel's Disabled Child Allowance, with possibly higher rates for severe cases, and the Carer Allowance in Australia. Elsewhere, a diagnosis may be required but a diagnosis alone does not guarantee access to benefits. This reflects a broader trend towards support-needs-based systems, where support is linked to the child's daily living needs rather than medical labels.

Benefit levels vary widely. Denmark's Compensation for Lost Earnings stands out for its generosity, covering a large share of income lost when parents reduce working hours to provide care. By contrast, in countries such as Germany or Estonia, allowances are modest and leave families with substantial income gaps. Means-testing adds another layer of variation: while benefits in countries like France and Sweden are universal, others, including Canada, Australia, and California (United States), reduce or eliminate payments for higher-income households.

Additional cost allowances can play an important role in funding therapies and services, often through individualised budgets. Australia's National Disability Insurance Scheme and the Ontario Autism Program exemplify this proactive approach, giving families flexibility to purchase supports. Some other countries rely on flat-rate payments or reimbursements for documented expenses.

Financial support systems reflect different policy priorities: some systems aim to compensate for lost earnings, others to promote inclusion and autonomy through flexible funding. Yet challenges remain. Benefit generosity does not always align with the intensity of care and support needs, and access to support can be uneven across income groups. Especially for parents who are compelled to reduce their working hours to care for a child with disability, state-provided income support can be crucial.

Countries offer a range of financial benefits for children with ASD

Government support for children with ASD and their families is provided through a range of financial benefits, including direct cash transfers and tax benefits. In all 11 countries covered by this comparative study (Australia, Canada (Ontario), Denmark, Estonia, France, Germany, Israel, the Netherlands, Sweden, the United Kingdom, the United States (California)[1]), some form of cash benefit is available. Except at provincial level in Canada, for instance in Ontario and British Columbia, none of the countries offer a national-level benefit that is specific to ASD; rather, children with ASD are included in the broader framework for children with disability or special needs. In each country reviewed, except Israel and to some extent Australia, children with ASD must undergo the same assessments and satisfy the same eligibility criteria as those with other disabilities. Although a formal ASD diagnosis may be required in some cases, it does not automatically confer eligibility for state financial support.

Allowances for children with disability can be classified into three categories

These three categories are, not necessarily mutually exclusive:

1. Carer allowances
2. Disabled child allowances
3. Additional cost allowances

The **carer allowance** is a financial benefit designed to support individuals – typically parents or other family members – who dedicate a significant amount of their time to caring for a person in need of support. These allowances serve multiple purposes: they help to offset lost income resulting from reduced working hours or complete withdrawal from the labour market (Jenson and Jacobzone, 2000[1]; Van Houtven et al., 2019[2]), formally acknowledge the contributions of carers, and promote the provision of care within the home setting (Anttonen and Karsio, 2016[3]). The latter aligns with the principle set out in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which advocates for de-institutionalisation across all aspects of life of persons with disability (United Nations, 2006[4]).

The **disabled child allowance** is a direct cash benefit provided to children with disability and their families, aimed at alleviating financial strain, supporting home-based care, and fostering the child's inclusion in society. Unlike the carer allowance, which centres on the caregiver and care needs, this allowance is more child-focussed, considering the specific needs of the child to help ensure financial security and an adequate standard of living. By offering additional financial resources, the allowance enables families to better support the child's development and participation in society.

Lastly, the **additional cost allowance** is a financial benefit aimed at covering specific disability-related expenses, such as specialised therapies, assistive equipment, or home adaptations. In contrast to the disabled child allowance, which offers general financial support based on disability status, this allowance is tied to the actual additional costs incurred by the family of the child. Eligibility is typically determined through a detailed assessment of the additional expenses directly attributable to the child's disability.

Classifying financial benefits according to their purpose facilitates a cross-country comparison of the support provided to children with ASD. That said, in practice, some allowances may not fit neatly into a single category, as they incorporate elements of more than one type of allowance. In these cases, the financial benefit can be assigned to the category that best reflects its primary function.

Israel's Disabled Child Allowance has a unique approach to determining eligibility

Unlike most other countries covered in this report, Israel provides only one type of financial benefit for children with disability – the Disabled Child Allowance. This monthly allowance is divided into five levels (50%, 100%, 112%, 188%, and 235%), ranging from NIS 1880 (USD PPP 522) to NIS 8 828 (USD PPP 2 453). A formal medical diagnosis is required and plays a central role in determining the allowance level, as Israel prescribes predefined benefit levels for most conditions. For example, a child with an ASD diagnosis automatically qualifies for the 100% rate, while a child diagnosed with mild intellectual developmental disability receives 50%. Children undergo a care needs assessment only to determine whether their parents' care provision warrants a higher rate than the standard for their condition. For instance, a child with Down Syndrome who requires intensive care may receive 188% rather than the standard 50-100%.

Israel's diagnosis-based approach, where benefit levels are tied to medical conditions and a care needs assessment is conducted only to determine whether a higher allowance level should be granted, poses challenges, especially for conditions such as ASD that span a broad spectrum of severity. As will be detailed in the following sections, this reliance on diagnoses is unique among the countries studied.

Carer allowances are commonly available in the countries reviewed

Except for Israel, Canada, and the Netherlands, every country under review offers at least one carer allowance that caregivers of children with ASD may qualify for (see Table 3.1). In countries where multiple carer allowances are available, these benefits are typically differentiated according to the level to which caregivers are limited in their capacity to work. This approach is intended to better support parents and other informal caregivers who must substantially reduce their working hours or exit the labour market entirely due to the significant care needs of the child.

Support needs and the hours of care required are determining factors for eligibility

In the eight countries providing a carer allowance, an assessment of the child's care requirements and support needs in daily life is a fundamental component of determining eligibility. These evaluations typically examine aspects of the child's life such as mobility, cognitive and communicative abilities, social participation, and self-care. Most assessments rely on documentary evidence, such as medical certificates and school reports, and may utilise standardised tools, including questionnaires. In instances where uncertainty remains, in-person evaluations are conducted on a case-by-case basis; in some countries however, notably Germany, in-person visits are the norm. Frequently, eligibility depends on the hours of care required, with some systems stipulating a minimum number of care hours per week as a condition for eligibility (Sweden's Assistance Allowance (*Assistansersättning*) and the United Kingdom's Carer's Allowance). Consequently, parents are commonly required to supply evidence demonstrating both the care provided and its impact on their capacity to engage in paid employment, particularly when the child's disability necessitates continuous care, potentially resulting in one parent having to leave their job.

It is important to note that across all countries covered in this report, these carer allowances are not limited to specific types of medical impairments or disability. In most cases, a formal diagnosis of ASD – or any medical impairment – is not a prerequisite for qualifying for an allowance. For example, in the United Kingdom, Carer's Allowance eligibility is determined solely by assessing the child's support needs in daily life and need for care, rather than by confirming a medical diagnosis of a condition. While some countries and regions, such as Australia and California (United States) explicitly require a formal diagnosis – of ASD or any other medical impairment – others, including Denmark, the United Kingdom, and Estonia (Caregiver's Allowance for Parents), do not. Nonetheless, most assessments incorporate some form of medical documentation describing the child's condition. However, in none of the eight countries offering a carer allowance does a formal ASD diagnosis automatically entitle an individual to an allowance – Australia's Carer Allowance is the only exception.

While assessments of a child's support needs play a crucial role in determining eligibility for a carer allowance, the regularity of reassessments varies greatly. In some countries, only a significant change in the child's condition triggers an ad hoc reassessment. In contrast, in France, reassessments are typically conducted every two to five years, and in Germany, for children, usually every two years. Age limits also vary among the countries considered: for example, while the German Care Allowance (*Pflegegeld*) applies to both adults and children, France and Australia have a specific carer allowance for children, imposing an age limit of 20 and 16 years, respectively.

Another important point of comparison is the administrative level at which these allowances are managed. Generally, carer allowances are administered at the federal or state level. In Estonia and Denmark, local authorities, such as municipalities, oversee the allowances. This decentralised approach partly explains why benefits in these countries, particularly in Denmark, tend to be individualised compared to the more standardised systems observed elsewhere.

Individual allowance amounts vary significantly between and within countries

There is also considerable variation in the generosity of benefits across countries. For example, Estonia's Caregiver's Allowance for Parents (*hooldajatoetus*) is on average EUR 90 (USD PPP 154) a month, while Denmark's Compensation for Lost Earnings (*Tabt arbejdsfortjeneste*) can reach up to DKK 36 622 (USD PPP 5 878) per month. Variation exists not only between but also within countries, as different levels of financial support are often allocated according to the severity of the child's disability and its impact on the caregiver's capacity to work. In France, the Education Allowance for Disabled Children (*Allocation d'éducation de l'enfant handicapé,* AEEH) comprises a basic monthly allowance of EUR 151.80 (USD PPP 218) plus a complementary amount based on the caregiver's ability to work, which can raise the total monthly benefit to EUR 1 415.87 (USD PPP 2 037). Similarly, Germany's Care Allowance (*Pflegegeld*) is structured into five levels of care need corresponding to the child's degree of care dependency, with a child classified at the highest level (level 5) qualifying for EUR 990 (USD PPP 1 388) per month.

There is no uniform approach to whether a carer allowance is means-tested. In English-speaking countries such as Australia, the United Kingdom, and California (United States), the caregiver's income and assets are considered to determine both eligibility and the benefit amount. For example, Australia's Carer Payment is income-tested and gradually reduced once the adjusted family net income exceeds a specified threshold, potentially declining to AUD 0. In the United Kingdom, working carers earning more than GBP 196 (USD PPP 289) per week after deductions are ineligible for the Carer's Allowance. Denmark employs an individualised approach: its Compensation for Lost Earnings (*Tabt arbejdsfortjeneste*) is income-based, providing parents with a percentage of their lost income calculated on the basis of their previous gross earnings, up to a maximum of DKK 36 622 (USD PPP 5 878) per month.

The carer allowances in Denmark and the United Kingdom stand out. Denmark's highly individualised approach features assessment procedures that vary by municipality and determine benefit amounts on a case-by-case basis, considering factors such as the child's support needs, the number of care hours required, and the caregiver's previous income. Although the United Kingdom does not adopt such an individualised method, its eligibility requirements are notably progressive, relying entirely on an assessment of the child's support needs and limitations in daily life without necessitating a formal medical diagnosis. This approach aligns more closely with the principles of the United Nations Convention on the Rights of Persons with Disabilities and the social model of disability.

Table 3.1. Carer allowances

Country	Benefit	Amount & levels	(ASD) diagnosis	Means-testing
Australia	Carer Allowance	Fortnightly payment of AUD 159.30. A child with an ASD diagnosis is automatically entitled to the benefit.	Required	Income-tested
	Carer Payment	Fortnightly payment with maximum at: AUD 1 149 for a single carer; AUD 1 732.2 for a couple if both care full-time	Required	Income- and asset-tested
Denmark	Compensation for Lost Earnings (*Tabt arbejdsfortjeneste*)	Benefit is a percentage of parents' lost income, however, at a maximum of DKK 36 622 per month.	Not strictly required	Income-tested
	Care Leave Scheme (*Pasning af nærtstående*)	During the leave, the carer is employed by the municipality and receives a salary of DKK 27 033 per month. However, this amount cannot be greater than the salary they would receive from their employer.	Not strictly required	Income-tested
Estonia	Caregiver's Allowance for Parents (*hooldajatoetus*)	Municipalities determine the exact amount on a case-by-case basis; on average EUR 90 per month.	Not strictly required	Usually not means-tested
	Care Allowance for Temporary Incapacity for Work (*hooldushüvitis*)	80% of caregiver's previous labour income.	Required	Income-tested
France	Education Allowance for Disabled Children (*Allocation d'éducation de l'enfant handicap,* AEEH)	Monthly basic allocation plus a complementary amount that varies depending on parents' capacity to engage in work: 2) EUR 460.14 – 3) EUR 588.22 – 4) EUR 828.11 – 5) EUR 1 016.15 – 6) EUR 1 439.94	Required	Not means-tested
	Leave Allowance (*Allocation Journalière de Présence Parentale,* AJPP)	Full day: EUR 65.80 – Half day: EUR 32.90 Plus possible monthly supplement: EUR 126.20	Not strictly required	Daily allowance not means-tested Monthly supplement means-tested
Germany	Care Allowance (*Pflegegeld*)	Monthly: 5 levels depending on the child's care needs: 1) not eligible – 2) EUR 347 – 3) EUR 599 – 4.) EUR 800 – 5) EUR 990	Not strictly required	Not means-tested
Sweden	Care Allowance (*Omvårdnadsbidrag*)	Monthly: 4 levels depending on the child's care needs: 1) SEK 3 063 – 2) SEK 6 125 – 3) SEK 9 188 – 4) SEK 12 250	Not strictly required	Not means-tested
	Assistance Allowance (*Assistansersättning*)	Benefit is calculated based on approved number of assistance hours multiplied by a standard hourly rate which is approximately SEK 343/hour.	Not strictly required	Not means-tested
United Kingdom	Carer's Allowance	GBP 81.90 per week	Not strictly required	Income-tested
	Universal Credit – Carer's Element	GBP 198.31 per month	Not strictly required	Means-tested
United States (California)	In-Home Supportive Services (IHSS)	Based on authorised service hours multiplied by the applicable hourly wage, which varies by county.	Required	Means-tested

Note: A detailed comparison of carer allowances can be found in Table A C.1.

Source: Information collected by the Secretariat and verified in discussions with national autism organisations and ministries.

Disabled child allowances also offer meaningful financial support

Countries typically provide either a carer allowance or a disabled child allowance, with only a few – namely Estonia, France, the United Kingdom, and California (United States) – offering both types of support. Most countries included in this comparison, except for Australia, Denmark, Germany, and Sweden,[2] provide some form of disabled child allowance. The United Kingdom stands out for offering two such allowances: one means-tested as part of the Universal Credit system (the Disabled Child Element), and the other – Disability Living Allowance – which is not subject to means testing (see Table 3.2).

An ASD diagnosis does not automatically entitle to a disabled child allowance

In most countries, an assessment of the child's support needs forms a central part of the eligibility determination for a disabled child allowance. Israel, however, is a notable exception. There, a formal assessment of needs and functioning is conducted only to evaluate whether a child with ASD may qualify for a rate higher than the standard 100% level automatically granted to children with an ASD diagnosis. In all other countries examined, a formal medical ASD diagnosis alone does not guarantee eligibility for a disabled child allowance. While the extent, depth, and alignment with the social model of disability of support needs assessments vary by country, some form of evaluation is always present.

Israel represents the most medically oriented approach among the countries studied. A formal ASD diagnosis is not only required but also entitles the child to receive a 100% benefit automatically. By contrast, to qualify for Canada's Child Disability Benefit (CBD), a child does not need to provide a formal medical diagnosis but must have one or more severe and prolonged impairments in mental or physical functions. However, such an assessment of the child's functioning is not conducted through a separate process; rather, the assessment is integrated into the medical certificate, in which a health professional evaluates the child's limitations in daily life. The Canadian allowance is income-tested and can be gradually reduced to CAD 0. Its maximum monthly amount is considerably lower than Israel's, at CAD 276.83 (USD PPP 244) (June 2025).

Overall, the support needs assessments used to determine eligibility for disabled child allowances across countries are typically identical to those used for carer allowances. These assessments focus on the child's support needs in key areas of daily life, such as self-care, communication, and social interaction. While the assessments rely heavily on documentary evidence (e.g. medical reports, educational evaluations), in-person evaluations may also be conducted. In France, for example, a multi-disciplinary team from the Department for the Disabled (*Maison départementale des personnes handicapées, MDPH*) responsible for determining eligibility for the *Allocation d'éducation de l'enfant handicapé* (AEEH) conducts in-person evaluations. Notably, decisions and processing times may vary significantly between different French departments, risking marked socio-territorial inequalities. The GEVA guide (*Guide d'évaluation des besoins de compensation des personnes handicapées*) is, however, commonly used in support needs assessments in France. In Germany, assessments for the Care Allowance (*Pflegegeld*) are carried out by a medical service from the long-term care insurance. In the Netherlands, the Centre for Indications for Care (*Centrum Indicatiestelling Zorg,* CIZ) evaluates whether a child qualifies for long-term care, based on a comprehensive assessment of medical, functional, and social factors.

As previously noted, the United Kingdom's Disability Living Allowance (DLA) stands out for relying entirely on a functional assessment of the child, with no requirement for a formal medical diagnosis. Given that many other British disability-related benefits are contingent on receipt of DLA, the United Kingdom's disability benefit system is function-based rather than diagnosis-based. The child's assessed actual needs and limitations in daily life determine not only eligibility for the allowance but also the level or amount of support granted.

Allowance levels commonly vary in line with the child's degree of functional impairment

In Estonia, for example, there are three benefit levels ranging from EUR 138 to EUR 242 (USD PPP 237 to USD PPP 415) per month, depending on the assessed degree of disability. In the United Kingdom, the DLA comprises two components – care and mobility. The care component is divided into three levels of severity, while the mobility component has two levels, reflecting the varying support needs levels of children with disability.

However, variations in the amount of disabled child allowance across countries are not always driven by the severity of the child's disability. In some cases, they result from income-testing. For instance, in California (United States) and Canada, where the allowance amount is adjusted to parents' income, exceeding a specified income threshold renders families ineligible for the financial benefit. In the Netherlands, the amount is not determined by either income or disability severity, but rather by the age of the child. The Dutch disabled child allowance, known as the Double Child Benefit (*Dubbele Kinderbijslag*), is essentially twice the standard child benefit which is age dependent.

In France, the AEEH consists of a basic allowance that falls under the category of a disabled child allowance. However, additional top-ups to the AEEH are granted based on the number of care hours required and the resulting reduction in working hours of parents or the incurrence of disability-related expenses. As such, these supplementary amounts align more closely with the purposes of carer allowances and additional cost allowances, respectively.

Given that the primary objective of disabled child allowances is to support financial stability and ensure an adequate standard of living for children with disability and their families – rather than to compensate for lost parental income or parents' complete withdrawal from the labour market – these allowances are typically set at lower levels than carer allowances.

Table 3.2. Disabled child allowances

Country	Benefit	Amount & levels	(ASD) diagnosis	Means-testing
Canada	Child Disability Benefit (CDB)	Up to CAD 3 322 per year (or about CAD 276.83 per month) for each child who qualifies for the Disability Tax Credit (DTC) (June 2025).	Not strictly required	Income-tested
Estonia	Disabled Child Allowance (*Puudega lapse toetus*)	Monthly: 3 levels depending on severity: 1) moderate disability: EUR 138 – 2) severe disability: EUR 161 – 3) profound disability: EUR 242	Not strictly required	Not means-tested
France	Education Allowance for Disabled Children (*Allocation d'éducation de l'enfant handicap, AEEH*)	Monthly basic rate of EUR 151.80. Top-ups (six levels) are determined by assessing additional expenses related to the disability and whether the child's care needs force parents to reduce or stop working.	Required	Not means-tested
Israel	Disabled Child Allowance (קצבת ילד נכה)	Monthly: 5 levels: 1) 50%: NIS 1 880 – 2) 100%: NIS 3 694 – 3) 112%: NIS 4 352 – 4) 188%: NIS 6 947 – 5) 235%: NIS 8 828 Child with an ASD diagnosis automatically entitled to 100% but can receive higher rate (up to 235%) if has co-morbidities and/or high dependency on others.	Required	Not means-tested
Netherlands	Double Child Benefit (*Dubbele Kinderbijslag*)	Quarterly: 3 levels according to child's age: 1) 0-5 years: EUR 583 – 2) 6-11 years: EUR 708 – 3) 12-17 years: EUR 833 EUR 2 702 annual extra payment if parents receive Double Child Benefit for a full year.	Required	Not means-tested
United Kingdom	Disability Living Allowance (DLA)	Weekly: two components based on the child's support needs. Care component: Lowest GBP 28.70 – Middle GBP 72.65 – Highest GBP 108.55 Mobility component: Lower GBP 28.70 – Higher GBP 75.75	Not strictly required	Not means-tested
	Universal Credit (UC) – Disabled Child Element	Two levels: Lower Rate Addition: GBP 156.11 per month – Higher Rate Addition: GBP 487.58 per month	Not strictly required	Means-tested
United States (California)	Federal Supplemental Security Income (SSI) & California State Supplementary Payment (SSP)	Up to USD 747.20 per month (SSI + California SSP).	Required	Income-tested

Note: A detailed comparison of disabled child allowances can be found in Table A C.2.
Source: Information collected by the Secretariat and verified in discussions with national autism organisations and ministries.

Additional costs allowances cover disability-related expenses

Additional cost allowances are financial benefits aimed at covering specific disability-related expenses, such as specialised therapies or assistive equipment. Among the countries reviewed, Australia, Canada (Ontario), Denmark, France, Germany, the Netherlands, Sweden and the United Kingdom offer such an allowance, which is notably often administered at the local level – by municipalities or other local authorities – as is the case in the United Kingdom, the Netherlands, Germany, and Denmark (see Table 3.3).

Eligibility is typically determined by support needs and an additional costs assessment

Eligibility for an additional cost allowance requires a direct link between the child's disability and the extra expenses incurred. Accordingly, the evaluation process typically comprises two components. First, the child's disability must be determined – a process that usually involves reviewing medical documentation (without necessarily requiring a formal medical diagnosis) combined with an assessment of the child's support needs. Second, an evaluation of the additional costs takes place to ascertain whether these expenses are necessary because of the disability and if they exceed those normally incurred by a child without a disability. Such additional expenses may include therapies (for instance, occupational or music therapy), modifications to the home or vehicle, and assistive technologies.

Within this second assessment component, a further distinction can be made between reactive and proactive allowances. Reactive allowances provide flat-rate payments or reimbursements for expenses that have already been incurred, without a prior agreement on what will be covered. In contrast, proactive allowances allocate a defined budget to be used for approved services or supports. Additional cost allowances, such as Germany's Integration Assistance (*Eingliederungshilfe*), Canada's Ontario Autism Program (OAP), Australia's National Disability Insurance Scheme (NDIS), the Netherlands' Personal Budget (*Persoonsgebonden Budget*, PGB), and the United Kingdom's Direct Payments fall into this proactive category. These schemes provide children with disability and their parents with a pre-approved budget, often guided by a detailed plan outlining which services the funds can be used for. For instance, instead of simply assessing extra expenses already incurred, Australia's NDIS provides individualised funding packages that enable participants to purchase supports and services – such as therapies, assistive equipment, personal care, and training – in accordance with their approved funding plan.

Some of the allowances even incorporate in-kind benefit characteristics, for example Germany's Integration Assistance or Canada's OAP which offers certain services, such as parent training programmes, directly and free of charge. In addition, OAP provides children with an annual budget for Core Clinical Services, according to predefined annual levels varying by the child's age and intensity of support needs. Parents use this budget to purchase services privately and are reimbursed for approved expenditures. Similar to the OAP, Germany's Integration Assistance allows children to access certain services directly, such as integration aides in school or autism-specific therapy. Alternatively, children and their parents may choose to receive the Integration Assistance in the form of a personal budget, enabling them to purchase these services privately. This flexible structure of Germany's Integration Assistance aims to empower individuals with disability by offering greater autonomy and choice over both the providers and the manner in which their support is delivered.

Certain countries set a minimum threshold of additional expenses to qualify for an allowance. For example, Denmark requires an annual minimum threshold of DKK 5 718 (USD PPP 918), after which the specific allowance is calculated based on the documented additional costs – consistent with Denmark's highly individualised, case-by-case approach. Like Ontario in Canada (OAP and Assistance for Children with Severe Disabilities, ACSD), France offers two additional cost allowances – the Disability Compensation Benefit (*Prestation de compensation du handicap,* PCH) which is income-based, and the AEEH expenses top-up. The latter acts as a top-up to the basic AEEH and consists of four pre-defined levels, each with its own monthly expense threshold (for instance, to qualify for the top-up Level 1 of EUR 113.85

(USD PPP 164), monthly extra expenses must exceed EUR 265.65 (USD PPP 382)). Sweden’s model is quite similar to France’s, with its *Merkostnadsersättning* structured into five tiers, each corresponding to a specific monthly expense threshold. In contrast, the United Kingdom adopts a fully individualised approach, determining allowance amounts on a case-by-case basis without resorting to predefined benefit levels – an approach also pursued by Australia, Ontario in Canada (for its ACSD), Denmark, Germany and the Netherlands.

Distinct provisions for children with ASD compared to children with other disabilities exist

A formal, medical ASD diagnosis alone does not automatically entitle a child to an additional cost allowance, a condition that holds true for both carer allowances and disabled child allowances in all reviewed countries – except Israel’s Disabled Child Allowance and Australia’s Carer Allowance. In every other country, eligibility for any of these benefits is contingent upon a functioning or support needs assessment of the child. However, these assessments may still vary considerably in their depth and alignment with the social model of disability vis-à-vis the medical model. Notably, within each country, disability assessments tend to be largely consistent across the three allowance categories.

Even Canada’s provincial OAP, which is the only ASD-specific allowance among the countries reviewed, requires a support needs assessment to determine the annual budget a child may receive to purchase therapy hours and other clinical services. It is relatively common that provinces in Canada provide allowances targeted to specific types of disability or levels of need – for example, OAP or Alberta’s Assured Income for the Severely Handicapped (AISH), which provides financial support for adults with severe permanent disability – since Canada’s federal financial supports, such as the Child Disability Benefit, and services offer for people with disability are comparatively modest. In that sense, Ontario’s Autism Program fills a gap in Canada’s social protection system – at least for children with ASD. In Ontario (Canada), children with disabilities other than autism may benefit from the Assistance for Children with Severe Disabilities (ACSD) which is open to children with severe disability and offers individualised payments to cover incurred extra expenses. Unlike the OAP, however, the ACSD is means-tested.

Among the allowances reviewed in this section, Australia’s NDIS – open to all children with disability, i.e. not ASD-specific like Canada’s provincial OAP – probably comes closest to the characteristics of Israel’s Disabled Child Allowance. While NDIS eligibility ultimately depends on whether a child’s ASD results in a substantial reduction in functional capacity, children diagnosed with ASD Level 2 or Level 3 used to access the scheme more easily, as ASD Level 2 and Level 3 are included in the NDIA “List A: Conditions that are likely to meet the disability requirements”. However, the NDIA is currently transitioning to greater reliance on functioning and support needs instead of diagnostic labels to determine eligibility.

Table 3.3. Additional cost allowances

Country	Benefit	Amount & levels	(ASD) diagnosis	Means-testing
Australia	National Disability Insurance Scheme (NDIS)	No standardised levels; amount varies depending on individual support needs. In 2025, an average annual NDIS budget of AUD 24 000 for a child with ASD.	Not strictly required	Not means-tested
Canada (Ontario)	Ontario Autism Program (OAP)	OAP's funding for Core Clinical Services and Supports is divided in four age groups (0-3 years; 4-9 years; 10-14 years; 15-17 years) and three levels of support needs ranging from limited, to moderate, to extensive. Children aged 15-17 with limited support needs receive the smallest annual budget (CAD 6 600), while children aged 3-9 with extensive support needs receive the biggest annual budget (CAD 65 000).	Required	Not means-tested
	Ontario's Assistance for Children with Severe Disabilities (ACSD)	Monthly benefit ranges from CAD 25 to CAD 646, based on: a) Household income (max. CAD 76 200/year); b) Family size; c) Severity of the child's disability; d) Extraordinary disability-related costs	Required	Means-tested
Denmark	Additional Expenses Allowance (*Merudgiftsydelse*)	Allowance covers necessary additional costs directly attributable to the child's disability. The specific amount is determined based on documented additional expenses and must exceed the annual minimum threshold of DKK 5 718 to qualify for support.	Not strictly required	Not means-tested
France	Education Allowance for Disabled Children (*Allocation d'éducation de l'enfant handicap,* AEEH)	Monthly basic allocation plus a complementary amount that varies depending on additional expenses caused by the disability: 1) EUR 265.65 – 2) EUR 460.14 – 3) EUR 588.22 – 4) EUR 828.11	Required	Not means-tested
	Disability Compensation Benefit (*Prestation de compensation du handicap,* PCH)	100% of extra expenses linked to the disability are reimbursed if the household's annual income is EUR 30 398.54 or below. If annual household income is above, 80% of expenses are reimbursed.	Required	Income-tested
Germany	Integration Assistance (*Eingliederungshilfe*)	No predefined levels; funding is individually tailored based on assessed support needs. Options: either in-kind services or a Personal Budget (*Persönliches Budget*) which is a full-choice, self-managed monthly cash allowance.	Required	Partially means-tested
Netherlands	Personal Budget (*Persoonsgebonden Budget,* PGB)	Budget depends on assessed support needs and individual municipality rates.	Not strictly required	Not means-tested
Sweden	Additional Cost Allowance (*Merkostnadsersättning*)	Five levels – amount depends on actually incurred additional costs: 1. Costs are at least SEK 14 700 per year: receive SEK 1 470 per month. 2. Costs are at least SEK 20 580 per year: receive SEK 1 960 per month. 3. Costs are at least SEK 26 460 per year: receive SEK 2 450 per month. 4. Costs are at least SEK 32 340 per year: receive SEK 2 940 per month. 5. Costs are at least SEK 38 220 per year: receive a maximum amount of SEK 3 430 per month.	Not strictly required	Not means-tested
United Kingdom	Direct Payments	No standardised amount; based on individual care needs and costs of services required.	Not strictly required	Means-tested

Note: A detailed comparison of additional cost allowances can be found in Table A C.3.
Source: Information collected by the Secretariat and verified in discussions with national autism organisations and ministries.

Benefit entitlements differ markedly across countries and family situations

While different countries provide different types and combinations of benefits to support families with children with ASD, this section investigates the overall financial support package available to selected model families, to illustrate some typical real-life situations. Most countries consider the intensity of a child's support needs and often also the extent to which these needs affect parental capacity to engage in paid employment when allocating financial assistance, particularly carer allowances. The two following tables display the total monthly support a family can expect to receive in each country, based on the child's level of support needs and under two distinct scenarios. All model family types are assumed to be two-parent households with a 12-year-old child formally diagnosed with ASD and with each parent earning the national average monthly salary. In some countries, results would look very different for low earners. Additional cost allowances are excluded, as including them would necessitate excessive assumptions regarding monthly expenses and distort the findings insofar as they would essentially reflect these assumptions.

- Scenario 1 (Table 3.4) assumes that one parent reduces working hours to be able to personally care for their child. For children with mild support needs (fewer than ten hours of care per week), both parents are assumed to maintain full-time employment. For moderate support needs (10-30 hours/week), one parent is assumed to reduce working hours by 50%, thus earning half the average salary. In cases of severe support needs (more than 30 hours/week), one parent is assumed to stop working entirely to provide full-time care.
- Scenario 2 (Table 3.5) outlines a situation in which parents remain fully employed and instead hire a caregiver to provide the necessary care. For a child with moderate support needs, a caregiver is assumed to be hired for 20 hours per week; and for a child with severe support needs, for 40 hours per week. To allow for cross-country comparisons, including countries such as Estonia, where direct service provision is more common than offering a cash allowance for parents to hire a caregiver, these services have been monetised using the national average hourly wage for a caregiver, multiplied by the required care hours (20 or 40 hours per week).

It is important to note that while some countries officially offer services or financial support to enable parents to hire full-time caregivers, this may be uncommon in practice. For instance, in Australia, in practice, the NDIS may fund a support worker for a child with ASD for a few hours per week, but it is uncommon for the scheme to cover the costs of a full-time caregiver. Similarly, in Estonia, families may be provided with a caregiver to support their child and enable parental employment; however, decisions on the provision of such services are made on a case-by-case basis at the municipal level.

Children with mild support needs would typically not receive an allowance

For children with ASD and mild support needs, most countries would not provide any financial benefit, except for Australia, Canada and Israel. In Israel, children diagnosed with ASD, even if they have only mild support needs, are automatically entitled to 100% of the Disabled Child Allowance, amounting to USD PPP 1 004 (NIS 3 694) per month, based on their medical diagnosis. Notably, less than 10% of children with ASD receiving Israel's Disabled Child Allowance are eligible for a higher amount because of significant dependency on others (i.e. an allowance level higher than 100%). While Australia and Ontario (Canada) would also offer financial support for children with mild support needs, their funding explicitly serves to enable parents to purchase therapies and related services, such as occupational therapy, that are otherwise not, or not sufficiently, available free of charge through the public system. In contrast, most other countries – including Israel – provide these services directly through public systems, whether via the health system, the education system, or other policy channels. As Ontario (Canada) and Australia operate schemes that allocate funds directly to families to buy services themselves, they offer some financial support even for children with mild support needs – approximately USD PPP 554 (CAD 633) and

USD PPP 896 (AUD 1 228), respectively. In Israel, like in most other countries, parents are not expected to arrange or finance (most) therapeutic services privately. Instead, services such as speech therapy are provided publicly and may even be integrated into the child's school day, for example within communication classes for children with ASD. As a result, Israel's Disabled Child Allowance stands out as comparatively generous for children with ASD who have only mild support needs.

Benefit generosity varies significantly across countries

Families in California (United States) with both parents earning an average wage are not eligible for any disability-related allowance, regardless of the intensity of the child's support needs, as California's benefits for families with a child with disability (ASD or otherwise) are means-tested. At a gross monthly income of approximately USD 4 841 (or about 75% of one average wage), a two-parent household with one child (diagnosed with ASD) exceeds the income threshold for Supplemental Security Income (SSI) and State Supplementary Payment (SSP) benefits. Families with earnings below this threshold may qualify for a maximum benefit of USD 747.2 per month. Even one employed parent earning the United States' national average salary of approximately USD 6 676.25 would already render the family ineligible for SSI, which is primarily intended for very low-income households.

At the other end of the generosity spectrum are Sweden and Denmark. Denmark's financial support – the Compensation for Lost Earnings – is incomparably generous, on average amounting to USD PPP 3 240 (DKK 20 750) for moderate support needs and USD PPP 5 719 (DKK 36 622) for severe support needs (Table 3.4). Nevertheless, a parent who reduces working hours or exits the workforce entirely to care for their child would still face some income loss. For example, a parent previously earning Denmark's national average monthly salary of USD PPP 6 480 (DKK 41 500) would lose around 12% of income in the severe-case scenario, despite the generous compensation.

The gap between lost earnings and the allowance received is significantly wider in some other countries. In Germany, where the average monthly salary is roughly USD PPP 5 491 (EUR 4 025), assuming a child's moderate support needs require a parent to reduce working hours by 50% would imply that the parent would lose approximately USD PPP 2 746 (EUR 2 013) per month. Yet, the parent would receive only USD PPP 473 (EUR 347) as monthly allowance. In Israel, the average monthly full-time wage is USD PPP 4 475 (NIS 16 463), hence a parent reducing working hours by 50% would lose USD PPP 2 238 (NIS 8 232) and receive USD PPP 1 004 (NIS 3 694) in monthly Disabled Child Allowance. Sweden's Care Allowance does not suffice either to compensate for the lost earnings a parent would encounter if they had to reduce their working hours by 50% to care for their child with ASD.

In the Netherlands, there is no dedicated carer allowance. Instead, families may access a Personal Budget (PGB) to purchase disability-related supports and care, including informal care provided by relatives or friends. Parents who reduce their working hours to care for their child may therefore receive compensation for the care they provide through the PGB. The Dutch benefits reflected in Table 3.4 consist of the Double Child Benefit – a fixed, age-dependent payment that does not vary with the intensity of the child's support needs or the parent's income loss – and the PGB. Even with these financial supports, a parent of a child with moderate support needs could face a reduced monthly income of USD PPP 4 752 (EUR 3 514), compared with the average monthly wage of USD PPP 6 259 (EUR 4 628.50) previously earned.

While some countries may appear less generous in terms of direct allowances for parents of children with significant care needs, they may offer alternative forms of mainstream income support that help offset lost earnings. Calculations in Table 3.4 do not capture the full scope of financial supports available to families with a child with disability but considers exclusively those payments that are directly linked to the child's disability. This could explain the large differences observed between countries like Denmark and Sweden for a child with moderate support needs.

Table 3.4. Monthly financial benefit across three levels of support needs – parental care

Scenario 1: One parent reduces working hours in line with care needs of the child (0%, 50% and 100%)

	Mild support needs (0% working hours reduction)			Moderate support needs (50% working hours reduction)			Severe support needs (100% working hours reduction)		
	National currency	Percentage of average wage	USD (PPP)	National currency	Percentage of average wage	USD (PPP)	National currency	Percentage of average wage	USD (PPP)
Australia	AUD 1 228	15%	896	AUD 2 004	25%	1 452	AUD 3 556	44%	2 577
Canada (Ontario)	CAD 633	9%	554	CAD 1 731	26%	1 516	CAD 3 722	55%	3 259
Denmark	DKK 0	-	-	DKK 20 750	50%	3 240	DKK 36 622	88%	5 719
Estonia	EUR 0	-	-	EUR 138	7%	229	EUR 251	12%	417
France	EUR 0	-	-	EUR 578	16%	806	EUR 999	28%	1 393
Germany	EUR 0	-	-	EUR 347	9%	473	EUR 800	20%	1 091
Israel	NIS 3 694	22%	1 004	NIS 3 694	22%	1 004	NIS 6 947	42%	1 888
Netherlands	EUR 0	-	-	EUR 1 200	26%	1 623	EUR 2 678	58%	3 622
Sweden	SEK 0	-	-	SEK 6 125	14%	695	SEK 64 004	151%	7 258
United Kingdom	GBP 0	-	-	GBP 115	3%	166	GBP 619	17%	892
United States (California)	USD 0	-	-	USD 0	-	-	USD 0	-	-

PPP: purchasing power parities.
Note: The assumed reference family is a two-parent household with a 12-year-old child formally diagnosed with ASD, in which both parents earn the national average monthly salary. Average wages of 2023.
Country-specific information and assumptions:
Australia: includes Carer Allowance, Carer Payment, Child Disability Assistance, Carer Supplement, and National Disability Insurance Scheme. The average annual NDIS budget of a child with ASD in the age range 9-14 in 2025 is roughly AUD 18 622. A child with moderate support needs likely receives this average, while a child with mild support needs was assumed to receive half the average, and a child with severe support needs double the average.
Ontario (Canada): includes Child Disability Benefit (federal) and Ontario Autism Program (provincial). Ontario Autism Program's annual (core clinical services) budgets of a child with ASD vary by age and intensity of support needs. At age 10-14, intensity of support needs ranges from limited to moderate to extensive, thus assumed to mirror the three levels of support need in the above table.
Denmark: includes Compensation for Lost Earnings and Care Leave Scheme. Compensation for Lost Earnings is capped at DKK 36 622 per month.
Estonia: includes Caregiver's Allowance for Parents, Care Allowance for Temporary Incapacity for Work, and Disabled Child Allowance. The Disabled Child Allowance is divided in three levels (moderate, severe, profound). A child with mild support needs most likely does not fall into any of these categories, while a child with moderate needs would most likely be eligible for Level 1 of the allowance, and a child with severe needs for Level 2.
France: includes Education Allowance for Disabled Children (AEEH) and Leave Allowance. To be eligible for AEEH, the child must have a disability rating of ≥ 80% or a rating of 50-79% with "adapted schooling". The rates are the following: mild = 1-15%; moderate = 20-45%; significant = 50-75%; severe = 80-95%. Consequently, a child with mild support needs is assumed to be ineligible for AEEH. A child with moderate support needs might receive Level 3 AEEH, a child with severe support needs Level 5 AEEH.
Germany: includes Care Allowance. The Care Allowance is divided in five levels – a child with mild support needs is assumed to receive Level 1 (= EUR 0), a child with moderate support needs Level 2, a child with severe needs Level 4.
Israel: includes only Disabled Child Allowance. A child with serve support needs is most likely entitled to a higher than standard rate because of their dependency on others, estimated at a level of 188%.
Netherlands: includes Personal Budget (PGB) and Double Child Benefit. Does not include the annual Extra Child Benefit Payment because one parent is assumed to become the child's paid informal carer and thus exceeds the income threshold. The above amount shows the total Double Child Benefit, which includes the regular Child Benefit all parents receive. We assume that a child with "moderate support needs" does not fulfil the requirement of "intensive care needs" for entitlement to the Double Child Benefit. We assume that a parent that reduced working hours to care for their child receives the PGB as an informal carer with an hourly wage of EUR 15 which is slightly above the minimum wage.

Sweden: includes Care Allowance and Assistance Allowance. The Care Allowance is divided in four levels depending on the child's care needs – a child with mild support needs is assumed ineligible, a child with moderate support needs could receive Level 2, and a child with severe needs would most likely receive Level 3. The standard hourly rate for the Assistance Allowance is SEK 342.6. A child with mild or moderate support needs would not meet the severity threshold of very extensive care needs. A child with severe support needs is considered to meet the threshold. In this case, one parent can be hired as the official carer for their child – here 40 hours/week.

United Kingdom: includes Carer's Allowance, Universal Credit Carer's Element, Disability Living Allowance (DLA), and Universal Credit Disabled Child Element. A child with mild support needs is deemed ineligible for DLA, a child with moderate support needs might receive the lowest Care Component of DLA, and a child with severe support needs the middle Care Component of DLA.

California (United States): includes In-Home Supportive Services (IHSS) Program, Federal Supplemental Security Income (SSI), and California State Supplementary Payment (SSP).

Source: OECD (2025[5]), *Annual Purchasing Power Parities and exchange rates* (dataset), https://data-explorer.oecd.org/s/3sp. OECD (2025[6]), *Average annual wages* (dataset), https://data-explorer.oecd.org/s/3sq. Compilation of OECD material.

StatLink https://stat.link/7ro6kc

In Sweden, the Assistance Allowance is reserved for children with very extensive care needs and is therefore generally not available to children with ASD who have moderate support needs. In such cases, the Care Allowance would replace only about 29% of lost income due to working hours reduction. By contrast, for children with severe support needs who qualify for the Assistance Allowance, parents may choose to either hire a caregiver or to serve as their child's formal caregiver themselves. In such cases, the total monthly benefit even exceeds the average monthly wage in Sweden.

Allowances may create different incentives across income levels

While Table 3.4 and Table 3.5 both assume parental wages at the country's national full-time average, families with below-average earnings may find disability-related financial supports considerably more generous, particularly in countries where these allowances are determined not by parental income but solely by the child's support needs. For instance, in Sweden, a parent earning the average or below average monthly wage may find it more attractive to leave their employment and become their child's official caregiver. In Australia and Ontario (Canada), despite most allowances being means-tested, total benefit amounts would differ only marginally between families with average and below-average incomes. In the Netherlands and Germany, allowance rates are fixed and not means-tested (except for the Dutch Extra Child Benefit Payment), thus remaining stable regardless of household income. In contrast, in Denmark and California (United States), household income significantly affects the level of financial support: in Denmark, Compensation for Lost Earnings is calculated based on previous earnings, while in California (United States), current income (via a means-test) determines both eligibility and the amount.

For lower-income families receiving non-means-tested but fixed-rate disability benefits, the relative loss of income from reducing working hours to care for a child is (much) smaller than for average-earning families. This may create a stronger incentive to reduce employment and rely on allowances, especially in systems where costs of third-party care must be borne privately. Conversely, in countries where carer allowances do not sufficiently compensate for lost income, leaving families with significantly reduced financial resources, there may be a greater motivation to remain in the workforce and instead hire an external caregiver. However, this option assumes sufficient availability of care staff, which may be unrealistic given the shortages of qualified personnel in many OECD countries (OECD, 2023[7]).

Hiring a caregiver is more beneficial in some countries than reducing employment

Table 3.5 outlines the total monthly benefits under Scenario 2, in which both parents maintain full-time employment and hire a third-party caregiver to provide the necessary care for their child with disability. As previously noted, caregiving services are monetised by multiplying the estimated national average hourly wage of a caregiver by the required number of care hours (20 and 40 hours, respectively).

Table 3.5. Monthly financial benefit across three levels of support needs – formal care

Scenario 2: Parents hire a third-party caregiver instead of reducing their own working hours

	Moderate support needs (20 care hours/week)		Severe support needs (40 care hours/week)	
	National currency	USD (PPP)	National currency	USD (PPP)
Australia	AUD 5 204	3 799	AUD 9 956	7 267
Canada (Ontario)	CAD 3 223	2 822	CAD 6 706	5 872
Denmark	DKK 12 000	1 874	DKK 24 000	3 748
Estonia	EUR 858	1 425	EUR 1 601	2 659
France	EUR 1 666	2 324	EUR 1 742	2 430
Germany	EUR 796	1 086	EUR 1 859	2 536
Israel	NIS 3 694	1 004	NIS 6 947	1 888
Netherlands	EUR 1 440	1 947	EUR 3 158	4 271
Sweden	SEK 6 125	695	SEK 64 004	7 258
United Kingdom	GBP 1 395	2 010	GBP 2 851	4 108
United States (California)	USD 0	0	USD 0	0

PPP = purchasing power parities.
Note: The assumed reference family is a two-parent household with a 12-year-old child formally diagnosed with ASD, in which both parents earn the national average monthly salary. Average wages of 2023.
Country-specific information and assumptions:
Australia: includes Carer Allowance, Carer Payment, Child Disability Assistance, Carer Supplement, and NDIS. NDIS funding for support workers falls under "CORE – Assistance with Daily Life". The national average hourly wage of a caregiver is estimated to be AUD 40.
Ontario (Canada): includes Special Services at Home, Child Disability Benefit (federal), and Ontario Autism Program (provincial). Special Services at Home covers the costs of a special needs worker. The national average hourly wage of a caregiver is estimated to be CAD 20.
Denmark: includes Additional Expenses Allowance. Family can hire a caregiver and have costs covered by Additional Expenses Allowance, but rather uncommon. Some municipalities may provide a caregiver as a direct service – decisions are made on a case-by-case basis. The national average hourly wage of a caregiver is estimated to be DKK 150.
Estonia: includes Disabled Child Allowance and direct municipal support. Municipalities decide on a case-by-case basis on the necessity of a caregiver, but rather uncommon. The national average hourly wage of a caregiver is estimated to be EUR 9.
France: includes AEEH and Disability Compensation Benefit (PCH). Parents can hire a caregiver and have costs covered by PCH; however, only possible for a maximum of 3h/day. PCH will reimburse only 80% of caregiver salary due to high family income and at a max. of EUR 18.96 per hour.
Germany: includes Care Allowance as a service. Germany offers care services with a maximum budget per month according to *Pflegegrad* (level of care needs).
Israel: includes only Disabled Child Allowance. A child with serve support needs is most likely entitled to a higher than standard rate because of their dependency on others, estimated at a level of 188%.
Netherlands: includes Double Child Benefit and Personal Budget. Family can either benefit from a caregiver provided by ZIN (Care in kind) or hire a caregiver with costs covered by their Personal Budget (PGB). The national average hourly wage of a caregiver is estimated to be EUR 18. The above amount includes the total Double Child Benefit, which includes the regular Child Benefit all parents receive.
Sweden: includes Care Allowance and Assistance Allowance. The hourly rate in 2025 is SEK 342.6.
United Kingdom: includes DLA and Direct Payments. Family can hire a caregiver and cover costs with Direct Payments. However, Direct Payments are income- and assets-tested: financial benefit begins to be reduced as those increase, but there are no standard thresholds; decisions are made on a case-by-case basis at municipal level.
California (United States): IHSS would be the relevant benefit but parents' income is too high to qualify for it.
Source: OECD (2025[5]), *Annual Purchasing Power Parities and exchange rates* (dataset), https://data-explorer.oecd.org/s/3sp. OECD (2025[6]), *Average annual wages* (dataset), https://data-explorer.oecd.org/s/3sq. Compilation of OECD material.

StatLink https://stat.link/nj32yq

In the Netherlands, where no carer allowance is available, the Personal Budget provides families with funding to purchase, amongst others, care services. This gives parents a strong financial incentive to remain in employment, as parents who previously earned an average monthly wage would still experience an income loss even if they became their child's official caregiver and received compensation through the

PGB (see above). In contrast, in countries such as France and Germany, the available financial support for purchasing care services is most likely insufficient to fully cover the actual costs, potentially limiting the feasibility of this option for many families. Similarly, in Sweden, the Care Allowance is insufficient to cover the cost of a caregiver for a child with moderate support needs who is not eligible for the Assistance Allowance, effectively requiring a parent to provide this care themselves. In Israel, the Disabled Child Allowance can be used to pay for a caregiver and may be sufficient to fully cover the associated costs if parents choose to remain in full-time employment. However, this might be feasible primarily because wages of care personnel in Israel are relatively low compared to the national average salary (approximately ≤ 50% of the average wage). In countries where caregiver wages are higher, aligning more closely with national average earnings, parents may face greater challenges affording a caregiver for their child with the state-provided allowance.

The total monthly benefit may also be influenced by the number of children with care needs in a family. In most countries, allowances are child-dependent, meaning parents receive a separate allowance for each eligible child; this is the case, for example, in Germany and the Netherlands. Denmark, by contrast, follows a different approach: its Compensation for Lost Earnings is based on the reduction in parental working hours and corresponding income loss, rather than the number of children with disability.

Excluding allowances compensating additional costs from these calculations – except for Australia's NDIS and Ontario's Autism Program – may underestimate the actual generosity of some countries' financial supports for children with disability. This is likely true for Sweden, offering an Additional Cost Allowance in addition to the Care Allowance and the Assistance Allowance. However, estimating additional expenses for children with disability in different country contexts exceeds the scope of these comparative tables. Similarly, the comparisons also exclude tax benefits, such as tax deductions and non-refundable credits (for example Canada's Caregiver Credit or Disability Tax Credit), since these are generally modest in value compared to other financial benefits.

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Notes

[1] As policies in Canada and the United States vary strongly by province/state, much of the information refers to Ontario (Canada) and California (United States) – the regions with the most developed programmes for children with autism.

[2] Sweden's Assistance Allowance in fact combines elements of a carer allowance with elements of a disabled child allowance: on the one hand, it ensures that children with disability, through individually tailored support provided by an assistant, can live and participate in the society on an equal basis with others; on the other, it reduces some of the supervision and care burden on parents by enabling them to hire an assistant for several hours per week.

4

Services for children with autism spectrum disorder

This chapter compares how OECD countries determine eligibility and deliver services for children with ASD, showing that needs-based assessment is central across education, health, and social services. It examines the wide variation in how countries conduct support-needs assessments – from highly standardised, multi-disciplinary procedures to more flexible, school- or family-led approaches – and how these differences shape access to services. The chapter also highlights cross-country differences in educational inclusiveness, noting that although many countries aim to expand inclusion in regular schools, substantial shares of children with SEN, and especially those with ASD, continue to be educated in special education classes or schools. The chapter also contrasts limits of Israel’s diagnosis-linked therapy with more flexible, needs-driven models used elsewhere. Finally, it reviews the breadth of social services available across countries offering support to children as well as their families.

In Brief

Education, health and social support for children with autism

Access to services for children with ASD varies widely across countries, but one principle is common: eligibility is primarily based on assessed needs rather than diagnosis alone. Services typically span education, health, and social support, aiming to promote development, autonomy and inclusion. Needs assessments are therefore central to determining what support a child receives and in what setting.

Education systems illustrate the diversity of approaches. While international frameworks such as the UNCRPD advocate for inclusive education, countries differ substantially in how far they have moved from segregated to mainstream schooling for children with special educational needs (SEN). Most countries offer a continuum of options – from dedicated schools to integrated classes. In some countries, such as France and Sweden, fewer than 20% of children with SEN attend special schools, while in others, like Israel, more than half of children with autism are enrolled in special education settings. In Australia most children with autism are in regular classes, although they are more likely to be educated in special settings than other children with disability. These differences reflect not only policy choices but also resource availability and the capacity of mainstream schools to provide individualised support.

Support needs assessments are central to determining entitlement for SEN services, but their depth and standardisation vary widely. Some systems rely on flexible, school- or parent-led decision making, while others, such as France, the United Kingdom and Estonia, use regulated multi-disciplinary procedures that may include in-person observations. Countries also differ in the role that medical diagnoses play; in many systems, assessed needs alone determine eligibility, while in places such as Canada, the United States, France, and Israel a formal diagnosis acts as a gatekeeping requirement.

Therapy services follow a similar pattern of variation. Children may access speech, occupational, and other paramedical therapies through public health systems, educational settings, or dedicated disability programmes. In most countries, the primary route is the public health system, typically requiring a doctor's referral, whereas schemes such as Australia's NDIS and Ontario's Autism Program provide individualised budgets that allow families to purchase the services they need. Across all systems, early intervention is strongly emphasised, and many countries deliberately waive diagnostic requirements in early childhood to avoid delays in support, reflecting a shared commitment to fostering better developmental outcomes for young children.

Social services complement education and health supports, offering measures such as respite care, specialist transport, and parent training. Although often administered locally and varying in availability and scope, these services play a crucial role in easing the caregiving burden on families and supporting children's autonomy and participation in community activities.

Eligibility for services for children with ASD is primarily based on needs

Services for children with ASD may be grouped into three broad categories: educational services; health and medical services; and social services. The comparison of the policy setup in 11 selected OECD countries demonstrates that, in most countries, needs assessments are essential for determining entitlement not only to financial benefits, as discussed above, but even more so to services of any kind.

To be effective and meaningful, services packages are adapted to the child's specific needs and abilities, making needs assessments an integral part of eligibility procedures. Services generally aim to promote the personal development of children with disability through targeted, individualised support, and to enable them to lead as autonomous a life as possible. Certain policies for children with disability also extend beyond the individual child to address systemic barriers and foster an inclusive society.

Variations in the inclusiveness of national education systems persist

Countries offer a continuum of inclusion in education for children with SEN

The UNCRPD calls for the implementation of inclusive education policies (Article 24) that genuinely integrate children with disability into the regular education system, with any reasonable accommodations they may require to develop and learn on an equal basis with their peers (United Nations, 2006[1]). The OECD supports this shift towards more inclusive education systems (OECD, 2025[2]).

Across OECD countries, children with special educational needs (SEN) typically have access to a range of schooling options that differ in their degree of inclusiveness. In previous work, the OECD has identified six broad categories that capture the most common types of educational provision for children with SEN: (i) dedicated schools, (ii) dedicated classes, (iii) regular classes with indirect support, (iv) regular classes with resource support, (v) integrated classes, and (vi) withdrawal classes (OECD, 2023[3]). This six-tier framework may not always correspond precisely to how national education systems for children with SEN are organised in practice, as some OECD countries do not provide the full range of these options but offer a more streamlined model. For instance, Israel operates with a three-tier model for children with SEN: 1) regular classes at mainstream schools, with personalised support; 2) special education classes at mainstream schools; and 3) special education schools.

Special education schools are often criticised for creating a parallel education system for children with SEN, thereby promoting segregation rather than inclusion (Mezzanotte, 2022[4]). While these schools may offer more extensive and specialised support, such as increased and specialised teaching staff, adapted materials and environments, individualised curricula, and on-site therapies, they do so at the expense of an inclusive system, limiting shared learning experiences and interaction between children with and without SEN. Most countries offer special education schools that cater to specific types of SEN, most commonly schools for blind or vision-impaired children and children with severe learning disabilities.

An alternative to special schools are special education classes in regular schools, often offering smaller class sizes, specialised teaching staff, and adjusted curricula, while children can simultaneously interact and learn with peers without SEN during certain classes, breaks, and other school activities.

In the most inclusive option – integrating a child with SEN into a regular class within a mainstream school – the child usually receives additional individualised support. This often includes Individualised Education Plans (IEPs), a teaching assistant who may accompany the child for some hours or the entire school day, and assistive technologies that facilitate full and equal participation in education alongside peers. The use of AI plays an increasingly relevant role in such individualised support (Linsenmayer, 2025[5]). AI tools are used to support students with ASD by personalising feedback and strengthening communication and social skills – areas that are often particularly challenging for many children with autism (ibid.).

While the UNCRPD calls upon countries to transition from special education settings to the integration of children with disability into mainstream settings (United Nations, 2006[1]), the practical implementation of such a shift is complex and requires careful planning. The success of educational inclusion hinges on a multitude of factors, such as the availability of sufficient resources, specialised expertise to ensure quality support, capacity building, and monitoring and evaluation (OECD, 2023[3]). Therefore, policies encouraging integration in mainstream classes and schools must, amongst others, be accompanied by a corresponding shift of resources and expertise to mainstream settings to ensure children with special educational needs are adequately accommodated (Taub Center, 2022[6]).

Enrolment patterns across schooling options differ significantly between countries

Despite growing international consensus on the benefits of inclusive education, countries continue to vary significantly in the extent to which they encourage placement in regular schools and invest in individualised educational supports within those settings. Figure 4.1 illustrates semi-comparative data on the distribution of children with SEN and ASD in Israel, children with ASD and with all types of disability in Australia, and children officially recognised with SEN status in the European countries across three broad schooling options: regular classes, special education classes, and special education schools.

Children with disability and those identified as having special educational needs do not always represent the same group; a child may have a disability without being classified as having SEN, and vice versa. Cross-country comparability is further complicated by substantial variation in how SEN is defined and operationalised, with some countries applying relatively narrow criteria. From a policy perspective, this heterogeneity limits the ability to evaluate education settings and interventions and compare outcomes across countries. A general recommendation for OECD countries is therefore to work towards greater harmonisation of definitions and reporting standards, alongside strengthening the institutional infrastructure needed to collect high-quality, internationally comparable data on SEN.

To a certain extent, the distribution across different educational settings reflects the inclusiveness of a country's educational policy framework and the quality and quantity of supports available in regular classes. In each of the European countries – except the Netherlands – more than 50% of children with SEN are enrolled in mainstream schools, either in regular or special education classes. In the Netherlands, the allocation of additional support within mainstream schools is managed by the school itself in collaboration with the regional level through school alliances (*samenwerkingsverband*). Because such provision of extra support in a mainstream setting is not centrally recorded as a formal determination of SEN status, data from the European Agency for Special Needs and Inclusive Education capture only those children whose SEN status is formally recognised through eligibility for admission to special education schools (*Toelaatbaarheidsverklaring*, TLV). Consequently, Figure 4.1 indicates that 100% of children officially identified as having SEN in the Netherlands attend special education schools.

France and Sweden report the lowest shares of children with SEN status in special education schools among the selected countries, each below 20%. In Sweden, however, data are not disaggregated by class type within mainstream schools. In Germany, available data only capture enrolment in regular classes in mainstream schools – including slightly more than 50% of children with SEN status. Such lack of disaggregated data also illustrates how the availability of specific schooling options may not always be officially or systematically recorded at the national level, as these may be administered regionally, locally or even left to the discretion of individual schools.

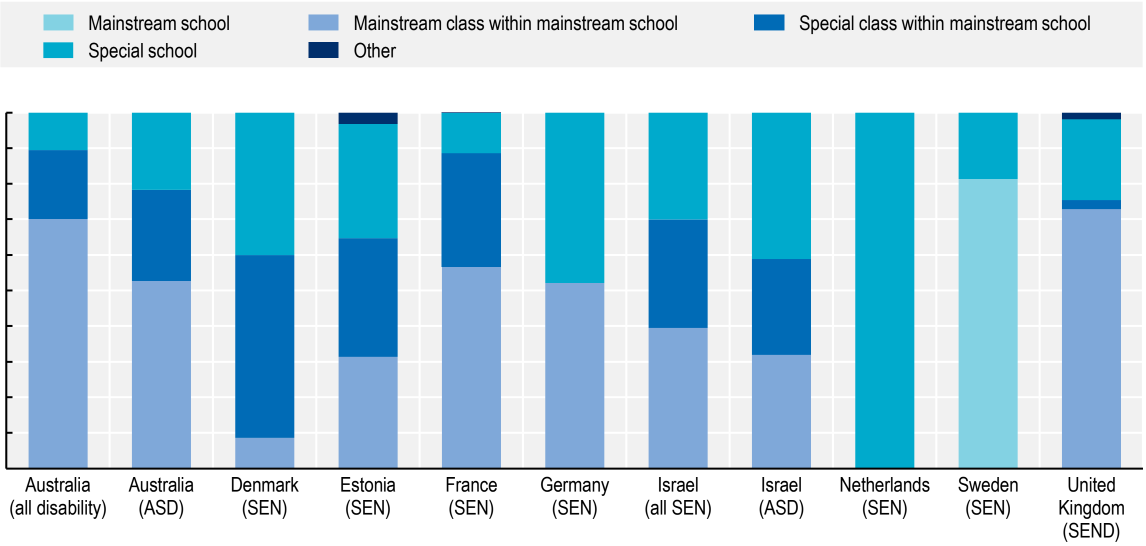
Regarding placement within mainstream schools, the United Kingdom and Denmark take notably different approaches. In the United Kingdom, most children with SEND[1] status enrolled in regular schools are placed in regular classes, whereas in Denmark, the majority attends special education classes within mainstream schools. Estonia shows a relatively balanced distribution, with roughly one-third of children with SEN status placed in each of the three settings. In Israel, the pattern is reversed when comparing all children with SEN to those with SEN and ASD. While most children with SEN attend a mainstream class (around 40%) and roughly 30% are enrolled in special schools, children with SEN and ASD are more likely to attend special schools (approximately 40%) and only about 30% are in mainstream classes within mainstream schools.

In Australia, the proportion of children with ASD enrolled in special education schools is nearly half of that in Israel, at around 20%. However, the share of children with ASD in special classes resembles Israel's.

Australian data further indicate that children with ASD are more likely to be placed in special education settings, both schools and classes, than children with disability overall – an observation that also applies to Israel. In Australia, only about 55% of children with ASD are enrolled in mainstream classes, compared to about 70% of all children with disability. Additionally, the proportion of children with ASD in special schools (20%) is double that of all children with disability (10%). Anecdotal evidence suggests a similar pattern might exist in the Netherlands, where children with ASD are reportedly entering special education schools in growing numbers.

Figure 4.1. Approaches to inclusive schooling for children with ASD or SEN status differ widely

Share of children with special educational needs by type of school or class, latest available year



ASD: autism spectrum disorder, SEN: special educational needs, SEND: special educational needs and disability.
Note: Data only covers children enrolled in school.
Australia: children with (ASD and) reported disability; ages 5-20; year 2022.
European countries: children with SEN(D); International Standard Classification of Education (ISCED) Level 1 (primary education) and 2 (lower-secondary education); year 2021/22. European Agency for Special Needs and Inclusive Education: Question 2.3a “All children/learners with an official decision of SEN educated with their peers in mainstream groups/classes for 80% or more of the time” = regular class; Question 2.3b “All children/learners with an official decision of SEN educated in separate groups/classes, spending less than 80% of the time with their peers in mainstream groups/classes” = special class.
Israel: all children with SEN, as well as those with SEN and ASD; all school forms (pre-primary, primary, post-primary); year 2024.
Source: Data for Israel provided by national authorities. Data for European countries based on European Agency for Special Needs and Inclusive Education (2025[7]), *Data tables and background information*, https://www.european-agency.org/activities/data/data-tables-background-information. Data for Australia based on Australian Bureau of Statistics (2024[8]), *Autism in Australia, 2022*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads.

StatLink https://stat.link/ronwaz

Some ASD-specific educational supports exist

The special educational support that Israel provides to children with ASD is relatively extensive. In particular, “communication classes” – which are special education classes specifically designed for children with ASD and commonly available in Israel (>150) – offer robust support, including on-site therapies, very small class sizes, and ASD-specialised teaching staff and assistants. While most other countries, such as Australia, Canada, Denmark, Estonia, France, the United Kingdom and California (United States) also offer specialised classes or programmes for children with ASD, these vary in availability and structure. Such programmes typically include specially trained teachers, adapted learning environments and materials, and access to on-site therapies like occupational or speech therapy.

Australia even offers a very small number of ASD-specific schools. Across the countries reviewed, such ASD-specialised schools do exist but are typically private rather than public. For example, in California (United States) and the United Kingdom, public authorities may place a child with SEN(D) status in a private special education school if no suitable place is available in the public system. However, aside from the relatively rare ASD-specific schools and more commonly available ASD-specific support classes – in most countries, specialised classes for specific types of SEN exist – children with ASD are not generally entitled to more generous or distinct services than those provided to children with other disabilities.

Children with ASD are typically covered by the same policy framework that applies to all children with SEN. In Israel, the situation looks somewhat different: school-aged children with ASD can access special educational settings based solely on their diagnosis. They are expected to undergo an assessment of their support needs and be placed into one of four predefined support levels, which determine their eligibility for special education and the scope of their personal services basket, as is the case for other children with disability. However, children with ASD at any support need level can access a dedicated special education class.

Depth and standardisation of support needs assessments vary across countries

The main aim in OECD countries is that children with ASD, like children with other disabilities, benefit from educational support measures and services adapted to their individual needs (see Table A C.4 for detailed country-specific information on special education). Assessments of each child's support needs are thus a core component of eligibility determination procedures for special education services in almost all countries selected for comparison. However, these assessments vary significantly across countries. In some countries, they are less standardised and regulated but more individualised; for example, in Australia, the child's school placement and support measures are typically determined jointly by the parents and the school; in California (United States), an Individualised Education Program (IEP) Team, comprising the child's parents, a special education teacher, a regular education teacher, and a qualified representative of the school district, assesses the child and decides on school placement and appropriate special educational services, which are then outlined in the child's IEP.

In some other countries, children's needs assessments are much more regulated. In France, the child's teacher completes the GEVA-Sco guide (*Guide d'évaluation des besoins de compensation en matière de scolarisation*) to document the student's support needs. The report is subsequently discussed in a meeting typically involving the school director, parents, teachers and, where relevant, other professionals, after which the report is finalised by the designated reference teacher and submitted to the MDPH. A multi-disciplinary evaluation team (*équipe pluridisciplinaire d'évaluation*, EPE) of the MDPH then reviews the submitted documentation and, if necessary, conducts home or school visits to assess the child in-person. Based on their assessment, the decision-making body (*Commission des droits et de l'autonomie des personnes handicapées*, CDAPH) of the MDPH determines school placement and educational support services for the child. In Estonia, the support needs assessment is also relatively standardised: a multi-disciplinary school support team (including pedagogue, psychologist, speech therapist, etc.) carries out a pedagogical-psychological assessment of the child's learning, social and self-care needs and prepares recommendations, which the municipal counselling committee reviews (alongside medical certificates and reports) to advise on school placement and support services; the child's school director and parents formalise the final decision together. Effective co-ordination and sufficient staffing for such in-depth assessments are essential to minimising waiting times for educational services.

These assessments do not always involve in-person evaluations. In most cases, support needs assessments are primarily based on documentary evidence, such as medical reports and educational records, while in-person observations and interviews are only carried out when uncertainty remains. In some countries, however, such as Sweden and Denmark, in-person evaluations are a standard component of a child's needs assessment.

The types of documents considered, and the experts involved in support needs assessments also vary across countries. While all countries incorporate the perspectives of different types of professionals, such as special education teachers, social workers, or pedagogues – thus going beyond purely medical considerations – how much emphasis they place on these professional opinions relative to medical perspectives differs. In most countries, a formal medical diagnosis is in fact not required to access special educational support; while some form of medical documentation may be requested, the child's actual support needs are the decisive factor for eligibility and the nature of the services provided. A medical diagnosis often offers limited insight into a child's needs, especially in the educational setting. Ideally, every child that needs special education support to fully and equally participate in education should receive that support. However, in some countries, such as Israel, Canada, California (United States), and France, a formal medical diagnosis is considered a prerequisite for access to special education services. In these systems, diagnoses function as gatekeeping mechanisms, even if the special educational support ultimately offered is adapted to the individual needs of the child. A diagnosis may, however, also be required in other countries, such as Estonia, to access special education classes specifically designed for certain types of SEN, including ASD-specific classrooms. Outside of these specific cases, access to and the composition of special education support services are based on the individual support needs of the child.

In Israel, parents play a central role in the application and decision-making process of their child's SEN supports. They participate in the Eligibility and Characterization Committee, the body authorizing SEN supports and special education placements, by providing input and documentation. Parents also collaborate closely with the multi-disciplinary team at school to help design and review their child's Individual Education Plan (IEP). It is indeed crucial to incorporate the perspectives and wishes of parents in decisions related to special educational support for their children with SEN. In Australia, Estonia, and Germany, parents usually decide on or must approve their child's school placement. In all other countries reviewed, parents may not officially be the ones to make that decision, but they are typically closely involved in both the assessment process and the placement decision. For instance, in California (United States), parents are part of the IEP team that evaluates the child and determines support services. In Sweden, parental input is actively incorporated during the needs assessment process, which relies on documentary evidence, as well as in-person evaluations, including observations and interviews with the parents.

Three special education funding models – input, throughput, and output funding

Countries also differ in how they are funding special education and allocating resources for special education provisions. According to a classification framework initially proposed by the European Agency for Special Needs and Inclusive Education (European Agency for Special Needs and Inclusive Education, 2016[9]) and already applied by the OECD (Brussino, 2020[10]), there are three general funding models for special education: 1) input funding; 2) throughput funding; and 3) output funding.

1. **Input funding** follows a demand-driven logic – typically, a specific amount of funding is allocated to schools for each student identified with SEN status, sometimes weighted according to the severity of the child's support needs. Australia and Israel largely follow this approach. In Israel, each child eligible for special education support is allocated a personal basket of support hours, including instructional, therapeutic, and aide hours, based on their assessed level of needs and diagnosis. These personal service baskets are converted into earmarked monetary budgets that are allocated to the children's schools. In Australia, schools receive per-student funding under the Schooling Resource Standard (SRS), with an additional percentage loading for students with disability. The level of loading depends on the student's support needs, classified into four

categories: 1) quality-differentiated teaching practice; 2) supplementary; 3) substantial; and 4) extensive support. Students at the lowest level of need do not actually qualify for a disability loading.

2. **Throughput funding**, which is less commonly used, follows a more supply-driven logic. In this model, schools receive lump-sum budgets to deliver specified services, regardless of the precise number of students with SEN status or the severity of their needs. Sweden's system incorporates elements of both input and throughput funding. Schools receive a lump-sum budget based on total enrolment and are responsible for allocating resources, including for SEN provisions. For pupils with extensive support needs that exceed what can normally be provided, schools may apply for additional funding from the municipality. Both schools and municipalities can also apply for targeted grants from the National Agency for Special Needs Education and Schools (*Specialpedagogiska skolmyndigheten*, SPSM) for specific initiatives. The Netherlands likewise adopts a mixed-model approach, in which the Ministry of Education provides lump-sum funding to regional school alliances (*samenwerkingsverbanden*), which in turn allocate resources to individual mainstream and special education schools. With this funding, regular schools are required to ensure that pupils with SEN receive appropriate educational support and may request additional funding from the school alliance only if they are unable to meet a student's needs with their existing resources.
3. The third approach, **output funding**, allocates budgets based on students' educational outcomes, such as the educational progress made by students with SEN status. This model, however, remains the least commonly used of the three (Brussino, 2020[10]).

Box 4.1. Children with special educational needs and disabilities (SEND) in the United Kingdom

Special educational needs (SEN) support

> *SEN support means support that is additional to, or different from, the support generally made for other children of the same age in a school. It is provided for pupils who are identified as having a learning difficulty or a disability that requires extra or different help to that normally provided as part of the school's usual curriculum offer. A pupil with SEN support will not have an education, health and care plan. (Department for Education, 2025[11])*

SEN support is delivered directly by the school and may include a range of measures, such as differentiated instruction and additional teaching support (Brereton, 2025[12]). A formal medical diagnosis is not a requirement to receive SEN support. The school's Special Educational Needs Co-ordinator (SENCo), working in partnership with teachers, parents, and – where relevant – local authority specialists (e.g. educational psychologists or health professionals), assesses the child's needs and prepares an individual SEN Support Plan. These plans follow a graduated "assess-plan-do-review" cycle and set out the specific adjustments and supports required (Scope, n.d.[13]). All costs associated with SEN support are typically financed from the school's regular budget (Brereton, 2025[12]).

Education, Health and Care Plans (EHCPs)

> *A local authority may issue an EHC plan for a pupil who needs more support than is available through SEN support. This will follow a statutory assessment process whereby the local authority considers the pupil's special educational needs and any relevant health and social care needs; sets out long term outcomes; and specifies provision which will deliver additional support to meet those needs. (Department for Education, 2025[11])*

EHC Plans are not only more comprehensive and specific than SEN support, but children with an EHC Plan also have a statutory right to receive all the support detailed in the plan from their local authority

(Brereton, 2025[12]). A request for an EHC Plan can be submitted by anyone who considers it necessary – including parents, teachers, or GPs – provided there is sufficient evidence that existing interventions have not been effective (Council for Disabled Children, n.d.[14]). A formal medical diagnosis is not required; instead, eligibility is based on a holistic assessment of the child's needs. EHC needs assessments are carried out by the local authority, which must gather information on the child's educational, health, and care needs from a range of actors (parents, school's SENCo, educational psychologist, healthcare practitioners, social worker, etc.). The assessment relies primarily on documentary evidence (e.g. school reports, medical and therapy records) but may also include in-person evaluations. Based on the gathered information, the local authority decides whether the child requires an EHC plan and, if so, drafts one which parents then review before final approval by the local authority (IPSEA, n.d.[15]).

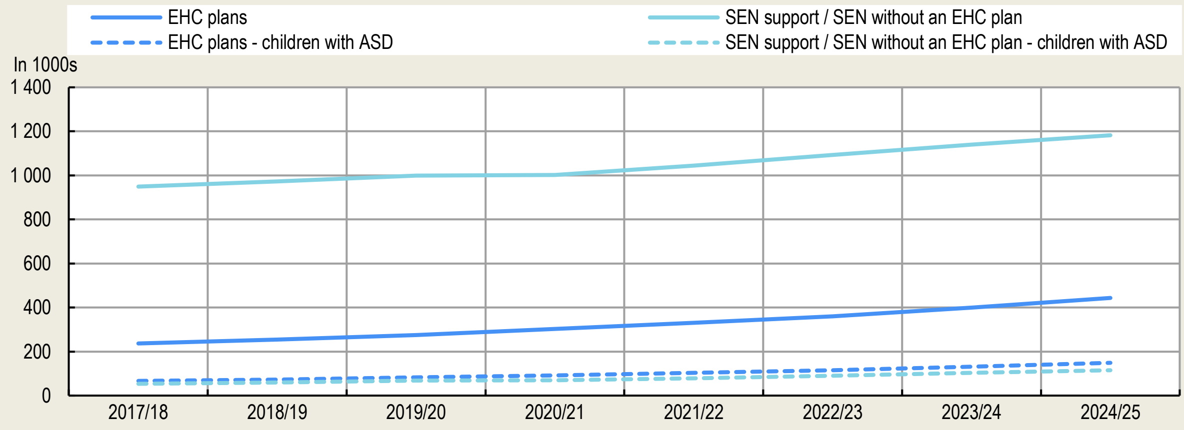
Children with ASD as their primary type of need represent a substantial share of all children with SEN

The numbers of children receiving SEN support and those with an EHC plan have risen almost in parallel since 2017/18, reaching a combined total of nearly 1.7 million pupils with SEN in England by 2024/25 (Figure 4.2, Panel A). The number of children whose primary need is ASD has also increased steadily across both groups. In 2024/25, pupils with ASD as their primary type of need accounted for around 10% of those receiving SEN support but represented almost 34% of all pupils with an EHC plan.

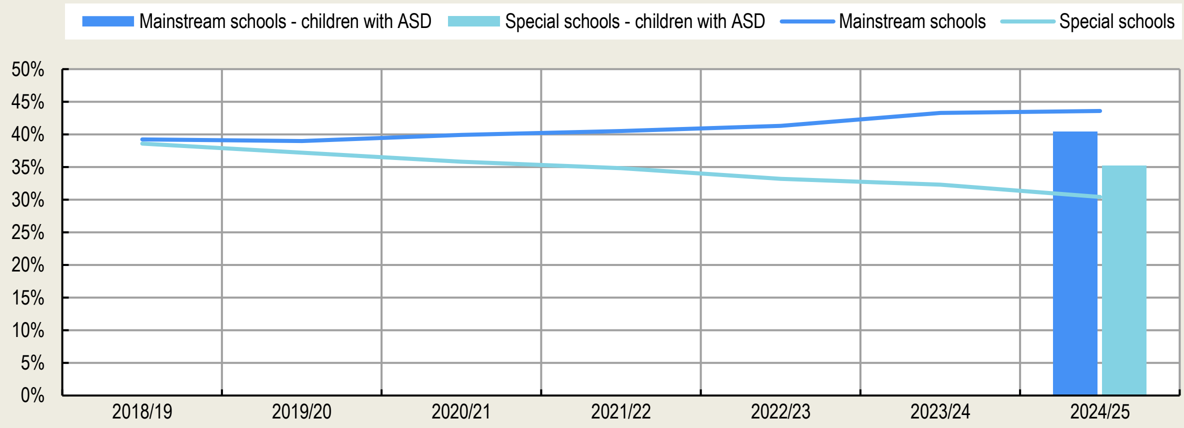
Panel C provides further context by showing that, after ASD, the most common needs among pupils with an EHC plan are "Speech, Language and Communication Needs" and "Social, Emotional and Mental Health", both of which are also the predominant categories among pupils receiving SEN support. For these latter two groups, the numbers of pupils receiving SEN support, however, are nearly twice as large as those with ASD. Notably, more than half of the children with ASD and SEND require substantial educational support that cannot be met through schools' SEN support alone and instead necessitates an EHC plan (Panel C). Taken together, these figures indicate that children with ASD as their primary type of need are much more likely to require or receive extensive support, beyond what schools can provide through SEN support alone, compared with pupils with other types of needs.

This observation aligns with Panel B, which shows that children with ASD as their type of need and an EHC plan are more likely to attend special schools than the average pupil with an EHC plan – 35% compared with 30% in 2024/25. At the same time, Panel B highlights a positive trend: increasing inclusion in mainstream education. The proportion of all pupils with an EHC plan attending mainstream schools has grown from about 40% in 2018/19 to roughly 44% in 2024/25, while the share in special schools declined from 40% to 30% over the same period. However, this trend may also reflect an increase in the number of children with comparatively lower levels of need being issued an EHC plan.

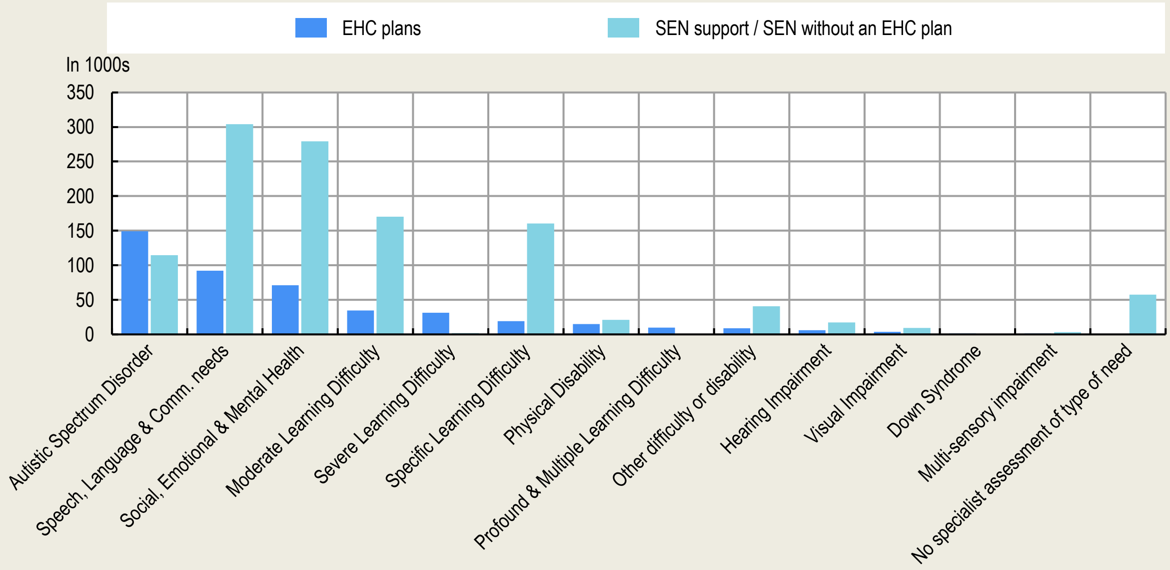
Figure 4.2. SEN support and EHCPs in England over time, by placement type and need



A. Total annual number of pupils with an EHC plan or SEN support



B. Share of EHC plans as at January each year, by placement types



C. Number of pupils with an EHC plan or SEN support, by type of need, 2024/25

ASD: autism spectrum disorder, EHC: education, health and care, SEN: special educational needs.
Note: Panels A and C: Includes state-funded nursery, primary, secondary and special schools, non-maintained special schools and state-funded alternative provision schools. Does not include independent schools. Panel C excludes the category “Missing”, as numbers were negligible. Panel B: Includes also independent schools.
Source: Government of the United Kingdom (2025[16]), *Explore educational statistics – Special educational needs in England*, https://explore-education-statistics.service.gov.uk/data-tables/special-educational-needs-in-england. Government of the United Kingdom (2025[17]), *Explore educational statistics – Education, health and care plans*, https://explore-education-statistics.service.gov.uk/data-tables/education-health-and-care-plans.

StatLink https://stat.link/dk5sfy

Paramedical therapies for children with ASD are extensive across most countries, especially at a young age

Children with disability can access therapies through different pathways

Countries typically offer multiple pathways for children with disability to access paramedical therapies such as speech, occupational, or psychotherapy (see Table A C.5 for detailed information on access to therapies across countries). These channels generally fall into three categories: 1) coverage through the public health system, usually contingent on a doctor’s referral; 2) specialised support programmes or institutions for people with disability, such as Australia’s NDIS or Ontario’s Autism Program; and 3) the education system, where special education services often include paramedical therapies, particularly speech and occupational therapy, delivered on-site and integrated into the child’s school day.

In Israel, for instance, children with ASD can access therapies through several routes. One option is via Israel’s public health system through Health Maintenance Organisations (HMOs),[2] with an official ASD diagnosis and a referral from a paediatrician or psychiatrist. Subject to availability, this pathway provides up to three hours of therapy per week. Another key access point is the education system: children with ASD who receive a positive decision from the Eligibility and Characterization Committee – responsible for assessing SEN and eligibility – can either access therapies through their personal services basket when they are in mainstream education or attend a special education setting in which therapy hours are integrated into the child’s school day. Additionally, Israel offers an Early Childhood Program specifically for children with ASD aged 0-6, providing up to 14 hours of therapy per week. To qualify for this early intervention program, the child must have a formal medical ASD diagnosis.

The most common approach across countries for accessing therapies is through a prescription and/or referral from a doctor to a therapist, with the costs covered by public health insurance. This model is used in countries such as Estonia, Germany, the Netherlands, Sweden, and the United Kingdom. While these systems are generally more accessible, they may also be more susceptible to longer waiting times, for example, in the United Kingdom’s National Health Service (NHS).

Denmark takes a distinct approach compared to the standard access pathways described above. In Denmark, the responsibility for allocating and funding paramedical therapies for children with disability lies with municipalities. These therapies are typically integrated into the child’s school day. Each municipality operates a Pedagogical Psychological Counselling service (*Pædagogisk Psykologisk Rådgivning,* PPR), which is tasked with assessing a child’s need for special educational support, including therapies such as speech and language therapy, through a thorough evaluation of the child’s academic, personal, and social development. If therapy is deemed necessary, it is usually delivered within the child’s educational setting. This central role played by municipalities in Denmark resembles the approach in Sweden where rather than being hired directly by individual schools, therapists are typically employed by municipalities and shared across multiple schools and daycare centres.

A child's therapy hours are typically tailored to their needs

Again, Israel somewhat stands out in its approach to therapeutic services for children with ASD due to its uniquely standardised allocation of therapy hours. Unlike other countries, where children receive as many hours of therapy as they need, Israel sets fixed weekly limits for publicly funded therapies based on medical diagnosis – for instance, children with ASD are entitled to exactly three hours of therapy per week through HMOs. No other country reviewed predefines therapy hour limits by diagnosis. One partial exception is Ontario (Canada), whose Autism Program does not specify the number of therapy hours a child may receive, but instead allocates fixed budgets based on the child's age and assessed support needs. In practice, this also limits the number of therapy hours parents can afford to purchase. Australia's NDIS follows a similar approach: the NDIA first assesses a child's support needs to determine the scope of the child's individualised budget across various support categories; the number of therapy hours funded is then established within that budgetary envelope.

The predefined weekly therapy limits in Israel are noteworthy, particularly given the relatively low take-up rate – according to anecdotal evidence, on average, children with ASD receive only one out of the three therapy hours they are entitled to each week. This may reflect a child's limited need for additional therapy, but it could also point to challenges faced by parents in co-ordinating therapy sessions or a shortage of available therapists, preventing children with ASD from accessing the full range of paramedical services they are officially eligible for. Furthermore, this standardised approach and heavy reliance on medical diagnoses may result in an imbalance of service provision, potentially leading to over-servicing of children with lower support needs, while under-serving those with higher support needs who may require more than three hours of therapy per week. Especially in a context of constrained resources, Israel's approach risks insufficient service provision for children with disability with the highest levels of need.

OECD countries recognise the importance of early childhood support

Another distinctive feature of Israel's approach is its ASD-specific Early Childhood Programme, which offers up to 14 hours of therapy per week. The only other country with a somewhat comparable programme is France, which has established special units, which are ASD-specific classrooms within mainstream kindergartens and elementary schools, respectively. These units deliver specialised support to young children with ASD (ages 3-11). Unlike in Israel, therapy hours in France – even in these ASD-specific units – are determined entirely by each child's individual needs and available resources rather than by a fixed limit. However, it is important to note that individual therapies outside of specific provisions, such as the early intervention package (*forfait d'intervention précoce),* are not always fully but rather partially reimbursed by France's national health insurance scheme. Furthermore, France's approach may create unintended disparities in therapy provision depending on the local resources available.

Inequalities in service access are also shaped by socio-economic factors, as suggested by Salomone et al. (2015[18]). In their cross-country survey of parents in 20 European countries on early intervention for children with ASD – covering both public and private therapy provision – one in ten parents reported that their child was not currently receiving any type of therapy intervention. These children who were not receiving intervention did not differ by age or verbal ability; however, this group included significantly more children whose parents had a lower level of education. Their findings also highlight pronounced cross-country disparities. While children with ASD up to age seven received on average 16 hours of therapy per week in Denmark, they received around ten hours in France and only about four hours in Germany. Across all European countries covered by the survey, children received an average of around nine hours of early intervention per week, with speech and language therapy being the most common intervention for the majority of children.

As a growing body of research demonstrates the importance of early intervention, several European countries recommend early intervention in national autism guidelines (Salomone et al., 2015[18]), such as those issued by the National Institute for Health and Care Excellence (NICE) in the United Kingdom and France’s national strategy for neurodevelopmental disorders, which includes conditions such as autism, ADHD, dissociative identity disorder and learning disorders (Box 4.2).

Box 4.2. France’s national strategy for neurodevelopmental disorders

Since 2018, France has continuously invested in a national strategy for autism and other neurodevelopmental disorders. Defining main areas of focus (commitments), the strategy also includes specific measures to respond to issues persons with autism and other NDDs may face. The first four-year strategy was launched in 2018, followed by a second four-year strategy in 2023.

The new national strategy for neurodevelopmental disorders (2023-2027)

The new strategy currently in place is running from 2023 through 2027 and includes all NDDs from the previous strategy (autism spectrum disorder, intellectual disability, specific learning disorders (SLDs) – dyslexia, dysgraphia, dyscalculia, dyspraxia, dysphasia, dysorthographia – and attention-deficit/hyperactivity disorder), as well as dissociative identity disorder (DID). It is interesting to note that the epidemiological data cited by the new strategy were higher than those cited by the previous strategy. Among the key numbers, autism was now thought to affect 1-2% of the population, whereas the 2018 strategy only put this number at maximum 1%; estimated numbers for the other NDDs were also higher.

The current strategy is also larger than the previous one, with six key commitments including 81 measures, compared to only five commitment areas and 20 measures in 2018. The six commitment areas in the current strategy are:

- Commitment 1: Expanding research on neurodevelopmental disorders and accelerating knowledge dissemination to all stakeholders;
- Commitment 2: Guaranteeing support for every individual, high-quality interventions through the lifespan, and intensifying training for professionals;
- Commitment 3: Advancing the age of detection and diagnosis and intensifying early interventions;
- Commitment 4: Adapting education to the specific needs of students from pre-school to higher education;
- Commitment 5: Supporting adolescents and adults during major life stages, particularly those who are the most vulnerable;
- Commitment 6: Making life easier for individuals and their families, and raising societal awareness of neurodevelopmental disorders.

Concrete measures – a total of 81, each embedded within one of the six commitment areas – include creating a “Child Brain Institute” (Commitment 1); reinforcing the professionals and expert structures in charge of diagnosing ASD, ADHD, DID, and SLDs (Commitment 2); offering to all parents of children with ASD, ADHD, DID or SLDs training to help them understand how their child functions and how to support their development (Commitment 3); continuing to support specialised full-time education of children with autism in pre-school from the age of 3 (Commitment 4); creating more inclusive housing and providing the necessary adaption to the specific needs of persons with autism (Commitment 5); and revising the guidelines to better assess individuals’ support needs and implement the disability compensation benefit (*prestation de compensation du handicap*, PCH) for human assistance for NDDs (Commitment 6); among others.

In November 2023, an interministerial delegation responsible for the strategy was named under the purview of the Ministry of Health, Family, Autonomy and Disabled Persons, underlying the importance France gives to the strategy and to addressing the needs of people with neurodevelopmental disorders, including persons with autism.

Note: ASD: autism spectrum disorder; DID: dissociative identity disorder; NDD: neurodevelopmental disorder; PCH: p*restation du compensation du handicap* (disability compensation benefit); SLD: specific learning disorder.
Source: Ministère de la santé, des familles, de l'autonomie et des personnes handicapées (2021[19]), *La stratégie nationale autisme et troubles du neurodéveloppement (2018-2022)*, https://handicap.gouv.fr/la-strategie-nationale-autisme-et-troubles-du-neurodeveloppement-2018-2022; Secrétariat d'état chargé des personnes handicapées (2018[20]), *Stratégie nationale pour l'Autisme au sein des troubles du neuro-développement*, https://handicap.gouv.fr/sites/handicap/files/files-spip/pdf/strategie_nationale_autisme_2018.pdf; Ministère de la santé, des familles, de l'autonomie et des personnes handicapées (2023[21]), *Nouvelle stratégie nationale pour les troubles du neurodéveloppement : autisme, Dys, TDAH, TDI*, https://handicap.gouv.fr/nouvelle-strategie-nationale-pour-les-troubles-du-neurodeveloppement-autisme-dys-tdah-tdi; Délégation interministérielle à la stratégie nationale pour les troubles du neurodéveloppement : Autisme, Dys, TDAH, TDI (2023[22]), *Stratégie nationale 2023-2027 pour les troubles du neurodéveloppement: Autisme, DYS, TDAH, TDI*, https://handicap.gouv.fr/sites/handicap/files/2025-11/DP-strategie-nationale-TND-2023-2027.pdf.

An emphasis on early intervention programmes for children with disability – often without the requirement of a formal medical diagnosis – can be observed in many of the countries reviewed in this report. For instance, in the United States, California's Early Start programme provides, among other services, occupational and physical therapy to children with developmental delays without requiring an official medical diagnosis. Similarly, under the early intervention criteria, Australia's NDIS offers services and funding to children with developmental delay, only requiring proof of such developmental delay. Ontario (Canada) follows a comparable approach, as its Preschool Speech and Language Program does not require children to have a formal medical diagnosis to access support. The widespread availability of such early intervention programmes in countries including France and Israel reflects a shared recognition of the strong potential of early paramedical therapies, such as speech and occupational therapy, to positively influence the developmental outcomes of young children with developmental delay, including those with ASD (Rogers and Vismara, 2008[23]). For example, in their study, Soref et al. (2023[24]) find that 9-12 sessions of occupational therapy already promote greater participation in daily activities and substantively improve sensory-motor skills of preschool-aged children with developmental disability. Driven by such recognition of the effectiveness of early therapeutic support, many countries intentionally waive the requirement for a formal medical diagnosis to access early intervention therapies, to ensure that young children with developmental disability can access these essential services as early as possible without any undue delays – often caused by long waiting lists for a formal diagnosis.

OECD countries also provide a broad range of social services

The list of social services presented in Table 4.1 is non-exhaustive and provides only a glimpse of the wide range of supports available to children with disability in the countries reviewed in this report. One of the most common services provided is free or subsidised access to public transport. In some cases, such as Sweden, alternative transport services are available for children with disability who are unable to use public transport. Additionally, many countries offer free transportation to school or daycare facilities. For example, in Israel, municipalities provide special transport to daycare centres and schools for children with SEN.

In addition to these child-focussed services, many countries also offer services aimed at supporting parents of children with disability. One key example is respite care which gives parents a planned break by providing qualified care and supervision for children with disability – either at home or through short-term out-of-home stays – thereby temporarily relieving parents of caregiving responsibilities. Such a third-party care service can range from a few hours of in-home supervision to multi-day residential stays. Most countries offer both, in-home and out-of-home respite care options, though some provide only one form of care – for example Israel which offers only short-term stays in specialised facilities. Funding for these services can be either direct, where the government (often through local authorities) arranges and pays for the respite service, or indirect, where parents receive funding to purchase the service themselves. Examples of indirect funding include Australia's NDIS and Germany's care insurance, both of which provide dedicated payments to parents for in-home respite care for their child with disability. Typically, the duration of such respite care services is based on individual needs and circumstances, although some countries set limits. For instance, Germany allows up to eight weeks of respite care per year.

Another parent-focussed support is the provision of extra paid leave. In Israel, parents of children with ASD are entitled to 18 paid leave days for ASD-related appointments and care annually; in Estonia, parents may take ten working days of childcare leave per year until their child reaches the age of 17 (compared to age 14 for parents of children without disability); and in Sweden, parents can also receive ten days of extra paid leave per year.

A third common parent-focussed service – often provided locally, such as by municipalities – includes training courses, parent support groups and counselling for parents. While these programmes are frequently ASD-specific, equipping parents with skills and knowledge tailored to caring for a child with ASD, most other social services are generally available to all children with disability, although eligibility and scope typically depend on the child's level of support needs.

Social services, along with educational and health services as well as financial benefits described in this report, are needed by children with ASD to varying degrees. For example, children with severe support needs and their parents may find it essential to have access to free special transport for school and after-school therapies or activities. Without this, parents would need to either personally bring their child or privately arrange transport, which could become unmanageable, especially given the high number of therapy sessions and other appointments likely required. In contrast, children with mild support needs who are able to take regular public transport and attend only occasional therapy sessions may not require special transport services. Similarly, children with severe support needs typically require a higher number of therapy hours and more extensive special educational support, whereas those with milder needs might manage well in mainstream classrooms with just a few hours of weekly assistance from a teaching aide and perhaps one hour of speech therapy to address minor difficulties. Financial benefits also play a different role depending on the level of support needs: parents of children with severe support needs who had to leave the workforce would rely heavily on financial supports to compensate for lost earnings, whereas parents of children with milder needs who maintained full-time employment or only slightly reduced hours might not depend on financial benefits for financial stability.

Table 4.1. Social services support children and their families

Country	Social service
Australia	• NDIS funds respite care services and parent training programmes. • NDIS also provides funding for special transport to paramedical therapies and other activities. • Free school transport for eligible students with disability (varies by state).
Canada (Ontario)	• Special Services at Home (SSAH) programme provides respite care funding and assistance for the child to participate in activities that support their development. • Ontario Autism Program funds foundational family services, such as caregiver workshops and follow-up coaching sessions, and caregiver-mediated early years programmes to teach parents therapeutic strategies. • Ontario Autism Program offers an entry to school programme that helps children develop school-readiness skills and provides transition supports. • Ontario's Infant Child Development Program provides parents of a child with developmental disability with information and counselling. • Discounted/free public transport passes in some cities.

Country	Social service
Denmark	• Municipalities provide respite care services (short-stay, in-home support, etc.). • Parent training programmes and family guidance usually available through municipalities. • Half-price public transport for children with disability; accompanying carer may travel for free. • Some municipalities may fund special leisure programmes and summer camps.
Estonia	• Free public transport for children with disability. • Social Rehabilitation Centres also provide counselling to parents. • Parent can receive paid caregiving leave for up to 14 days per episode at 80% of their salary. • Parents get ten working days of child leave per year until the child is 17 years old. • Up to 90% of costs of necessary technical aids and assistive devices covered by the state.
France	• Department-funded school transport for children with ≥50% disability. • CAMSP often provide parent guidance and training (availability varies by region). • Many regions have a *Centre Ressources Autisme* (CRA), which are autism-specific centres providing expert diagnostic assessments and guiding families to services. • Carte Mobilité Inclusion (Mobility Inclusion Card, CMI) which entitles the child and family to certain conveniences, such as free/discounted entry to many public facilities.
Germany	• Up to eight weeks/year of respite care services for children with higher care levels. • Parent training programmes, typically organised by local health and social services. • Free public transport and parking placards for children with "severe disability ID". If a "B" is marked on this ID, a companion can travel free of charge with them.
Israel	• Special transport provided by municipalities to daycare and schools for those children with SEN. • After-school clubs and holiday camps during the summer break. • Provision of technical aids and alternative communication devices free of charge. • State-backed counselling and social worker support for families. • Up to 18 employer-paid leave days/year (36 for single parents) for ASD-related appointments and care.
Netherlands	• Municipalities may provide day programmes and respite care services. • Free public transport for a caregiver if the child cannot travel alone (OV-Begeleiderskaart). • Individual cities may provide free special transport to school/daycare.
Sweden	• Municipalities offer respite care services. • One parent can shorten working hours by 25% if one of the parents is receiving the Care Allowance for the child. • Free/subsidised special transport for children who cannot use regular public transit. • Parents can receive up to ten days/year of extra paid leave ("Contact Days"). • Counselling and parent training programmes available through regional habilitation centres and municipalities.
United Kingdom	• Local authorities provide respite care services for families. • Transport concessions such as Disabled Persons Railcard and Blue Badge are available for children and their carers.
United States (California)	• Regional Centres offer family training and ASD-specific educational workshops. • Free/discounted public transport available in some municipalities. • Paratransit services provided at very low cost for those that cannot take public transport. • If the child's IEP determines transportation to school is needed, the school must provide it at no cost.

Note: The enumeration of countries' social services is non-exhaustive; several additional services available are not included in this table.
Source: Information collected by the Secretariat and verified in discussions with national autism organisations.

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Notes

[1] The United Kingdom has generally replaced the term SEN (Special Educational Needs) with the broader term SEND (Special Educational Needs and Disabilities) in its education policy.

[2] A Health Maintenance Organisation is a medical insurance group that provides healthcare services. HMOs usually have their own network of doctors, hospitals and other healthcare providers who have agreed to accept payment at a certain level of any services they provide.

Part II Country case studies

5 Autism policies in Australia

This chapter explores how Australia has responded to the growing prevalence of autism through a comprehensive and evolving policy framework. It traces the progression from early advocacy and the legal recognition of autism as a disability to the introduction of inclusive education standards and the establishment of the National Disability Insurance Scheme (NDIS). The chapter examines the shift towards a needs-based model, balancing universal disability rights with targeted interventions such as income support for carers and individualised funding through the NDIS. It also reviews diagnostic practices guided by national standards, the relationship between medical diagnosis and functional assessments, and their implications for access to supports. Finally, the chapter considers the challenges of promoting inclusion in mainstream education, managing rising demand for disability services, and ensuring fiscal sustainability. It underscores the importance of cross-sector collaboration and a people-centred approach to address the diverse needs within the autism community.

In Brief

Australia’s autism policy: Building a comprehensive support system

- Autism-related disability policies in Australia have progressed significantly, from early advocacy in the 1960s to legal recognition in 1992, followed by the introduction of inclusive education standards in 2005. Since 2025, Australia also has a National Autism Strategy.
- About 4.3% of 5-14-yer-old children in Australia report having ASD. Co-morbidities are common, especially learning difficulties, though 9% of individuals with ASD report no other disabilities.
- Australia’s National Guideline for autism assessment and diagnosis sets the best-practice standard for clinicians. The process involves a Comprehensive Needs Assessment and a Diagnostic Evaluation, conducted by a single qualified practitioner or a multi-disciplinary team. While the guideline is not mandatory, it is widely used in both public and private sectors.
- Despite rising ASD diagnosis rates among children and the fact that a diagnosis automatically qualifies parents for a Carer Allowance, the growth in uptake of both Carer Allowance and Carer Payment has been modest – with 657 275 and 314 320 recipients, respectively, in June 2024 – as both claims and exits from Carer Allowance and Carer Payment have increased.
- In 2025, 37% of Carer Allowances and 30% of Carer Payments were received for a person with a “Psychological or Psychiatric” condition (including ASD). Among children needing care, the respective proportions were 66% and 59%.
- While uptake of Carer Allowances appears only modestly influenced by rising ASD diagnoses, the National Disability Insurance Scheme (NDIS) has been much more directly affected. Among all 740 000 NDIS participants in 2025, those with ASD represented 40% in 2025, up from 34% in 2022. Children aged 0-18 with ASD represent approximately 30% of all NDIS participants.
- Australians with disability, including those with autism, can access the NDIS if they meet the requirements set out in the NDIS Act of 2013, including age, residency, and disability or early intervention requirements. To meet the disability criteria, the person must have an impairment that is likely to be permanent and causing a substantial reduction in functioning capacity. Early intervention supports can also be provided for eligible people with likely permanent impairment or children younger than six with developmental delay, where the supports are likely to benefit the person and reduce the impact of their impairment. While medical diagnoses can facilitate access to the NDIS, they are not strictly required.
- Compared to the broader population of persons with disability, children with autism are significantly more likely to attend special education settings. While 66% of all children with disability are enrolled in mainstream classes, this share falls to 50% for children with ASD.

Introduction

Australia has developed a comprehensive policy framework for children and adults with autism over the last decades, beginning with the formal recognition of autism as a disability under the Disability Discrimination Act in 1992. Parent-led organisations have played a crucial role in shaping support systems. Over time, government initiatives such as the National Disability Insurance Scheme (NDIS) and inclusive education reforms have shifted support toward a needs-based model.

The main forms of government support for children and families with autism include the Carer Allowance, the Carer Payment, and the NDIS. Uptake of both the Carer Allowance and the Carer Payment has grown only modestly in recent years, despite rising autism diagnosis rates among children. By contrast, participation in the NDIS has expanded rapidly, reflecting its more comprehensive and individualised approach to support. In education, policies have increasingly promoted inclusion, leading to a gradual shift away from specialised schools toward mainstream schooling with tailored supports for students with SEN. Most recently, the release of the National Autism Strategy 2025-2031 marks a co-ordinated effort to address the diverse and evolving needs of people with autism living in Australia across all life stages.

Additionally, an important distinction is made in Australia between individuals with autism who have a disability, and those who have autism but do not view themselves as having a disability. The second group mostly involves people with low support needs who need minimal or no adjustments to live independently and successfully integrate into education and the labour market. According to anecdotal evidence, this division is also visible in the autism community in which these two subgroups do not necessarily always share the same perspectives and ideas, as well as demonstrate different abilities to advocate for themselves. It is also relevant to highlight the overlap between autism and intellectual disability (ID). This distinction is important, as autism without ID presents differently to autism with co-morbid ID and has a different support needs profile – including among people who identify as having disability.

This case study examines the evolution and impact of autism-related policies in Australia, with particular attention to children and different support available to families.

Throughout this report, the OECD predominantly uses the terms "children with ASD/with autism" (see the Note *on language* at the beginning of the report). The authors acknowledge, however, that the Australian Government adopts identity-first language ("autistic children"), reflecting feedback gathered through its national consultation process for developing the National Autism Strategy.

Autism-related disability policies have a long history in Australia

Autism first started to gain widespread recognition in Australia with the foundation of its first autism organisations in the 1960s. Autism SA (Autistic Children's Association) was founded in 1964 in South Australia, by people with autism and their families, with the aim of ensuring access to information, education and support for individuals with autism (Autism SA, n.d.[1]). Similar parent-led groups followed, such as Autism Spectrum Australia (Aspect, founded in 1967 under the name Autistic Children's Association of New South Wales), focussing on providing autism-specific educational programmes (Aspect, 2025[2]); and Amaze (previously Victorian Autistic Children's and Adult's Association, founded in 1976) created with the aim of providing information and supporting individuals with ASD and their families. By the 1970s, these associations managed to create tangible support for children with autism and their families, notably by establishing the first autism-specific schools in Australia (Autism SA, 2025[3]).

In 1992, autism became a legally recognised disability in Australia, under the **Disability Discrimination Act 1992** (Act No. 135, 1992). The Act defines disability as relating to a person who suffers from a physical, intellectual, psychiatric, sensory, neurological, and/or learning disability, physical disfigurement, and/or disease-causing organisms in the body. Due to its neurological basis and impact on various other aspects of functioning, autism falls under this broad definition of disability (Centre Disability Support, 2024[4]).

In the 1990s, special education schools started closing in favour of more inclusive education options, notably Autism SA's Clinic School was closed in 1991 (Autism SA, 2025[3]). In 2005, the **Disability Standards for Education 2005** entered into force. The standards – under the purview of the Disability Discrimination Act – aim to ensure that "children with disability can access and participate in education on the same basis as students without disability" (Australian Government, 2025[5]). The standards are reviewed every five years and were under review at the time of writing. The standards require that education providers make reasonable adjustments in the curriculum, teaching methods, and assessment procedures to accommodate the needs of students with disability, including students with autism (ibid.). The introduction of the standards marks a move in Australia towards more inclusive education practices, promoting the integration of students with ASD into mainstream classrooms (Centre Disability Support, 2024[4]).

In 2013, Australia introduced the National Disability Insurance Scheme through the **National Disability Insurance Scheme Act 2013** (Act No. 20, 2013). Administered by the National Disability Insurance Agency (NDIA), the NDIS aims to provide persons with a permanent and significant disability with individualised support, as well as provide support for their families and carers. The aim of the scheme is to help individuals with disability "to be more independent and engage socially and economically" (NDIA, 2022[6]). A person with ASD is eligible for the NDIS if their impairment(s) have a substantial impact on their functional capacity (Autism Awareness Australia, 2024[7]). Young children under the age of 6 with developmental delay (as defined by the NDIS Act 2013) and/or children under the age of 9 with disability, including autism, can access the "Early childhood approach" (NDIA, 2024[8]).

In August 2025, the Australian Government announced a new scheme for children with developmental delays and autism, called "Thriving Kids" that will start from 1 October 2026. The Australian Government announced a contribution of AUD 2 billion over five years (equal to about 4% of its spending on disability services in 2023/24, see Figure 5.10). The new programme will be designed to divert children with developmental delay and disability with low to moderate support needs, away from the NDIS. The new model is meant to relieve pressure on the NDIS with an increasing number of individuals with developmental disorders applying for NDIS funding in recent years (The Guardian, 2025[9]; Australian Government, 2025[10]).

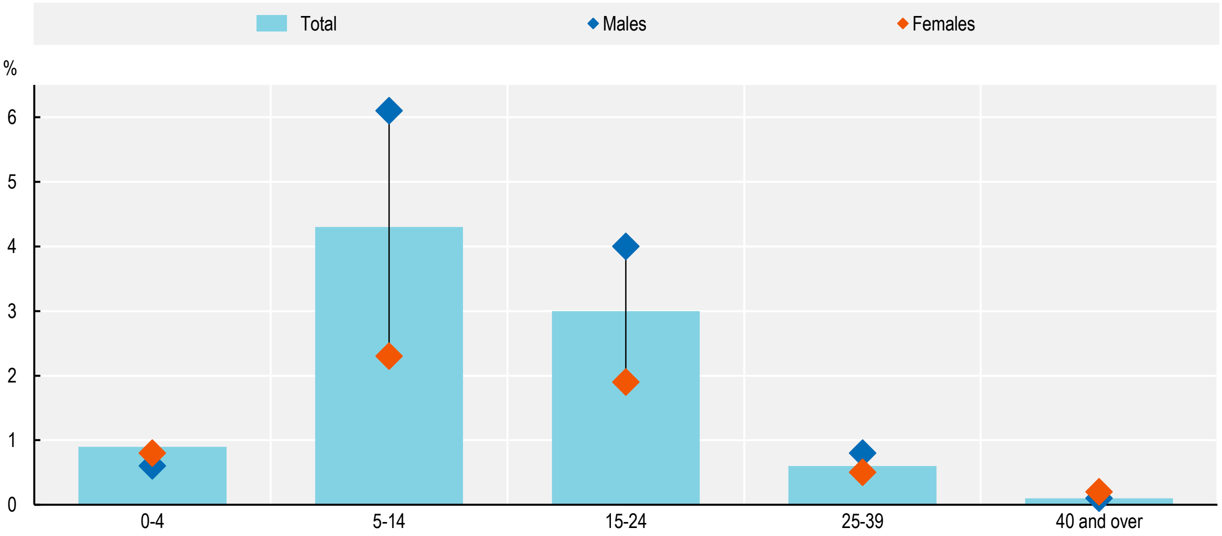
As of 2025, Australia has its first National Autism Strategy. Released by the Australian Government in January 2025, the **National Autism Strategy 2025-2031** aims to provide a national approach to services and supports for people with autism and their families. The strategy was developed through a co-design process involving the autism community, their families and carers. The strategy is a comprehensive seven-year framework aiming to improve outcomes for individuals with autism and focussing on four key outcome areas: 1) social inclusion; 2) economic inclusion; 3) improving diagnosis, services and support; and 4) health and mental health (addressed through the National Roadmap to Improve the Health and Mental Health of Autistic People 2025-2035) (Australian Government, 2025[11]).

The proportion of children with autism in Australia is high, at around 4.3% among 5-14 year-olds

As established in the main part of the report, it is very challenging to establish accurate estimates of the prevalence of autism and to compare rates across countries and over time. In Australia, autism prevalence is estimated through a population survey. The Survey of Disability, Ageing and Carers (SDAC) collects data on self-reported autism – by asking respondents whether they have a long-term health condition lasting for six months or more, autism being one of the conditions respondents can report – and estimates the rate of persons with autism in Australia (Australian Bureau of Statistics, 2024[12]). Other countries with available data on estimated prevalence of autism in the population include Canada, Israel, the Netherlands and the United States. Among these countries, Australia has the second highest estimated prevalence of autism among children over time, preceded only by the Netherlands (Figure 2.1). In 2022, according to data from the SDAC, the average share of people with autism out of the overall population was 1.1% which is in line with global estimates. When looking at data by sex and age groups, much higher self-reported rates emerge for younger people and especially for boys and young men. In 2022, the proportion of individuals reporting ASD was 6.1% for boys aged 5-14 years and 4% for young men aged 15-24 years (Figure 5.1)

Figure 5.1. Australian boys and young men report particularly high rates of ASD

Share of individuals with autism by age and sex, 2022



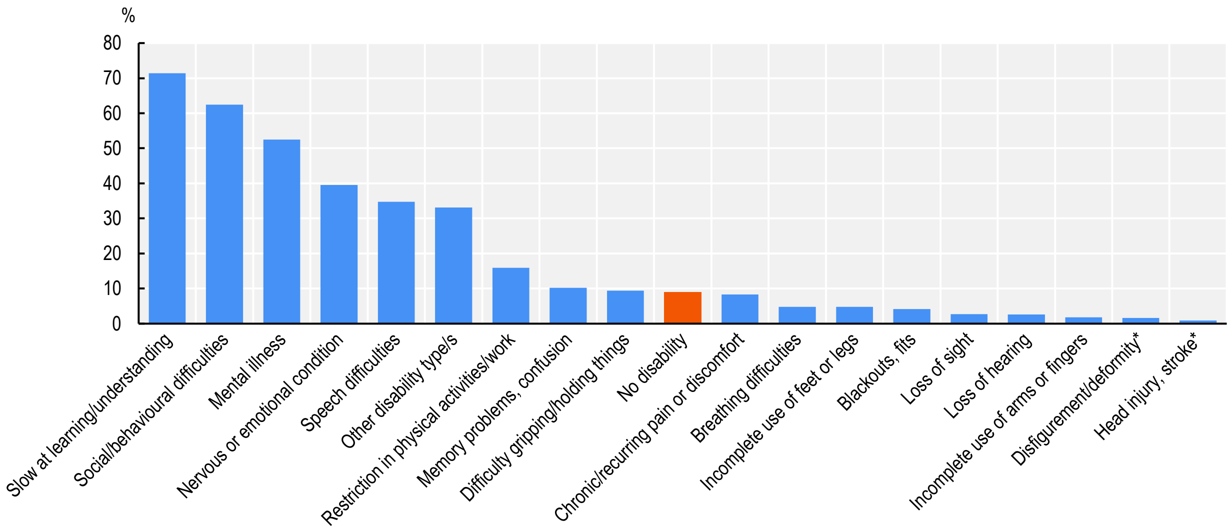
ASD: autism spectrum disorder.
Source: Australian Bureau of Statistics (2024[13]), *Survey of Disability, Ageing and Carers*: *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads.

StatLink https://stat.link/r2a9fz

Co-morbidities and co-occurring disabilities are common with autism, also in Australia. According to the latest SDAC data, in 2022 the most common co-morbidity for individuals with autism was "slow at learning or understanding", affecting over 70% of individuals self-reporting with autism. This was followed by social/behavioural difficulties (over 60%) and mental illness (over 50%) (Figure 5.2). Note that these co-occurring conditions – such as slow at learning, social/behavioural difficulties, mental illness, etc. – are defined as "co-morbidities" in SDAC. As mentioned before, not all individuals with autism consider themselves to have a disability. According to data from SDAC, in Australia in 2022 only 9% of individuals with self-reported autism did not identify as having a disability (Figure 5.2).

Figure 5.2. “Slow at learning or understanding” is the most common co-morbidity among persons with autism in Australia

Share of disabilities among persons with autism, by type of disability, 2022



Note: Conditions on the x-axis are defined as “type of disability” in the data.
*High margin of error and should be used with caution.
Source: Australian Bureau of Statistics (2024[13]), *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads.

StatLink https://stat.link/t43y0f

Diagnosis of autism in Australia follows rigorous guidelines

Accurate and consistent diagnosis of autism is essential for ensuring access to appropriate supports and services. In Australia, this process is guided by the National Guideline for the assessment and diagnosis of autism, which sets out best-practice recommendations for clinicians across public and private settings. While the guideline is not mandatory, it provides a unified framework aligned with international standards and is widely regarded as the industry benchmark. Meeting strict diagnostic requirements is also necessary for eligibility under List A of the National Disability Insurance Scheme, which currently applies additional criteria beyond those outlined in the guideline.

A diagnosis can be obtained in both the public and the private sector, with high reliability of the diagnosis regardless of where it is made and with no reported variability in reliability of the diagnosis between the two settings. High reliability of private diagnoses may be due to the existence of the Medicare Benefits Schedule, a federal scheme to publicly fund certain private medical services, including private diagnosis in primary care. Nevertheless, barriers to diagnosis persist, notably due to a shortage of medical and allied health professionals – including paediatricians, psychiatrists and psychologists – to co-ordinate diagnosis and complete assessments.

The National Guideline for the assessment and diagnosis of autism in Australia provides the industry standard for diagnosis and assessment

The diagnosis of autism in Australia follows the *National Guideline for the assessment and diagnosis of autism in Australia* developed by Autism CRC and approved by the Australian Government. Published originally in 2018 and revised in 2023 by Goodall et al., the guideline represents the first unified approach to the assessment and diagnosis of autism in Australia. The guideline and subsequent recommendations reflect evidence from research, clinical practice, as well as including views and preferences of the autism community in Australia (Autism CRC, 2023[14]). Although not compulsory, the recommendations set out in the guideline serve as best practice for practitioners involved in the diagnosis and assessment of autism in Australia.

The guideline follows international assessment standards set out in the latest edition of the DSM (DSM-5-TR, 2022) and the ICD (ICD-11, 2019). According to the guideline, the process for assessment and diagnosis for autism in Australia should include the following steps (Goodall et al., 2023[15]):

- Upon an individual seeking advice from a health practitioner, the professional (typically a GP) makes a referral within the assessment and diagnostic process.

The process then has two main steps: the "Comprehensive Needs Assessment" and the "Diagnostic Evaluation" (ibid.) (Figure 5.3):

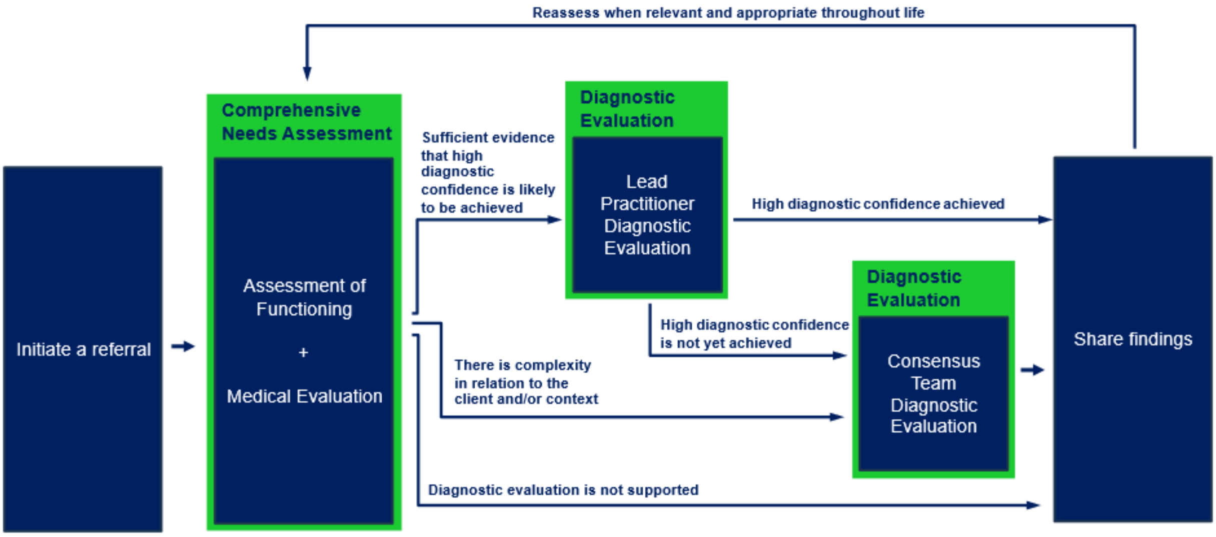
- During the "Comprehensive Needs Assessment", the diagnosing professional seeks to understand all relevant aspects of the person's characteristic, functioning, environment and context, strengths and support needs. The assessment has two main components: the "Assessment of Functioning" and the "Medical Evaluation".
    - "Assessment of Functioning" contributes to the identification of characteristics that may be relevant for the autism diagnosis or other related conditions. It includes taking a case history and using interview, observations, and assessment tools to examine functioning in relevant domains of the International Classification of Functioning, Disability and Health (ICF) by the World Health Organization.
    - "Medical Evaluation" typically includes taking a case history, conducting a general physical examination and performing further clinical assessments, as needed.
- The second part is the "Diagnostic Evaluation", focussing on whether the individual meets the diagnostic criteria for a clinical diagnosis of autism, and/or other related conditions. The latest DSM and ICD criteria should be used and differential diagnosis should be made if needed. In line with the DSM-5 (APA, 2013[16]), the guideline also highlights that although standardised diagnostic instruments (e.g. ADOS or ADI-R) may be used to assist the diagnostic process, these do not replace a full autism assessment.

The guideline proposes two ways to conduct the assessment: either by one professional ("Lead Practitioner Diagnostic Evaluation"), or through a multi-disciplinary team evaluation ("Consensus Team Diagnostic Evaluation") (Figure 5.3). The professionals involved in the evaluation are the following (Goodall et al., 2023[15]):

- the "Lead Practitioner Diagnostic Evaluation" can be conducted by one or more relevant practitioners. Relevant practitioners include:
    - paediatrician, psychiatrist, neurologist;
    - GP with at least six years of experience in the assessment and diagnosis of neurodevelopmental conditions;
    - psychologist specialised in clinical psychology, clinical neuropsychology, and/or educational/developmental psychology.
- the "Consensus Team Diagnostic Evaluation" should include at least one additional practitioner in addition to what's been defined under lead practitioner. It is recommended to refer to a team in more complex cases. The additional practitioner(s) should be one or several of the following:
    - paediatrician, psychiatrist, neurologist;

- GP with at least six years of experience in the assessment and diagnosis of neurodevelopmental conditions;
- psychologist specialised in clinical psychology, clinical neuropsychology, and/or educational/developmental psychology;
- occupational therapist;
- speech pathologist;
- registered nurse, which can be: a nurse practitioner, mental health nurse practitioner, or a registered nurse with relevant experience as a clinical nurse specialist/consultant;
- social worker.

Figure 5.3. Process for assessment and diagnosis of autism in Australia



Source: Based on Goodall et al. (2023[15]), *National Guideline for the assessment and diagnosis of autism in Australia*, Figure 2.3, https://www.autismcrc.com.au/best-practice/assessment-and-diagnosis.

The national guideline sets out recommendations for both public and private settings. According to anecdotal evidence, it is however more common in public hospitals to do multi-disciplinary assessments. Persons with autism and their families usually turn to the public sector for diagnosis and assessment, unless the waiting list is too long. Then, if they can afford it, they might turn to the private sector, where a single practitioner can also diagnose autism (corresponding to the “Lead Practitioner Diagnostic Evaluation” approach in the guideline). Nevertheless, whether the diagnosis and assessment are made in the public or private sphere, the diagnosis is recognised and valid in the whole country. Since most private practitioners also work in the public sphere and vice versa, the national guideline remains the industry standard in both spheres for diagnosis and assessment of autism.

The NDIS has strict diagnosis and assessment requirements

Access to NDIS is mainly based on an applicant’s impairment and functional capacity and not solely on medical diagnosis. Under the National Disability Insurance Act (NDIS Act), applicants must meet age, residency, and disability or early intervention requirements. A diagnosis is not legally required to access the scheme. However, historically the NDIS introduced access lists (List A and List B) as a transition mechanism to expedite consideration for some cohorts.

For example, autism diagnosed by a specialist multi-disciplinary team, paediatrician, psychiatrist, or clinical psychologist using DSM-5 criteria has often been used to support access decisions. DSM-5 categorises autism into three levels: Level 1 (requiring support), Level 2 (requiring substantial support), and Level 3 (requiring very substantial support). Those diagnosed with Level 2 or 3 autism have typically qualified more easily under List A, while Level 1 autism (List B) requires evidence of substantially reduced functional capacity in one or more areas – such as communication, social interaction, learning, mobility, self-care, or self-management – or meeting early intervention criteria (NDIS, 2024[17]). A person can still meet access criteria if they do not have a condition on List A or B if they have a permanent disability with substantially reduced functional capacity and are likely to require NDIS supports for life.

Following a 2023 review of the NDIS *Working together to deliver the NDIS*, the diagnosis and assessment requirements are currently being revised. The report recommended removing automatic access to the scheme using the access lists as it has led to a focus on medical diagnosis rather than function or need (Department of the Prime Minister and Cabinet, 2023[18]). Furthermore, according to interviews conducted with policymakers, the distinction between List A and List B will change significantly and might even disappear in the future. Future access criteria are expected to place greater emphasis on needs-based assessment and functional impairments rather than diagnosis.

Australia offers multiple allowances to parents of children with disability

Australia provides two primary and two supplementary allowances to parents and carers of children with disability or a medical condition, including children with ASD: the Carer Allowance, Carer Payment, Child Disability Assistance Payment, and Carer Supplement. All four are administered by Services Australia; the two primary allowances have child (care receiver aged under 16 years) and adult (care receiver aged 16 years and over) streams of payment (see Table A C.1 for details). The Carer Allowance is a fixed fortnightly income supplement of AUD 159.3 (per month approximately 4% of average monthly wage), unaffected by the family's financial situation unless annual income exceeds AUD 250 000, in which case entitlement is withdrawn. By contrast, the Carer Payment is strictly means-tested. It provides a maximum fortnightly payment of AUD 1 149 (per month about 28% of average monthly wage) for a single carer or AUD 1 732.2 (per month approximately 43% of average monthly wage) for a couple providing full-time care (according to March 2025 rates). This payment is gradually reduced once adjusted family net income surpasses a defined threshold, currently AUD 380 per fortnight for a partnered carer. In addition, parents receiving either the Carer Allowance or Carer Payment as of 1 July 2025 qualify for the Carer Supplement, an annual lump-sum payment of AUD 600. Similarly, recipients of the Carer Allowance on 1 July 2025 are eligible for the Child Disability Assistance Payment, which amounts to AUD 1 000 annually. Provided that eligibility conditions are met, parents of a child with disability can receive all four allowances simultaneously (Services Australia, 2025[19]; 2025[20]; 2025[21]).

Australia's total expenditure on these allowances for the 2024-2025 financial year was (Australian Government - Department of Social Services, 2025[22]):

- AUD 7 925.6 million on the Carer Payment (includes children and adults)
- AUD 848.3 million on the Carer Allowance (children only)
- AUD 649.9 million on the Carer Supplement
- AUD 214.7 million on the Child Disability Assistance Payment

Both medical diagnosis and assessed care needs shape eligibility for allowances

While Carer Allowance and Carer Payment require a formal medical diagnosis of the child's impairment – in this case, ASD – they differ slightly in their additional eligibility criteria. Qualification for both Carer Payment and Carer Allowance is based on the type and level of care an individual requires and is provided by their carer. To access the allowances, the care needs of the individual need to meet a qualifying score under the Adult Disability Assessment Tool for adults 16 years and over, or the Disability Care Load (Child) Assessment (DCLA) for children under 16 years of age (Australian Government, 2025[23]).

To qualify for the Carer Allowance for children, eligibility is first assessed against the List of Recognised Disabilities. The List forms part of the Disability Care Load Assessment (Child) Determination (DCLAD) and contains certain disabilities and medical conditions considered to consistently require a level of care significant enough to qualify the parent or carer for Carer Allowance (child) automatically. ASD features on this List (Australian Government - Department of Social Services, 2025[24]).

Where a condition is not on the List, eligibility for Carer Allowance further depends on the child demonstrating "intense" care needs, meaning the carer must provide "daily care and attention" to the child due to the child's condition. The child's care needs are assessed through the Disability Care Load Assessment (Child) (DCLA). The DCLA is based on the Assessment of Care Load (ACL), completed by the child's carer, and a Medical Report completed by the treating health professional of the child. The ACL covers the following three domains: behaviour, functional abilities, and special care needs. It asks parents to report on daily care tasks and support needs across areas including communication and language, mobility and transfers, self-care (feeding, dressing, toileting), supervision and safety, behaviour and emotional regulation, and specialised medical or nursing needs. The questionnaire allocates scores to each question. Some scores reflect comparisons between the child's functioning and the developmental expectations for a child of the same age without an impairment; others are drawn from other standardised functional assessments. The ACL questionnaire and Medical Report are reviewed separately, and minimum thresholds must be met for both, in order to generate an overall qualifying DCLA rating (Australian Government, 2025[23]). Notably, eligibility is typically determined without an in-person assessment and there are no periodic reassessments for the Carer Allowance. A review may, however, be triggered if the child's condition or care situation changes.

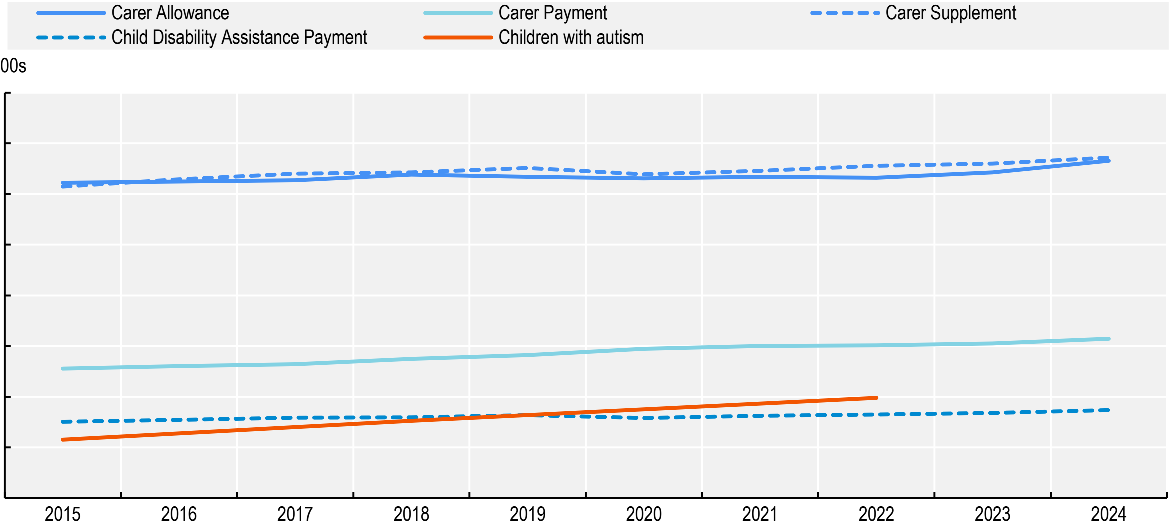
The Carer Payment is an income support payment available to carers who are unable to support themselves through paid employment due to the constant care they provide. To qualify for this benefit, the child must have a formal medical diagnosis and require constant care, defined as care provided for a substantial portion of the day, roughly equivalent to a standard working day. Carers may engage in paid or self-employed work for up to 100 hours per four-week period without affecting eligibility. The constant care requirement is an additional, non-clinical criterion unique to the Carer Payment (Services Australia, 2025[25]). The child's care needs, however, are assessed through the same DCLA framework used for the Carer Allowance: the carer completes the ACL questionnaire, while the child's treating health professional completes the corresponding Medical Report.

Rising ASD diagnosis rates are not fully matched by growth in allowance uptake

The prevalence of ASD diagnoses among the entire population in Australia rose markedly, from 700 per 100 000 people in 2015 to 1 100 per 100 000 in 2022 – an increase of 57% (Figure 1.1). Over a comparable period (2015-2024), however, overall growth in allowance uptake has been far more modest. The number of all Carer Allowance recipients (not only those carers of a child with ASD) rose by only 6.9%, while Carer Payment recipients increased by 23% (Figure 5.4). The rise in ASD diagnoses in Australia does not appear to directly translate into higher demand for disability-related allowances. This suggests that the allowance system remains relatively stable and resilient to shifts in diagnosis rates, reflecting the fact that – at least for the Carer Payment – a diagnosis alone is not sufficient to meet eligibility criteria. The relatively modest increase in allowance uptake, compared to the significant rise in ASD diagnoses, might also suggest that some of the observed increase in ASD diagnoses stems from diagnostic substitution, with conditions that might previously have been classified differently now being identified as ASD. While data disaggregated by ASD are not available, it cannot be ruled out that the rise in ASD diagnoses has been a driver of the increase in allowance recipients. According to anecdotal evidence, ASD is the top medical condition for which a carer qualifies for both Carer Allowance (child) and Carer Payment (child). However, the only disaggregated data available is by the care recipient's broader medical condition (Figure 5.5 and Figure 5.6). In Figure 5.6, ASD is covered under the "Psychological / Psychiatric" category.

Figure 5.4. Uptake of Australia's disability allowances has remained stable in the past decade

Recipients of different disability allowances in Australia and number of children with autism, 2015-2024

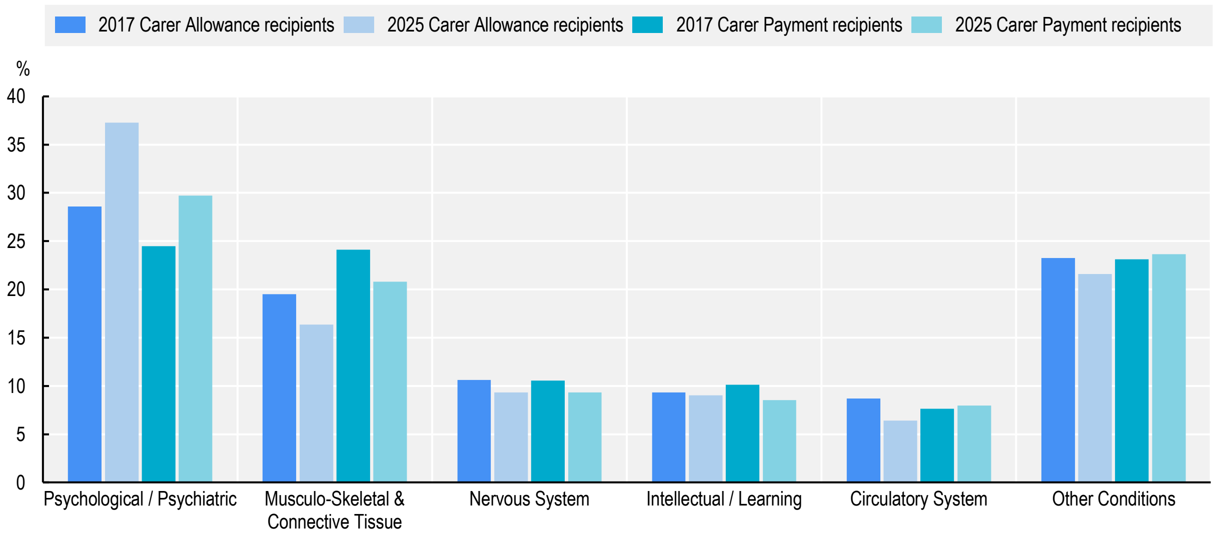


Note: Data includes all allowance recipients; information specific to carers of children with ASD is not available. "Children with autism" is the total number of children with autism (2015, 2018, and 2022) in Australia; it is an OECD estimation based on data from SDAC.
Source: Australian Government (2025[26]), *Report on Government Services 2025*, https://www.pc.gov.au/ongoing/report-on-government-services/2025/data-downloads.

StatLink https://stat.link/g0dtsy

Figure 5.5. Mental health conditions are on the rise for recipients of care benefits in Australia

Distribution of care receivers by top five medical conditions among Carer Allowance and Carer Payment recipients, Australia, March 2017 and 2025



Note: Data includes all allowance recipients, i.e. not only carers of children.
Source: Australian Government (2025[27]), *DSS Benefit and Payment Recipient Demographics – quarterly data*, https://data.gov.au/data/dataset/dss-payment-demographic-data.

StatLink https://stat.link/x1gnzq

In 2025, the most common medical condition of care recipients whose carers receive either the Carer Allowance or Carer Payment is "Psychological / Psychiatric", accounting for 37% and 30% of care receivers, respectively. Carer Payment recipients, however, are more likely than Carer Allowance recipients to care for someone with "Musculo-Skeletal & Connective Tissue" conditions, which is consistent with the benefit's requirement that carers provide constant daily care, roughly equivalent to a full working day. The distribution of medical conditions among care recipients was largely similar in 2017 and 2025. The primary changes observed by 2025 are a small drop in the "Musculo-Skeletal & Connective Tissue" condition, and an increase in the share of care recipients classified with a "Psychological / Psychiatric" condition. In 2017, only 29% (37% in 2025) of care recipients whose carers received the Carer Allowance had a "Psychological / Psychiatric" condition and only 25% (30% in 2025) of care recipients whose carers received the Carer Payment belonged to that medical category. Correspondingly, the shares in the other four medical condition categories either declined or remained roughly unchanged between 2017 and 2025.

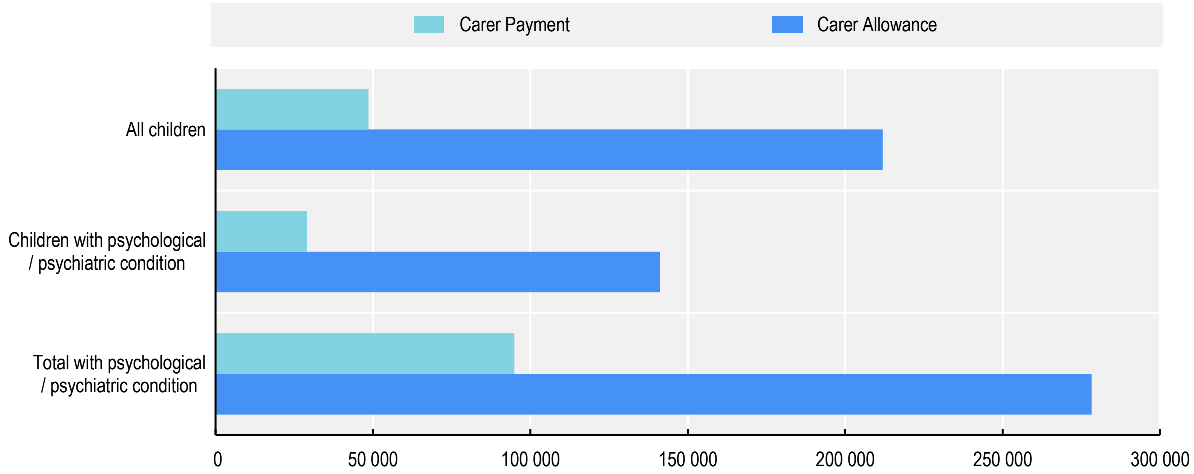
ASD is covered by the "Psychological / Psychiatric" medical category. The growing number of ASD diagnoses has likely contributed to the expanding share of care recipients recorded within this medical condition category. The number of children in this condition category is particularly notable – they represent a huge share both relative to all care receivers in this category, children and adults combined, and within the population of all children receiving care. This in turn supports the hypothesis that the rise in ASD diagnoses, especially among children, has played a role in the recent, albeit moderate, increase in allowances uptake.

As of March 2025 (Figure 5.6):

- 141 160 children with a psychological / psychiatric condition qualified a carer to receive the Carer Allowance, out of a total of 211 965 children whose carers received this allowance.
- 28 980 children with a psychological / psychiatric condition qualified a carer to receive the Carer Payment, out of 48 560 children whose carers received this payment.

Figure 5.6. Many children receiving care report psychological / psychiatric medical conditions

Care recipients by benefit type and medical condition, Australia, March 2025



Note: "All children" includes all children of all medical conditions (under 16 years of age); "Children with Psychological / Psychiatric condition" includes only children (under 16 years of age) that have said medical condition; "Total with Psychological / Psychiatric condition" includes all care receivers (children and adults) that have said medical condition.
Source: Australian Government (2025[27]), *DSS Benefit and Payment Recipient Demographics – quarterly data*, https://data.gov.au/data/dataset/dss-payment-demographic-data.

StatLink https://stat.link/7npqxd

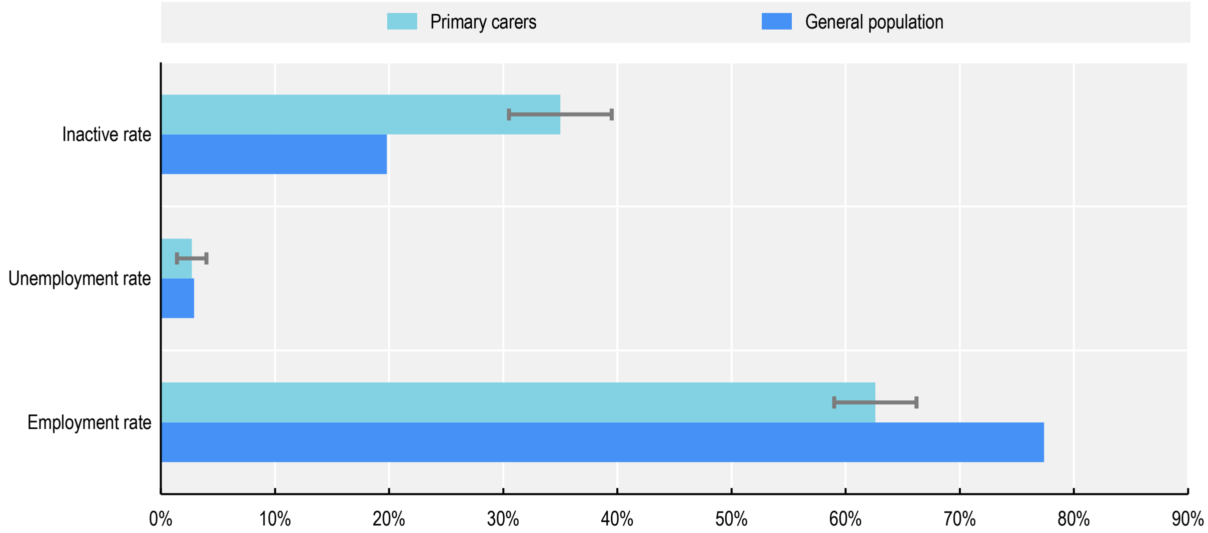
Income support is available for parents of children with disability and intensive care needs

Australia's Carer Payment explicitly requires carers to provide constant daily supervision or care to the person with a disability, offering income support to those who cannot participate in the labour market or have had to drastically reduce their working hours due to their care responsibilities (Services Australia, 2025[25]). Indeed, the share of primary carers who are not in the labour force is significantly higher than that of the general population (Figure 5.7). Likewise, the employment rate among primary carers is substantially lower than in the general population. These figures underscore that caring for a person with a disability often restricts employment opportunities and highlight the critical role of income support for this group.

While the Carer Payment provides essential financial assistance, it does not fully compensate for the lost income of a parent who previously earned, or could have earned, a full-time average monthly salary. As an alternative to reducing work hours or leaving the workforce, some parents may thus hire a caregiver for their child to maintain employment. In such cases, the parent would generally no longer qualify for the Carer Payment. However, the costs of hiring a caregiver may be partially covered by NDIS funding, for example, for a few hours per week – a full-time support worker is rarely funded in practice.

Figure 5.7. Employment rates of primary carers are lower than for the general population

Labour force status of primary carers (aged 15-64 years) who are caring for people aged under 65 years with a disability, Australia, 2022



Source: OECD estimates based on Australian Government (2025[26]), *Report on Government Services 2025*, https://www.pc.gov.au/ongoing/report-on-government-services/2025/data-downloads.

StatLink https://stat.link/ma9htw

Australia's National Disability Insurance Scheme is a key pillar of support

In Australia's otherwise largely means-tested social protection system, the NDIS, which began roll out in 2013 and reached national coverage in 2016, stands out as a non-means-tested and uncapped (demand-driven) programme. This publicly funded scheme operates independently of other programmes and is specifically designed to provide individualised support to people with permanent and significant disability or those who would benefit from early intervention support, thereby addressing a key gap in Australia's public services landscape. Administered by the National Disability Insurance Agency (NDIA), the NDIS offers personalised funding plans tailored to each participant's individual needs. These plans may include funding for therapies, assistive technologies, personal care, home or vehicle modifications, transport, employment-related supports, innovative capacity-building programmes, and other essential disability-related supports (NDIS, 2024[28]). The scheme's design places emphasis on early intervention to minimise long-term disability impacts and maximise outcomes over a participant's lifetime. The NDIS is jointly funded by the Commonwealth and state/territory governments through bilateral agreements; the Commonwealth contributes more than half of the scheme's total funding (Parliament of Australia, 2022[29]). In recent years, governments have worked together to ensure that the NDIS remains financially sustainable and can continue to deliver for people with disability into the future. This includes agreeing on future funding arrangements that balance growth with long-term viability of the scheme.

Accessing the NDIS – the role of diagnosis and functional capacity assessments

The NDIS determines eligibility based on the impact of an impairment, not the type of diagnosis, illness, injury, or how an impairment was acquired. Australians with disability, including those with autism, can access the NDIS if they meet the requirements set out in the National Disability Insurance Scheme

Act 2013, including age, residency, and disability or early intervention requirements. To meet the disability criteria, the person must have an impairment that is likely to be permanent and causes a substantial reduction in functional capacity. Early intervention supports can also be provided for eligible people with likely permanent impairment or children younger than six with developmental delay, where the supports are likely to benefit the person and reduce the impact of their impairment. Evidence of a child's developmental delay can be provided by an NDIS Early Childhood Partner, in order to access early intervention supports (see Table 5.1) (NDIS, 2024[17]). Early Childhood Partners are local organisations funded by the NDIA to deliver the NDIS Early Childhood Approach. They consist of teams of professionals with experience and clinical expertise in working with young children with developmental delays or disability and their families.

Children who do not meet the eligibility requirements for individualised supports through the NDIS, but show evidence of developmental concern, may be able to benefit from other supports delivered through the NDIS Early Childhood Approach. The Early Childhood Approach supports families who have a child with developmental delay or disability by connecting them and their child with the most appropriate supports in their area. The support offered under the Early Childhood Approach may include the provision of information, referral to mainstream services or short-term early intervention (NDIS, 2025[30]).

An applicant must demonstrate substantially reduced functional capacity due to the impact of their impairment in one of the following six areas: communicating, socializing, learning, mobility, self-care, and self-management. Information on functional capacity across these six domains is collected through an access request form, which includes a dedicated section about the applicant's functional abilities. Applicants can either themselves complete that section in their application or have a professional, such as their general practitioner, do so. Additional evidence demonstrating reduced functional capacity should be provided, such as medical reports or other professional statements (NDIS, 2024[17]).

Such evidence may include comprehensive functional capacity assessments, typically conducted by allied health professionals or other qualified specialists, often occupational therapists, who assess the person's functioning in various domains of daily living. In contrast to most other countries, NDIS applicants (or their legal guardians) are responsible for arranging their own capacity assessment, as the NDIA does not conduct functioning assessments in-house, nor does it rely on a single designated state agency. While a NDIS participant may decide to use their NDIS budget to cover the costs of a comprehensive assessment, applicants are often required to cover the costs out of their own pocket. An ongoing reform aims to establish an internal agency to conduct such functioning assessments.

Table 5.1. Disability and early intervention requirements for NDIS eligibility

Disability requirements	Early intervention requirements
The NDIA must have evidence of all the following: • Applicant has a disability attributable to one or more impairments. This means their disability and impairments are linked. • Applicant's impairment is likely to be permanent. • Applicant's impairment means they have a substantially reduced functional capacity to do one or more daily life activities. These activities include moving around, communicating, socialising, learning, undertaking self-care, or self-management tasks. • Applicant's impairment affects their ability to work, study or take part in social life. • Applicant will likely need NDIS supports for their lifetime.	The NDIA must have evidence of all the following: • Applicant has an impairment that's likely to be permanent, or that applicant is a child younger than 6 with developmental delay. • Early intervention will benefit the applicant by reducing their need for supports in the future. • Early intervention will benefit the applicant by either reducing the impact their impairment has on their functional capacity or support their informal supports to build their skills to help them. Or the early intervention will prevent the deterioration of their functional capacity or improve it. • The early intervention supports the applicant needs are NDIS supports.

Source NDIS (2024[17]), *Applying to the NDIS*, https://www.ndis.gov.au/applying-access-ndis/how-apply#applying-to-the-ndis.

In practice, however, functional capacity has not consistently influenced eligibility decisions, partially due to resource and time constraints. The NDIA has relied heavily on diagnostic labels to determine both eligibility for and the scope of NDIS funding. For instance, applicants diagnosed with ASD Level 2 or Level 3 have enjoyed easier access to the NDIS than those with ASD level 1, as only the former two are included in the NDIA access "List A: Conditions that are likely to meet the disability requirements"[1] (NDIS, 2024[17]). In other words, while applicants with ASD Level 1 were typically required to demonstrate that their reduced functional capacity met a threshold to be eligible for the scheme, those with ASD Level 2 and 3 were automatically deemed eligible for NDIS funding without further assessment of their functional capacity, provided the applicant met the rest of the disability requirements. Notably, a medical diagnosis of any condition is not required to be able to access the NDIS – entering the scheme is also possible without a formal diagnosis; to access the NDIS through an access list, however, a medical diagnosis is necessary.

Recently, there has been growing momentum to clearly prioritise functioning over diagnostic categories for the purpose of eligibility. The Independent Review into the NDIS recommended establishing a more consistent and robust approach to assessing eligibility based on functional capacity and a reformed early intervention pathway. Their proposal included removal of the access lists with automatic access (Department of the Prime Minister and Cabinet, 2023[18]).

Once eligibility for the NDIS is determined based on the above mentioned eligibility criteria, a local area co-ordinator or early childhood partner of the NDIA develops a tailored NDIS plan, outlining the specific services and supports the applicant will receive funding for, such as types of therapies and their respective hours, according to the applicant's support needs and in close, in-person collaboration with the applicant. As of 1 January 2025, new participants also receive a Notice of Impairments, which specifies the impairment categories – currently six: intellectual, cognitive, neurological, sensory, physical, and psychosocial – under which they have met the access requirements (NDIS, 2024[17]).

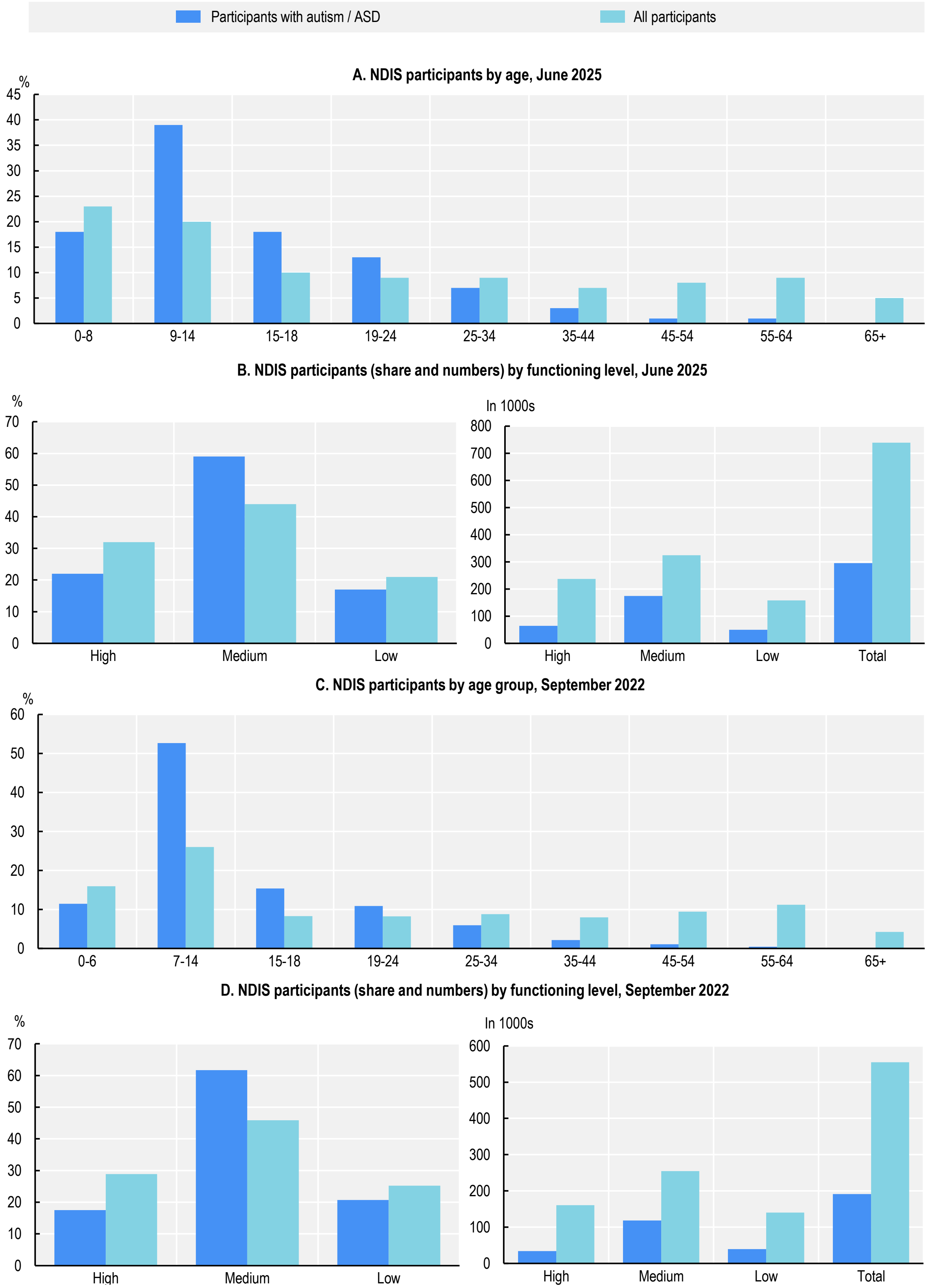
NDIS participation – ASD cases are particularly frequent in young people

In June 2025, Australia's NDIS had 739 414 active participants of which 40% (294 960 individuals) were diagnosed with ASD. Children aged 0-18 with ASD make up a particularly large group among NDIS participants (220 590 individuals), representing approximately 30% of all NDIS participants. While 44% of all NDIS participants are assessed as having a medium level of functioning, this proportion is even higher among participants with ASD, at 59%. 22% of NDIS participants with autism reported having a high level of functioning, compared to 17% with a low level of functioning (Figure 5.8 Panels A and B). Participants with ASD who have additional co-morbidities – particularly intellectual disability – are likely to exhibit higher levels of support needs than those with ASD alone.

Three years earlier, the distribution of participants across categories looked similar, but absolute numbers were considerably lower (Figure 5.8 Panels C and D). In September 2022, Australia's NDIS had 554 917 active participants, 34% of whom (191 251 individuals) had an ASD diagnosis. The overall number of active participants has grown by 33% over the course of those three years, while the number of participants with autism rose by 54%. In September 2022, 151 915 active NDIS participants were children with ASD aged 0-18, accounting for 27% of all NDIS participants at the time.

The distribution of functioning levels among all participants and those with ASD in 2022 was broadly similar to 2025. 46% (44% in 2025) of all NDIS participants were assessed as having a medium level of functioning, compared to 62% (59% in 2025) of NDIS participants with ASD. By contrast, 29% of all NDIS participants were classified as having a high level of functioning, but only 18% of participants with ASD fell into this category. Finally, 25% of all participants reported a low level of functioning in September 2022, compared with 21% of those participants with ASD.

Figure 5.8. NDIS participants in Australia have increased sharply from 2022-2025



ASD: autism spectrum disorder; NDIS: national disability insurance scheme.
Note: Age groups differ slightly between 2022 and 2025: Group 1 includes ages 0-6 and group 2 includes ages 7-14 in 2022 while group 1 includes ages 0-8 and group 2 includes ages 9-14 in 2025. For some NDIS participants, functioning level data is missing.
Source: NDIS (2025[31]), *Autism*, https://dataresearch.ndis.gov.au/reports-and-analyses/participant-dashboards/autism.

StatLink https://stat.link/nmuibs

These figures not only highlight the sharp rise in demand for NDIS supports in recent years but also underscore the growing prominence of participants with ASD – particularly children with ASD – within the scheme. Whereas in 2022, individuals with ASD made up 34% of all participants, by 2025, their share has risen to 40%.

Reform efforts currently underway in Australia will fundamentally transform this picture. Australia's Minister for Health and Aging and Minister for Disability and the National Disability Insurance Scheme recently announced the establishment of a new scheme, the Thriving Kids Program, set to launch in the second half of 2026. The programme will provide support for children with developmental delay and disability with low to moderate support needs, redirecting them away from the NDIS by mid-2027. This will most likely concern many children with ASD.

NDIS spending has risen markedly

While the number of active NDIS participants grew substantially by 33%, the increase in participants with ASD was especially pronounced, rising by 54% between September 2022 and June 2025. This surge in demand for NDIS supports has driven a sharp rise in NDIS spending: total annual payments for participants with autism climbed from AUD 5 571 million in the year ending September 2022 to AUD 9 453 million in the year ending June 2025 – a 70% increase over just three years. The NDIS was not fully rolled out across Australia until July 2020. The continuous growth in demand and public spending on NDIS supports in recent years may thus be partly explained by delays in implementation at the local level, i.e. even once the scheme had become fully available across all geographical areas, it has likely taken time for all eligible individuals to become aware of it, complete the application process, and begin receiving support.

In the 12-month period ending September 2022, AUD 2 958.4 million were allocated to children with ASD aged 0-18, accounting for more than half of all costs on NDIS plans for participants with ASD. By contrast, in the 12-month period ending June 2025, AUD 4 555.6 million were allocated to children with ASD, representing almost half of the total costs for NDIS plans for participants with ASD. While total spending for children with autism increased markedly over this period, their share of overall ASD spending declined slightly.

Average costs of NDIS plans per participant also rose. In June 2025, the average annual cost of a NDIS plan per participant with ASD reached AUD 36 000 (~35.5% of average annual wage of 2024), while the costs for children with ASD under 18 were considerably lower at AUD 24 000 (~23.6% of average annual wage of 2024). Three years earlier, in September 2022, these averages were AUD 31 900 (~34.3% of average annual wage of 2022) and AUD 21 200 (~22.8% of average annual wage of 2022), respectively.

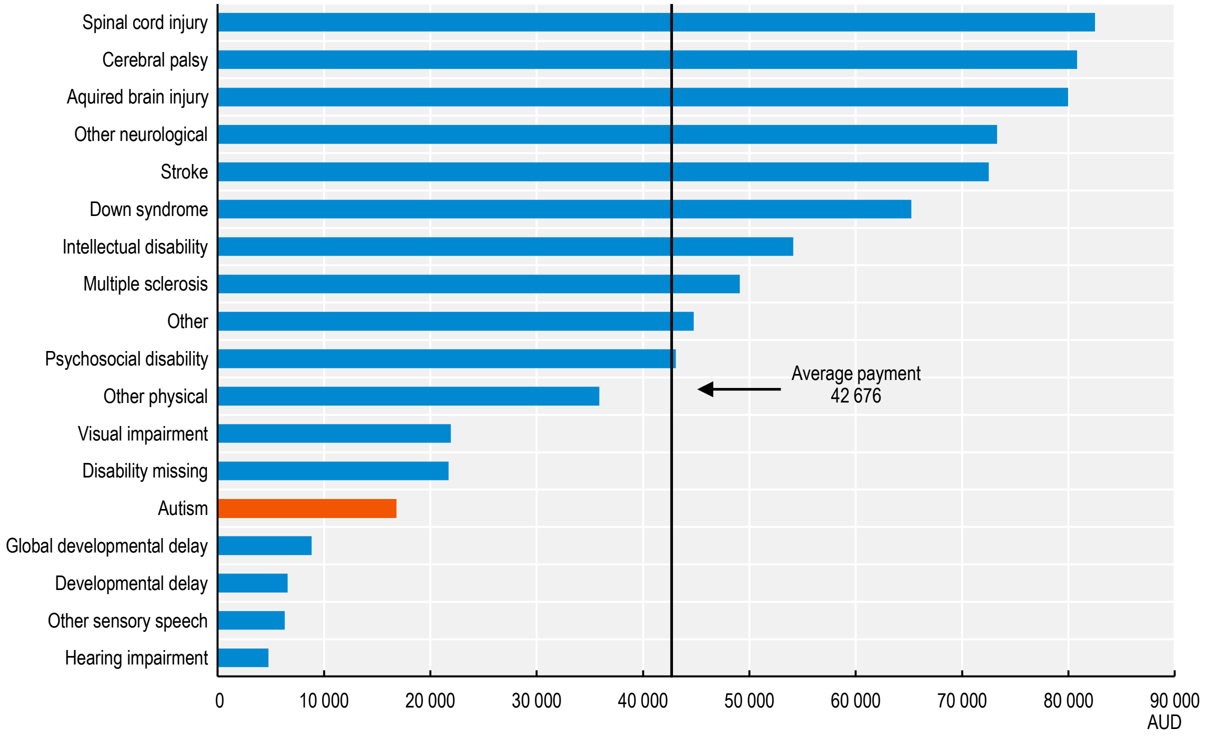
These figures highlight two important dynamics: first, the absolute level of funding for children with ASD has expanded substantially, underscoring their significant presence within the NDIS; second, the relative shift in spending patterns indicates that adults with ASD are accounting for an increasing share of total ASD expenditure, possibly reflecting both rising adult participation and greater recognition of their long-term support needs.

Although participants with ASD represented as much as 40% of all NDIS participants in June 2025, they accounted for only 20% of total annual NDIS spending, which reached AUD 46.35 billion. The contrast is even more pronounced for children with ASD, who represented around 30% of all NDIS participants but received only about 10% of total annual spending on NDIS plans.

On average, an NDIS participant received an AUD 31 130 NDIS plan over the six-month period from July to December 2024, whereas participants with ASD received about half of that amount, averaging only AUD 16 790. In the 12 months from July 2024 to June 2025, the average annual NDIS plan for a child aged 0-18 was AUD 22 044,[2] while the average for children with ASD was AUD 24 000. This likely indicates that the average NDIS budget for a child with ASD is broadly similar to that of an average child in the NDIS. However, as participants age, the average spending for participants with ASD drops relative to the entire participant population, resulting in substantially lower average spending for people with ASD compared to the scheme-wide average. One possible explanation is that adults with autism, on average, may have lower support needs than individuals in other disability cohorts. Figure 5.9 presents average costs of NDIS plans by primary disability for NDIS participants of all ages.

Figure 5.9. Average spending on an NDIS plan for a participant with autism is comparatively low

Average spending on NDIS plans by primary disability, July-December 2024, Australia



NDIS: national disability insurance scheme.
Note: The horizontal line represents the average NDIS budget for all disabilities combined. NDIS participants of all ages.
Source: NDIS (2025[32]), *Explore data*, https://dataresearch.ndis.gov.au/explore-data.

StatLink https://stat.link/zq1ne0

Majority of Australia's social and paramedical services are covered by the NDIS

Before the introduction of the NDIS, disability-specific health and social services were primarily delivered by NGOs funded by state and territory governments. Because coverage and eligibility criteria varied widely across jurisdictions, this system created a fragmented service landscape for people with disability, often leaving significant gaps in provision. The NDIS was established to address these inconsistencies (Community Support, n.d.[33]). Today, only a limited number of public services for people with disability are provided outside the NDIS framework.

Children with ASD can access paramedical therapies via several different channels

Since paramedical therapies fall within the scope of NDIS disability services, the NDIS has become the primary pathway for children with disability to access supports such as occupational therapy, speech and language therapy, and psychotherapy. For children under six years of age, evidence of developmental delay and the associated need for paramedical intervention is sufficient . Aiming to ensure that young children in need of therapy can access it as quickly as possible, this approach reflects Australia's recognition of the importance of early intervention.

Each child entering the NDIS receives an individually tailored budget across the scheme's three budget categories: Core Supports, Capacity Building Supports, and Capital Supports. Paramedical therapies are funded under the Capacity Building Supports budget, specifically within the Improved Daily Living sub-category (NDIS, 2025[34]). This NDIS budget is then managed by the child's plan manager – either parents, the NDIA, or a registered plan manager. The parents or child representative decide how the available funding is allocated across therapy types and hours. The NDIS budget a child receives depends on their assessed support needs. That budget, in turn, determines how many hours of paramedical therapy they can access, thus making eventual therapy hours depend on the child's support needs.

As an alternative to the NDIS, children with disability may access limited Medicare-subsidised allied health services, such as speech or occupational therapy, via a GP-initiated Chronic Disease Management plan (up to five sessions per year) or under mental health initiatives (10 hours/year of psychotherapy) (Australian Institute of Health and Welfare, 2024[35]). These rebates cover only part of the costs. Medicare is Australia's universal public health insurance scheme which provides rebates for a wide range of medical and allied health services.

A third pathway for accessing therapy is through mainstream community health services or hospital-based care. These services, funded by state governments and provided free of charge, are generally available to children with disability who are not NDIS participants, subject to local inclusion and exclusion criteria. However, access varies considerably across regions: some areas have no paediatric therapy services at all, while others operate with long waiting lists, and most services are limited to children under nine years of age. Many children with autism and low support needs, as well as those awaiting a diagnosis, receive therapy through mainstream health services delivered by a range of allied health and nursing professionals – though the availability and consistency of this support differ markedly across the country.

A fourth pathway to access therapies is through the education system. In practice, however, mainstream schools – which are typically the default option for children with disability unless their needs are too extensive to be met at their local school – rarely provide therapy on site. Special education schools are far more likely to integrate therapy into the school day. Whether a child with ASD ultimately receives therapeutic support at school depends not only on the type of school but also, to a large extent, on the individual school's resources and policies. Some schools have sufficient funding to offer therapy, while others do not. Access to paramedical therapy through school is possible in theory but inconsistent in practice and far from standardised. Parents are left dependent on the discretion of the school, both in recognising the need for therapy and in having the resources to provide it as part of educational support.

Similarly, certain schools may allow external providers, for example those funded through the child's NDIS budget, to deliver services on school premises, whereas others – sometimes citing space constraints – decline to do so.

Through the NDIS and schools, there are no fixed minimum or maximum hourly limits for therapy for children with disability, including those with ASD. The number of hours a child ultimately receives depends on several factors, such as their individual support needs, the available NDIS budget, and the school's resources. In these two pathways, access to paramedical therapy is highly individualised. By contrast, Medicare is far more limited in its provision of therapy for children with disability, generally covering only a small number of hours. This cap applies not only to children with ASD but to all children with disability who qualify for Medicare rebates. Children with ASD are not automatically entitled to additional therapy hours beyond those available to other children with disability. This principle applies across all four therapy access pathways described above.

Social services are equally funded through the NDIS budget

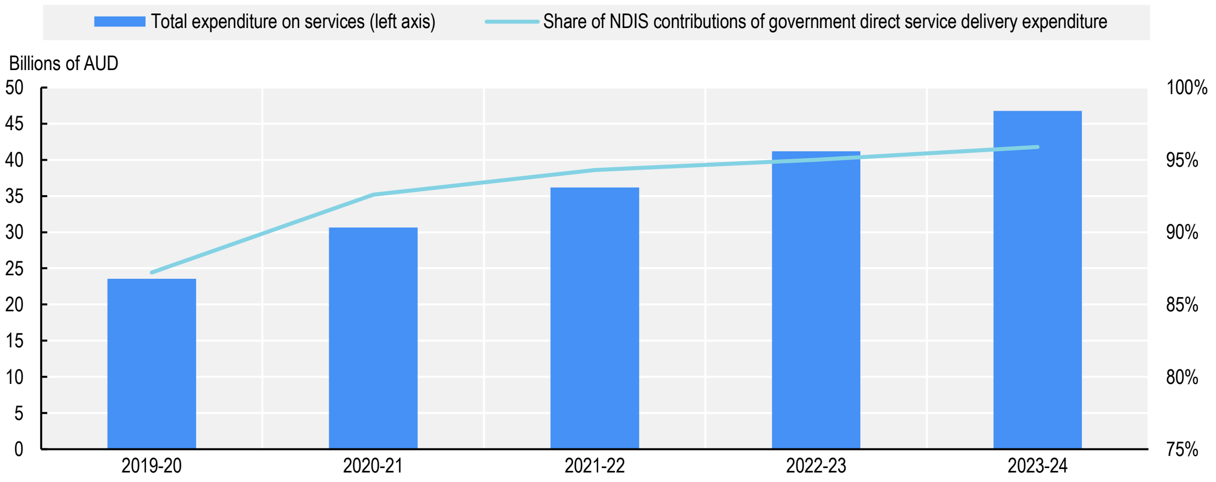
In addition to therapy interventions, the NDIS funds a wide array of social supports for children with disability. This includes short-term respite care and parent/carer capacity-building (such as training programmes) designed to help families manage their child's needs. Where a child cannot travel independently, the NDIS plan's *Transport component* of *Core Supports* can cover specialised transport for attending therapies or other activities. Within *Core Supports*, plans may also cover assistance with daily living tasks and supported social and community participation. Separately, the *Capacity Building* budget can fund *Improved Daily Living Supports*, such as training to enhance the child's independence, and *Increased Social and Community Participation*, which supports skill-building through participation in social and recreational activities (NDIS, 2025[34]).

NDIS makes up largest share of public spending on disability services

The central role of the NDIS in funding disability-related services is clearly reflected in government expenditure on disability services. In 2019/20, NDIS contributions already accounted for around 87% of total government spending on direct service delivery, and this share grew further to about 96% by 2023/24, as the scheme expanded its coverage and alternative service pathways were phased out. Today, the NDIA is by far the dominant actor in enabling Australians with disability to access funds to purchase supports and services themselves. At the same time, total annual government expenditure on disability services has grown substantially, doubling from roughly AUD 23 billion in 2019/20 to around AUD 47 billion in 2023/24 (Figure 5.10).

Figure 5.10. Government expenditure on disability services has grown substantially

Government expenditure on disability services (all persons with disability) and share of NDIS contributions of government direct service delivery expenditure



NDIA: national disability insurance agency, NDIS: national disability insurance scheme

Note: Direct services include: Accommodation support; Community support; Community access; Respite services; Employment services; Advocacy, information and print disability; Other support services; NDIS contributions.

Government direct service delivery expenditure excludes costs, such as for the NDIA agency or administration expenditure. Total expenditure on services, however, includes these administrative costs, though these remain relatively modest.

Source: Australian Government (2025[26]), *Report on Government Services 2025*, https://www.pc.gov.au/ongoing/report-on-government-services/2025/data-downloads.

StatLink https://stat.link/73iogr

An individualised approach to schooling for children with SEN in Australia

Australia's schooling system is primarily the responsibility of state governments, resulting in considerable variation across the country, further reinforced by the significant freedom and flexibility granted to individual schools. For children with ASD, as well as other children with disability, four main schooling options are available: mainstream schools, special education classes, special education schools, and homeschooling. The default pathway is enrolment in the local mainstream school, where children with SEN typically receive individualised support tailored to their needs. Special education schools also exist but their numbers are limited. These schools generally serve children with extensive support needs that cannot be met in a mainstream setting.

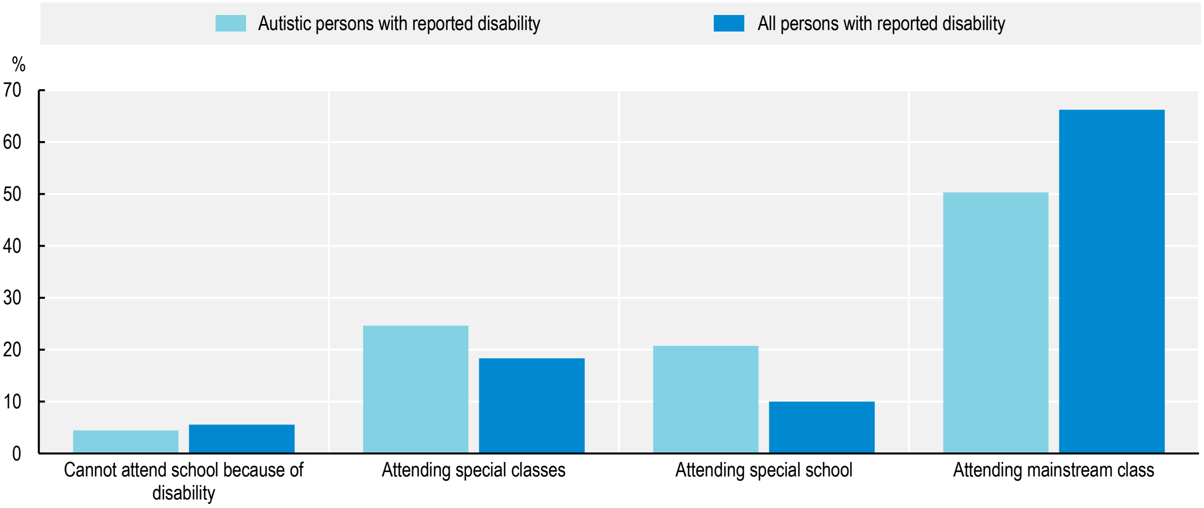
School placement is not determined by a standardised assessment or central authority. Instead, the decision is shaped by parental choice and the school's capacity to provide appropriate support. This gives parents significant influence over their child's educational pathway. However, while parents and specialised professionals, such as therapists or educational psychologists, can provide input and recommendations, the final responsibility for deciding on concrete support measures for the child rests with the school (NSW Government, 2023[36]). These measures are documented in the child's Individual Learning Plan (ILP) and may include additional resources, learning support staff, or paramedical therapies, such as speech and language therapy (Autism Awareness Australia, n.d.[37]). Ultimately, the scope of individual special education support depends on the school's resources and expertise. Access to special education classes or schools may require a formal medical diagnosis.

Inclusion of children with ASD in mainstream schools is common

Compared to the overall population of persons with disability, persons with autism are more likely to attend special education classes (25%) and special education schools (21%). While around 66% of all children with disability are enrolled in mainstream classes, this figure falls to just 50% for children with ASD. In addition, anecdotal evidence suggests that a non-negligible share of children with autism in Australia are educated through home schooling. It is important to note that Figure 5.11 only includes persons with autism who are also classified as having a disability. The picture would likely look quite different if the data covered all pupils with autism, including those without disability – most of whom are likely individuals with ASD but low support needs. In that case, the proportion of children with ASD enrolled in mainstream classes would almost certainly be higher. Nevertheless, among both, students with ASD and disability and the entire population of children with disability, the share enrolled in mainstream classes remains considerable – particularly when compared with many other countries (Figure 4.1).

Figure 5.11. In Australia, children with autism are more likely to attend special education settings

Enrolment patterns of children (aged 5-20) with disability, Australia, 2022



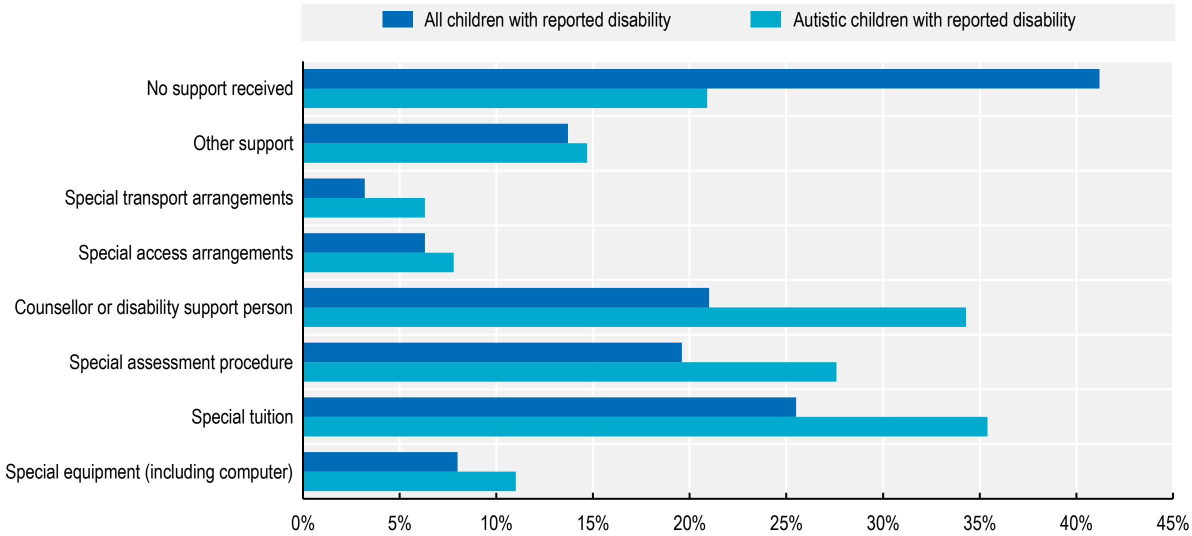
Source: Australian Bureau of Statistics (2024[13]), *Survey of Disability, Ageing and Carers*: *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads.

StatLink https://stat.link/7onvyb

Figure 5.12 aligns with the observations on school attendance, showing that persons with autism are significantly more likely to receive supports or special arrangements in school than the wider population of persons with disability. Whereas 41% of all persons with disability reported receiving no support at school, this share is much lower – 21% – among persons with autism and disability. Substantial proportions of children with autism and disability access special education measures, such as the support of a counsellor or disability support person (34%), special assessment procedures (28%), or special tuition (35%). However, co-morbidities may be a key factor in this context. For instance, it may be the presence of conditions such as intellectual disability, which frequently co-occur with autism, that primarily drives the demand for SEN support, rather than autism itself.

Figure 5.12. Children with autism in Australia also appear more likely to receive SEN support

Type of educational support or special arrangements provided in Australia for children aged 5-20, 2022



SEN: special educational needs.
Source: Australian Bureau of Statistics (2024[13]), *Survey of Disability, Ageing and Carers*: *Autism in Australia*, https://www.abs.gov.au/articles/autism-australia-2022#data-downloads.

StatLink https://stat.link/vd89eq

Australia funds special education supports through disability loadings

Under the Australian Education Act 2013, the responsibility for recurrent school funding is shared between the Australian Government and state and territory governments. Recurrent funding is calculated using the Schooling Resource Standard (SRS) – a needs-based funding model comprising a base amount and up to six additional loadings that address disadvantaged schools and priority equity cohorts, including students with disability (Australian Government - Department of Education, 2025[38]). In 2024, the Australian Government's share of the SRS was estimated to be AUD 29.7 billion, including AUD 4.0 billion for the Student with Disability Loading.

The Australian Government pays recurrent funding to each school's Approved Authority. The Australian Education Act recognises that Approved Authorities are best placed to understand the individual needs of their students and schools. Approved Authorities distribute the Commonwealth funding they receive among their school(s) either:

- according to the Schooling Resource Standard (under subsection 78(4) of the Act); or
- if they are an Approved System Authority for multiple schools, by choosing to redistribute that funding among its individual member schools according to their own needs-based funding arrangements (under subsection 78(5) of the Act).

The level of Student with Disability loading depends on the student's support needs which are classified into four categories: 1) quality-differentiated teaching practice (QDTP); 2) supplementary; 3) substantial; and 4) extensive support. Students at the lowest level – QDTP – do not qualify for a disability loading.

Table 5.2. Only a small share of Australian students receives extensive adjustments at school

Share of students with disability by level of adjustment, 2024

Level of adjustment	Share of students with disability
Support within Quality Differentiated Teaching Practice (QDTP)	28.6%
Supplementary	43.1%
Substantial	18.5%
Extensive	9.9%

Source: Australian Curriculum Assessment and Reporting Authority (2024[39]), *School students with disability*, https://www.acara.edu.au/reporting/national-report-on-schooling-in-australia/school-students-with-disability.

StatLink https://stat.link/wa70hv

In 2024, 1 062 638 school students received an educational adjustment due to disability, representing 25.7% of total enrolments, up from 24.2% in 2023. The largest share of students with disability qualifies for supplementary adjustments (43.1%) (Table 5.2), which is the first adjustment level that also attracts a disability loading (Table 5.3). These loadings increase progressively across the categories – supplementary, substantial, and extensive – and are higher for primary students than for secondary students. The highest loading therefore applies to primary students requiring extensive adjustments, amounting to 312% of the baseline SRS funding for 2025, or AUD 43 652.

Table 5.3. Substantial funding is available for Australian schools through disability loadings

Student with Disability SRS loading by level of adjustment, 2025

School level	Estimated SRS funding amount in 2025	Supplementary	Substantial	Extensive
Primary student	AUD 13 991	42% (AUD 5 876)	146% (AUD 20 427)	312% (AUD 43 652)
Secondary student	AUD 17 582	33% (AUD 5 802)	116% (AUD 20 395)	248% (AUD 43 603)

SRS: schooling resource standard.
Source: Australian Government – Department of Education (2025[38]), *Schooling Resource Standard*, https://www.education.gov.au/recurrent-funding-schools/schooling-resource-standard#toc-srs-loadings.

StatLink https://stat.link/8uxwk7

Spending on SEN supports, allowances, and NDIS for children with ASD

For carers of children with ASD that have only mild support needs, the extent of financial support and NDIS funding is relatively modest – AUD 1 228 per month (see Table 5.4). What makes Australia stand out, however, is that children with mild support needs receive financial support at all – something uncommon in most other countries (see Chapter 3). This is due to two main factors: 1) ASD is included on the List of Recognised Disabilities, which automatically qualifies parents/carers for the Carer Allowance; and 2) the NDIS provides budgets for people with disability to purchase services. While public services are difficult to monetise in most countries, in Australia the calculation is more straightforward, since almost all disability services, such as paramedical therapy, are covered by an NDIS budget. With this important feature of Australia's system in mind, the monetary amounts shown in Table 5.4 may appear relatively modest, given that little to no additional disability services or supports are provided outside the NDIS framework.

When moving from a child with ASD and mild support needs to one with moderate support needs, monthly expenditure more than doubles – AUD 2 488 per month. In such cases, parents receive a substantially larger NDIS budget to purchase the additional services and supports their child would need. On top of this, the government is also likely to incur additional costs through an SRS disability loading, which provides funding to schools to help meet the child's special educational needs.

For a child with severe support needs, monthly expenditure more than doubles again, reaching AUD 5 256. Because such children require extensive assistance across all areas of daily life, their NDIS budget is substantially higher than that of a child with moderate support needs. The same applies to educational support: moving from a supplementary to a substantial adjustment level under the SRS Student with Disability loading represents a sharp rise in costs. By comparison, the monthly allowance of AUD 452 – equivalent to just 5.3% of the average monthly wage in Australia in 2024 – seems negligible, particularly for families where one parent has left the workforce to provide full-time care for their child.

Table 5.4. Most support in Australia is provided through the NDIS

Monthly spending on a child with ASD in Australia by spending category and support needs, 2025

Spending category	Mild support needs (0% working hours reduction)		Moderate support needs (50% working hours reduction)		Severe support needs (100% working hours reduction)	
Financial Benefits[1]	AUD 452		AUD 452		AUD 452	
NDIS[2]	AUD 776		AUD 1 552		AUD 3 104	
Education[3]	AUD 0		AUD 484		AUD 1 700	
Total	AUD 1 228	USD (PPP) 890	AUD 2 488	USD (PPP) 1 803	AUD 5 256	USD (PPP) 3 809

ASD: autism spectrum disorder, NDIS: national disability insurance scheme, PPP: purchasing power parities, QDTP: quality differentiated teaching practice, SRS: schooling resource standard.
Note: Average annual wages of 2023.
1. Financial Benefits: Carer Allowance, Carer Payment, Child Disability Assistance, Carer Supplement.
2. The average annual NDIS payment for a 12-year-old child with ASD is about AUD 18 622 in 2025.
3. Education spending only includes the SRS Student with Disability loading which is divided into four levels of adjustment.
Core assumptions:
a) Parental care – one parent reduces working hours in line with care needs (0%, 50% and 100%).
b) Parents earn the average annual wage and work full-time in baseline scenario.
c) 12-year-old child with formal ASD diagnosis, attending secondary school.
d) Level of adjustment: QDTP for mild support needs, supplementary for moderate support needs, substantial for severe support needs.
e) NDIS: half the average payment for mild support needs, average payment for moderate support needs, twice the average payment for severe support needs.
Source: OECD (2025[40]), *Average annual wages* (dataset), https://data-explorer.oecd.org/s/3sq and compilation of OECD material.

StatLink https://stat.link/4vwupc

Conclusion

Australia's approach to autism has evolved into a comprehensive policy framework among OECD countries, combining universal disability rights with targeted supports. The rapid rise in autism diagnoses, particularly among children, has tested the responsiveness and sustainability of Australia's disability and social protection systems. While the Carer Allowance and Carer Payment continue to provide some income support to families, these payments seem to play a supplementary rather than central role in addressing the needs of families of children with autism. In contrast, the NDIS has become the cornerstone of autism support, providing individualised, needs-based assistance and early intervention. The scheme has been shifting towards greater reliance on functioning assessments to determine eligibility. However, the increasing share of NDIS participants with autism raises questions about long-term fiscal sustainability and the balance between early support and dependency on the scheme.

In education, inclusion has become a key policy goal, yet progress remains uneven. While most children with autism are now supported within mainstream schools, a significant share continue to attend special education settings, highlighting the need for continued investment in teacher training, classroom adjustments, and cross-sector collaboration. The gradual transition toward inclusive education should therefore be accompanied by strengthened capacity within schools to meet diverse learning and behavioural needs.

Looking ahead, the implementation of the National Autism Strategy (2025-2031) provides an opportunity to consolidate gains and address remaining gaps in co-ordination and service delivery. Ensuring that supports are equitably distributed across levels of need, that families can navigate available assistance without undue complexity, and that education and health systems are better aligned will be critical. Continued efforts to recognise and respond to the diversity of experiences within the autism community – including those who identify as having autism but not disabled – will also help ensure that policies reflect the full spectrum of needs and perspectives. Sustaining Australia's progress will require balancing individualised supports with broader system reforms to promote inclusion, efficiency, and long-term well-being for people with autism and their families.

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Notes

[1] Access lists, such as List A, were introduced as a mechanism during the transition phase of the Scheme, to expedite consideration of access for some cohorts. The lists do not override the provisions of the NDIS Act and an applicant does not need a condition on a list to gain access to the NDIS.

[2] This estimate is based on the average spending for the six-month period from 1 July to 31 December 2024 (AUD 11 022), which was doubled to approximate the average annual spending for a child, assuming spending remained relatively stable for the following six months (1 January – 30 June 2025). The estimate for the six-month period from 1 July to 31 December 2024 is calculated from total payment amount for children aged 0-18 divided by total number of active children aged 0-18.

6 Autism policies in Germany

This chapter examines Germany’s evolving approach to supporting individuals with ASD, highlighting a shift from limited recognition to a comprehensive rights-based framework. Over the past two decades, Germany has strengthened its legal foundations through the Social Code, the Disability Equality Act, and reforms under the Federal Participation Act, aligning national policy with the United Nations Convention on the Rights of Persons with Disabilities. While ASD prevalence data remain restricted to documented diagnosis in inpatient and outpatient care, Germany has introduced rigorous clinical guidelines for ASD diagnosis and therapy, widely respected by professionals. The chapter explores two key benefits: the Care Allowance, based on assessed care needs via long-term care insurance, and Integration Assistance, which provides tailored services or personal budgets to promote social participation and educational inclusion. It also reviews statutory health insurance coverage for therapies and the gradual, yet modest, progress toward inclusive education.

In Brief

Autism policy in Germany: Legal framework and available supports

- Initially, Germany was slow to recognise the rights and needs of people with ASD. However, in the last two decades Germany developed a strong legal basis for the protection of rights of people with disability, which includes individuals with autism.
- Germany has no available data on the population prevalence of autism or rates of diagnosis, although data on documented autism diagnoses in inpatient and outpatient care indicate a considerable increase.
- Germany has rigorous guidelines for the diagnosis and therapy for children, adolescents and adults with ASD. Although the guidelines are not compulsory, they are generally respected by professionals and considered as good practice in the medical community.
- To access Germany's Care Allowance administered by statutory long-term care insurance, a child with ASD must undergo an assessment of care needs conducted by an independent medical service. The assessment evaluates the child's day-to-day support needs, determines whether these needs entitle the care provider to the allowance, and if so, assigns the child to one of five care-need levels. Although medical documentation is required, a formal medical diagnosis, such as of ASD, is neither mandatory for eligibility nor sufficient on its own to qualify for a Care Allowance.
- The number of children assessed for Care Allowance has risen considerably over the past decade, to about 162 000 assessments in 2024. This growth is likely linked to a far-reaching reform in 2017 expanding access for individuals with psychological or psychiatric conditions, including children with ASD, who had previously been disadvantaged in the assessment criteria.
- Children with an ICD-10 diagnosis F84 (pervasive developmental disorders, see Chapter 2) account for a substantial proportion of all children eligible for Care Allowance – around 15%. The largest single diagnostic group are children with a F90 (ADHD) diagnosis, representing roughly 21% of children receiving a Care Allowance.
- Uptake of Integration Assistance, Germany's other major financial support for children with disability – provided either as in-kind service or through a personal budget – has also increased in recent years. While the number of children with mental health conditions receiving the benefit continues to rise, growth among children with physical and/or intellectual disability appears to have slowed. Typically, children with ASD qualify for Integration Assistance under Social Code VIII (for mental disability), unless they also present intellectual and/or physical disabilities, in which case Social Code IX applies.
- Germany's statutory health insurance system covers medically prescribed rehabilitation services for children with disability, such as occupational and speech therapy. The Integration Assistance plays a more prominent role in financing supports aimed at social participation and educational inclusion – for instance, an integration aide at school for children attending regular schools who require additional support.
- Despite a gradual shift toward inclusive education over recent years, most of Germany's nearly 600 000 students with SEN in 2023/24 remain enrolled in special education schools.

Introduction

Germany's approach to supporting individuals with ASD has undergone significant transformation over the past two decades. Historically, recognition of the rights and needs of people with autism was limited, leaving families to advocate for services through legal channels. Today, Germany has established a robust legal framework aligned with international standards, notably through the ratification of the United Nations Convention on the Rights of Persons with Disabilities in 2009 and reforms under the Federal Participation Act (*Bundesteilhabegesetz*). While comprehensive population prevalence data on ASD remain unavailable, Germany has implemented rigorous clinical guidelines for diagnosis and therapy, widely respected within the medical community.

Beyond healthcare, Germany offers a multi-layered system of financial and social support designed to address the diverse needs of children with disability, including those with ASD. Two key benefits – Care Allowance and Integration Assistance – play complementary roles: Care Allowance compensates family caregivers based on assessed care needs, while Integration Assistance provides tailored services or a personal budget to promote social participation and educational inclusion. These measures are supported by statutory health insurance, which covers medically prescribed therapies such as occupational and speech therapy, ensuring that core rehabilitation services are accessible without direct cost to families. Education policy has also seen gradual progress towards inclusion, with increasing numbers of students with special educational needs (SEN) attending regular schools, although special schools continue to enrol most students with SEN, reflecting the ongoing challenge of implementing inclusive education nationwide.

Initially Germany was slow to recognise the needs of people with autism

Historically, people with autism in Germany often lacked recognition and support. Autism Germany, now the German federal Association for Autism (*Bundesverband autismus Deutschland e.V.*), was founded in 1970 by parents of children with ASD, to provide support for people with autism and their families. In parallel, the first autism therapy centres were established, an important step at a time in Germany when parents had to go to court to get therapy financed for their children, as service providers disputed the need for special autism therapies (Frese, 2017[1]).

Germany has developed a strong legal basis for the protection of rights of people with disability

In the past two decades, Germany's disability rights framework has progressively evolved, strengthening considerably the rights of people with disability, including children with ASD. Legal provisions include (Frese, 2017[1]; Bundestag, 2021[2]):

- **Social Code (*Sozialgesetzbuch*, SGB) IX**, which came into force in July 2001 and contains general provisions on the rehabilitation and participation of persons with disability in society. According to Section 2 of the Social Code, a person with disability is a person who has "physical, mental, intellectual or sensory impairments which, in interaction with attitudinal and environmental barriers, are likely to hinder their equal participation in society for more than six months. An impairment as defined in the Social Code exists if the physical condition and state of health deviate from the condition typical for the age" (Bundestag, 2016[3]). Additionally, regulations on "long-term care insurance" (an independent branch of the social insurance system) were introduced under the Social Code (SGB) XI in 1995 and apply to everyone with statutory or private health insurance.
- The **Disability Equality Act (*Behindertengleichstellungsgesetz*, BGG)** came into effect in May 2002, laying down the equal treatment of people with disability in all areas of life and accessibility in the public sphere.

- The **General Equal Treatment Act (*Allgemeine Gleichbehandlungsgesetz*, AGG)** came into force in August 2006, regulating the equal treatment of people with disability in civil law.
- In March 2009, Germany ratified the United Nations Convention on the Rights of Persons with Disabilities which lays down important principles such as inclusive education and anti-discrimination. To implement the UNCRPD, Germany has passed comprehensive reforms of the Social Code, implemented through the **Federal Participation Act (*Bundesteilhabegesetz*, BTHG)**, which has come into effect in stages between 2017 and 2023. The Social Code promotes self-determination, independent living and community inclusion. Notably, the Act updated SGB IX and SGB XII on social assistance to improve access to Integration Assistance and other services for people with disability, including people with autism.

Germany's data on autism is limited to documented diagnoses in routine care

In Germany, in contrast to other OECD countries, no data on the population prevalence of ASD is available to date. Administrative information and frequencies of autism diagnoses and cases are available using routine data from outpatient and inpatient care.

Analysis of outpatient claims data from a statutory health insurance fund (*Handelskrankenkasse*) for 2023 indicates that the proportion of children, adolescents, and young adults (aged 0-24 years) with an outpatient ASD diagnosis increased from 0.4% in 2013 to 0.8% in 2019. Subsequently, this proportion remained largely unchanged until 2022. The most frequently documented outpatient diagnoses among these cases were F84.0 childhood autism (36.8%) and F84.5 Asperger syndrome (31.9%), based on the ICD-10 classification system (Nymbach, 2023[4]).

Analyses of outpatient mental disorder diagnostic spectrum were conducted by the Central Research Institute of Ambulatory Healthcare in Germany on behalf of the Robert Koch Institute. These analyses revealed that both the absolute number and the proportion of ASD diagnoses among all outpatient mental disorder diagnoses increased between 2012 and 2024. The number and proportion of documented F84.0 childhood autism diagnoses rose from 0.56% (n=61 723) to 1.41% (n=252 414), the number of F84.1 atypical autism diagnoses from 0.11% (n=12 342) to 0.25% (n=44 183), and the number of F84.5 Asperger syndrome diagnoses from 0.28% (n=30 906) to 0.48% (n= 85 919) (Thom et al., 2024[5]).

The same trend was observed among adults. Between 2012 and 2024, the number and proportion of documented F84.0 childhood autism diagnoses increased from 0.06% (n= 61 559) to 0.13% (n=207 697), the number of F84.1 atypical autism diagnoses from 0.01% (n= 14 833) to 0.04% (n=59 947), and the number of F84.5 Asperger syndrome diagnoses from 0.02% (n=23 315) to 0.10% (n= 162 066) (Thom et al., 2024[5]).

Additional information is available from the Federal Statistical Office on the main diagnoses of patients during hospital stays. While autism rarely requires inpatient treatment – making these data unsuitable for estimating autism prevalence or for international comparisons – they do provide information on the frequency of diagnoses in inpatient care. Between 2000 and 2023, these frequencies increased substantially. The number of cases for pervasive developmental disorders (F84) rose almost threefold, from 1 283 in 2000 to 3 842 in 2023 (Statistisches Bundesamt, 2026[6]).

Germany has detailed guidelines for both the diagnosis and treatment of ASD

Germany has so-called S3 guidelines for a wide range of diseases and medical conditions that outline diagnostics and therapeutic treatment for the healthcare system. S3 guidelines are the most rigorous type of guideline issued by the Association of the Scientific Medical Societies in Germany (*Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften*, AWMF) and they combine evidence-based systematic analysis with a structured consensus-based process by an expert steering committee – thereby combining the requirements for an S1 guideline, which is based on recommendations by experts, and an S2 guideline, which is based on a structured consensus process or a systematic literature review.

The latest guidelines for autism spectrum disorders in childhood, adolescence and adulthood were issued in two parts: diagnostics and therapy. Part 1 on diagnostics was issued in 2016 and is currently being revised. Part 2 on therapy was published in 2021 and is valid until 2026 (AWMF, 2016[7]; AWMF, 2021[8]). According to these guidelines, Germany still uses and accepts older classifications for autism, as understood under DSM-III-R, DSM-IV-TR (Autism, Asperger's disorder, PDD-NOS), and ICD-10 (F84.0 Early Childhood Autism, F84.5 Asperger Syndrome, F84.1 Atypical Autism), in addition to the newer DSM-5 classification of ASD (ibid.). As the healthcare system still uses ICD-10 coding, diagnoses are often made, or at least recorded, according to ICD-10 criteria, i.e. autism is still often referred to as pervasive developmental disorder rather than autism spectrum disorder.

Best practices for the diagnostic process in Germany

In Germany, most people receive their autism diagnosis from the public health system, but both in the public and in the private sector professionals generally follow the above-mentioned S3 guidelines, which are considered industry standard. Part 1 of the S3 guidelines breaks down the diagnostic process into three steps: screening, referral and the diagnostic procedure itself (AWMF, 2016[7]).

Screening

Screening is generally done by the primary healthcare provider, if a child has pre-defined risk factors and at least one additional symptom indicating autism. Pre-defined risk factors include (ibid.):

- Genetic findings with increased rate of ASD;
- Drug exposure during pregnancy;
- Viral infection during pregnancy;
- Birth weight under 1500g;
- Premature birth;
- Neonatal seizures;
- Siblings with ASD

Screening tools are optional, but if used, the guidelines recommend screening tools depending on the age and ability of the child. These are the following (ibid.):

- for toddlers: Modified Checklist for Autism in Toddlers (M-CHAT);
- for preschool and elementary school-aged children: Social Communication Questionnaire (SCQ);
- for primary school aged children and adolescents with lower support needs: Marburg Assessment Scale for Asperger's Syndrome (MBAS);
- for children and adolescents with intelligence impairment: Scale for the Assessment of Autism Spectrum Disorders in the Less Abled (SEAS-M).

Referral

According to the S3 guidelines, referral should be made to a centre specialising in ASD diagnostics, if ASD seems clinically likely and/or if parents/caregivers also report corresponding symptoms (ibid.).

Diagnostic procedure

The diagnostic procedure is the main part of the assessment, at the end of which one or more professionals may establish an autism diagnosis. The assessment includes a variety of components, requiring a wide range of information to be gathered. According to the S3 guidelines, the assessment should be conducted by one or more healthcare professionals knowledgeable and skilled in mental and developmental disorders and in the use and interpretation of the appropriate screening instruments. The guidelines also describe the skills required by a professional participating in the diagnostic procedure, including skills in differential diagnosis, in performing internal medicine-neurology examinations, and in professional counselling, among others. The guidelines also require that the diagnosis is made in consultation with one of the following (AWMF, 2016[7]):

- a specialist in child and adolescent psychiatry and psychotherapy, or
- a specialist in child and adolescent medicine who is specially qualified for this purpose.

The diagnostic process should include a detailed medical history and several medical examinations, such as an assessment of hearing and visual disturbances and a complete internal neurological examination. Autism-specific diagnostic testing should be performed, including a standardised interview with a parent or guardian, with the use of Autism Diagnostic Interview – Revised, ADI-R, recommended for children, and semi-standardised behavioural observation, with CARS (Childhood Autism Rating Scale) and ADOS-2 (Autism Diagnostic Observation Schedule, Second edition) as the recommended tools. The guidelines highlight that standardised diagnostic instruments should be used in addition to clinicians' observations and not replace a full autism assessment. Throughout the assessment process, differential diagnosis should also be considered and the child's strengths, skills, level of impairments and needs should also be evaluated (AWMF, 2016[7]).

Germany offers a carer allowance and an additional cost allowance

Germany provides two financial benefits for children with disability, both of which are available to families of children with ASD: Care Allowance (*Pflegegeld*) and Integration Assistance (*Eingliederungshilfe*), with the latter functioning as an additional cost allowance. Very few individual federal states offer supplementary benefits, as is the case in Bavaria where individuals with a care need level of 2 or higher are entitled to an additional annual payment of EUR 1 000 (Bayerisches Landesamt für Pflege, n.d.[9]).

Care Allowance provides cash support for home-based care

Entitlement to Care Allowance, which is available to individuals with support needs of all ages, is primarily determined by the assessed level of care needs and designed to compensate those providing such care, in most cases family members. It is a monthly, non-means-tested benefit administered through the long-term care fund (*Pflegekasse*). Care Allowance is structured according to five levels of care need (the degree of care, or *Pflegegrad*), corresponding to the following monthly amounts in 2025 (Bundesministerium für Gesundheit, 2025[10]):

- Level 1: EUR 0
- Level 2: EUR 347 (approximately 8.3% of the average monthly wage in Germany in 2024)
- Level 3: EUR 599 (approximately 14.3%)
- Level 4: EUR 800 (approximately 19.1%)
- Level 5: EUR 990 (approximately 23.6%)

In addition, a supplementary Relief Amount (*Entlastungsbetrag*) of up to EUR 131 per month is available at all care levels (1-5). This amount is offered to reimburse quality-checked provisions to ease the workload of informal carers and to promote the independence and self-determination of people with care needs in the organisation of their everyday life (Pflege, 2025[11]). While individuals assessed at Level 1 (*Pflegegrad 1)* are not entitled to a Care Allowance, they are eligible for a range of other supports, including the Relief Amount, individual care counselling provided by their long-term care insurance, subsidies for aids and home adaptations, and free care training courses for relatives (Bundesministerium für Gesundheit, 2025[12]).

An assessment of the need for care is central to accessing the Care Allowance

While some form of medical documentation regarding the child's or adult's condition is required to qualify for Care Allowance, a formal medical diagnosis is neither mandatory nor sufficient on its own to guarantee eligibility. The primary determinant of entitlement is the individual's assessed need for care and support. The Medical Service (*Medizinischer Dienst*) is commissioned by the person's long-term care insurance and typically conducts these assessments in-person through a home visit or, if permitted by legal requirements, a telephone interview. Medical services are staffed by specially trained care professionals and physicians. The assessment is generally carried out by a single representative of the Medical Service, who consults directly with the person receiving care and/or their primary caregiver (Medizinischer Dienst, 2025[13]).

The assessment of care needs follows a standardised protocol that evaluates the child's independence and required level of support across six key domains of daily life. Each domain is weighted differently in the overall evaluation of care needs: 1) mobility (10%); 2) cognitive and communicative abilities (15%); 3) behaviour and psychological issues (15%); 4) self-care (40%); 5) managing illnesses and therapies (20%); and 6) social participation and daily life structuring (15%). For each domain, the Medical Service assesses the extent of care and support a child requires compared to a child of the same age without a disability or long-term health condition. The assessor assigns scores for each domain, where higher scores indicate greater care needs. The weighted sum of these scores determines the child's overall care level (*Pflegegrad*), which in turn defines the corresponding monthly allowance amount. The five care levels are divided as follows (Pflegeverband, 2025[14]):

- Level 1: 12.5 to under 27 points
- Level 2: 27 to under 47.5 points
- Level 3: 47.5 to under 70 points
- Level 4: 70 to under 90 points
- Level 5: 90 to 100 points

In addition to determining the level of care need, the Medical Service may also suggest, where appropriate, assistive devices, preventive measures, medical rehabilitation, or adaptations to the home environment to help sustain a person's independence or improve caregiving conditions. Reassessments of children's care needs are typically carried out every two years, although the precise frequency may vary depending on individual circumstances. Reassessments can also be initiated at any time if the condition of the person receiving care changes; for example, the person concerned or their caregiver may request a reassessment when care needs are believed to have increased (Dr. Weigl & Partner, 2025[15]).

A major reform of Germany's long-term care system – the "*Care Strengthening Acts*" of 2015-2017 – fundamentally changed both the terminology and the methodology of care assessments. The reform introduced a more holistic approach evaluating physical, cognitive, and psychological or psychiatric impairments equally and comprehensively. As a result, individuals with psychological or psychiatric conditions, previously highly disadvantaged in the assessment process, have since gained improved access to the Care Allowance (Medizinischer Dienst Bund, 2025[16]).

The total number of Care Allowance recipients has been growing steadily

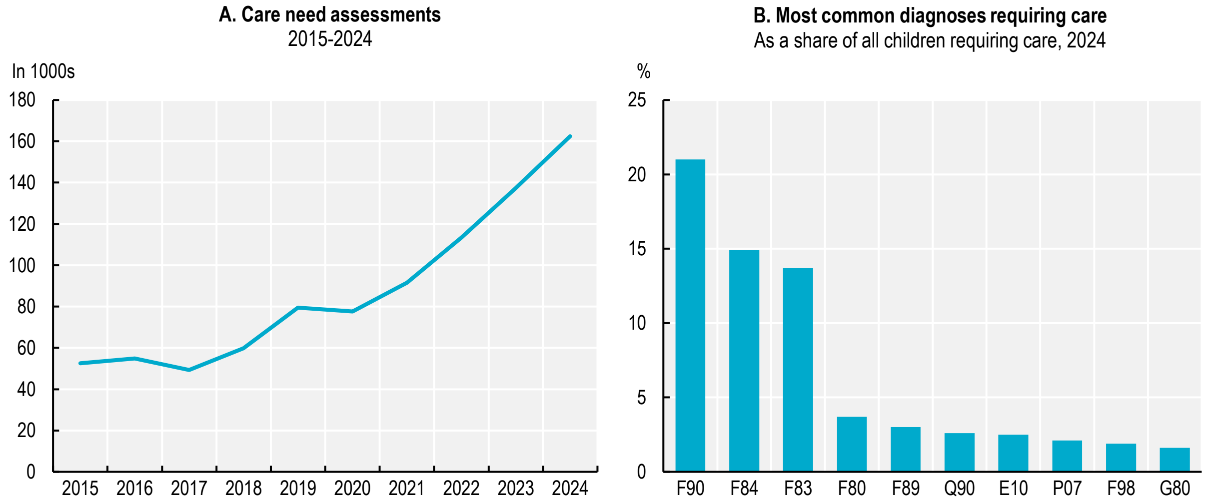
Since the major reform of Germany's care system in 2017, the number of care needs assessments of children has risen markedly, with only a brief plateau in 2019-2020. The number of assessments has increased from approximately 53 000 in 2015 to around 162 000 in 2024 (Figure 6.1, Panel A).

In 2024, the sizes of diagnostic groups among children requiring care were far from equal. Three diagnostic groups clearly stand out: F90 (hyperkinetic disorders), F84 (pervasive developmental disorders), and F83 (mixed specific developmental disorders). Hyperkinetic disorders account for roughly 21% of all children with care needs. A diagnosis of pervasive developmental disorders, which includes autism, represents the second largest group at around 15%, followed closely by mixed specific developmental disorders at approximately 14% (Figure 6.1, Panel B). All other common diagnoses each represent fewer than 5% of children with care needs.

The distribution of care levels among children closely mirrors that of the overall population assessed for care needs (Figure 6.2). Approximately 10% of all assessed individuals and children are determined ineligible for Care Allowance. Most recipients, children and adults alike, are classified under care Level 2 or level 3, with Level 2 being most common. Care Level 5 is by far the least frequent among both children and all assessed individuals. However, children are slightly less likely to be classified in the higher care levels (4 and 5), and more frequently fall into Level 2 (around 37%) or Level 3 (approximately 28%).

Figure 6.1. Care Allowance assessments for children in Germany have tripled since 2017 reform

Assessments of children (aged 0-18) to determine care needs and most common diagnoses among children requiring care



Note: F90: Hyperkinetic Disorders; F84: Pervasive Developmental Disorders; F83: Mixed Specific Developmental Disorders; F80: Specific Developmental Disorders of Speech and Language; F89: Unspecified Disorder of Psychological Development; Q90: Down Syndrome; E10: Type 1 Diabetes Mellitus; P07: Disorders related to short gestation and low birth weight, not elsewhere classified; F98: Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence; G80: Infantile Cerebral Palsy.
Source: Medizinischer Dienst Bund (2025[16]), *Report Pflegebedürftigkeit 2025*, https://md-bund.de/themen/pflegebeduerftigkeit-und-pflegebegutachtung/report-pflegebeduerftigkeit.html.

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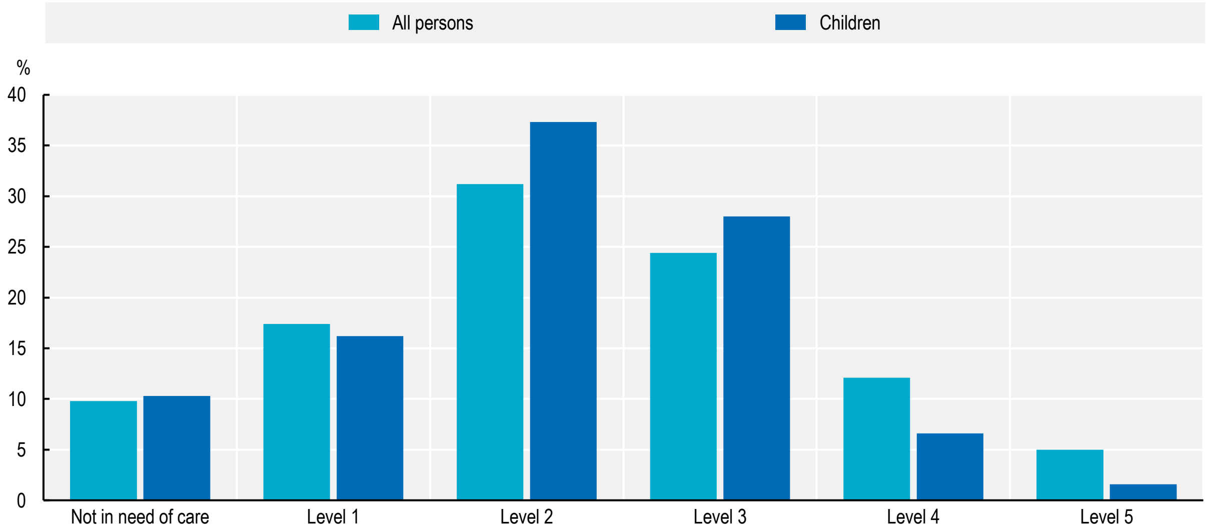
Figure 6.2. Almost two in three children are granted a Care Allowance at Level 2 or 3 in Germany

Distribution of Care Allowance recipients by care level, for all people and children (ages 0-18), 2024



Note: Levels 1-5: Level of care needs on a 100-points scale, e.g. Level 1=12.5-27 points and Level 5=90-100 points. Those “not in need of care” do not receive a Care Allowance.
Source: Medizinischer Dienst Bund (2025[16]), *Report Pflegebedürftigkeit 2025*, https://md-bund.de/themen/pflegebeduerftigkeit-und-pflegebegutachtung/report-pflegebeduerftigkeit.html.

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Integration Assistance offers funding for disability-related services

In addition to Care Allowance, children with ASD and their families can access Integration Assistance (*Eingliederungshilfe*), which serves a different purpose: to cover the costs of necessary disability-related services and supports. Unlike Care Allowance, Integration Assistance is not organised into predefined levels but fully individually tailored. The exact scope and amount of support a child or adult receives – since the benefit is accessible across all ages – depends entirely on their assessed needs (betanet, 2025[17]).

In contrast to Care Allowance, Integration Assistance is partially means-tested, although thresholds are set at comparatively lenient levels. For Integration Assistance under Germany's Social Code (*Sozialgesetzbuch,* SGB) IX, income and assets of parents are considered if they exceed certain thresholds. Many support services for children covered by Integration Assistance under SGB IX are exempt from co-payments. For Integration Assistance under SGB VIII, parents of children under the age of 18 are not required to contribute financially to outpatient services, while co-payments for inpatient or daycare services may be requested depending on household income (betanet, 2025[17]).

What further distinguishes Integration Assistance from Care Allowance, as well as from many comparable benefits in other countries, is that it is not strictly a cash allowance. It may be provided as an in-kind benefit, such as an integration aide in school or autism-specific therapies, or alternatively as a financial benefit. Eligible individuals can therefore choose between receiving services directly or obtaining a personal budget (*Persönliches Budget*), a self-managed monthly payment capped at the cost of equivalent publicly funded services, allowing them to purchase supports privately (Bundesministerium für Arbeit und Soziales, n.d.[18]). This flexible structure of Germany's Integration Assistance aims to empower individuals with disability by offering greater autonomy and choice over both the provider and the manner in which their support is delivered.

Integration Assistance for children is accessible through two different channels

Children with ASD may access Integration Assistance under two different statutory frameworks and correspondingly different administrative bodies depending on the type of disability identified. A child with ASD is typically covered under Germany's Social Code (SGB) VIII and receiving Integration Assistance via the Youth Welfare Office (*Jugendamt*). Integration Assistance under SGB VIII applies exclusively to children and young adults with mental disorders, including ASD, generally up to age 21 and in exceptional cases up to age 27. Where a child with ASD also has a physical and/or intellectual disability, access to Integration Assistance shifts to SGB IX, with the competent authority varying across federal states. Adults, typically from age 21 onward, are covered under SGB IX regardless of disability type (betanet, 2025[17]).

Eligibility for Integration Assistance under SGB VIII requires that the child has a mental or behavioural disorder that significantly impairs, or is expected to impair, social participation for more than six months. A formal medical diagnosis, including the relevant ICD-10 code, must be provided to confirm the disorder. Such a diagnosis of a mental disorder must be issued by one of the following qualified professionals (betanet, 2025[17]):

- a doctor specialising in child and adolescent psychiatry and psychotherapy,
- a child and adolescent psychotherapists,
- a psychotherapist with additional training in the treatment of children and adolescents, or
- a doctor or psychotherapist with experience in mental disorders in children and adolescents.

For ASD specifically, the diagnosing clinician must also confirm that no physical or intellectual disability is present to establish the Youth Welfare Office's jurisdiction under SGB VIII rather than SGB IX. However, a diagnosis alone is insufficient (betanet, 2025[17]). The Youth Welfare Office must additionally determine whether the child's mental disorder results in current or impending participation restrictions (*Teilhabebeeinträchtigung*), such as difficulties in attending school or engaging in social and leisure activities and identify the specific support needs. This assessment is carried out in a consultation with the child, their parents, and ideally the diagnosing physician, and may include input from other professionals such as therapists and teachers as well as relevant documentation, such as school reports. The outcome of the assessment and consultation is a Help Plan (*Hilfeplan*) defining the child's support needs, goals, and the services required to ensure participation in everyday life on an equal basis with others. Progress is reviewed in regular follow-up meetings where adjustments to the Help Plan may be made (betanet, 2025[19]).

The application procedure for Integration Assistance under SGB IX for children with ASD and co-occurring physical and/or intellectual disability is largely similar, but the needs assessment is somewhat more standardised and comprehensive. In addition to requiring a formal medical diagnosis, it also entails a collaborative in-person process between social workers, the child, and their parents, drawing on medical, psychological, and educational documentation to determine participation restrictions and necessary supports, including their type and frequency. As under SGB VIII, professionals working closely with the child may be invited to contribute. The assessment is strongly person-centred, based on the ICF framework, and focusses on how the child's impairment affects their daily life – in areas, such as self-care, mobility, communication, learning, and social interaction – and on services and supports that are required (betanet, 2025[20]). For both SGB VIII and SGB IX, comprehensive reassessments should take place regularly and at least every two years to ensure support remains appropriate and responsive to the child's developmental progress.

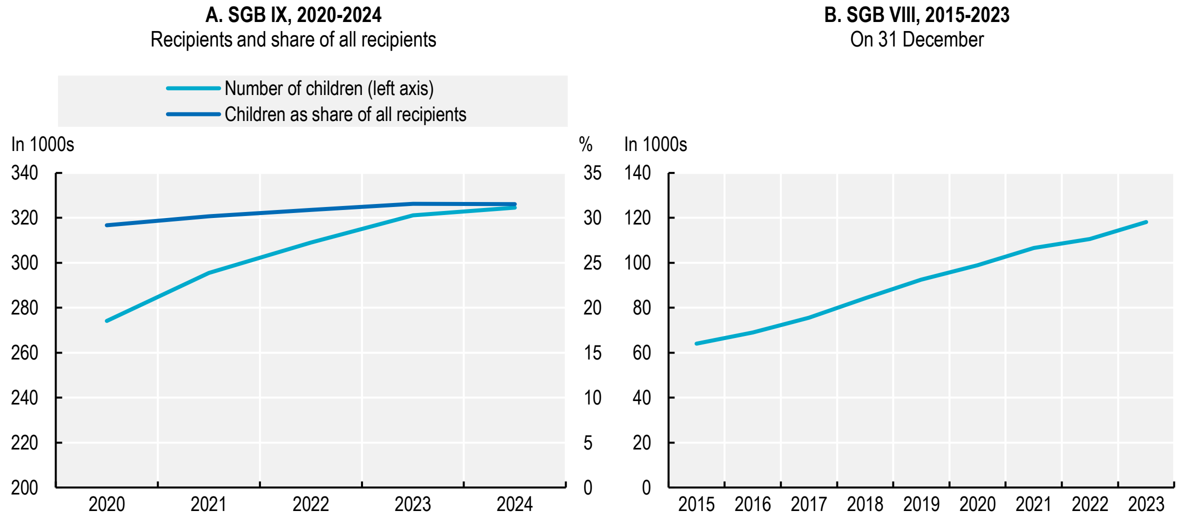
A considerable number of children benefit from Integration Assistance

Over recent years, the number of children with disability receiving Integration Assistance under both SGB IX and SGB VIII has risen steadily. The annual number of children supported under SGB IX has grown from roughly 274 000 in 2020 to about 325 000 in 2024 (Figure 6.3). Similarly, children benefiting from Integration Assistance under SGB VIII at the end of each year increased from about 92 000 in 2019 to 118 000 in 2023. Adding SGB IX and SGB VII entitlements together, this is about three times the number receiving a Care Allowance. While growth under SGB IX appears to be slowing, the number of children supported under SGB VIII (i.e. those with mental disorders) continues to rise sharply. Notably, the share of children among all individuals receiving Integration Assistance under SGB IX has remained relatively stable at around 30% (Panel A, Figure 6.3). It is also important to mention that a major reform reassigned Integration Assistance from SGB XII to SGB IX in the year 2020, potentially affecting data availability in 2020.

In parallel to the growing uptake of Integration Assistance, annual costs under SGB IX for adults and children together have steadily increased in recent years, from EUR 20.8 billion in 2020 to EUR 28.7 billion in 2024, an increase of about 37.7% (Federal Statistical Office Germany – Destatis, 2025[21]).

Figure 6.3. The number of children receiving Integration Assistance in Germany continues to rise

Children and young adults receiving Integration Assistance under SGB IX and SGB VIII



SGB: *Sozialgesetzbuch* (Social Code)
Note: Children aged 0-17 (Panel A); children and young adults up until 27 years of age but typically only until 21 years (Panel B).
Source: For Integration Assistance under SGB VIII: Federal Statistical Office Germany – Destatis (2025[22]), *Erzieherische Hilfen/Beratungen: Deutschland, Jahre, Geschlecht, Migrationshintergrund, Art der Hilfe*, https://www-genesis.destatis.de/datenbank/online/table/22517-0002/search/s/MjI1MTctMDAwMg%3D%3D. For Integration Assistance under SGB IX: Federal Statistical Office Germany – Destatis (2025[23]), *Empfänger von Eingliederungshilfe: Deutschland, Jahre, Geschlecht, Altersgruppen, Leistungsarten*, https://www-genesis.destatis.de/datenbank/online/table/22161-0001/search/s/MjIxNjEtMDAwMQ%3D%3D.

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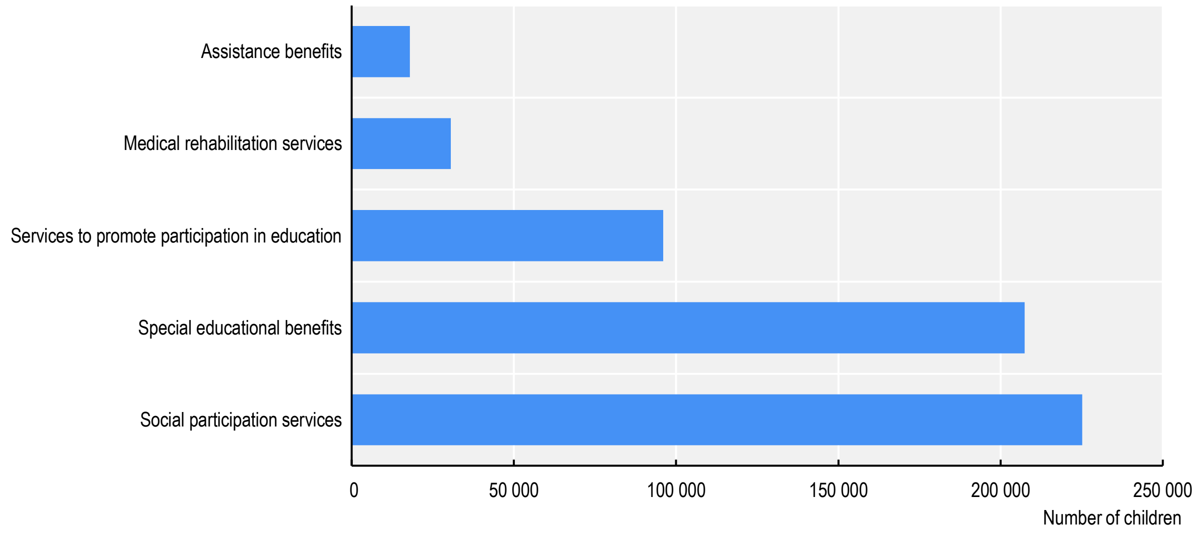
Integration Assistance encompasses a wide range of supports that aim to enable persons with disability to participate fully in society. These services may be medical (such as, e.g. therapies not covered by health insurance), educational (such as school integration aides), vocational, mobility-related, or social-assistive (e.g. personal assistance). For children with intellectual and/or physical disability who receive Integration Assistance under SGB IX, the most frequently accessed supports are those related to social participation and education, i.e. services which are not covered through other instruments or institutions (Figure 6.4). Medical rehabilitation services, though among the top five services, are comparatively rare as they are in most cases covered by health insurance.

Figure 6.4. Integration Assistance in Germany supports children’s participation in education and social life

Most common types of services provided to children (aged 0-17) under Integration Assistance (SGB IX), 2024



SGB: *Sozialgesetzbuch* (Social Code)
Source: Federal Statistical Office Germany – Destatis (2025[23]), *Empfänger von Eingliederungshilfe: Deutschland, Jahre, Geschlecht, Altersgruppen, Leistungsarten*, https://www-genesis.destatis.de/datenbank/online/table/22161-0001/search/s/MjIxNjEtMDAwMQ%3D%3D.

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Therapy costs are usually covered by statutory health insurance

The relatively limited use of medical rehabilitation services through the Integration Assistance is explained by the role of Germany’s statutory health insurance system. Statutory health insurers cover medically necessary rehabilitation services, such as occupational, speech and language therapy, and psychotherapy for children with disability, including those with ASD. This health insurance pathway is in fact the primary mechanism for accessing paramedical therapies in Germany. To receive therapy, a child must obtain a doctor’s prescription specifying their diagnosis, how it affects their functioning, and the type, frequency, and duration of therapy required. With this prescription, the child can access the appropriate therapeutic provider, and all prescribed services are covered by health insurance (Lebenshilfe, 2025[24]; 2025[25]). As a result, the amount of therapy a child receives is driven mainly by their assessed individual needs – and, in practice, the availability of providers and associated waiting times – rather than any diagnosis-based caps on service hours.

Children seeking access to specialised therapies – such as music therapy, therapeutic horseback riding, or autism-specific interventions like Applied Behaviour Analysis (ABA) delivered in dedicated autism centres – would typically not have these supports reimbursed by statutory health insurance, unlike standard therapies. Families must therefore either pay out of pocket or apply for Integration Assistance, which is designed to fund individually tailored support measures for persons with disability, including those with ASD. During the assessment process, if the respective individual and legal prerequisites are met and the responsible social worker determines these specialised therapies would meaningfully promote the child’s autonomy and/or support their social inclusion and participation, individually tailored support measures can be approved as in-kind services or as part of their Personal Budget – depending on whether the parents prefer direct provision of services or a budget to organise support themselves.

Another common pathway for accessing therapeutic support in Germany is through the education system, particularly within special education schools. These schools often provide therapies on-site and integrated into the student's daily schedule. A multi-disciplinary school team typically identifies the child's needs, after which the school authority makes recommendations regarding appropriate support. Responsibility for funding depends on the nature of the therapy: if it is deemed an educational intervention, costs are usually covered by the school or regional education budgets or even the Integration Assistance, whereas therapies classified as medical interventions are financed by statutory health insurance. The school then develops an individual support plan specifying the exact type and frequency of therapy, based on both the medical prescription and the school's understanding of the child's educational needs. For medical interventions, the same requirements apply as for all other interventions reimbursed by the healthcare system, as described above – namely, a confirmed medical diagnosis and a doctor's prescription.

Special education schools still play a prominent role in Germany

The two main schooling options available to children with special educational needs (SEN) in Germany are enrolment in a regular school or in a special education school (*Förderschule*). Because responsibility for education policy lies with the individual federal states, there are no nationwide regulations governing how exactly school placement and support measures for children with SEN should be determined. When parents or teachers suspect that a child requires more extensive support than what is currently provided at school, they can request a SEN assessment (*Sonderpädagogisches Gutachten*) from the competent school authority. These assessments are typically led by a SEN Service (*Sonderpädagogischer Dienst*) of the school authority (sofatutor-Magazin, n.d.[26]; Inklusion und Schule, n.d.[27]).

Assessments may be carried out by a single specialist or a multi-disciplinary team that can include regular and special education teachers, and where needed, additional professionals such as medical or psychological experts. The evaluation draws on classroom observations, discussions with the child and parents, and a review of relevant documentation, including previous school and medical reports. It typically also involves functional tests across areas such as learning, communication, socio-emotional development, motor skills, and self-care. A formal medical diagnosis is not usually required, as placement and support decisions are based primarily on the child's assessed educational needs. At the end of the process, the school authority issues recommendations on appropriate special support measures and, where relevant, on whether placement in a special education school is advised (sofatutor-Magazin, n.d.[26]). Parents play a crucial role throughout the process, including in the final decision making.

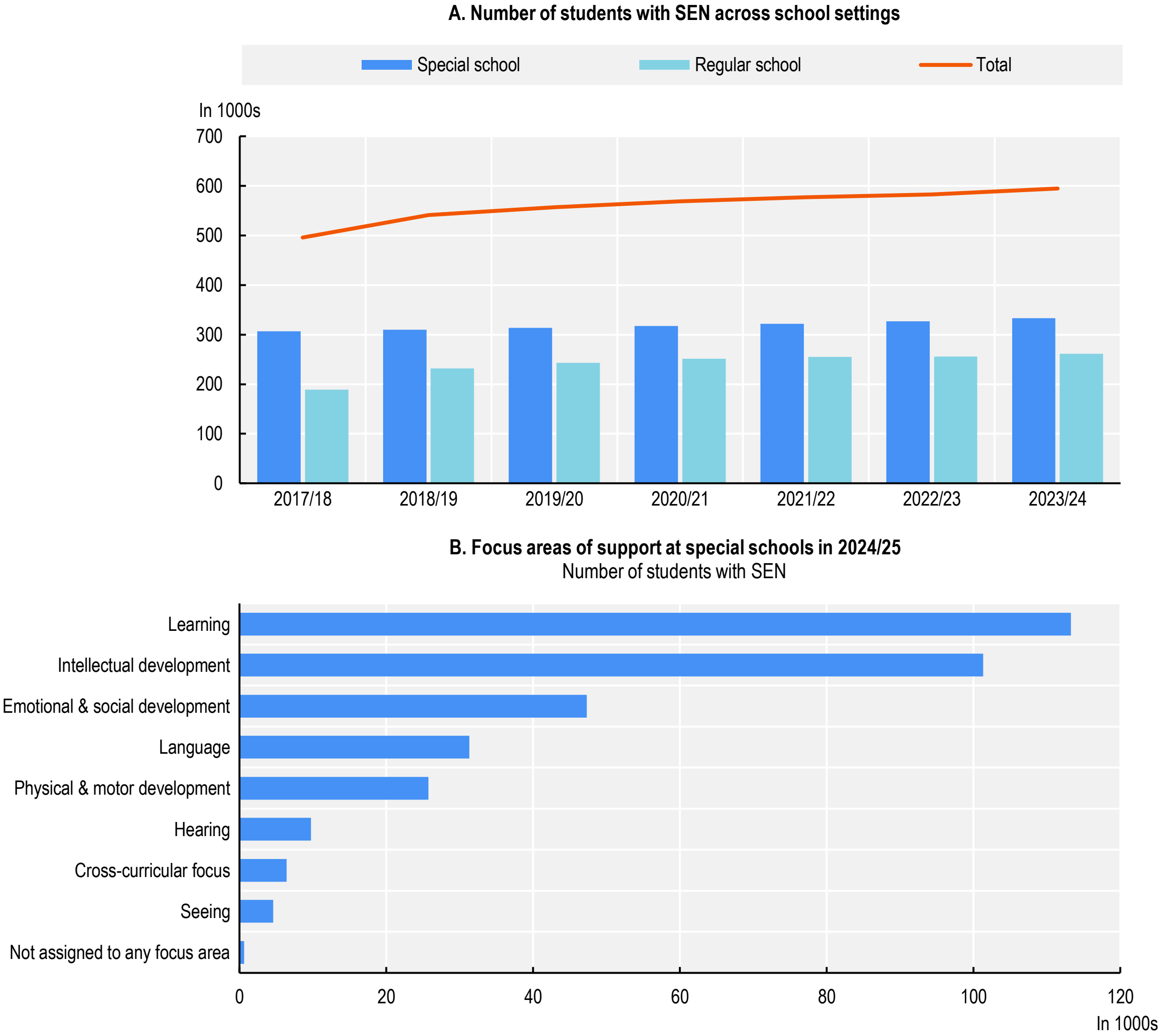
A wide range of support measures may be made available to children with SEN, including integration assistants, assistive technologies, adapted curricula and teaching methods, and on-site therapy. When required supports, such as an integration assistant, cannot be provided directly by the school, families may utilise Integration Assistance to cover the associated costs. As shown in Figure 6.4, educational supports are among the most frequently funded services through Integration Assistance for children. Integration Assistance can also finance additional therapeutic interventions at school and other educational support where school-based provision is insufficient.

Children with SEN increasingly attend regular schools but the pace of change is slow

Since 2017/18, the number of students with SEN in Germany has increased from approximately 496 000 to around 595 000 in 2023/24 (Figure 6.5, Panel A). The sharpest rise has occurred among students with SEN enrolled in regular schools, reaching about 262 000 in 2023/24. This number still falls short of those enrolled in special education schools, which stood at roughly 333 000 in 2023/24. Thus, while there is a gradual shift toward inclusion in regular schools, the transition to fully inclusive education is ongoing.

Figure 6.5. The distribution of students with SEN across type of school changes slowly

Students with SEN by school setting and focus area of support at special schools, Germany (2024/25)



SEN: Special Educational Needs
Note: Data available only for special schools in Saarland. No data available for some mainstream schools for 2017 in Bavaria. Pupils with SEN are statistically recorded as pupils who receive special educational support, regardless of whether a SEN status has been formally identified or not. The total number of students and their distribution across settings thus differ from those shown in Figure 4.1, which is based on data from the European Agency for Special Needs and Inclusive Education and includes only students with an official SEN decision.
Source: Federal Statistical Office Germany – Destatis (2025[28]), *Pupils with special educational support: Germany, school year, type of school, main areas of support*, https://www-genesis.destatis.de/datenbank/online/table/21111-0007/search/s/MjExMTEtMDAwNw%3D%3D.

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The most common focus areas of support of students enrolled in special education schools in 2024/25 are "Learning" and "Intellectual Development", accounting for about 113 000 and 101 000 students, respectively (Figure 6.5, Panel B). The SEN assessment described above determines the primary focus of educational support for each child – the focus area of support (*Förderschwerpunkt*) – which falls into one of seven categories: Learning, Language, Hearing, Seeing, Intellectual Development, Emotional and Social Development, and Physical and Motor Development. Depending on the child's identified focus area, schools are provided with additional resources specifically allocated to support that child's needs.

Conclusion

Germany’s experience reflects a gradual but significant shift toward a rights-based approach to supporting individuals with autism. Over the past two decades, the country has strengthened its legal framework, aligned disability policy with international standards, and expanded access to financial and practical supports tailored to assessed needs rather than solely to medical diagnoses. The introduction of comprehensive clinical guidelines for autism diagnosis and therapy has contributed to greater consistency in service provision, while reforms to available benefits, Care Allowance and Integration Assistance, have improved access for families. At the same time, persistent challenges remain, including the absence of reliable population prevalence data and the slow transition to inclusive education. Continued efforts to enhance implementation of existing guidelines, ensure equitable access to supports across regions, and maintain a strong focus on participation and autonomy will be essential to sustaining Germany’s progress in meeting the needs of children with ASD and their families.

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7

Autism policies in Israel

This chapter examines Israel's policy framework for supporting children with ASD amid an eightfold increase in diagnoses between 2011 and 2024. Autism has been legally recognised as a disability in the late 1990s. Israel's approach to services and benefits is highly standardised and diagnosis-driven: a formal medical diagnosis alone largely determines eligibility for financial benefits, therapeutic services, and educational supports. Children with ASD automatically qualify for 100% of the Disabled Child Allowance and access to therapy and special education, regardless of their level of support needs. While this model ensures broad coverage, it risks under-serving children with severe needs due to its uniform support structure. The increase in diagnoses has strained public resources, fuelled demand for private diagnostic services, and raised concerns about the sustainability and availability of services for the most vulnerable. The chapter highlights the need for more nuanced, needs-based policies to balance equity, efficiency, and fiscal sustainability.

In Brief

Israel’s diagnosis-driven approach to autism support

- Recognition of autism as a disability in the legal framework in Israel started in the late 1990s. Rights and entitlements of individuals with ASD have been regulated through law ever since.
- The number of children with ASD has grown exponentially in the past 15 years and was eight times higher in 2024 than in 2011. Diagnosis rates vary among population groups, influenced by both socio-economic status and religious and ethnic group. Unlike other OECD countries, rates tend to be higher in higher-status population groups.
- Israel’s system of financial benefits and services for children with disability is highly standardised and medically driven. A child’s medical diagnosis alone largely determines their eligibility for, and the extent of, benefits and services they receive. This approach applies across the Disabled Child Allowance, special educational supports, and therapeutic services.
- All children diagnosed with ASD are entitled to a uniform Disabled Child Allowance of 100% (NIS 3 694 in 2025) per month, irrespective of their level of needs. A higher rate may be granted if the child is deemed fully dependent but only few children with ASD fall into this group.
- School-age children with ASD are entitled to a fixed package of three therapy hours per week (occupational, speech or psychotherapy). In early childhood, Israel offers a considerably more extensive early-intervention package with up to 14 therapy hours per week, but many children with ASD only retrieve a fraction of the services they would be entitled to.
- An ASD diagnosis also provides near-automatic access to the full spectrum of special education supports. Although an Eligibility and Characterization Committee assesses the degree of functioning (Level 1 to 4), children with ASD can attend special communication classes and special schools regardless, with more extensive supports (e.g. longer school days, more comprehensive therapeutic support) than most other types of disability. Alternatively, parents may choose inclusion in a regular class with reasonable accommodations in the form of an individualised services basket.
- This standardised, diagnosis-based approach makes Israel’s system comparatively generous for children with mild support needs but ungenerous for children with severe support needs, as benefits and services remain largely uniform across different levels.
- Together with falling stigma and higher awareness of ASD, Israel’s approach has made seeking an autism diagnosis very attractive. Demand for diagnosis has overstretched the capacity of the public diagnosing system and has led to the development of a growing private diagnosing market. Privately sought diagnoses are fully accepted by the system without any public controls.
- Israel’s diagnosis-based eligibility system combined with growing diagnosis rates is increasingly straining the public system’s capacity to deliver the support to which children are formally entitled. Persistent shortages of special education teachers and paramedical therapists have widened the gap between formal entitlements and actual service provision.
- Rising ASD diagnosis rates have led to a substantial increase in public expenditure in recent years. In 2024, Israel spent NIS 4 619 million on special education, NIS 1 110 million on therapies in day-cares and kindergartens and NIS 2 513 million on the Disabled Child Allowance for children with ASD, together 0.41% of Israel’s GDP.

- Rising ASD diagnosis rates are not the only driver of overall growth in public spending. While children with ASD now constitute 37% of all Child Disability Allowance recipients (up from 25% in 2012) and 33% of the corresponding spending (up from 27% in 2012), Israel has a broader problem of fast-growing expenditure on children with disability which is not discussed in this report but calls for an in-depth policy debate.

Introduction

Israel has experienced a dramatic surge in autism spectrum disorder (ASD) diagnoses over the past 15 years, with the number of children diagnosed increasing eightfold between 2011 and 2024. This exponential growth has placed significant pressure on the country's disability support systems, prompting a need to evaluate the effectiveness and sustainability of current policy strategies. Autism has been legally recognised as a disability in Israel since the late 1990s, and the country has developed a highly standardised, diagnosis-based framework for delivering financial benefits, therapeutic services, and educational support to children with disability.

The Israeli model is characterised by its predominantly medical approach, where a formal diagnosis largely determines eligibility for services, rather than assessed support needs. Children with ASD automatically qualify for the full Disabled Child Allowance, currently set at NIS 3 694 per month, and are entitled to a fixed package of therapeutic and educational services. While this system ensures broad access to support, especially for children with mild support needs, it has proven less responsive to those with more severe support requirements due to its uniform benefit structure.

This case study provides an overview of Israel's policy framework for children with ASD, highlighting its strengths, limitations, and the challenges posed by rising diagnosis rates.

Autism has been a recognised disability in Israel since the late 1990s

Autism and autism-like conditions have been a recognised disability in Israel since 1998 under the general umbrella disability law, the **Equal Rights for Persons with Disabilities Law, 5758-1998**. The law defines a person with disability as "a person with a physical, mental or intellectual, including cognitive, impairment, whether permanent or temporary, which substantially limits their functioning in one or more of the central spheres of life" (Ministry of Justice, 2018[1]).

Even before the legal recognition, there were already efforts to provide support for children with autism and their families from the 1970s. The first autism-specific organisation, ALUT – the Israeli Society for Children and Adults with Autism – was founded in 1974 as a parents' association with the goal to offer dedicated support and a positive housing environment for children with autism and their families (ALUT, n.d.[2]).

In 1988, the *Knesset* (Israel's unicameral Parliament) adopted the **Special Education Law**, which guarantees free and accessible education for children with disability. Since 2002, the act includes explicitly autism-like conditions (at the time still referred to as pervasive developmental disorders) (Knesset, 2023[3]).

The main disability benefit provided for children with autism is the Disabled Child Allowance. Any child between the age of 91 days and 18 years and 3 months with an autism diagnosis, regardless of their level of need, is currently eligible for this allowance. The diagnostic requirements are set out in the **Circular n°15 of 2013 of the Ministry of Health** (Ministry of Health, 2013[4]).

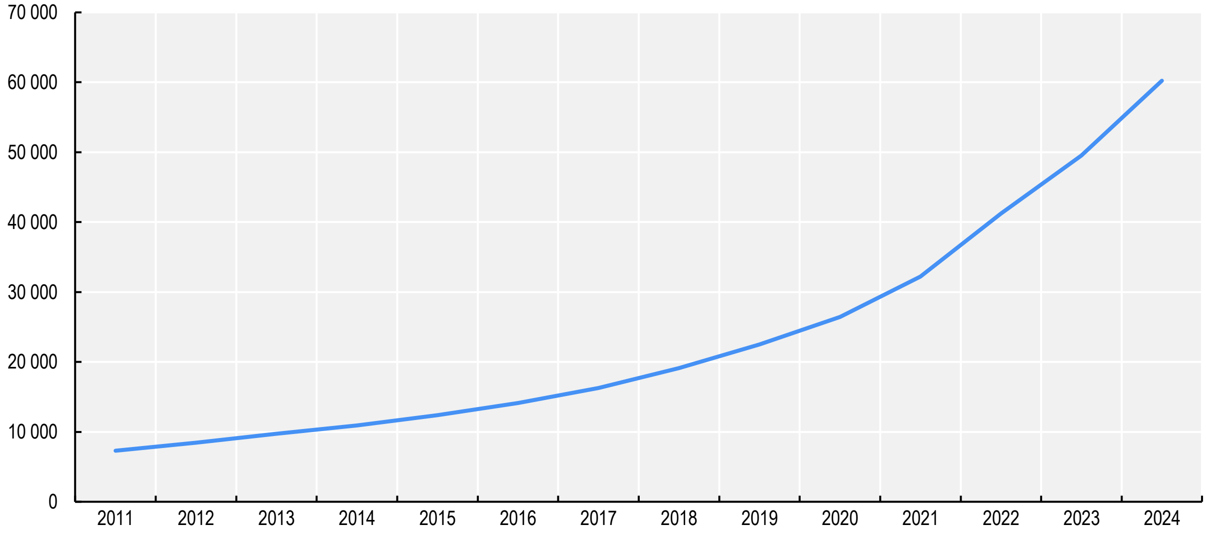
In 2022, the *Knesset* introduced the Welfare Services for People with Disabilities Law, 5782-2022. In force since January 2024, this law moved Israel towards a more person-centred rights-based framework for persons with disability in areas including housing, employment and community living (Knesset, 2024[5]).

The number of children diagnosed with autism has been growing exponentially

In Israel, data on children diagnosed with ASD, many of whom receive state-funded services, are collected by different agencies. The National Insurance Institute's (*Bituah Leumi*, NII) registry of children eligible for the Disabled Child Allowance is one of the most reliable data sources, especially since this allowance is granted to all children diagnosed with ASD, regardless of their level of need or functioning. Thus, it is reasonable to assume that the NII's registry covers a very high percentage of children diagnosed with autism in Israel, making it a good indicator for the rate of autism among children in Israel. According to this data, the number of children receiving a Disabled Child Allowance due to an autism diagnosis has been growing exponentially in the past 10-15 years, from 7 292 in 2011 to 60 195 in 2024 (Figure 7.1). This growth is especially alarming in terms of sustainability of disability support, when considering that Israel has by far the highest fertility rate in the OECD; in 2022 this was almost double as the OECD average. Although the total fertility rate has been decreasing slightly over time – the rate changed from 3.14 in 1980 to 2.95 in 2000 and 2.9 in 2020 – the average number of children per woman remains quite high at 2.89 in 2022 compared to an OECD average of 1.51 (OECD, 2024[6]).

Figure 7.1. Disabled Child Allowance receipt with autism diagnosis has been growing exponentially

Children diagnosed with autism receiving the Disabled Child Allowance, Israel, 2011-2024



Note: Autism includes both pervasive developmental disorder (DSM-IV) and autism spectrum disorder (DSM-5). The number of children with autism is defined as the number of persons receiving the Disabled Child Allowance in Israel in a given year.
Source: Data provided by the Israeli national authorities.

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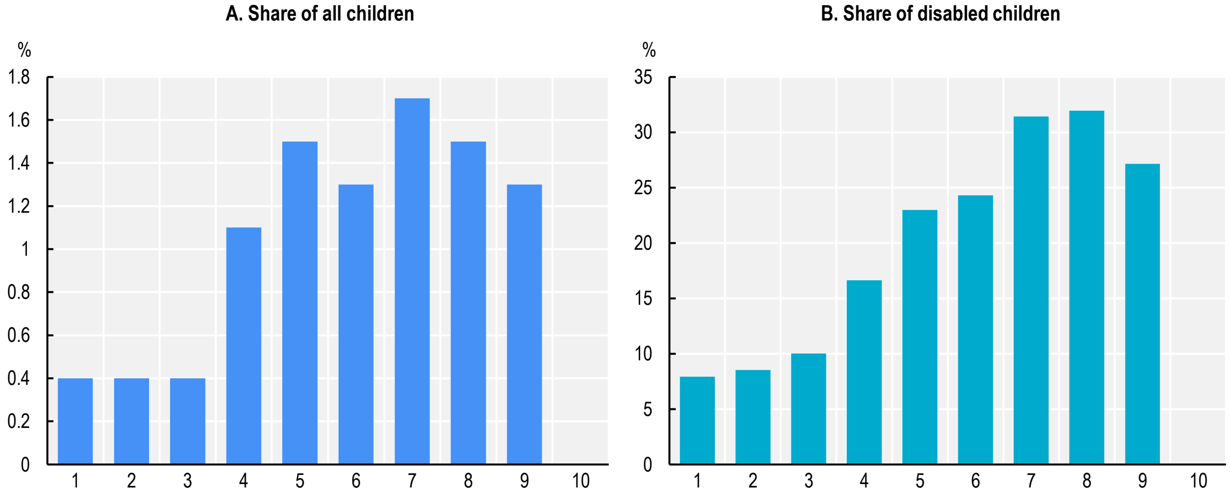
Important differences exist in the diagnosis rate among the different population groups

Socio-economic factors play an important role in ASD diagnosis rates among children. In Israel, receiving an ASD diagnosis can provide access to supports such as the Disabled Child Allowance, which may influence families' incentives to seek diagnosis. Among the ten socio-economic clusters identified, diagnosis rates are highest among children from socio-economic clusters 4 to 9. In contrast, children in clusters 1 to 3 (the lowest socio-economic levels) have considerably lower diagnosis rates. Diagnosis rates are also lower among children from the most affluent families (cluster 10), who may have less financial motivation to pursue a formal diagnosis, even if developmental concerns are present (Figure 7.2).

There are several possible explanations for lower diagnosis rates among children from lower-income families. These families may have limited access to diagnostic services (e.g. due to language for Arab populations). They may also have lower awareness of the benefits associated with receiving a diagnosis. Additionally, lower income is often linked with lower educational attainment, which can reduce parents' ability to navigate the health, social care, and educational systems and to advocate for appropriate assessment and support for their child (Akiva et al., 2024[7]). Another explanation, related to all the other reasons, is the high share of specific ethnic and religious population groups in the lowest income deciles, as underlined by a recent study by Silverman, Amit and Sadaka (2026[8]). Their analysis, based on data from the National Insurance Institute, found significant gap in eligibility rates for the Disabled Child Allowance (which all Israeli children with an ASD diagnosis are entitled to) with notably fewer children diagnosed in the Arab sector and low-SES neighbourhoods compared to the general population. Children in Haredi neighbourhoods also face delay in the age they first enter the support system – on average at age 4.7 compared to an average of 2.7 years in the non-Haredi Jewish neighbourhoods), although this gap becomes smaller in higher socio-economic clusters.

Figure 7.2. ASD diagnoses in Israel are less frequent in the lowest socio-economic groups

Share of children (aged 0-18) diagnosed with ASD by socio-economic status, 2023



ASD: autism spectrum disorder.

Note: Socio-economic clusters 1-10 represent the Israeli Central Bureau of Statistics' classification of localities (or statistical areas) by socio-economic status, based on a composite index of demographic, education, employment, income, and living-standards indicators. Cluster 1 denotes the lowest socio-economic status and cluster 10 the highest.

Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/93eoi6

Diagnosis of ASD follows strict legal guidance in Israel

To qualify for relevant state aid, including the National Insurance Institute's Disabled Child Allowance, a child's autism diagnosis – regardless of whether that diagnosis was made in a public or private practice – must follow the requirements set out in the Ministry of Health Circular No. 15 of 2013. The Circular emphasises that a diagnosis should be based on a comprehensive view of the child, considering medical, emotional, communicative, social, cognitive and functional aspects (Ministry of Health, 2013[4]).

An ASD diagnosis should start with a medical evaluation and can only be made by a medical professional with specialisation in one of the following fields:

- Child and adolescent psychiatry;
- Developmental paediatrics (with at least three years of institutional experience);
- Child development;
- Neurology.

In addition to the medical evaluation, the diagnostic process must include an assessment conducted by an expert clinical psychologist trained in child or developmental psychology. Rehabilitation or educational psychologists may also conduct this assessment, provided they have documented training in autism diagnosis. Other health professionals may contribute to the diagnostic process as needed (Ministry of Health, 2013[4]).

The diagnosis must align with the DSM-5 criteria and should reference the child's developmental and cognitive level. The assessment should therefore include:

- A developmental or cognitive evaluation;
- A functional assessment;
- An assessment of autism symptoms.

In Israel, concrete tools are recommended for each part of the assessment process but contrary to some other international guidelines (such as Germany's S3 or the UK's NICE guidelines), the Circular does not precise whether these tools should be complementary to the diagnostic process, or if they should be the main basis for the final diagnosis. Recommended assessment tools include:

- Developmental/cognitive assessment:
  - Up to age 3 (developmental) diagnosis: *MULLEN*. If there is no familiarity with the tool, *BAILEY-III* or *BAILEY-II* can be used.
  - Ages 3-7 (cognitive diagnosis): *WPPSI-III* (or other alternative age-appropriate cognitive tests).
- Functional assessment:
  - *VINELAND-II* or *ABAS-II*
- Assessment of autism symptoms:
  - Screening and assessment questionnaires:
    - Parent questionnaires e.g. *SRS-2*, *SCQ*, *CARS-2*
    - Kindergarten teacher/educator report e.g. SRS-2
  - Diagnostic tools: *ADOS*, *ADI-R* (if necessary and provided that training is available).

The reports prepared by each professional must clearly state which assessment tools were used and describe the child's strengths and difficulties. The diagnosis is recognised only when both the qualified medical professional and the psychologist agree on the diagnostic conclusion (Ministry of Health, 2013[4]). Diagnosis by both publicly and privately practising medical professionals need to follow these guidelines, but there is much less supervision and enforcement tools on the private ones. Anecdotal evidence has raised concerns about the validity of privately established diagnoses compared to publicly established ones, due to financial incentives potentially overriding diagnostic rigour as well as a lack of checks of these privately established diagnoses by the public institutions that decide eligibility for disability entitlements. According to some stakeholders interviewed by the OECD, private practitioners are more prone to be pressured to establish an ASD diagnosis so the family can access the Disabled Child Allowance – an allowance that is harder to access if the child has another disability – as well as other entitlements.

Children in Israel are diagnosed relatively early

Diagnosis in Israel is relatively early. A systematic review and meta-analysis by van't Hof et al. (2020[9]) showed that among 40 countries, Israel had the lowest mean age of diagnosis for children with autism, at 30.9 months. According to the meta-analysis, the mean age of diagnosis across more than 30 studies was identified at 60.5 months, with a range of 30.9 to 235 months (van 't Hof et al., 2020[9]).

The mean age of diagnosis of 30.9 months in Israel was identified by a study by Mishaal et al. (2014[10]). The Israeli study identified several key factors in early identification of ASD, including the education of parents and parental experience with typical development of an older sibling, among others (Mishaal, Ben-Itzchak and Zachor, 2014[10]). Other reasons for early diagnosis in Israel might include the *Tipat Halav* system and wide awareness of the generous disability package available for families of children with diagnosed ASD.

In a more recent study, Magen-Molho et al. (2020[11]) found that out of a cohort of 1 786 194 children – out of which 11 699 were diagnosed with ASD (rate of 655 per 100 000 children) – the average age of diagnosis was 3.5 years, with a distribution of 83.5% boys and 16.5% girls. Although higher than the average calculated for Israel by Mishaal et al. (2014[10]), 3.5 years (or 42 months) is still well below the average of 60.5 found by the international meta-analysis (van 't Hof et al., 2020[9]).

Another Israeli study found that ethnicity and socio-economic status also had an effect on age of diagnosis. According to this study, those in higher SES, typically identifying as "secular and modern religious Jews" were diagnosed earlier, and population groups generally belonging to lower SES, such as Ultra-Orthodox Jews and Arabs were generally diagnosed later (Koller et al., 2019[12]). Data from a recent study (Silverman, Amit and Sadaka, 2026[8]) also shows that children from Haredi neighbourhoods are diagnosed later, especially when they belong to lower socio-economic clusters (1-4), but this gap becomes smaller in higher clusters (5-8). On average, children with autism from Haredi neighbourhoods first enter the disability support system at age 4.7 compared to an average of 2.7 years among children with autism from non-Haredi Jewish neighbourhoods. Interestingly, at an average of 4.7 years, children from Haredi neighbourhoods get diagnosed relatively early, compared to the international average of 60.5 months (~5 years) identified by van t' Hof et al. (2020[9]).

Israel offers one allowance for children with disability

Israel's Disabled Child Allowance (קצבת ילד נכה) is a monthly, untaxed, non-means-tested benefit provided to parents of a child with disability. Its purpose is to help alleviate the family's financial burden and promote the child's inclusion in society. The allowance can be paid retroactively for up to one year prior to the submission of the claim and typically applies to children up to the age of 18 years and three months.[1] Administered by Israel's National Insurance Institute, the benefit is structured into five payment tiers (NII, 2025[13]):

- 50% – NIS 1 880 in 2025 (~14% of average monthly wage in Israel in 2025 (Israel Central Bureau of Statistics, 2025[14]))
- 100% – NIS 3 694 in 2025 (~27% of average monthly wage (ibid.))

- 112% – NIS 4 352 in 2025 (~32% of average monthly wage (ibid.))
- 188% – NIS 6 947 in 2025 (~51% of average monthly wage (ibid.))
- 235% – NIS 8 828 in 2025 (~65% of average monthly wage (ibid.))

The allowance level allocated to a child is determined through a complex, standardised and largely diagnosis-based assessment system grounded in four statutory eligibility categories defined in the National Insurance Law and the Disabled Child Regulations: 1) a child requiring special medical treatment; 2) a child dependent on the assistance of others; 3) a child requiring supervision; and 4) a child with a "special impairment". ASD constitutes a standalone statutory ground for eligibility as an explicit sub-category of the "special impairment" category, alongside a limited number of other clearly defined conditions, such as severe visual impairment, severe hearing impairment and moderate, severe or profound intellectual disability. Other conditions, such as epilepsy, are not defined as independent statutory grounds; entitlement in such cases is assessed under one of the other three eligibility categories, most commonly the "requiring supervision" or "special medical treatment" category. Eligibility categories may distinguish between different levels of severity, which determine the corresponding allowance rate. For example, a child with Down Syndrome would receive between 50% and 100% of the allowance depending on their age and level of support needs (NII, 2025[15]). By contrast, a diagnosis of ASD confers entitlement at the 100% rate, regardless of age and support needs (NII, 2025[16]).

Notably, in cases where a child has multiple qualifying conditions, the allowance is calculated according to the impairment that grants the highest benefit level. A family with two or more children with disability is entitled to a 50% increase in the benefit amount for each child, calculated according to the benefit rate determined for each individual child. For instance, if a family has two children with disability who are entitled to benefit rates of 100% and 50% respectively, each benefit will be increased by 50% – the first child will receive a benefit at a rate of 150%, and the second at a rate of 75% (NII, 2025[16]).

With a medical diagnosis, children with ASD automatically qualify for the allowance

Each eligibility category has its own eligibility criteria and documentation requirements, typically involving some form of medical certification. Compared to disability allowances in several other countries (see Chapter 3), where eligibility is determined primarily based on assessed support needs rather than a formal diagnosis, Israel's Disabled Child Allowance adopts a distinctly medicalised approach. What particularly sets the Israeli system apart is that children with a formal medical diagnosis of ASD (for further details on the criteria a medical diagnosis must satisfy to be recognised by the NII, see above) automatically qualify for the 100% allowance rate, without any further assessment of their daily support needs. A child with ASD can receive the allowance from 91 days of age up to 18 years and three months (NII, 2025[16]).

To apply for the Disabled Child Allowance, parents or legal guardians of a child with ASD must submit the following documents to the National Insurance Institute (NII, 2025[16]):

- Claim Form for Disabled Child Allowance (submitted online, by phone, or on paper);
- Medical diagnosis from a child and adolescent psychiatrist, neurologist, or developmental paediatrician;
- Psychological diagnosis from a clinical, developmental, educational, or rehabilitation psychologist, including a standardised psychological test appropriate to the child's age;
- Statement specifying the diagnostic tool used (e.g. CARS, ADOS, ADI-R);
- School certificate form.

The school certificate form provides some details about the child's behaviour and support needs in their daily school environment. Once submitted, the application documents are reviewed by a physician or other medical professional from the NII, who determines eligibility for the allowance. If the documentation is incomplete or uncertainties remain regarding eligibility or the appropriate allowance level, the child may be referred for an in-person assessment of their daily support needs by the NII Medical Board – a formal body composed of doctors and other medical professionals. However, for children with ASD, such in-person assessments are typically not conducted. Because a formal diagnosis automatically qualifies them for the allowance, the eligibility decision is based solely on the documents submitted by the parents or legal guardians, according to NII regulations.

In light of the marked increase in applications for the Disabled Child Allowance on the basis of ASD in recent years, coupled with a growing number of diagnoses that do not meet the standards set out in the Director General's Circular of the Ministry of Health or the medical guidelines of the National Insurance Institute, referrals for re-evaluation by professionals acting on behalf of the NII have become more frequent than in the past.

A higher than standard rate may be granted for children highly dependent on others

Although a child's eligibility for the Disabled Child Allowance is primarily determined by their medical condition, their allowance rate may be higher than their condition's standard rate if the child requires assistance with daily activities to a significantly greater extent than other children of the same age (eligibility category 2). For example, a child with Down Syndrome who needs intensive support in everyday activities may receive an allowance rate higher than the standard 50%-100%. The same applies to children with ASD: while the automatic standard rate is 100%, children whose support and care needs are particularly extensive may receive up to 235%.

The support needs of a child with ASD do not determine whether they are eligible for the Disabled Child Allowance in the first place, but rather whether their level of dependency on others justifies a higher than standard benefit rate.

To assess entitlement to a higher rate, a child must undergo a dependency assessment, which is typically initiated at the request of the parents or legal guardians. This assessment is carried out in-person by the NII Medical Board. The Board's medical staff evaluate the child's functioning and support needs across five domains of daily living: mobility at home, dressing and undressing, bathing, eating and drinking, and personal hygiene. Each domain contains several levels of functioning, with age-specific point values assigned based on the child's degree of independence.[2] The total score across all domains determines the benefit rate. If this rate exceeds the standard allowance rate that would otherwise be granted based on the child's medical condition, the child receives this higher rate (NII, 2025[17]):

- 5-7 points – 50% allowance rate
- 8-9 points – 112% allowance rate
- 10-12 points – 188% allowance rate
- 13 or more points – 235% allowance rate

Israel's diagnosis-based approach to the Disabled Child Allowance, where benefit levels are tied to medical conditions and a comprehensive functioning and support needs assessment of the child is conducted only to determine a possible higher than standard rate, poses challenges, especially for conditions such as ASD that span a broad spectrum of severity. This reliance on diagnoses is unique among the countries studied.

Reassessments of children with ASD have become rare

Whether, and how often, a child receiving the Disabled Child Allowance is reassessed for continued eligibility – or for an increase or decrease of their allowance rate – is determined on a case-by-case basis. The decision primarily depends on the child's specific diagnosis, the duration of entitlement initially granted, and whether the NII considers the entitlement temporary or permanent. Whenever a child's condition or circumstances change, a re-evaluation is typically conducted, requiring updated medical certification.

For children diagnosed with ASD, a regulation introduced in 2022 stipulates that if the diagnosis is made after the age of three, eligibility for the allowance – once established – is automatically extended until the child reaches 18 years and three months, without any interim reassessment. For children diagnosed before the age of three, a re-evaluation requiring updated medical certification around age ten is mandatory. The regulation was introduced to reduce the bureaucracy associated with repeated reassessments of children with ASD. It followed a survey conducted by the Disabilities and Rehabilitation Administration of the NII, which found that the eligibility status of 97% of surveyed children with ASD remained unchanged after they had been invited to a re-evaluation by the Medical Board with updated medical documentation at age 7 (NII, n.d.[18]).

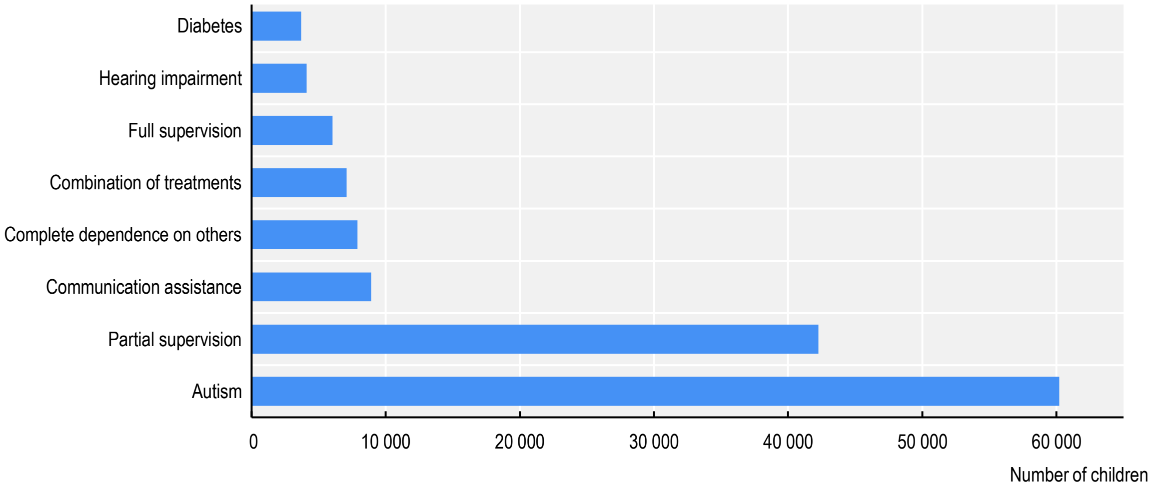
The largest share of Disabled Child Allowance recipients are children with autism

Children classified under the categories "autism" and "needs partial supervision" were the two largest groups by far among all recipients of a Disabled Child Allowance in 2024. In that year, 60 195 children with autism and 42 254 children requiring partial supervision received the allowance. By contrast, the number of children qualifying under other categories remains comparatively small (Figure 7.3).

Both the "autism" and "needs partial supervision" groups have grown substantially in recent years, driving much of the overall increase in the number of children receiving a Disabled Child Allowance (Figure 7.4). The total number of recipients rose from 33 308 in 2012 to 153 525 in 2024, while the share of children with ASD among all recipients increased from around 25% to approximately 39% over the same period. Growth in the "needs partial supervision" category is largely driven by payments granted to children with allergies. In 2012, only around 2% of children receiving the allowance fell into the "needs partial supervision" category, compared to a striking 28% in 2024.

Figure 7.3. Autism is the leading cause of entitlement to a Disabled Child Allowance in Israel

The eight leading causes of allowance entitlement in Israel, 2024



Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/37sbea

Box 7.1. “Partial and full supervision” entitles to a Disabled Child Allowance

Children aged between 91 days and 18 years and three months who require the presence of an adult to prevent danger to a significantly greater extent than is typical for their age are eligible for the Disabled Child Allowance. The benefit amount depends on the degree of supervision required: parents receive a 50% rate (NIS 1 880 in 2025) if their child qualifies for Level 1 of the supervision category, or a 100% rate (NIS 3 694 in 2025) if the child meets the criteria for Level 2.

Level 1 – partial supervision – generally applies to children who need close supervision to protect themselves or others from harm due to a limited understanding of danger resulting from their disability, chronic disease, or disorder. This group includes, for example, children with life-threatening allergies or severe behavioural disorders.

Level 2 – full supervision – covers children who require the constant presence of a parent to prevent dangerous situations arising from a severe illness, impairment, disorder, or disability. This may be because the child is unaware of imminent risks or because they experience medical incidents that demand immediate intervention.

When applying for the allowance, parents must submit a claim form, a recent educational report from the child’s school or special education institution, and a medical certificate from a relevant medical specialist detailing the child’s condition and explaining the need for enhanced supervision. If the submitted documentation is sufficiently comprehensive, the child may not be required to appear before the NII’s Medical Board for an in-person assessment.

The NII retains administrative discretion to determine which conditions require partial or full supervision, in contrast to certain other impairments that are explicitly classified by law as sub-categories within the “special impairments” eligibility category.

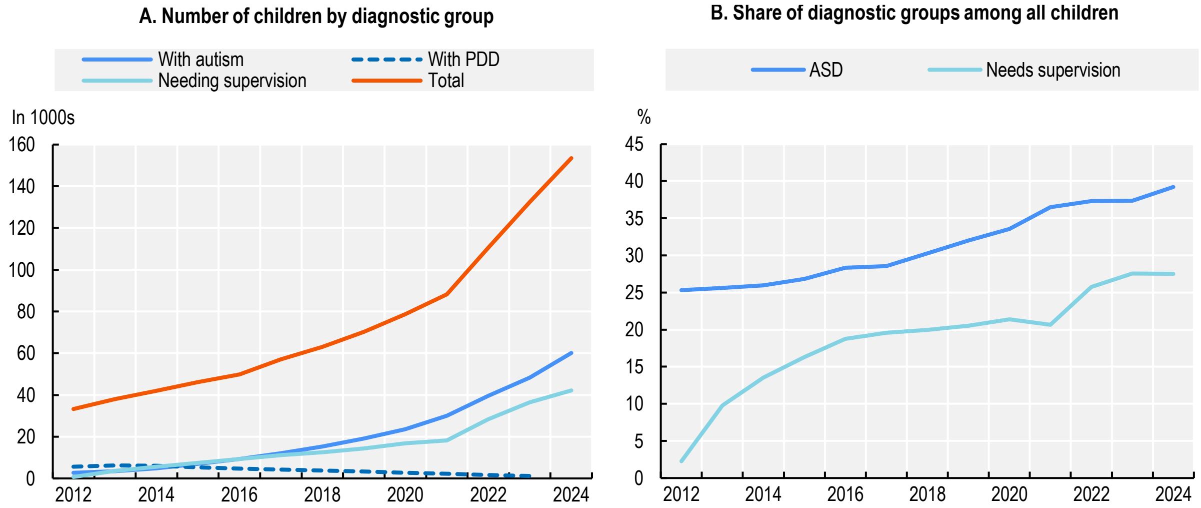
Source: Israel’s National Insurance Institute (2025[19]), *Partial and full supervision*, https://www.btl.gov.il/English%20Homepage/Benefits/Disabledchild/Who%20is%20entitled/Pages/Supervision.aspx.

Reflecting the broader upward trend in the number of children receiving a Disabled Child Allowance, total annual payments have risen sharply in recent years, particularly since 2021, reaching approximately NIS 7.4 billion in 2024 (Figure 7.5). Payments on children with ASD have increased in parallel, from about NIS 293 million in 2012 to NIS 2 513 million in 2024.

Importantly, Israel’s child population has continued to grow over the past decade – from around 2.96 million individuals under the age of 20 in 2014 to approximately 3.45 million in 2024 – in contrast to many other OECD countries where child populations have remained stable or declined (OECD, n.d.[20]). This demographic growth at least partly explains the absolute increase in the number of children accessing disability-related services and benefits in Israel. Nonetheless, there has been a substantial increase in the share of children with ASD and a Disabled Child Allowance of the total child population (under 20 years of age) in Israel, rising from 0.3% in 2012 to 1.44% in 2023.

Figure 7.4. The number of children receiving a Disabled Child Allowance has increased markedly

Children receiving an allowance by diagnostic group and share of diagnostic groups of all children receiving an allowance, Israel, 2012-2024

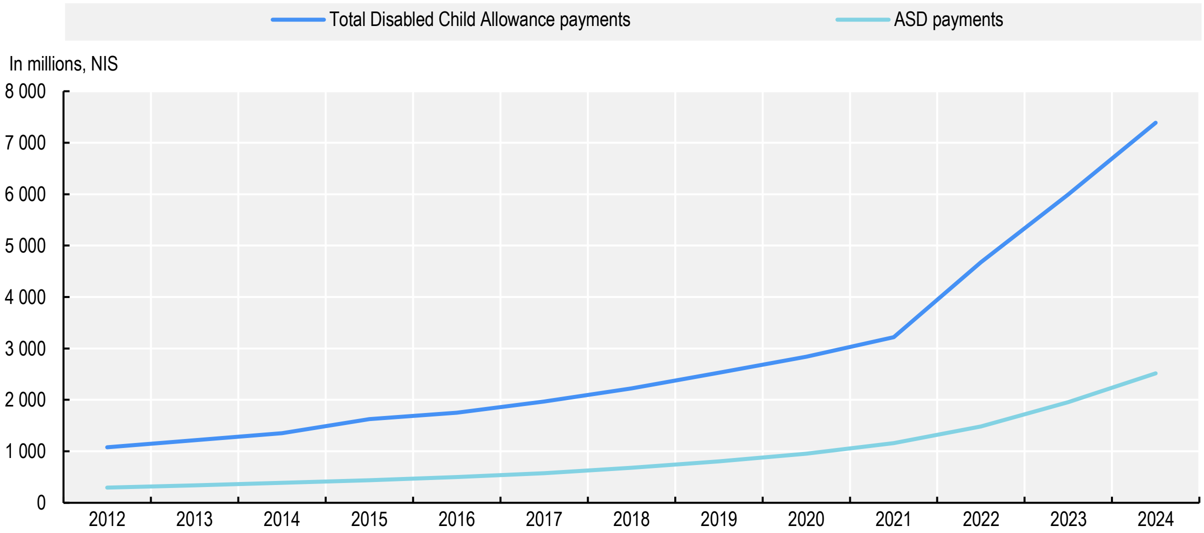


ASD: autism spectrum disorder, PDD: pervasive developmental disorder.
Note: Panel A: “autism” includes the category PDD only in 2024. Panel B: “autism” includes the category PDD.
Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/fpea0k

Figure 7.5. Disabled Child Allowance payments have grown at a fast pace

Disabled Child Allowance and ASD payments, Israel, 2012-2024



ASD: autism spectrum disorder, NIS: new Israeli shekel, PDD: pervasive developmental disorder.
Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/vud25w

Weekly hours of therapeutic services for children with ASD are strictly defined

Early childhood support for children with ASD is a core priority

Israel demonstrates a strong commitment to early childhood support, as reflected in its generous provision of therapeutic support for young children with ASD. Through its Early Childhood Programme, children with ASD aged 0-3 years are entitled to receive up to 14 hours of therapy per week, including occupational therapy, speech and language therapy, and psychotherapy. Of these 14 hours, 10.5 hours are devoted to direct one-on-one sessions, while 3.5 hours are provided indirectly, for instance on staff training (ALUT, 2021[21]).

Access to the Early Childhood Programme – offered exclusively to children with ASD – requires an official medical diagnosis of ASD. Children (ages 0-3) typically receive the programme's therapies at a special daycare centre, where therapy sessions are delivered on-site. Admission to a special daycare centre requires both a formal ASD diagnosis and approval from the National Insurance Institute.

Notably, children below the age of two for whom diagnostic uncertainty persists, or who are undergoing an extended diagnostic process, may access speech and occupational therapy without a formal diagnosis through health maintenance organisations, following referral from Child Development Clinics. In addition, Observation Preschools provide early intervention to children with developmental delays where the underlying condition has not yet been clearly identified, with some children later transitioning to diagnosis-specific special education settings, including those for ASD.

Children of kindergarten and school-age access therapy services primarily through the education system

A child with ASD of kindergarten age (4-6 years) may either attend a special "communication" kindergarten, where they receive the same 14 weekly hours of therapy provided under the Early Childhood Programme directly on-site, or attend a regular kindergarten and receive a personalised "basket of services" that may include therapy sessions (ALUT, 2021[21]). In both cases, access is contingent upon an assessment and approval by the Eligibility and Characterization Committee, which authorises not only attendance at a special kindergarten but also determines a child's individual service basket size when they attend a regular kindergarten, thereby defining the number of therapy hours a child in a regular setting can receive per week.

From the age of seven onwards, children with ASD, like children with other disabilities, can access a maximum of three hours of therapy per week through the public health system, which provides these services via Health Maintenance Organisations (ALUT, 2021[21]). To receive these therapies which include occupational, speech and language, and psychotherapy, children with ASD must present an official medical diagnosis and obtain a referral from either a paediatrician or a psychiatrist. According to anecdotal evidence, however, children with ASD on average receive only one of the three weekly therapy hours from the HMOs they are formally entitled to. This low take-up rate may suggest either that relatively few children require the full three hours – for example, because they already receive an adequate number of therapy sessions at school – or that parents face substantial challenges in co-ordinating therapy sessions and integrating them into family life, or that limited availability of qualified therapists constrains access to the full range of therapeutic services. Notably, once therapy has commenced, parents typically schedule a structured series of treatment sessions. While shortages of qualified therapists contribute to waiting times prior to treatment initiation, such shortages generally play a smaller role once a treatment plan is underway.

Children with ASD or other disabilities of school-age can receive more than the standard three hours of weekly therapy provided through HMOs by accessing additional therapeutic support via the education system. This can occur in two main ways, similar to the kindergarten system: through an individualised basket of service hours for students in regular classes, or through enrolment in a special education ("communication") class within either a mainstream or special education school, where therapies are integrated into the school day. A child with ASD would receive three hours of therapeutic support per week in a special education class. To receive therapies through any of these educational pathways, a child must present an official medical diagnosis and approval by the Eligibility and Characterization Committee (see below for details).

Therapists providing services to children in kindergartens and schools are employed by the Ministry of Education. In practice, they typically prioritise children enrolled in special kindergartens or special education classes before attending to those in mainstream educational settings. According to anecdotal evidence, there is a general shortage of therapists within the education system for children with disability, which often results in limited access to therapy for children integrated into regular classrooms or kindergartens.

Children with ASD have access to comprehensive educational support

Israel offers three schooling options for children with SEN

Some flexibility exists in the number of therapy hours a child with disability may receive through the education system. While the size of a child's services basket – i.e. the number of weekly service hours available to children attending a mainstream class – is determined by the Eligibility and Characterization Committee, the basket's specific composition is typically agreed upon jointly by the child's parents and the school staff.

For instance, a service basket of 8.2 hours per week entitles the child to funding equal to the cost of 8.2 hours of a personal teacher per week. However, the family is not obliged to use these hours exclusively for a personal teacher. Instead, they may allocate the corresponding budget toward hiring a teaching assistant who is generally less costly, thereby allowing the child to receive a greater number of support hours overall. The same budget may also be used to fund therapeutic services, such as occupational or speech therapy. In practice, such decisions on service basket composition are heavily influenced by professional staff availability. While the service basket provides some flexibility in how special education support is delivered, these services, such as therapy, ultimately remain subject to a weekly hourly ceiling.

As an alternative to receiving therapy through a personal services basket in an inclusive school setting, a child may instead access therapeutic support by attending a special education class either at a mainstream school or at a special education school. In a special education ("communication") class, for example, a child with ASD benefits from a personalised curriculum, extended school hours compared to a regular class, a vacation schedule, organised transportation to and from school, and therapeutic support amounting to three hours per week. In practice, a special education class within a mainstream school offers nearly identical levels of support to those provided in a special education school, while allowing integration into a regular classroom for certain subjects as appropriate for the individual child. Children with ASD can remain enrolled in such settings until the age of 21.

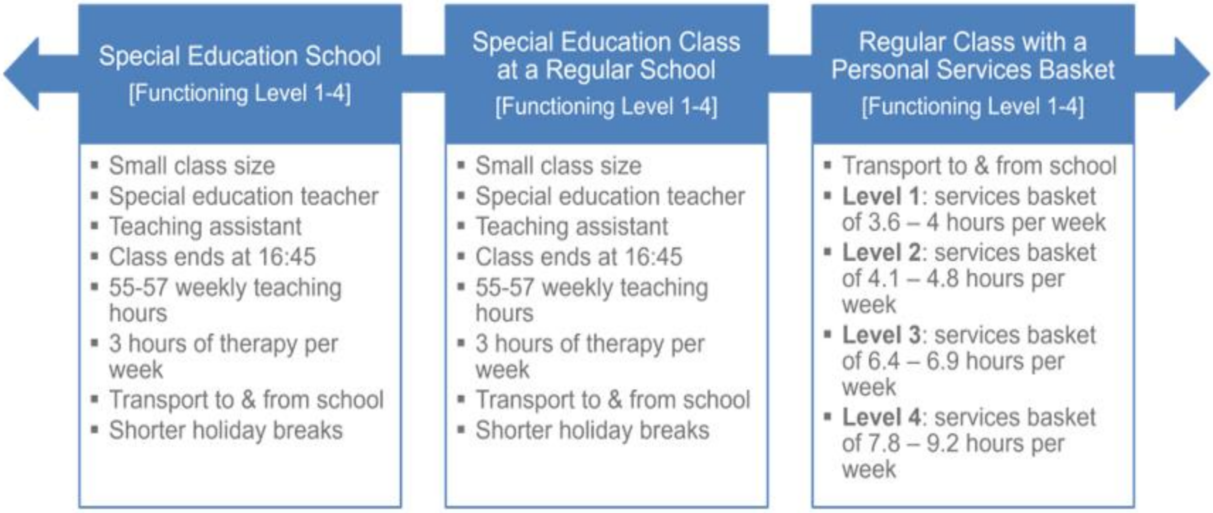
A high degree of standardisation characterises Israel's special education system

What sets Israel's special education system apart is the decisive role that medical diagnoses play in determining both school placement and the range of educational supports available to a child with SEN. Not only is medical documentation required to access special education, whether in the form of a personal support basket or through attendance in a special education class, but each class is specifically designated for one type of medical condition or disability. For instance, there are separate special education classes for children with ASD, developmental delay, speech delay, mild intellectual disability, hearing impairment, cerebral palsy, rare diseases, and borderline intellectual functioning, among others.

Each class type is governed by precise national standards that define, in detail, the start and end time of the school day, the number of therapy hours provided to each child, the maximum class size, the staffing ratios, and the total number of teaching hours per week. This high degree of standardisation ensures uniformity across the country, though it leaves limited room for individualised flexibility.

The same meticulous approach extends to the personal service baskets available to children in mainstream education. Every child is categorised according to their specific medical condition or disability, and combined with their assessed level of functioning, this classification determines the exact number of weekly support hours they are entitled to. In other words, there is a predefined allocation of support hours for each disability type across four functional levels (see Figure 7.6 for children with ASD and Figure 7.7 for other diagnostic categories). Notably, some categories do not entitle to any service hours at functioning Level 1 – such is the case for children with mental disorders and developmental delay.

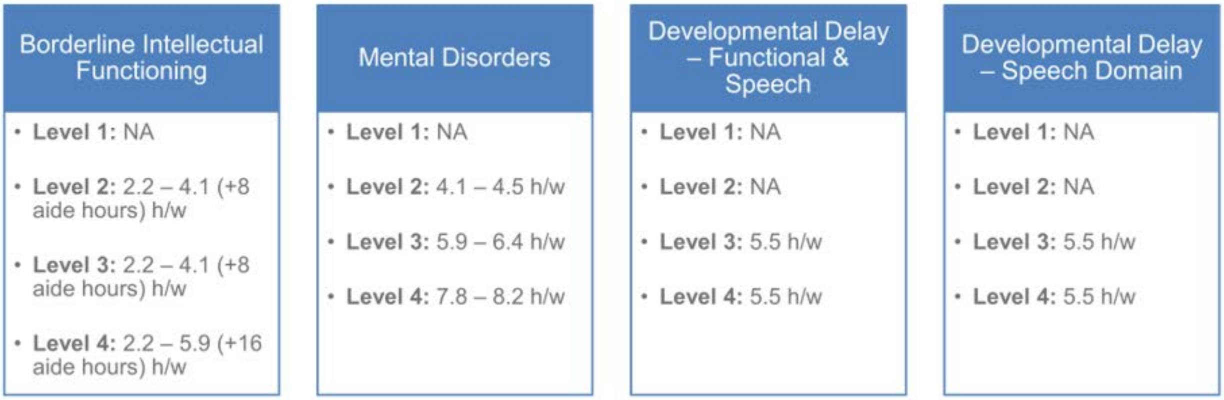
Figure 7.6. Education pathways for children with ASD in Israel – a spectrum of inclusion



Note: The lists of special education services are not exhaustive. In Israel, a regular school day typically ends between 14:00 and 15:00.
Source: Information collected by the Secretariat.

Such a highly standardised, diagnosis-based approach to special education as well as therapeutic service provision is unmatched in any other OECD country analysed in this report. Israel's model risks creating imbalances in service distribution, potentially leading to over-servicing of children with relatively low support needs, while under-servicing those with more substantial needs. This risk is particularly likely to materialise for conditions such as ASD, which encompass a wide spectrum of functional abilities and support needs. This model also risks under-servicing children with other disabilities in the context of constrained resources. Anecdotal evidence suggests that families of children with disabilities other than ASD often perceive that children with ASD benefit from preferential access to supports, while they encounter comparatively greater barriers in accessing similar services. Where the provision of services is not aligned with the actual needs of children, existing shortages of special education teachers and paramedical professionals are further exacerbated, thereby undermining the availability and effectiveness of services for all eligible students.

Figure 7.7. Individual service baskets differ markedly across diagnostic categories



Borderline Intellectual Functioning	Mental Disorders	Developmental Delay – Functional & Speech	Developmental Delay – Speech Domain
Level 1: NA	**Level 1:** NA	**Level 1:** NA	**Level 1:** NA
Level 2: 2.2 – 4.1 (+8 aide hours) h/w	**Level 2:** 4.1 – 4.5 h/w	**Level 2:** NA	**Level 2:** NA
Level 3: 2.2 – 4.1 (+8 aide hours) h/w	**Level 3:** 5.9 – 6.4 h/w	**Level 3:** 5.5 h/w	**Level 3:** 5.5 h/w
Level 4: 2.2 – 5.9 (+16 aide hours) h/w	**Level 4:** 7.8 – 8.2 h/w	**Level 4:** 5.5 h/w	**Level 4:** 5.5 h/w

Note: h/w = hours per week
Source: Information provided by national authorities.

An Eligibility and Characterisation Committee must approve special education support

In Israel, Eligibility and Characterization Committees are entrusted with the authority to determine a child's eligibility for special education services, characterise the child's disability, and determine their level of functioning and scope of services basket. Operating at the local level – there are approximately 369 such Committees across the country – each Committee is composed of five members: representatives of the Ministry of Education, the local authority, and the superintendent of Special Needs Education, a parent of a child with special educational needs, and an educational psychologist.

Together, these members assess each child's level of functioning, ranging from (1) mild to (4) very extensive support needs, and determine eligibility for special education placement as well as the size of a "basket of services". Decisions are based primarily on documentary evidence, although the child, their parents, teacher, and other professionals may be invited to attend the Committee meeting. Referrals to the Committee can be made by the child or their parent, a recognised educational institution, the education department of the local municipality, or a representative of a public organisation. The final decision regarding school placement ultimately rests with the parents.

The documentation submitted to the Committee typically includes medical and psychological reports establishing the child's medical condition or disability, and a RAMA (National Authority for Measurement and Evaluation in Education) questionnaire completed by the child's teacher. The RAMA questionnaire evaluates multiple dimensions of the child's functioning, including cognitive ability, communication and social interaction, emotional regulation, and functional independence and organisation. However, according to anecdotal evidence, the RAMA questionnaire is no longer consistently applied, as it was found to be too lengthy and of limited reliability. Anecdotal evidence further suggests that the majority of children with ASD are classified by the questionnaire and followingly the Committees as Level 3 or 4, a pattern that may not accurately reflect the wide range of support needs encompassed by autism spectrum disorder.

While a child's disability, in combination with their assessed level of functioning, is intended to determine the type of schooling and support they are entitled to, in practice, a child's level of functioning does not always influence these entitlements. For instance, a child with ASD, regardless of their assessed level of functioning – even at Level 1 – is automatically eligible to attend a special education class at either a mainstream or special education school (see Figure 7.6 for details). In contrast, a child with ADHD can only access such classes if they are assessed at Level 3 or 4 of support needs.

When a child has been granted a personal services basket, the parents, together with the child's teachers and, where relevant, other school staff, collaborate to design and review the child's Individual Education Plan (IEP). The IEP specifies the type and frequency of support the child will receive, for instance, whether the allocated service hours will be used for a personal teacher, a teaching assistant, or therapy sessions. The IEP is reviewed annually, while reassessments by the Eligibility and Characterization Committee take place every three years.

Children with ASD frequently attend special education schools and classes

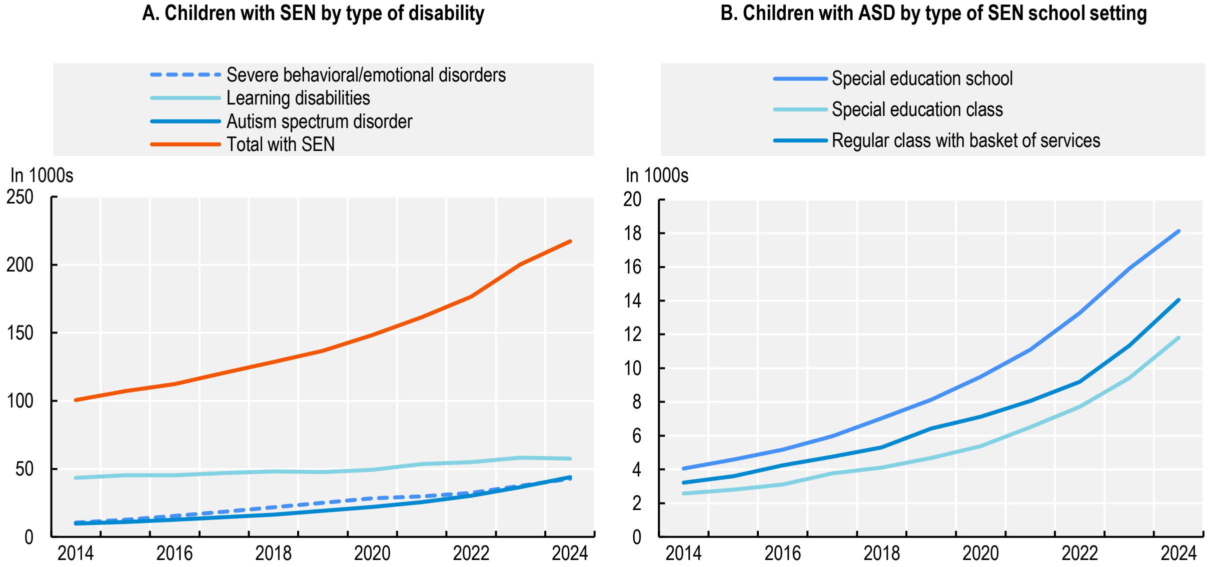
The number of children receiving special educational support in Israel has risen steadily since 2014, more than doubling from around 100 000 in 2014 to approximately 220 000 in 2024 (Figure 7.8, Panel A). While some categories, such as learning disabilities – though among the largest categories – have remained relatively stable over time, others have driven much of this growth, notably children with ASD and those with severe behavioural or emotional disorders. In 2014, only about 10 000 children with ASD received special education support, whether through placement in a special education school, a special education class, or via an individual services basket. By 2024, this number had increased more than fourfold to roughly 44 000. A nearly identical growth pattern is observed among children with severe behavioural or emotional disorders.

For children with ASD, the increase has occurred across all types of SEN supports – special schools, special classes, and regular classes with individualised service baskets (Figure 7.8, Panel B). The most pronounced rise, however, appears to be among those attending special education schools, growing from roughly 4 000 in 2014 to about 18 000 in 2024. Since children with ASD are eligible for placement in special education schools and "communication" classes regardless of their assessed level of support needs, the large share enrolled in special education settings likely reflects not only higher support needs but also comparatively greater resources and quality of support available in these special schools and classes. The fact that therapists first serve children at special schools and special classes before attending to those in regular classes supports this observation. Parents' preference for special education settings may thus reflect an imbalance of SEN supports available across the three schooling settings.

Notably, the share of all children with SEN included in mainstream classes with personalised service baskets has grown from about 24% in 2016 to 40% in 2024. The distribution of children with ASD across the three school settings, however, has remained relatively stable during this period (Figure 7.9). In 2018, Israel introduced a special education reform that replaced the former Placement Committees with Eligibility and Characterization Committees, expanded parental choice in decisions regarding school placement, and promoted inclusion in mainstream classrooms rather than special education settings (Silverman and Blass, 2025[22]). Figure 7.9 suggests that the reform has contributed to increased enrolment of students with SEN in regular classes overall but has had little to no effect for students with SEN and ASD. Research indicates that significant gaps persist between the reform's legislative objectives and parents' experiences of the education system (Huri and Shoshana, 2023[23]).

Figure 7.8. Children receiving special education supports in Israel continues to rise

Children with SEN by type of disability and those with ASD by type of SEN school setting, 2014-2024



ASD: autism spectrum disorder, SEN: special educational needs.
Note: The data only covers children that receive one of the three forms of special education support, i.e. those with an approval for special education from the Eligibility and Characterization Committee.
Source: Data provided by the Israeli national authorities.

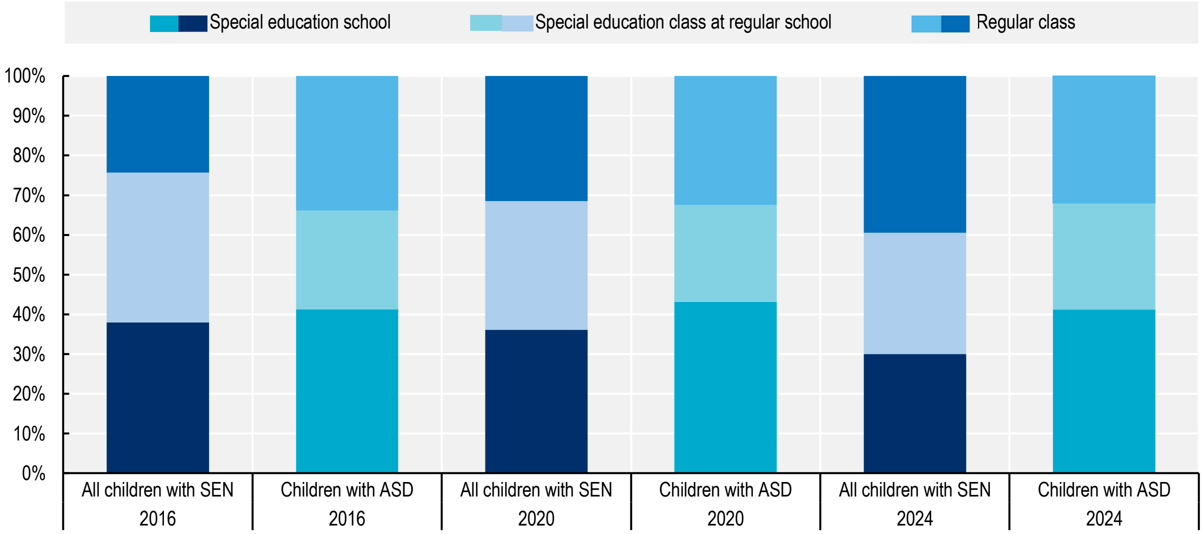
StatLink https://stat.link/fy6su5

Many children with ASD receive a Disabled Child Allowance but no SEN support

Among children with SEN, the largest group consists of those with learning disabilities, followed by children with ASD and those with severe behavioural or emotional disorders. In 2023, approximately 36 700 children with ASD received some form of special education support, compared to around 48 300 children with ASD receiving a Disabled Child Allowance. This suggests that roughly 11 600 children with ASD received the allowance but did not access any form of SEN support. Given that an official ASD diagnosis automatically qualifies a child for an allowance, as well as SEN supports, this likely implies that many of these 11 600 children have relatively low support needs and can participate in mainstream education without additional assistance. At the same time, it may also indicate that some children face structural barriers in accessing SEN support despite their formal eligibility. A study by the Taub Center (Silverman and Blass, 2025[22]) in Israel found that while preschool special education enrolment has risen sharply in recent years, this growth is accompanied by structural inequities in who has access to evaluations, diagnoses, and support. The researchers identify substantial barriers facing Arab, Bedouin, Haredi, and low-SES communities, who are underrepresented in all forms of preschool special education despite having equal or even higher developmental risk factors. This pattern suggests that structural aspects rather than solely underlying need shape who receives SEN support, raising concerns about the equity and inclusiveness of Israel's preschool special education system.

Figure 7.9. Distribution across school settings has changed except for children with ASD

Distribution of children with ASD and all children with SEN across school settings in 2016, 2020 and 2024



ASD: autism spectrum disorder, SEN: special educational needs.
Note: Children with SEN are all those that have an approval for special education from the Eligibility and Characterization Committee. Children with ASD are also only those with an approval for special education from the Committee.
Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/yctvfn

Costs per student with ASD are the highest among all students with SEN

The comparatively extensive special education supports provided to children with ASD are also reflected in the annual costs per student, which are the highest for students with ASD, followed by those with severe mental disorders and those with severe or profound disability (Table 7.1). Across these categories – as well as most other categories – annual costs for students receiving support through a personal services basket in a regular class are lower than those for students in special education schools or classes. This likely reflects the generally lower support needs of children with SEN included in mainstream settings but may also indicate that comparatively fewer resources are allocated to inclusive education. In total, Israel spent approximately NIS 4 619 million on SEN supports for children with ASD in 2024 (Figure 7.10).

Table 7.1. Average annual costs per student are the same in special classes and special schools

Average annual costs in NIS per student for the three most expensive categories of disability, Israel, 2024

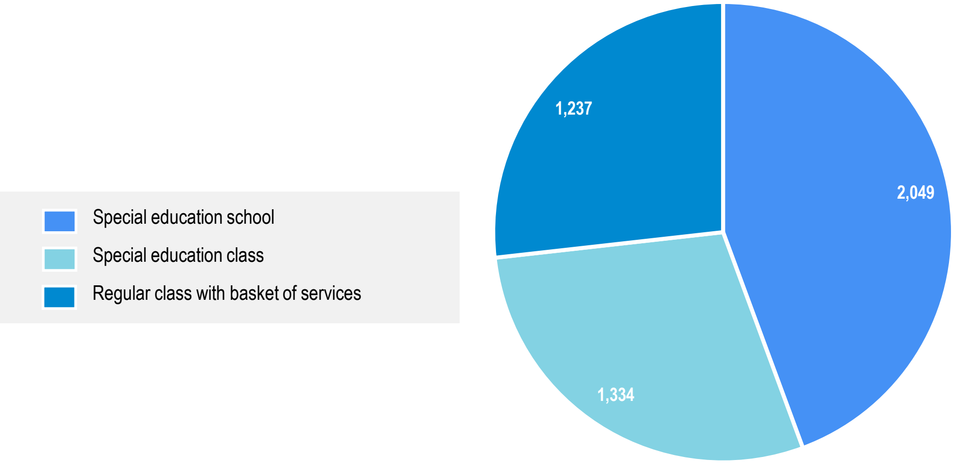
Type of class	Special education school	Special education class at regular school	Regular class
Autism spectrum disorder	113 000	113 000	88 000
Severe mental disorders	102 000	102 000	88 000
Severe/profound disability (nursing care)	98 000	98 000	/

NIS: new Israeli shekel.
Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/swhu6c

Figure 7.10. Almost half of SEN spending for children with ASD is directed to special schools

Annual spending in millions of NIS on SEN supports for children with ASD in Israel, 2024



ASD: autism spectrum disorder, NIS: new Israeli shekel, SEN: special educational needs
Source: Data provided by the Israeli national authorities.

StatLink https://stat.link/9imj5b

Israel provides a broad range of social services to children with ASD

In addition to therapeutic and educational services, children with ASD and their families have access to a broad range of social services, some of which are aimed directly at the child and others designed to assist their parents and caregivers. Among the parent-oriented services are counselling programmes, as well as up to 18 paid childcare leave days per year (18 for each parent and 36 for single parents). Parents of a child with ASD receiving a Disabled Child Allowance are also automatically eligible for discounts on water bills and local property taxes, as well as tax credits and reduced car registration fees, which together can amount to several thousand NIS in annual savings (ALUT, 2021[21]). Additionally, respite care services provide parents with temporary relief from caregiving responsibilities through short-term stays for children with disability in specialised facilities offering professional care and supervision.

Child-focussed social supports include free transportation to and from school, kindergarten, or daycare for children with SEN supports approved by the Eligibility and Characterization Committee, and subsidised or free of charge after-school programmes and school holiday camps, administered by the Ministry of Labour and Welfare (ALUT, 2021[21]). In addition, children with ASD who experience significant communication difficulties can obtain supportive or alternative communication devices through Israel's Health Maintenance Organisations.

Spending on SEN supports, allowances, and therapy for children with ASD

Israel's distinctive approach to determining eligibility for allowances and services – based almost exclusively on medical diagnoses rather than assessed support needs – means that children with ASD can access a wide range of benefits and services solely based on a formal ASD diagnosis. This structure results in comparatively generous support for children with mild support needs. For instance, families of a child with ASD and mild support needs receive a Disabled Child Allowance equal to 100% (NIS 3 694 per month in 2025), representing approximately 27% of the average monthly wage in Israel in 2025 (Israel Central Bureau of Statistics, 2025[14]). In addition, nearly all services relevant to children with ASD, including therapeutic and educational supports, are provided free of charge. Children with ASD and mild support needs may access up to three hours of HMO-funded therapy per week, as well as special education support, with the choice between inclusion in a regular classroom with a personal services basket, attendance in a communication class at a mainstream school, or enrolment in a special education school. Taken together, total monthly public expenditure on allowances, SEN supports, and therapeutic services for a child with mild support needs is estimated at NIS 12 859, representing 94% of the average monthly wage (ibid.).

Because eligibility and levels of the Disabled Child Allowance are not differentiated by the severity of support needs, a child with ASD and moderate support needs receives the same monthly allowance as well as access to public therapies and SEN supports as a child with mild support needs. Differences in total monthly expenditure between mild and moderate support needs (see Table 7.2) arise from school placement choices, as it can reasonably be expected that a child with ASD and moderate support needs would rather attend a special education class or special education school where SEN supports are more extensive and therapeutic services are guaranteed.

The generosity of support for children with mild support needs diminishes for families of children with severe support needs, where one parent had to stop working entirely to provide full-time care. In such cases, a Disabled Child Allowance of 188% (NIS 6 947 in 2025) replaces only about 51% of the income of a parent previously earning the national average wage (Israel Central Bureau of Statistics, 2025[14]). Moreover, therapeutic and educational support levels remain unchanged compared to those for children with mild or moderate support needs. As Israel considers the medical diagnosis rather than the support needs of a child with ASD to assess entitlement to benefit and services (with the exception of a higher allowance rate because of dependency on others), the overall level of public support varies little across different levels of support needs.

Although Israel’s monthly allowance for children with ASD and mild support needs is comparatively generous by OECD standards, its financial benefit for children with ASD and severe needs aligns closely with that of other OECD countries (see Chapter 3). However, a cross-country comparison including all benefits and services is challenging, as most other countries tend to offer flexible and potentially more intensive therapeutic services through their public health systems, which do not impose strict hourly limits, especially for children with severe support needs. The lack of precise data in such more flexible systems makes it difficult to quantify differences in services offer and cost.

Table 7.2. Education support is more costly than the Disabled Child Allowance

Monthly spending on a child with ASD in Israel by spending category and support needs, 2025

Spending category	Mild support needs (0% working hours reduction)		Moderate support needs (50% working hours reduction)		Severe support needs (100% working hours reduction)	
Financial benefit[1]	NIS 3 694		NIS 3 694		NIS 6 947	
Therapy[2]	NIS 1 832		NIS 1 832		NIS 1 832	
Education[3]	NIS 7 333		NIS 9 417		NIS 9 417	
Total	NIS 12 859	USD (PPP) 3 573	NIS 14 943	USD (PPP) 4 152	NIS 18 196	USD (PPP) 5 056

NIS: new Israeli shekel, PPP = purchasing power parities.
Note: Average annual wages of 2023.
1. Financial benefit: Disabled Child Allowance.
2. Those three hours/week of therapy that are provided through HMOs. One hour of therapy costs NIS 142 in 2025.
3. Education spending only includes the costs per student with SEN supports.
Core assumptions:
a) Parental care – one parent reduces working hours in line with care needs (0%, 50% and 100%).
b) Parents earn the average annual wage and work full-time in baseline scenario.
c) 12-year-old child with formal ASD diagnosis, attending secondary school.
d) A child with severe support needs is assumed to receive a higher than standard rate because of their dependency on others.
e) A child with mild support needs can be expected to attend a regular class with a personal basket of services, while a child with moderate or severe support needs will most likely opt for a special class or special school where more extensive support is offered.
Source: OECD (2025[24]), *Annual Purchasing Power Parities and exchange rates* (dataset), https://data-explorer.oecd.org/s/3sp. OECD (2025[25]), *Average annual wages:* https://data-explorer.oecd.org/s/3sq. Compilation of OECD material and data provided by the Israeli national authorities.

StatLink https://stat.link/n3y97o

Conclusion

Israel's experience reflects a highly standardised and diagnosis-based approach to supporting children with autism within its disability policy framework. Over the past decades, the country has expanded access to financial benefits, therapeutic services, and special education, ensuring that families receive comprehensive support once a formal diagnosis is established. This model has facilitated early identification and generous entitlements, particularly for children with mild needs, but its reliance on medical diagnosis rather than assessed support needs limits flexibility and responsiveness for those with more complex requirements.

The uniform structure of benefits and services, combined with rising diagnosis rates, has driven significant increases in public expenditure and raised questions about long-term sustainability. Moving forward, introducing greater differentiation based on functional needs, addressing shortages in therapeutic provision, and promoting balanced inclusion across educational settings will be critical to ensuring that Israel's system remains equitable, effective, and financially viable in meeting the diverse needs of children with ASD and their families.

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Notes

[1] The exact age limits for eligibility vary depending on the child's specific medical condition, impairment, or treatment. For example, a child with Down Syndrome may receive the allowance from birth, whereas a child diagnosed with ASD becomes eligible from 91 days of age.

[2] See https://www.btl.gov.il/English%20Homepage/Benefits/Disabledchild/Pages/vaadatlut.aspx for additional details on the NII's dependency assessment.

8

Autism policies in the Netherlands

This chapter analyses the Netherlands’ multi-layered approach to autism policy, combining strong legal protections, comprehensive healthcare provisions, and targeted social benefits. It outlines the country’s disability rights framework anchored in the Equal Treatment Act, the Participation Act, and the United Nations Convention on the Rights of Persons with Disabilities. Clinical practice is guided by national guidelines and the Autism Care Standard, ensuring structured diagnostic and treatment pathways. The chapter reviews financial supports such as the Double Child Benefit and the Personal Budget (PGB), highlighting strict eligibility criteria and regional variations that affect equitable access. It also examines therapeutic coverage under statutory health insurance and municipal Youth Care, alongside reforms introduced by the 2014 Act on Appropriate Education to promote inclusion. Finally, it considers persistent challenges, including gaps in service co-ordination, regional disparities, and the need for improved data collection to inform evidence-based policymaking.

In Brief

Autism policy in the Netherlands: Legal frameworks and available supports

- The Netherlands has a strong disability rights framework, anchored in the Equal Treatment Act (2003), the Participation Act (2015), and the United Nations Convention on the Rights of Persons with Disabilities (which it ratified in 2016), ensuring equal access and support across employment, healthcare, and daily life.
- Recent data from the National Health Survey show that, between 2022 and 2024, an average of 3% of the population reported having autism, a high share in international comparison.
- The Dutch Association of Psychiatry, in collaboration with other professional bodies, has developed comprehensive guidelines for ASD diagnosis and treatment. These guidelines emphasise multi-disciplinary assessment, developmental history, behavioural observation, and the use of standardised tools as supportive – but not standalone – measures.
- Two benefits are particularly relevant for families of a child with disability in the Netherlands: Double Child Benefit and Personal Budget (PGB). PGB is an individualised budget that allows recipients – in this case, typically the child's parents – to decide when, where, and by whom care services and other supports, such as assistive devices, are provided. PGB may also be used to compensate parents for the care they themselves provide to their child, provided that this care is set out in a formal care agreement and only for a maximum of 40 hours per week. Eligibility for PGB is determined by the extent of a child's care and support needs.
- A medical diagnosis of ASD alone does not entitle a child/family to neither a PGB nor a Double Child Benefit. Eligibility for Double Child Benefit requires a child to demonstrate extensive care and supervision needs. Children with ASD rarely meet these stringent care criteria and therefore typically do not receive Double Child Benefit. Consequently, the recent increase in Double Child Benefit recipients – from 33 000 in March 2020 to 52 000 in September 2025 – is unlikely to be explained by rising ASD rates in the Netherlands.
- The increase in ASD rates may have contributed to the moderate rise in enrolment in special schools (cluster 3 and cluster 4) in recent years, from 58 700 students in 2017/18 to 65 000 in 2023/24. These special schools, organised into four clusters corresponding to broad areas of need, serve children with extensive special educational needs. Cluster 4 schools cater to children with behavioural and psychiatric disorders, including ASD.
- In contrast, enrolment in special primary schools – a separate type of special education school in the Netherlands designed for children with mild learning or behavioural difficulties – has remained relatively stable over the same period.

Introduction

The Netherlands has developed an extensive and multi-layered approach to supporting individuals with autism spectrum disorder (ASD), combining strong legal protections, comprehensive healthcare provisions, and targeted social benefits. Autism is recognised as a mental health condition under Dutch law, and the country's disability framework is anchored in key legislation such as the Equal Treatment Act, the Participation Act, and the United Nations Convention on the Rights of Persons with Disabilities. Support for individuals with autism spans four major laws – the Long-Term Care Act, Youth Act, Social Support Act, and Health Insurance Act – ensuring coverage across the lifespan. Clinical practice is guided by detailed national guidelines for diagnosis and treatment, complemented by the Autism Care Standard, which consolidates best practices for care delivery.

Beyond healthcare, the Netherlands provides financial assistance to families through two main instruments: Double Child Benefit, which offers additional support for children with extensive care needs, and a so-called Personal Budget (PGB), enabling families to purchase tailored care services and, in some cases, compensate informal caregivers. Therapeutic services such as speech and occupational therapy are primarily covered by statutory health insurance, though caps and variations in coverage often require supplementary municipal support through Youth Care or PGBs. In education, the 2014 Act on Appropriate Education introduced significant reforms to promote inclusive schooling for children with special educational needs (SEN), including children with autism. Regional school partnership groups play a central role in allocating resources and determining placements in special education settings when mainstream schools cannot meet a child's needs.

The Netherlands has a strong legal framework for disability protection, including autism

Autism is a recognised disability under Dutch law and is generally treated as a mental health condition. Several legal acts form a strong disability framework in the Netherlands.

- The **Equal Treatment on the Grounds of Disability or Chronic Illness Act** of 2003 (*Wet gelijke behandeling op grond van handicap of chronische ziekte*, WGBH/CZ) ensures equal rights for people with disabilities and chronic illnesses in employment, through the provision of goods and services, in their living situation, in public transport and in their private life (Staatsblad, 2003[1]).
- In 2015, the **Participation Act** (*Gevolgen Participatiewet*) has replaced the previous Work and Social Assistance Act (*Wet Werk en Bijstand*, WsW) and in part, the Young Disabled Persons Act (*Wajong*). The Participation Act ensures support for people partially incapacitated for work for a longer period and employed by a regular employer. The Young Disabled Persons Act covers those who are fully and permanently incapacitated for work (NVA, 2019[2]; Rijksoverheid, 2019[3]).
- In July 2016, the Netherlands also ratified the United Nations Convention on the Rights of Persons with Disabilities, extending equal access requirements to all areas of life.

The Netherlands recognises that autism can impact all areas of daily living, such as self-care, housing, school, work, and relationships. Support for autism can therefore fall under four separate laws depending on the age of the individual and their need for assistance. Depending on the law to which the support a person is receiving belongs, assistance is reimbursed or paid by different types of insurers. These four laws are the following (for more information see the section on Personal Budget) (Vanuit Autisme Bekeken, 2021[4]):

- Long-term Care Act (*Wet langdurige zorg*, Wlz);
- Youth Act (*Jeugdwet*, JW);
- Social Support Act (*Wet maatschappelijke ondersteuning*, Wmo);
- Health Insurance Act (*Zorgverzekeringswet*, Zvw).

Recent data from the Netherlands shows an upward trend in self-reported ASD

The Netherlands has started collecting data on self-reported rates of autism only very recently and found that in the period of 2022-2024, on average, 3% of the population reported having autism. The analysis based on the National Health Survey also looked at differences between age groups, incidence of co-morbid anxiety and depression, and the employment status of those reporting to have ASD (Statistics Netherlands, 2025[5]).

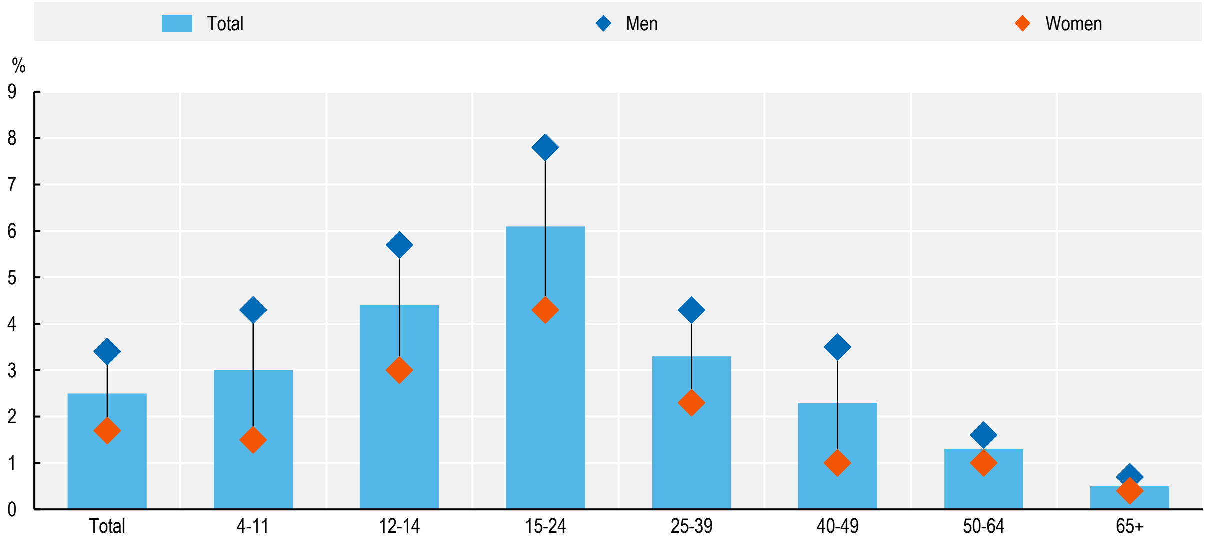
The Netherlands has some of the highest ASD rates among OECD countries

The Netherlands has started only recently to collect data on ASD rates. Data are collected annually through a population-level survey, the National Health Survey. In 2022, the question “Do you/does your child have autism spectrum disorder, or ASD, such as Asperger’s Syndrome or PDD-NOS?” was introduced, which in 2024 was simplified to: “Do you/does your child have autism spectrum disorder, or ASD?" (Statistics Netherlands, 2025[5]).

Based on this self-reported measure, 3.4% of men and 1.7% of women reported having ASD on average between 2022-24 (Figure 8.1). Across age groups, 15-24-year-old self-reported the highest rate of autism (6.1%), followed by 12-14-year-olds (4.4%), both markedly higher than the average of 2.5% for the overall population (Statistics Netherlands, 2025[5]). The high self-reported rates are an indication of lower stigma than in the past but must also be compared with caution due to possible misreporting. According to one clinician, half of the cases where parents think their child has ASD end up not receiving a diagnosis.

Figure 8.1. In the Netherlands the population reports high rates of ASD

Share of the population reporting to have ASD (self-reported) by age and sex, average 2022-2024



ASD: autism spectrum disorder.

Note: ASD is measured as the share of people who answered "yes" to the following question: "Do you/does your child have autism spectrum disorder, or ASD?". Prior to 2024, the question was: "Do you/does your child have autism spectrum disorder, or ASD, such as Asperger’s Syndrome or PDD-NOS?"

Source: Statistics Netherlands (2025[5]), *3 percent of the population report having autism spectrum disorder*, https://www.cbs.nl/en-gb/news/2025/14/3-percent-of-the-population-report-having-autism-spectrum-disorder.

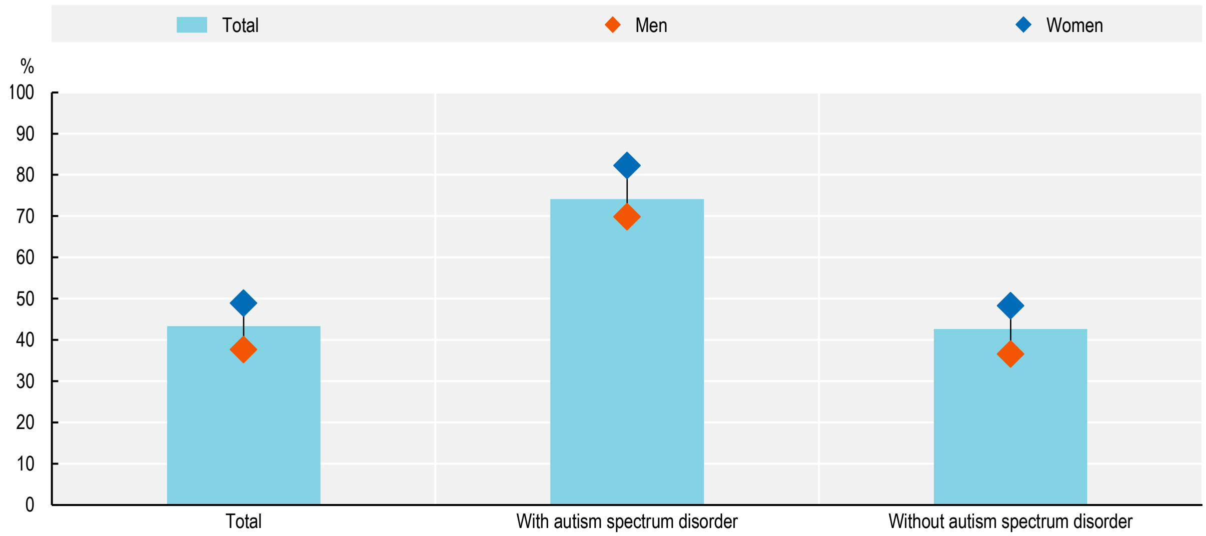
StatLink https://stat.link/a15uj9

Anxiety and feelings of depression are common among those with ASD

According to a recent analysis of Statistics Netherlands, those aged 12 years and above with ASD are much more likely to experience anxiety or feelings of depression than those without ASD – on average 74% of those with ASD reported having anxiety and feelings of depression in 2022-2024, compared to 42.6% of those without ASD (Figure 8.2). Women are generally more prone to reporting anxiety and feelings of depression, and this trend remains the same among those with ASD.

Figure 8.2. Dutch people with ASD experience anxiety and feelings of depression very frequently

Share of persons aged 12 and over who reported feeling anxious or depressed, by reported ASD and sex, average 2022-2024



ASD = autism spectrum disorder.
Note: Whether a person experiences feelings of anxiety or depression is derived from a score of 76 or lower in people aged 12 years or older on the Mental Health Inventory (MHI-5) for adolescents and adults.
Source: Statistics Netherlands (2025[5]), *3 percent of the population report having autism spectrum disorder*, https://www.cbs.nl/en-gb/news/2025/14/3-percent-of-the-population-report-having-autism-spectrum-disorder.

StatLink https://stat.link/6vt7uc

The Netherlands has extensive guidelines for the diagnosis and treatment of ASD

The Dutch Association of Psychiatry (*Nederlandse Vereniging voor Psychiatrie*, NVvP) has a leading role in developing and endorsing clinical guidelines for psychiatric and mental disorders that serve as industry best practice in psychiatry and mental healthcare. In co-operation with other professional associations, such as the Federation of Medical Specialists (*Federatie Medisch Specialisten*) and the Dutch Institute of Psychologists (*Nederlands Instituut van Psychologen*, NIP), the NVvP has developed guidelines for the diagnosis and treatment of ASD in both children and adults (NVvP, 2025[6]; NVvP and NIP, 2013[7]).

The latest clinical guideline for children and young people was published in May 2025 (NVvP, 2025[6]), an important update from the previous guideline dating back to 2009 (NVvP, 2009[8]). The guideline is based on the UK's NICE and the European Society of Child and Adolescent Psychiatry (ESCAP)'s guidelines. The NVvP guideline suggests that a diagnostic assessment starts with information gathering to help gain a full understanding of the child's development and concerns. This step may include information gathering about the following aspects (NVvP, 2025[6]):

- Early development, including pre- and perinatal factors and course of development to date
- Functioning of the child within the family
- Previous diagnoses and interventions
- Relevant family history

Following this, it is recommended to compare the behaviour of the child with their developmental age, intelligence level and language skills. This step can include several tests, such as a general developmental test, an intelligence test and a language test (NVvP, 2025[6]).

Combined with medical history, a physical examination is recommended to rule out any underlying co-morbid medical conditions. The physical examination can include the following (NVvP, 2025[6]):

- Assessment of current and past physical health
- Vision and hearing test
- Genetic testing

To assess autistic traits (social communication skills, restricted and repetitive behaviour), the diagnosing professionals should – according to the guideline – gather information from direct interaction with the child, as well as from parents and carers about the child's behaviour in diverse settings, e.g. home, day care, school. Behavioural observation should be done by a child psychiatrist, psychologist or developmental educationalist. The child's functioning in different settings should also be observed (NVvP, 2025[6]).

The guideline also underlines that standardised tools may be used as a support but never as a substitute for the clinical diagnostic process. The guideline recommends the use of the following tools as a support instrument for assessment: Childhood Autism Rating Scale (CARS); Social Communication Questionnaire (SCQ); Autism Quotient - child module (AQ-child); Social Responsiveness Scale (SRS); and two Dutch measures, the Children's Social Behaviour Inventory Questionnaire (*Vragenlijst voor Inventarisatie van Sociaal gedrag van Kinderen*, VISK/CSBQ) and the Autism Spectrum Questionnaire (*Autisme Spectrum Vragenlijst*, ASV). Instruments recommended for children with intellectual disability are the appropriate modules of the Autism Diagnostic Observation Schedule (ADOS/ADOS-2) and the Autism Diagnostic Interview – Revised (ADI-R). Finally, DSM-5-TR criteria (or its Dutch equivalent, DC:0-5) should be used to assess ASD and other related psychiatric issues (NVvP, 2025[6]). Guidelines recommend that diagnosis is done by a specialist multi-disciplinary team, but in practice this is not always possible. Diagnosis is usually done through Health Maintenance Organisations (HMOs), by a healthcare psychologist or a child psychiatrist.

Autism Care Standard

In 2017, the Autism Care Standard (*Zorgstandaard Autisme*) was published for the first time by the Alliance for Quality in Mental Healthcare (*Alliantie kwaliteit in de geestelijke gezondheidszorg*, Akwa GGZ). Akwa GGZ is an alliance that comprises organisations representing patients, their families, professionals, as well as other industry organisations in the mental health sector, such as insurers and HMOs. Akwa GGZ develops standards of care for all areas of mental healthcare, gathers tools and evaluates care processes in the mental healthcare system. First created in 2017, and reviewed in 2022, the Autism Care Standard covers areas of early detection, diagnosis and monitoring, as well as treatment and organisation of care and, more generally, quality indicators. The care standard consolidates best practices across the lifespan and is widely accepted as the standard of care for autism in the Netherlands. The care standard is also in line with NVvP guidelines (Akwa GGZ, 2023[9]).

The Netherlands offers two allowances relevant for children with ASD

Families in the Netherlands receive a quarterly, non-means-tested Child Benefit for each child, with amounts differentiated across three age bands. Children that require extensive care – which may be the case for some children with ASD – entitle their parents to twice the standard rate, referred to as the Double Child Benefit (*Dubbele Kinderbijslag*) (Sociale Verzekeringsbank, n.d.[10]). As of July 2025, the quarterly rates of the Double Child Benefit, which is administered by the Dutch Social Insurance Bank (*Sociale Verzekeringsbank, SVB*) are:

- Children aged 3-5: EUR 583
- Children aged 6-11: EUR 708
- Children aged 12-17: EUR 833

If a child has extensive care needs and the family has received the Double Child Benefit for a full year, parents may also qualify for an additional, means-tested annual payment of EUR 2 702 (in 2025) (Sociale Verzekeringsbank, n.d.[11]).

In addition, families can apply for a Personal Budget (*Persoonsgebonden Budget, PGB*) which is a benefit available to both adults and children. Eligibility assessment and approval for a PGB are conducted either by the municipality or another competent authority, depending on the type of care required. Unlike Double Child Benefit, PGB is not allocated according to predefined age-based tiers; rather, it is fully tailored to the child's individual support needs. Its purpose is to help offset disability-related costs, such as specialized assistance or personnel, with a primary focus on funding care services. Neither Double Child Benefit nor PGB is means-tested (Government of the Netherlands: Ministry of Health, Welfare and Sport, n.d.[12]).

Double Child Benefit is available for children with extensive care needs

Parents of a child with extensive care needs may qualify for double the standard quarterly Child Benefit, providing additional financial support. Unlike the regular Child Benefit, which is available from birth until age 18, the Double Child Benefit is restricted to children from age 3 onwards (Sociale Verzekeringsbank, n.d.[13]). While a medical diagnosis alone, for example a diagnosis of ASD, does not confer entitlement, it is required within the care assessment process (Centrum Indicatiestelling Zorg, n.d.[14]). However, eligibility for the Double Child Benefit depends primarily on whether the child's care requirements are extensive. This must be confirmed through a positive recommendation issued by the Care Needs Assessment Centre (*Centrum Indicatiestelling Zorg, CIZ*) which is the national authority responsible for determining the long-term care needs of individuals of all ages (Sociale Verzekeringsbank, n.d.[13]).

The CIZ issues a positive recommendation where the child either holds an existing long-term care indication under the Long-term Care Act (*Wet langdurige zorg*, Wlz), as determined by the CIZ, or meets the eligibility threshold under the care and supervision assessment framework for the Double Child Benefit. In the absence of a Wlz indication, the CIZ initiates the care and supervision assessment for the Double Child Benefit (Centrum Indicatiestelling Zorg, n.d.[15]). In recent years, administrative co-ordination has been streamlined: a positive Wlz indication can now be automatically shared with the SVB, and the SVB may in turn directly ask the CIZ for advice to determine whether the child indeed requires intensive care (Centrum Indicatiestelling Zorg, n.d.[14]).

To receive a Wlz indication for their child, parents may apply digitally or by post, enclosing documentation from the child's treating physician or specialist confirming the child's diagnosis, functional limitations, and ongoing and anticipated medical treatments. Additional reports from other professionals, such as teachers or therapists, may be provided to support the assessment. A Wlz indication can only be granted if the child:

- has a formally diagnosed intellectual disability, physical illness or disability, or sensory impairment,
- requires continuous supervision or proximity of a caregiver throughout day and night, and

- care needs are expected to be lifelong (Centrum Indicatiestelling Zorg, n.d.[16]).

As mentioned above, if the child does not have a Wlz indication, they may still qualify for the Double Child Benefit, with eligibility determined through a care and supervision assessment conducted by the CIZ. In addition to handing in their child's medical documentation, stating the child's medical diagnosis, parents must complete a questionnaire describing their child's everyday care and supervision needs and authorise the CIZ to consult professionals working with the child for further information (Centrum Indicatiestelling Zorg, n.d.[14]). If unclear or insufficient evidence is provided, the CIZ may request additional documents or conduct a video call with the parents and their child or a home visit.

In reviewing submitted information, particularly the parent questionnaire, the CIZ applies a two-component assessment framework – care and supervision – each divided into five functional domains:

- Care: personal hygiene, toileting, eating and drinking, mobility, medical care
- Supervision: behaviour, communication, being home alone, supervision outside the home, engagement and guidance

For each domain in which the CIZ finds intensive support is required, the child receives a score. To be deemed eligible, the minimum number of scored domains is:

- At least 5 domains for children aged 3-5
- 4 domains for children aged 6-9
- 3 domains for children aged 10-17 (Centrum Indicatiestelling Zorg, n.d.[15])

According to anecdotal evidence, children with ASD often do not satisfy the strict criteria relating to continuous care and supervision, resulting in comparatively low eligibility for Double Child Benefit. Reassessments of a child's care needs are generally not routine and conducted only in exceptional cases where the child's condition has significantly changed.

Personal Budget offers funding to purchase disability-related services

Parents of a child with extensive care needs may also apply for a Personal Budget (*Persoonsgebonden Budget*). The PGB is an alternative to receiving care services from the municipality, a care administration office, or the health insurance fund. It provides individuals that require care with a budget that enables them to choose who delivers care and support, as well as when and where it is provided (Government of the Netherlands: Ministry of Health, Welfare and Sport, n.d.[17]). The PGB can also be used to cover other disability-related expenses, such as assistive equipment, residential modifications, household support, respite care, or mobility aids such as wheelchairs (Gemeente Amsterdam, n.d.[18]).

The PGB is regulated under four separate legal frameworks, with the applicable law depending on the nature and intensity of the care required:

- Youth Act (*Jeugdwet*) – Governs most forms of care and support for children and adolescents under the age of 18, including, for example, day care and guidance.
- Social Support Act (Wmo) – Aims to help people live independently at home for as long as possible and to promote the social participation of persons with disability. A PGB under the Wmo act may cover assistance with daily living, personal support, or domestic help.
- Health Insurance Act (Zvw) – Applies to children and adults who require nursing or personal care for longer than one year, including palliative and terminal care.
- Long-term Care Act (Wlz) – Designed for individuals with chronic illnesses or disability who require permanent supervision or intensive care. A PGB under the Wlz act can be used to purchase comprehensive personal and nursing care services (Government of the Netherlands, n.d.[19]).

Children with ASD would typically receive a PGB under the Youth Act, unless their care needs are so extensive that they require continuous supervision and qualify under the Wlz which remains relatively rare. PGBs under the Youth Act are administered by municipalities (Government of the Netherlands, n.d.[19]). Parents applying for a PGB must provide detailed information about their child's daily care and support needs and the type of care and support required. The municipality reviews the documentation and conducts an in-person meeting to discuss the child's needs in more detail before determining the size of the budget to be granted (PerSaldo, n.d.[20]). A formal medical diagnosis is not a strict requirement. Notably, assessment procedures, budget ceilings, and the hourly rates paid to caregivers under the Youth Act differ across municipalities (Government of the Netherlands, n.d.[21]).

Recipients of a PGB – or, in the case of children, their parents – must be proven capable of self-managing the budget, including contracting, scheduling, and supervising care providers. The PGB also allows for informal care arrangements, meaning that relatives or friends can provide care and be compensated through the PGB. Parents of a child with ASD can therefore receive payment for the care they provide themselves, subject to a formal care agreement specifying the type of care, duration, and hours, all of which require municipal approval. The hourly rate for such informal care is set by individual municipalities and typically corresponds to, or is close to, the statutory minimum wage. Formal caregivers hired through the PGB are remunerated at higher rates. Compensation for informal care is capped at 40 hours per week (Government of the Netherlands, n.d.[21]).

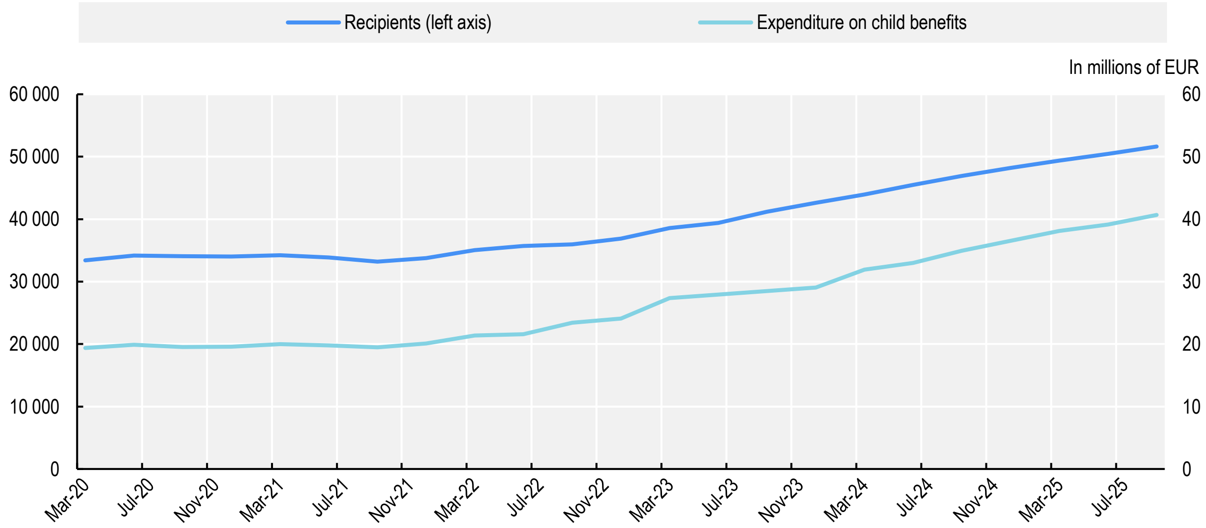
Expenditure on and uptake of Double Child Benefit has been increasing

While the number of Double Child Benefit recipients remained relatively stable until March 2022, it has risen steadily since then, reaching approximately 52 000 recipients in September 2025 compared with around 33 000 in March 2020 (Figure 8.3). This represents an increase of 57.6% in just five years. Total quarterly expenditure – covering both Child Benefit and Double Child Benefit – has grown in parallel. Quarterly spending increased from EUR 19.4 million in March 2020 to EUR 40.7 million in September 2025, thus, more than doubling over the same five-year period.

There is no data available on the diagnosis of children receiving Double Child Benefit. There is also a lack of longer-term trend data on ASD prevalence in children. Given consistent anecdotal evidence that children with ASD rarely meet the eligibility criteria for Double Child Benefit and will thus only receive the standard Child Benefit in most cases, the growth in the Double Child Benefit caseload in the Netherlands over the past five years is unlikely to be explained predominantly by increasing ASD rates.

Figure 8.3. The number of Double Child Benefit recipients has recently grown significantly

Double Child Benefit recipients per quarter and total expenditure on Child Benefit and Double Child Benefits (March 2020 – September 2025)



Note: Combined quarterly expenditure on Child Benefit and Double Child Benefits.
Source: Data provided by the Dutch Social Insurance Bank (*Sociale Verzekeringsbank*).

StatLink https://stat.link/qdb25h

Therapies are typically covered by statutory health insurance but may be capped

Children who require therapeutic services, such as speech and occupational therapy, generally access these therapies in the Netherlands through one of three pathways: through statutory health insurance, through municipalities (either in-kind or via a PGB), and, in some cases, through school-based services. As in countries such as Germany, the most common coverage is through statutory health insurance which depends in part on whether the child receives therapy from a provider contracted by the health insurer or from a non-contracted provider. In the latter case, parents typically need to present a doctor's referral confirming the child's diagnosis and the medical necessity of the therapy for the insurer to cover the costs. Coverage also varies by type of therapy – for example, speech therapy is typically uncapped, while occupational therapy may be subject to annual limits, often around ten sessions per year – and by the chosen insurance provider and insurance plan (CAK, n.d.[22]; Child Development, n.d.[23]; HollandZorg, n.d.[24]). Overall, however, statutory health insurance is the primary mechanism for accessing and financing therapeutic services in the Netherlands.

If a child's needs for therapy exceed what health insurance will cover, or if parents seek more specialised therapies, such as music therapy, they may request support from their municipality under Youth Care (*Jeugdhulp*). The municipality's therapeutic services can be provided either in-kind or through a PGB (see details above), which enables families to purchase therapies directly. When applying for Youth Care, the first contact point is typically a youth or neighbourhood team, followed by an in-person meeting with a municipal professional to explore the child's challenges and needs and determine the type and duration of services required. If in-kind provision of therapies is appropriate, parents are referred to contracted municipal providers; if not, a PGB may be granted. A medical diagnosis does not determine eligibility for Youth Care. Rather, the focus lies on the child's individual needs and the supports required to address them (Government of the Netherlands, n.d.[25]; n.d.[26]; n.d.[27]; n.d.[28]).

Finally, although uncommon in regular schools, some special education schools employ in-house therapists who provide on-site therapeutic support. These services are financed directly by the school from its budget allocated by the Regional School Partnership Group (*samenwerkingsverband*). If a child's need for therapy is determined, therapy sessions would be integrated into the school's educational offer for the child. The availability of such services, however, varies across schools.

The regional level plays a central role in the organisation of SEN provisions

A reform in 2014 introduced significant changes to the Dutch education system

With the introduction of the Act on Appropriate Education in 2014, the Netherlands embarked on a more inclusive approach to supporting children with special educational needs. The Act places a duty of care on schools, requiring them to offer every student a learning environment suited to their needs – an approach referred to as "appropriate education" (*passend onderwijs*) (Inspectorate of Education, n.d.[29]). Its core objective is to promote inclusive learning environments at mainstream schools, encouraging students with SEN to attend regular schools rather than special education settings.

The Act also brought significant changes to the financing of special education support. Prior to 2014, schools received earmarked funding for each student with SEN. Since the reform, however, schools have been allocated a general budget intended to support inclusive education for all students (Eerste Kamer der Staten-Generaal, n.d.[30]). One of the drivers behind this shift was the rapidly rising cost of earmarked SEN budgets. By moving to a throughput funding model (see Chapter 4 for more information on funding models), the Netherlands aimed to ensure greater sustainability while enabling a larger number of students to receive support within an inclusive educational framework.

Children are placed in a special education school only when all other options have been exhausted

The allocation of funding to individual schools is managed through *samenwerkingsverbanden* (regional school partnership groups) that include all schools – mainstream and special – within their area. There are roughly 150 such school partnership groups across the Netherlands (Floor Kaspers, 2025[31]). One of their core responsibilities is to distribute the government's funding among the schools they represent. Within each regional partnership group, schools jointly assess needs and determine how resources should be allocated. For example, a school with a significant number of students requiring special education support may request additional funding to better meet those pupils' needs. Each regional group also decides autonomously whether to limit its role to funding allocation or to develop its own specialised expertise, such as teams of special education teachers or behavioural specialists, who can then be deployed to their schools as needed.

Since the introduction of the 2014 Act on Appropriate Education, children with SEN are increasingly encouraged to attend mainstream schools, where they should receive the support necessary to participate on an equal basis with their peers. Parents can choose their child's school. The school then carries a statutory duty of care to provide appropriate support. The type or level of additional educational support that should be offered, such as for a child with ASD, is not regulated nationally; these decisions lie with individual schools. However, work is currently underway to define statutory minimum support standards for children with ASD. If a school lacks the expertise or resources required to accommodate a child's needs, it may request additional support from its regional partnership group, such as extra funding for psychological services or specialist input. If, even with this support, the mainstream school cannot provide an adequate learning environment, it must find an alternative suitable school, which may involve a special education school (Inspectorate of Education, n.d.[29]).

The Netherlands distinguishes two types of special education schools: Special Primary Schools (*Speciaal Basisonderwijs*) and Special Schools (*Speciaal Onderwijs*). Special Primary Schools follow the curriculum of regular primary schools but offer smaller class sizes and more individualised support, primarily for children with mild learning or behavioural difficulties. Special Schools serve children with more substantial support needs and provide adapted curricula, specialised teaching methods and staff, and much smaller class sizes (Floor Kaspers, 2025[32]). These Special Schools are organised into four clusters, each corresponding to a broad area of need:

- Cluster 1: Visual impairments
- Cluster 2: Hearing impairments and speech-language difficulties
- Cluster 3: Physical disabilities and chronic illnesses
- Cluster 4: Behavioural and psychiatric disorders

A child with ASD, like a child with ADHD, who is assessed to be best placed in a Special School would typically attend a Cluster 4 school. Importantly, medical diagnoses alone do not determine access – in fact, a formal medical diagnosis is not even needed. Instead, placement in a Special School as well as in a Special Primary School requires a Declaration of Admissibility (*toelaatbaarheidsverklaring, TLV*), issued by the regional school partnership group after assessing the child's support needs. Usually, the child's regular school initiates the TLV request to a TLV-Commission within their partnership group, already specifying the child's needs and support measures taken (Floor Kaspers, 2025[33]). These Commissions typically include educational, social, and health professionals (Partnership for primary education Amsterdam Diemen, n.d.[34]). Assessments are not standardised nationally – there are no uniform guidelines or assessment tools – and procedures may thus vary considerably across regional school groups. They are, however, mostly document-based, drawing on school reports and evaluations from professionals, with in-person meetings with teachers, parents, and the child conducted as deemed relevant. Parental involvement is central to the process (Partnership for primary education Amsterdam Diemen, n.d.[34]; Floor Kaspers, 2025[33]), though the degree of engagement may differ by region, too.

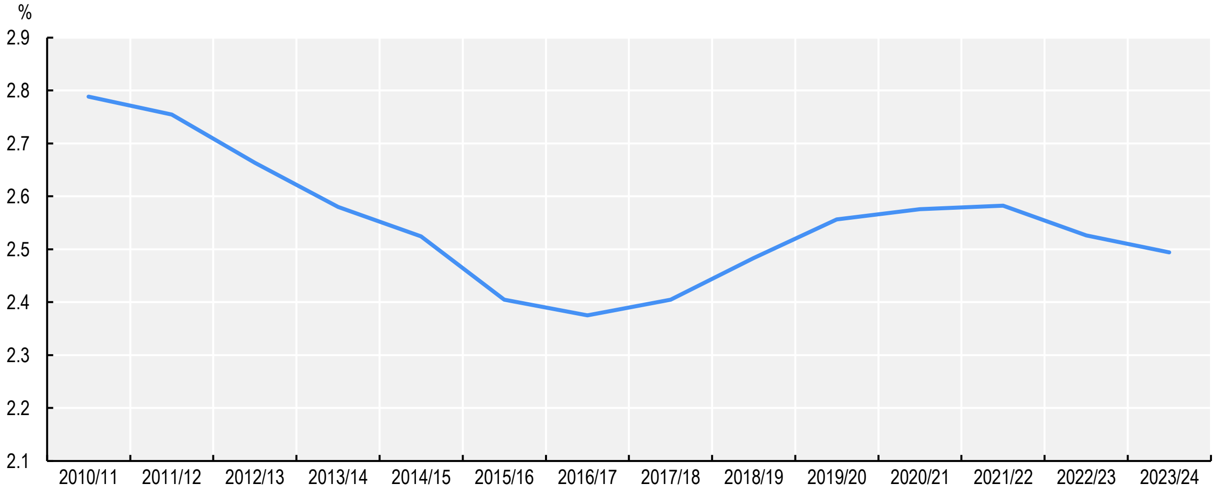
If the TLV-Commission concludes that a Special School is the most appropriate setting, it prepares an agreement outlining the child's goals, required supports and level of funding. While such a Development Perspective Plan is recommended for mainstream schools when a child requires additional support, it is mandatory in Special Schools (Nederlands Jeugdinstituut, n.d.[35]). TLVs are issued for a fixed period, typically two years, and specify the approved duration of placement. As expiry approaches, the school must review the child's progress and needs to determine whether to request a new TLV from their regional partnership group (Inspectorate of Education, n.d.[36]).

Enrolment in special education has remained relatively constant over recent years

While the overall share of students in Special Primary Education relative to those in Regular Primary Education appears slightly lower after the 2014 Act on Appropriate Education, the change is marginal (Figure 8.4). Between 2010 and 2024, the share of students in Special Primary Education has remained about 2.4%-2.8% – i.e. a rather small share of students attending special education settings throughout the period. It is important to note that the Netherlands does not have a national definition of special educational needs. As a result, children in regular schools requiring additional educational support are not centrally registered, making systematic data collection on this group impossible.

Figure 8.4. The share of special primary students has remained relatively stable over time

Students in Special Primary Schools as a share of students in all primary schools (2010/11-2023/24)



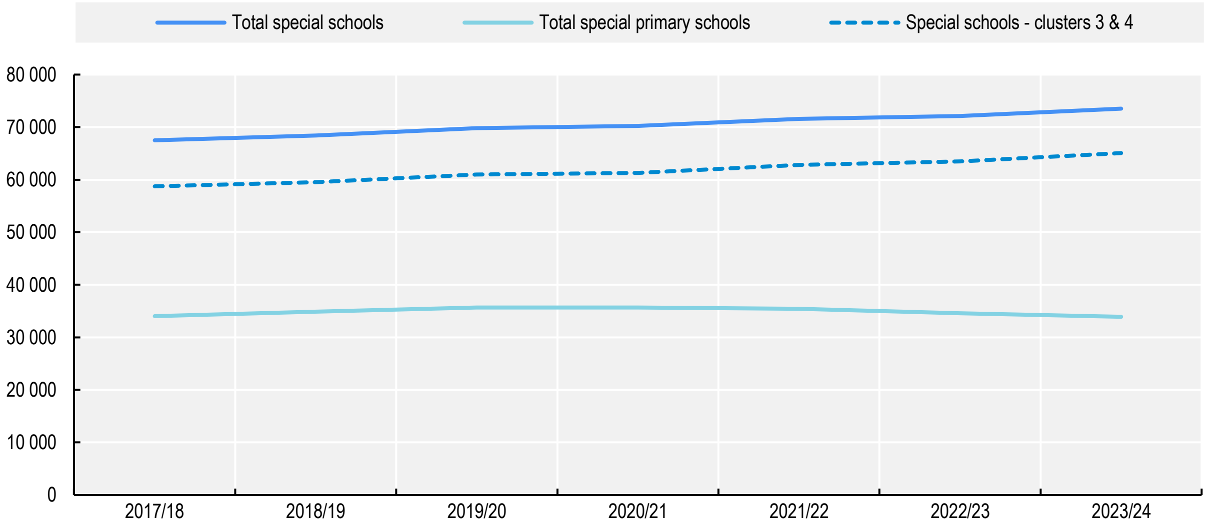
Note: Students in Special Primary Schools are those in *Speciaal Basisonderwijs*, i.e. not those in *Speciaal Onderwijs*.
Source: Based on Statistics Netherlands (2025[37]), *StatLine*, https://opendata.cbs.nl/#/CBS/nl/.

StatLink https://stat.link/ymkq60

Figure 8.5 further demonstrates that enrolment in Special Primary Schools has remained relatively stable in recent years. By contrast, the total number of students in Special Schools (*Speciaal Onderwijs*) has increased moderately, from around 67 500 in 2017/18 to approximately 73 500 in 2023/24. This growth is driven by rising enrolments in Cluster 3 and Cluster 4 Special Schools. As noted earlier, ASD is assigned to Cluster 4. This aligns with anecdotal evidence suggesting that children with ASD are increasingly being educated in Special Schools rather than in mainstream settings in the Netherlands. Additional anecdotal evidence also points to rising enrolment in Cluster 3, as well as suggests that a substantial proportion of children currently out of school in the Netherlands are children with ASD.

Figure 8.5. Children attendance in Cluster 3 and 4 Special Schools has been rising slightly

Students by school type, the Netherlands, 2017-2024



Note: "Total Special Schools" covers all four Clusters of *Speciaal Onderwijs* at both the primary and secondary levels. Data for Cluster 1 and Cluster 2 Special Schools are not shown separately due to their small enrolment numbers, but the figure presents the combined category "Special Schools – Cluster 3 & 4". The category "Total Special Primary Schools" refers to all *Speciaal Basisonderwijs*, which constitute a separate type of school distinct from *Speciaal Onderwijs*.
Source: Statistics Netherlands (2025[37]), *StatLine*, https://opendata.cbs.nl/#/CBS/nl/.

StatLink https://stat.link/kp62ua

Conclusion

The Netherlands has established a strong foundation for effective support for children with ASD through comprehensive legislation, clinical guidelines, and care standards. Other countries can learn from the Netherlands' integrated approach, which combines strong disability rights, detailed clinical guidance, and multi-tiered financial and educational support mechanisms. In particular, the Dutch system stands out for its non-means-tested allowances, such as the Personal Budget, which provides families with flexibility and autonomy in arranging care. Similarly, statutory health insurance ensures broad access to essential therapies like speech and occupational therapy, reducing financial barriers for most families.

Nevertheless, policy challenges persist across healthcare, social protection, and education. Financial supports, Double Child Benefit and the Personal Budget, provide important relief for families, yet strict eligibility criteria and significant regional variation in PGB administration limit equitable access. Similarly, while statutory health insurance covers core therapies, caps on certain services and inconsistent municipal provisions can leave gaps in care, particularly for families seeking specialised interventions. In education, the Act on Appropriate Education has advanced inclusion, but disparities in regional practices and the absence of national minimum standards for ASD-specific support hinder consistent implementation. Harmonising benefit eligibility and municipal procedures for Personal Budgets would seem desirable and improving data collection on autism prevalence, service uptake and outcomes would help guiding evidence-based policymaking.

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9

Autism policies in Sweden

This chapter examines Sweden’s evolving policy response to autism within its universal welfare system. It traces the shift from early references to “child psychosis” to a rights-based framework aligned with the United Nations Convention on the Rights of Persons with Disabilities since 2008. Key reforms include the Swedish Education Act mandating mainstream inclusion, and the introduction of three allowances (Care Allowance, Assistance Allowance, and Additional Cost Allowance) designed to support families based on assessed needs rather than diagnosis alone. The chapter reviews recent national guidelines for ADHD and autism, emphasising multi-disciplinary assessment and early intervention. It also explores inclusive education practices, funding mechanisms, and trends in benefit uptake amid rising autism diagnoses. Finally, it highlights Sweden’s holistic approach, combining financial support, paramedical therapies, and social services to promote participation and equity for children with ASD.

In Brief

Sweden’s autism policy: Social inclusion and needs-based support

- Sweden was slow to abandon the term “child psychosis” at first but has come a long way since. Since 2008, disability policy has been broadly in line with the United Nations Convention on the Rights of Persons with Disabilities, for instance through the Swedish Education Act, according to which all students should be included in mainstream schooling. In 2019, Sweden introduced two new disability allowances: Care Allowance and Additional Cost Allowance.
- Rates of autism diagnosis and contacts with the healthcare system have grown in Sweden, at least in the past 15 years. In response, the National Board of Health and Welfare has issued a national guideline for ADHD and autism in 2022 (updated in 2024), outlining recommendations for treating children and adults with ADHD and autism in the health and social care system.
- Sweden’s Social Insurance Agency offers three distinct allowances for children with disability. A Care Allowance recognising the care parents provide to their child; an Assistance Allowance ensuring the child can participate in society on an equal basis through individually tailored support provided by an assistant; and an Additional Cost Allowance designed to help parents cover extra expenses exceeding what is typical for children of the same age.
- Care Allowance is by far the most common allowance for families in Sweden, with 100 000 parents receiving it in July 2025. Children with pervasive developmental disorders (F84) accounted for nearly one-third of this group. In contrast, only 14% of children receiving an Additional Cost Allowance and 17% of those receiving an Assistance Allowance in 2024 had an F84 diagnosis.
- Eligibility for Sweden’s allowances is primarily determined by a child’s support and care needs. A formal medical diagnosis is only needed for Assistance Allowance, but a diagnosis alone is not sufficient, as a child must also demonstrate extensive daily support needs. Reassessments are conducted regularly for Care Allowance and Additional Cost Allowance but take place on an ad hoc basis for Assistance Allowance, triggered by signs that circumstances have changed.
- Since 2021, the number of newly granted Care Allowances for children with an F84 diagnosis has decreased following a spike associated with the transition from the former Care Allowance for Disabled Children to the new Care Allowance in 2019. The continued downward trend suggests that Sweden’s reliance on support needs assessments helps insulate the allowance from the broader national increase in autism diagnosis rates. The same phenomenon can be observed with the Additional Cost Allowance.
- Sweden strongly promotes the inclusion of children with SEN in mainstream education, where around 75% are enrolled. To ensure appropriate placement, comprehensive support needs assessments are carried out, which may recommend enrolment in an *Adapted School* or a *Special School* if necessary.
- Paramedical therapies for children with disability, such as speech and occupational therapy, are publicly funded and provided free of charge, most commonly through regional habilitation centres following a doctor’s referral. In addition, Sweden offers a broad range of social services for children with disability, many of which are guaranteed under Sweden’s Support and Service for Persons with Certain Functional Impairments Act.

Introduction

Sweden’s policy approach to autism has undergone significant transformation over the past decades, moving from the early use of the term “child psychosis” to a comprehensive, rights-based framework aligned with the UNCRPD since 2008. In response to rising rates of autism diagnosis and increased contact with the healthcare system over the past 15 years, the National Board of Health and Welfare introduced national guidelines for ADHD and autism in 2022, updated in 2024, providing evidence-based recommendations for the care and support of children and adults.

Eligibility for financial support is primarily based on assessed care and support needs rather than diagnostic status, with three main allowances available under Sweden’s social protection framework: the Care Allowance (replacing the former “Care Allowance for Disabled Child”), the Additional Cost Allowance and the Assistance Allowance. Among these, the Care Allowance is the most widely accessed, although the number of new grants for children diagnosed with autism has declined in recent years. Sweden places strong emphasis on inclusive education, with approximately three-quarters of children with special educational needs enrolled in mainstream schools and supported through comprehensive assessments and, where necessary, adapted or special school placements. In addition, a wide range of paramedical and social services – most of which are publicly funded and provided free of charge under the LSS (*Lagen om stöd och service till vissa funktionshindrade,* Act Concerning Support and Service for Persons with Certain Functional Impairments) – ensure that children with disability, including autism, receive multi-disciplinary support to promote their development and participation. This case study examines how these policies have evolved in practice and their take-up by children with autism in Sweden.

For long referred to as “child psychosis”, autism awareness started increasing in Sweden from the late 1970s onwards

In Sweden, up until the 1980s, autism was referred to as “child psychosis”, even though most of the world already converted to the term “autism” (see Chapter 2 for more information). In 1972, a parent-led advocacy organisation called “Association for Psychotic Children” was founded (now: Autism Sweden), with schooling of children with ASD as one of the focal issues of the association in its early years (Autism Sverige, 2013[1]). The founding of the association marked a turning point in social attitudes towards children with autism and their families in Sweden.

In 1976, the Swedish Parliament approved motion 1975/76:559 about the teaching of psychotic children in special education. The act included instructions to set up special education classes for children with autism in special education schools (Sveriges Riksdag, 1976[2]).

In 1982, the Swedish Government’s *Omsorgskommittén* (Care Committee) published a proposal for a new disability legislation, including “childhood psychosis” as a separate group. Two years later, in 1984 the government set up the “Rebecka Project”, a national initiative to set up services for children with ASD across the country. Finally, in 1986, Sweden enacted a new legislation for people with disabilities, the *Omsorgslag* (Care Act for persons with certain disabilities). This marked the recognition of autism as a disability in Sweden, separate from intellectual disability and psychiatric disorders (Autism Sverige, 2013[1]).

In the 1990s, the term “childhood psychosis” was completely abandoned in Sweden and disability policies were also reviewed, greatly benefiting children with ASD. In 1993, Sweden saw the introduction of the “LSS law” (Act Concerning Support and Service for Persons with Certain Functional Impairments). Under the new law, three categories of functionally impaired persons were targeted, one of them being “persons with an intellectual disability, autism or a condition resembling autism” (Socialstyrelsen, 2009[3]). The Act made counselling, personal assistance and other services available for children and adults with autism (ibid.).

The UNCRPD paved the way for more inclusive disability policies in Sweden

In 2008, Sweden ratified the United Nations Convention on the Rights of Persons with Disabilities. Progressively, education and employment policy in Sweden became more inclusive (van Kessel et al., 2019[4]). The 2008 Discrimination Act (Discrimination Act 2008:567) made it compulsory for schools, employers and public services to accommodate people with disability, including people with autism (Equality Ombudsman, 2025[5]).

In 2010, the Swedish Education Act (Education Act 2010:800) entered into force. According to the Act, all persons should be included in mainstream schooling, and placement in special education classes should be used only as a last resort (van Kessel et al., 2019[4]).

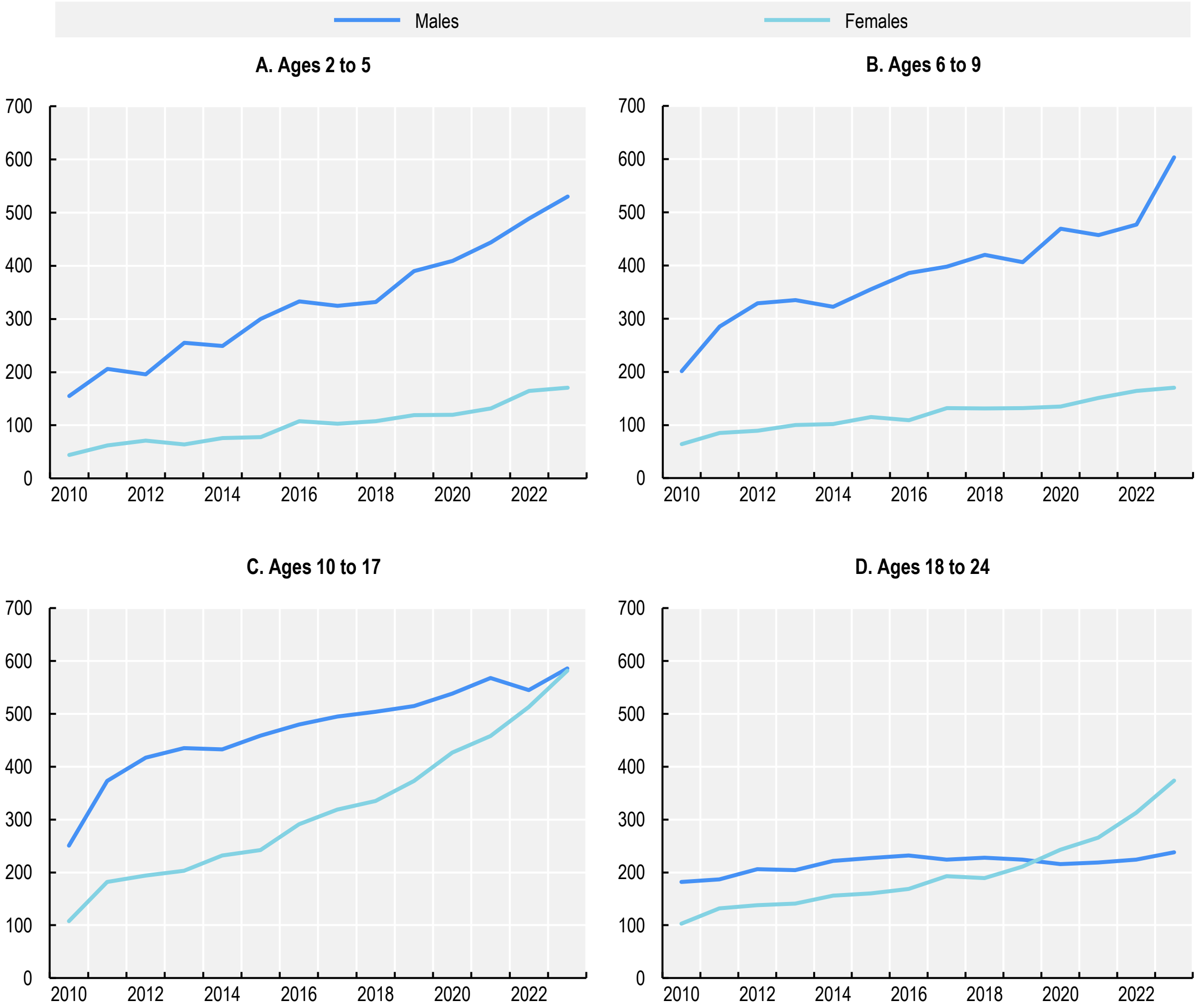
Autism diagnosis rates among children seem to be growing in Sweden

Sweden does not have a population-level survey to estimate the prevalence of autism in the population. Instead, Sweden has a national patient registry that records diagnoses of autism established in the health system. Autism is recorded as a primary diagnosis for individuals admitted to inpatient and/or specialised outpatient care. Although data on contacts with the healthcare system does not cover overall diagnostic rates, evolution of diagnoses in inpatient and/or specialised outpatient care can provide insight into how the rate of autism has evolved in Sweden. This data shows that the rate of autism among children has increased four-to-fivefold between 2008 and 2024 (Figure 2.1).

According to sex-disaggregated data from a recent report of the Swedish National Board of Health and Welfare (*Socialstyrelsen*, NBHW), although men are on average more diagnosed with autism than women, the gap has started to narrow since 2010, especially among older children and youth (Socialstyrelsen, 2024[6]). While in 2010, 10-to-17-year-old boys were on average diagnosed 2.3 times more than girls (251 new diagnoses per 100 000 boys compared to only 108 new diagnoses per 100 000 girls), by 2023 girls caught up to boys in terms of new autism diagnoses: 582 new diagnoses per 100 000 were recorded for 10-to-17-year-old girls and 586 for boys of the same age group (Figure 9.1). Among 18-24 year-olds, the trend even got inversed, as from 2020 onwards, more 18-to-24-year-old women got a new autism diagnosis than men of the same age, with the gap between the two sexes increasing exponentially since. By 2023, there were 1.6 times more new diagnoses recorded for 18-to-24-year-old women than for men (Figure 9.1). It is however important to note that these data refer to a first episode of care in specialised outpatient or inpatient care due to autism, meaning it does not reflect the actual number of diagnoses among men and women in Sweden. It is possible that young women with autism are being hospitalised more than their male counterparts. Nevertheless, the data points to an important increase in the number of girls and women diagnosed with autism in the last 10 years or so.

Figure 9.1. Sweden has seen a steady increase in the number of ASD cases over the past decade

New autism spectrum disorder (ASD) cases per 100 000 inhabitants, by age groups, 2010-2023



Note: Share of children / youth with a first episode of care in specialised outpatient or inpatient care due to autism, given calendar year.
Source: Socialstyrelsen (2024[6]), *Autism – Förekomst och samsjuklighet*, https://www.socialstyrelsen.se/publikationer/autism--forekomst-och-samsjuklighet-2024-11-9353/.

StatLink https://stat.link/g3debu

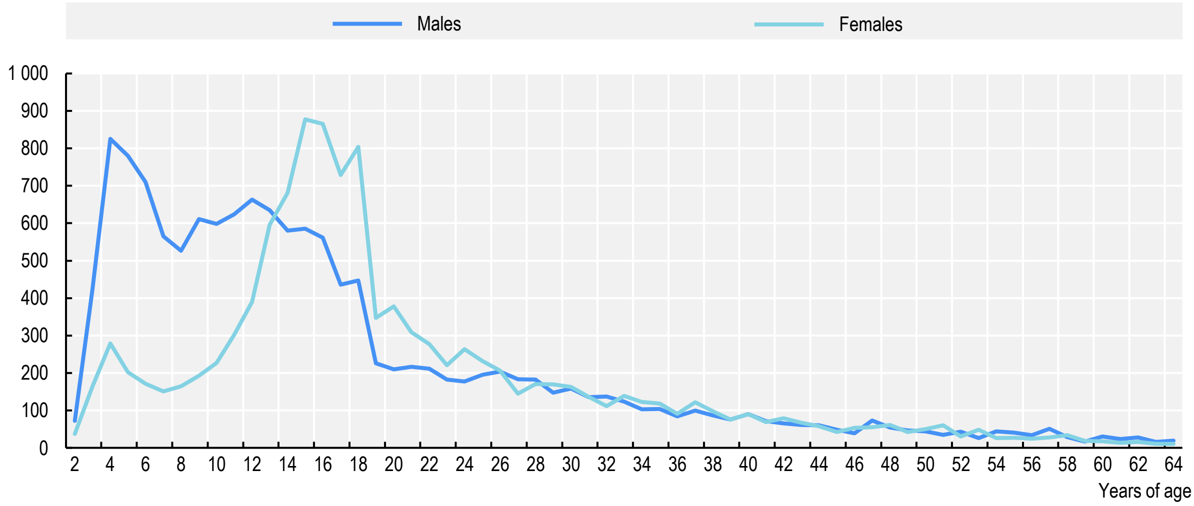
Studies have also found that the rate of autism in Sweden has been increasing, although it is unclear whether this is a real increase in the prevalence of ASD in the Swedish population or if the growing numbers are due to better detection. Lundstörm et al. (2015[7]) found that while the number of clinically diagnosed individuals with ASD increased substantially in a 10-year period (1993-2002), the measured level of autism symptoms actually remained stable. Similarly, a follow-up study by Arvidsson et al. (2018[8]) found that, while more autism diagnoses were made with time, this was due to a drop in the threshold of autism symptoms necessary for a diagnosis, rather than an increase in autistic symptoms in the population.

In Sweden, the age of first diagnosis is much earlier for boys than for girls

Based on a recent report of the National Board of Health and Welfare (*Socialstyrelsen*), there are considerable differences between sexes when it comes to the age at which a child or an adult is first diagnosed with autism (Socialstyrelsen, 2024[6]). Boys are diagnosed significantly younger than girls (Figure 9.2): in 2023 while most new diagnoses for boys were made among 4-year-olds (825 new diagnoses per 100 000 inhabitants), followed by boys aged 5 and 6 (780 and 710 new diagnoses per 100 000, respectively); for girls most new diagnoses were made at age 15 (877 new diagnoses per 100 000 inhabitants), followed by 16- and 18-year-old girls (865 and 804 new diagnoses per 100 000 respectively).

Figure 9.2. Young boys in Sweden are diagnosed with ASD on average 10 years earlier than girls

New autism diagnoses per 100 000 inhabitants by age, 2023



Source: Socialstyrelsen (2024[6]), *Autism – Förekomst och samsjuklighet*, https://www.socialstyrelsen.se/publikationer/autism--forekomst-och-samsjuklighet-2024-11-9353/.

StatLink https://stat.link/mlvz7x

There seems to be little difference in autism rates across different socio-economic groups

In Sweden, there seems to be little difference in autism diagnosis rates between children with different socio-economic status. According to a 2012 study, children from lower-income families and those with parents in manual occupations had a slightly higher risk of getting an ASD diagnosis – 1.4% compared to 1% for children with more affluent parents (Rai et al., 2012[9]). The availability of free and standardised diagnostic pathways and access to routine developmental screening likely leads to earlier and more equitable identification of ASD across socio-economic groups (ibid.).

Autism assessment guideline in Sweden recommends a holistic approach

Sweden published a national guideline for ADHD and autism, two of the main neurodevelopmental disorders, for the first time in 2022. An updated guideline was published in March 2024 by the National Board of Health and Welfare. In this guideline, the National Board of Health and Welfare outlines its main recommendations for supporting the treatment of neurodevelopmental[1] disorders in the health and social care services. The guideline places particular emphasis on early and timely intervention through diagnosis and assessment (Socialstyrelsen, 2024[10]).

According to the guideline's recommendations, assessment and diagnosis of neurodevelopmental disorders like ADHD and autism should be done through an individualised approach, involving a team of multi-disciplinary professionals. At a minimum, a physician and a licensed psychologist should be included in the assessment; ideally the physician should be a specialist physician or a resident in psychiatry with training in child and adolescent psychiatry or paediatrics (including paediatric neurology). According to the guidelines, other health and social care professionals should be included in the assessment and diagnostic process, as needed. Professionals can include the following (ibid.):

- Occupational therapist;
- Speech therapist;
- Physician with experience of addiction disorders;
- Social worker;
- Physiotherapist;
- Special needs teacher;
- Counsellor;
- Dietitian;
- Specialist nurse (e.g. midwife, paediatric nurse or psychiatric nurse).

Sweden's disability allowances, such as the Care Allowance do not require a medical diagnosis to access support, as eligibility is determined based on needs rather than based on diagnosis. However, to determine eligibility for the Assistance Allowance, a medical diagnosis plays a more prominent role (for more information on eligibility criteria see the section on Assistance Allowance).

Allowances in Sweden serve distinct purposes

Sweden provides three different allowances for children with disability, including those with ASD. All three allowances are administered by Sweden's Social Insurance Agency (*Försäkringskassan*) and are neither income- or asset-tested. Two of them fall within the category of carer allowances – the Care Allowance (*omvårdnadsbidrag*) and the Assistance Allowance (*assistansersättning*). The third benefit, the Swedish Additional Cost Allowance (*merkostnadsersättning*), naturally fits into the category of additional cost allowances. Each allowance serves a distinct purpose. The Care Allowance primarily provides families with financial support in recognition of the care parents provide to their child with disability or long-term illness. The Assistance Allowance combines elements of a carer allowance with elements of a disabled child allowance: on the one hand, it ensures that children with disability, through individually tailored support provided by an assistant, can live and participate in the society on an equal basis with others; on the other, it reduces some of the supervision and care burden on parents by enabling them to hire an assistant for several hours per week. Finally, the Additional Cost Allowance is designed to help parents cover extra expenses arising from their child's disability that exceed what is typical for children of the same age, thereby preventing financial strain on the family.

Care Allowance provides financial support to parents caring for a child with disability

The Care Allowance, available up to and including June of the year in which the child turns 19, is divided into four levels according to the child's need for care and supervision. These levels correspond to one-quarter, one-half, three-quarters, or the full monthly allowance, with current rates set at (Försäkringskassan, 2025[11]):

1. SEK 3 063 (~7% of average monthly wage in 2024)
2. SEK 6 125 (~13.9% of average monthly wage in 2024)

3. SEK 9 188 (~20.8% of average monthly wage in 2024)
4. SEK 12 250 (~27.8% of average monthly wage in 2024)

Although a parent is legally entitled to reduce their working hours by up to 25% if one of the parents receives the Care Allowance, the benefit is not designed to compensate fully for lost income in cases in which a parent substantially reduces their working hours (i.e. more than 25%). Even the full allowance only covers about 27.8% of Sweden's average monthly wage in 2024 (OECD, 2025[12]).

A child's need for care and supervision determines eligibility, not a medical diagnosis

Eligibility for the Care Allowance depends solely on the extent of care and supervision the child requires compared with a child of the same age without disability, assessed primarily against developmental milestones. The child's support needs are placed at the centre of this determination process. "Care" is interpreted broadly, covering not only medical care but also needs such as special training or motivational support. "Supervision" refers to the presence of an adult to ensure the child's safety and well-being, for example to prevent them from running away or encountering dangerous situations (Försäkringskassan, 2025[11]).

A formal medical diagnosis is not required to qualify for the allowance, although in practice most children recorded in the register of Sweden's Social Insurance Agency do have a diagnosis. Instead, the child's treating doctor must complete a medical report – the Medical Report for Care Allowance and Additional Cost Allowance. In this form, the physician describes in detail the child's everyday challenges, need for care and supervision, and ongoing treatment.

To establish eligibility and the appropriate allowance level, the medical report is complemented by an application form that parents complete online or on paper. This form consists mainly of open-ended questions, allowing parents to describe their child's individual needs in detail across key areas of daily life, including practical everyday support, communication and social interaction, and school-related needs.

The *Försäkringskassan* case administrator then reviews the medical report, parental application, and any additional documents provided, such as teacher reports. After this initial review, the case administrator typically holds a phone interview with the parents to discuss the child's needs in greater depth. Parents who prefer not to complete the written form can choose to rely on this phone interview exclusively (Försäkringskassan, 2025[11]). If uncertainties remain, the case administrator may seek input from the Social Insurance Agency's internal medical experts or consult the child's treating physician again. While case administrators are guided by an internal manual, there is no standardised point-scoring system to determine the child's level of support needs and corresponding allowance level. Reassessments – while resembling the structure of the initial eligibility assessment, though typically less extensive – are carried out every two years and differ according to the circumstances of each individual case.

Assistance Allowance funds several hours of personal assistance per week

Sweden's Assistance Allowance is the most individualised of the three available Swedish allowances. Unlike other allowances, such as the Care Allowance, it is not structured in tiers or levels. Instead, the key variables are the number of assistance hours granted per week and whether the standard or elevated hourly rate applies, based on the child's assessed needs. In 2025, the standard rate for an assistant was SEK 342.60 per hour, while an up to 12% higher hourly rate is available for applicants with special circumstances, such as those requiring specially qualified assistants. The allowance rate is therefore determined directly by the child's need for assistance (Försäkringskassan, 2025[13]). Parents then use the allocated funds to either purchase personal assistance services from their municipality or a private assistance provider, employ their own assistants or combine these alternatives. Such assistance services not only help the child navigate daily challenges and better integrate into social environments but also ease parents' care responsibilities. Notably, parents may also choose to serve as an assistant themselves –

either as employees of a municipal or private assistance provider or as self-employed assistants. Parents who opt to arrange the assistance themselves must report the activity to the Inspectorate for Health and Care and be registered as an employer with the Swedish Tax Agency.

A child can receive the Assistance Allowance if they fall into one of the eligibility groups of Sweden's Law on Support and Service for Persons with Certain Functional Impairments (LSS) and have a disability that causes significant difficulties in daily life. While ASD is included in the first eligibility group under the LSS, children with ASD as their sole diagnosis rarely meet the threshold of support needs to receive the allowance. Although a medical diagnosis is required to fall into the first and second eligibility group, the diagnosis alone does not qualify a child for Assistance Allowance. The child must also demonstrate the need for personalised assistance for more than 20 hours per week in daily activities such as personal hygiene, eating, dressing, or communication. For children requiring less than 20 hours of assistance per week, parents can instead apply for personal assistance through their municipality rather than the Swedish Social Insurance Agency (Försäkringskassan, 2025[13]).

The application and assessment process for the Assistance Allowance closely mirrors that of the Care Allowance. Parents complete a form specifying the number of assistance hours needed and, if possible, the types of activities for which support is required. They also submit their child's medical diagnosis and a medical statement describing the child's impairment and how it affects them. The remainder of the assessment follows the same steps as for the Care Allowance: after an initial desk review, the case administrator conducts a follow-up phone interview or an in-person meeting with the parents to discuss the child's support needs in greater detail.

In contrast to the Care Allowance, the Assistance Allowance is available not only to children but also to adults, up to the age of 66. Furthermore, reassessments are not carried out periodically but instead take place on an ad hoc basis, triggered only when there are signs that the child's circumstances have changed, making a review necessary.

Box 9.1. Sweden's Law on Support and Service for Persons with Certain Functional Impairments (LSS)

The LSS is a rights-based law designed to ensure that individuals with significant, permanent functional impairments receive the support and services necessary to live as full, independent, and participatory lives as possible. Responsibility for LSS is shared between the state (specifically the *Försäkringskassan*) and municipalities.

LSS defines ten categories of support services that eligible individuals can apply for, such as personal assistance, companion services, respite care in the home, and short-term supervision for pupils over the age of 12.

To be eligible under LSS, a person's impairment must fall into one of three groups:

- Group 1: intellectual disability, autism, or an autism-like condition;
- Group 2: significant and long-lasting cognitive impairment caused by brain injury in adulthood due to illness or trauma;
- Group 3: other major, long-term physical or mental disabilities that are clearly unrelated to normal ageing, which create substantial difficulties in daily life and require extensive support.

A medical diagnosis determines whether a person belongs to eligibility group 1 or 2. By contrast, eligibility for group 3 is not based on diagnosis but on an assessment of the person's difficulties in daily life arising from one or more impairments.

Source: Region Stockholm (2023[14]), *The Act on Support and Services for Certain Disabled People – LSS*, https://www.1177.se/Stockholm/sa-fungerar-varden/lagar-och-bestammelser/lagar-i-varden/lagen-om-stod-och-service-till-vissa-funktionshindrade---lss/.

Additional Cost Allowance compensates disability-related expenses

Sweden’s Additional Cost Allowance (*merkostnadsersättning*) is designed to financially support parents who face considerable extra expenses directly related to their child’s disability – costs that go beyond what is typical for children of the same age. These expenses may be one-off or recurring, such as specialised equipment, adapted transport, or a special diet. The allowance does not function as a strict reimbursement of actual costs but is instead paid as a fixed amount across different levels, provided the additional costs exceed a set eligibility threshold. The benefit, which is not means-tested, is structured into five levels, determined by the scale of the documented extra expenses (Försäkringskassan, 2025[15]):

- 30% Level: costs of at least SEK 14 700 per year lead to an allowance of SEK 1 470 per month
- 40% Level: costs of at least SEK 20 580 per year lead to an allowance of SEK 1 960 per month
- 50% Level: costs of at least SEK 26 460 per year lead to an allowance of SEK 2 450 per month
- 60% Level: costs of at least SEK 32 340 per year lead to an allowance of SEK 2 940 per month
- 70% Level: costs of at least SEK 38 220 per year lead to an allowance of SEK 3 430 per month

As with Care Allowance, a child does not need a formal medical diagnosis to qualify for the Additional Cost Allowance. Eligibility is established through medical documentation, provided in the form of a medical report completed by the child’s treating doctor. This is the same report form used for the Care Allowance. Parents must also complete an application form, either online or on paper, in which they detail all additional expenses directly linked to their child’s disability and explain how these costs arise from the disability (Försäkringskassan, 2025[15]). The subsequent assessment procedure mirrors that of the other Swedish allowances: a *Försäkringskassan* case administrator reviews the documents, conducts a follow-up phone interview or an in-person meeting with the parents, consults medical or internal experts if needed, and prepares the case for the decision maker. Assessments for the three allowances are carried out by different case administrators. However, some of the information and medical documentation gathered in one allowance assessment process could be used in another process if duly noted in the case. Reassessments for the Additional Cost Allowance – while resembling the structure of the initial eligibility assessment, though typically less extensive – are conducted every four years and differ according to the circumstances of each individual case. However, anecdotal evidence suggests that it is relatively uncommon for children with ASD as their only diagnosis to qualify for the Additional Cost Allowance.

Different trends in benefit recipients and expenditure across allowances

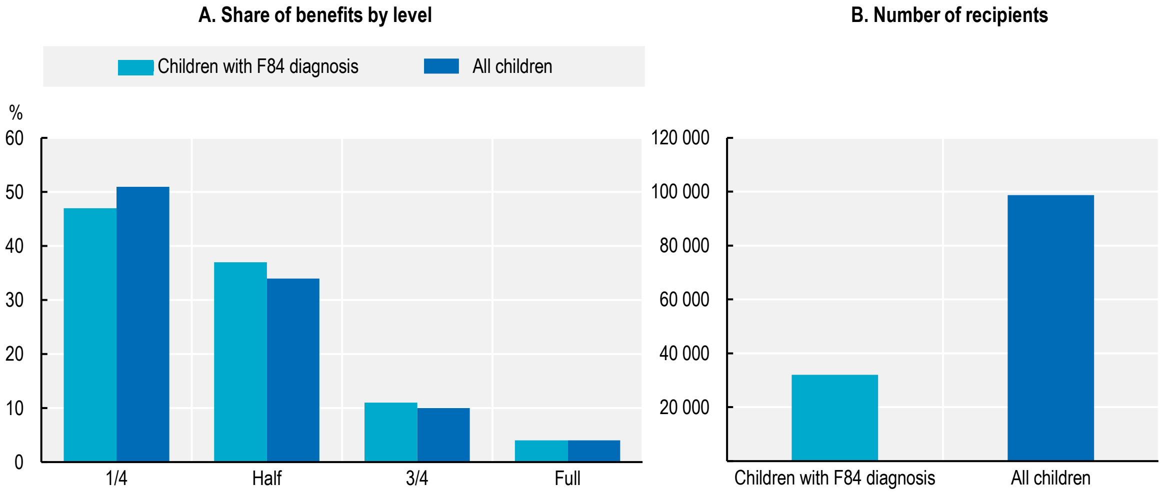
Children with an F84 diagnosis are overrepresented among Care Allowance recipients

Sweden’s Care Allowance is by far the most common benefit for parents of children with disability. In 2025, almost 100 000 children entitled their parents to a Care Allowance, roughly 32 000 with ICD-10 diagnosis code F84 “Pervasive Developmental Disorders” (Figure 9.3). The distribution of allowance levels (one-quarter to full allowance) of these children is in line with the trend of all children with disability, with only minor differences at the lower allowance levels. Children with F84 diagnoses not only account for around one-third of all Care Allowance recipients in 2025, but also for one-third of total payments in 2024. Total Care Allowance payments to this group of children amounted to about SEK 1 742 million (Figure 9.4).

The significant share of children with F84 is also reflected in the annual number of new claims (Figure 9.4). In 2023 and 2024 respectively, around 6 000 children with F84 diagnoses were newly granted a Care Allowance. Only children diagnosed with F90 "Hyperactivity Disorders" have entered in higher numbers. Until 2021, trends for F84 and F90 were similar, but they have since diverged: in 2024, approximately 10 000 children with F90 were newly granted a Care Allowance. The sharp increase and subsequent drop in newly granted Care Allowances seen for children with F84 and F90 diagnoses, as well as for other diagnostic groups, in 2021 is linked to the fact that the Care Allowance was only introduced in 2019. The Care Allowance replaced the former Care Allowance for Disabled Child, resulting in an increase in numbers in the first years as children had to transition from the old allowance to the new one.

Figure 9.3. About one-third of children whose parents receive Care Allowance have an F84 diagnosis

Recipients of the Care Allowance by allowance level and F84 diagnosis, Sweden, July 2025



Note: Care Allowance provides financial support to parents caring for a child with disability. Children are grouped according to their ICD-10 diagnosis code. Autism is classified under code F84 (Pervasive developmental disorders).
Source: Data provided by Sweden's Social Insurance Agency (*Försäkringskassan*).

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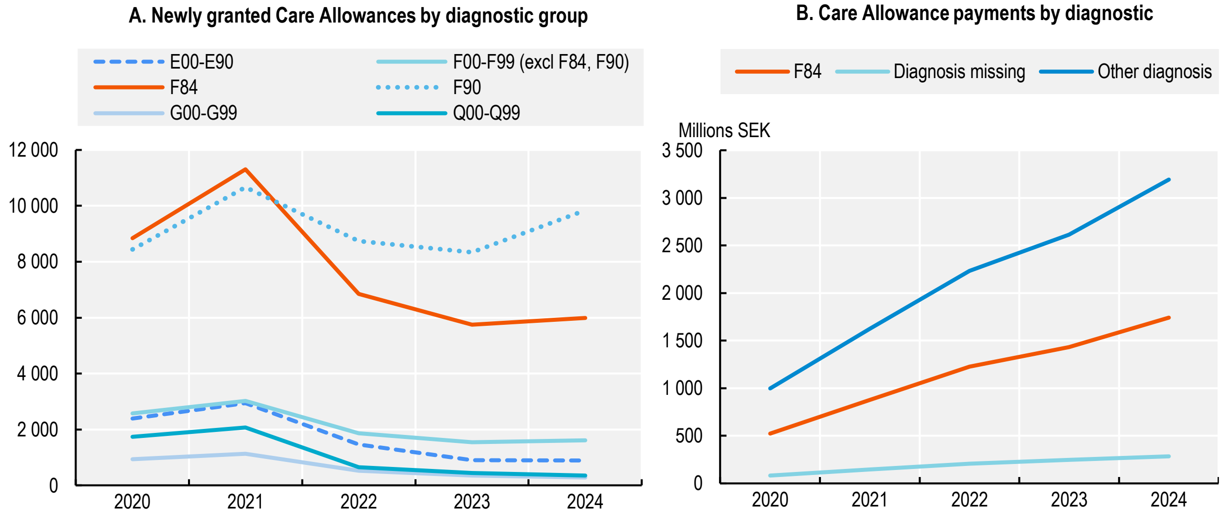
Figure 9.4. New Care Allowance approvals for children with F84 have decreased in Sweden

Newly granted Care Allowances and annual payments by ICD-10 diagnosis code, 2020-2024



Note: Panel A excludes children with no registered diagnosis and those with their diagnosis listed as “other”.
E00-E99: Endocrine disorders, nutritional disorders and metabolic disorders; F00-F99 (excludes F84, F90): Mental disorders and syndromes, and behavioural disorders (excluding F84, F90); F84: Pervasive developmental disorders; F90: Hyperactivity disorders; G00-G99: Diseases of the nervous system; Q00-Q99: Congenital malformations, deformities and chromosomal abnormalities.
Source: Data provided by Sweden’s Social Insurance Agency (*Försäkringskassan*).

StatLink https://stat.link/6kva1m

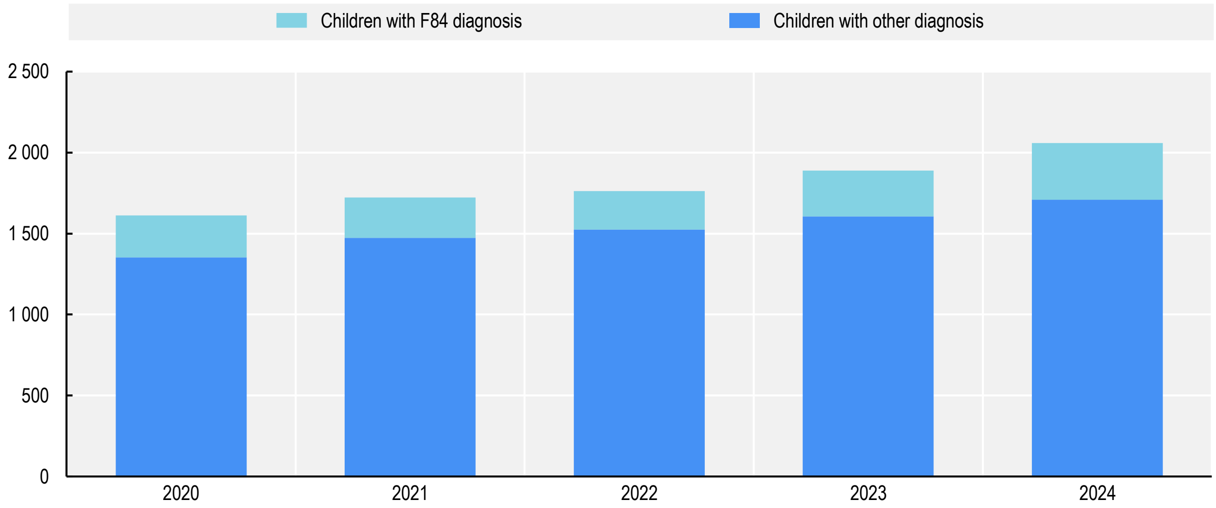
Assistance Allowance targets children with very extensive support needs

The number of Assistance Allowance recipients is much smaller, with about 2 000 children receiving it in 2024 (Figure 9.5). This reflects the fact that the allowance is reserved for children with disability who have very extensive support needs. Among these recipients, children with an F84 diagnosis accounted for 17% in 2024 – a considerably smaller share compared to their representation among Care Allowance recipients. While some children with an F84 diagnosis do require substantial hours of daily assistance, such extensive needs appear to be relatively rare within this group.

Because a formal diagnosis is required to qualify for the Assistance Allowance under LSS Group 1 and Group 2, more detailed diagnostic information is available. In July 2025, 89% of children with an F84 diagnosis receiving the allowance were specifically classified under F84.0, “Childhood Autism”. It is important to note, however, that the data only includes children with F84 as their main diagnosis. It is very possible that there are more children that have autism but as their secondary diagnosis – an argument that applies even more to the Care Allowance and Additional Cost Allowance.[2]

Figure 9.5. Only few Swedish children with F84 diagnosis are eligible for an Assistance Allowance

Children (aged 0-17) receiving Assistance Allowance by F84 diagnosis, 2020-2024



Note: F84 refers to pervasive developmental disorders. “Children with other diagnosis” includes children with no diagnosis.
Source: Data provided by Sweden’s Social Insurance Agency (*Försäkringskassan*).

StatLink https://stat.link/tm7orx

The low frequency of very extensive support needs is also reflected in the average number of weekly assistance hours children with an F84 diagnosis receive through the Assistance Allowance. On average, children aged 0-14 receive 131 hours of weekly assistance, and those aged 15-19 receive 127 hours. By contrast, children with an F84 diagnosis aged 0-19 receive an average of only 106 hours per week (Table 9.1).

In 2025, the average hourly rate of Assistance Allowance for children with an F84 diagnosis was SEK 343.63, slightly above the standard rate of SEK 342.6. This indicates that, while rare, a small number of children with an F84 diagnosis face particularly severe circumstances that entitle them to a higher hourly Assistance Allowance rate than the standard flat rate.

Table 9.1. Children diagnosed with F84 receive comparatively fewer assistance hours per week

Average weekly hours of Assistance Allowance granted (since 2022) by ICD-10 diagnosis code, Sweden

Diagnosis and age	Number of hours per week
All diagnoses, age 0-14 years	131
All diagnoses, age 15-19 years	127
F84 diagnosis, age 0-19 years	106

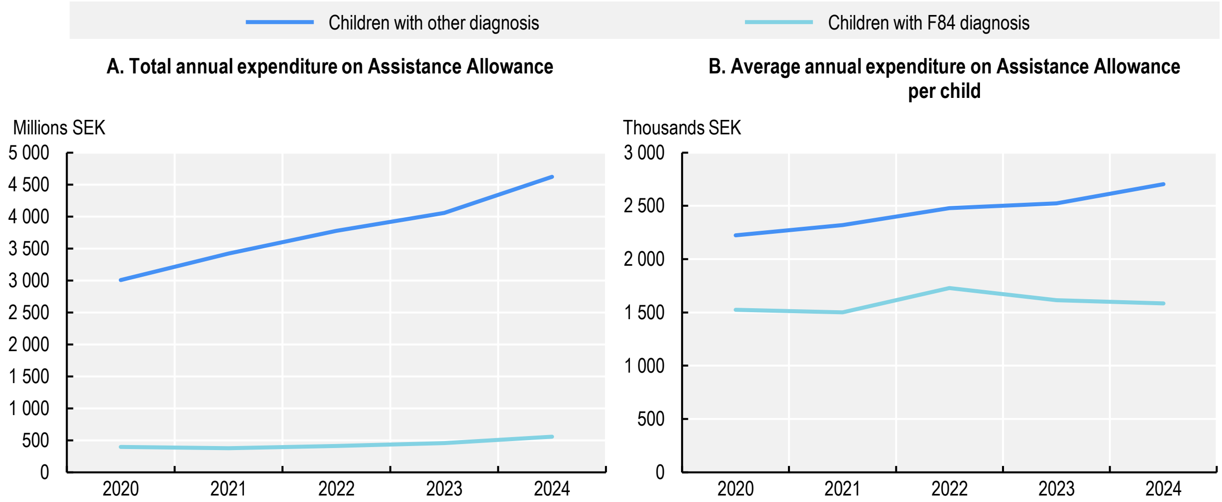
Note: Children aged 0-17. F84 refers to pervasive developmental disorders.
Source: Data provided by Sweden’s Social Insurance Agency (*Försäkringskassan*).

StatLink https://stat.link/v0ugsq

Spending data completes the above-described picture: children with an F84 diagnosis account for only a relatively small share of total annual Assistance Allowance expenditure (Figure 9.6), which has in fact been rising steadily for children with other diagnoses. In 2024, the average annual expenditure on Assistance Allowance for a child with an F84 diagnosis was about SEK 1 585 000, compared with approximately SEK 2 705 000 for a child with another diagnosis.

Figure 9.6. Children diagnosed with F84 account for only a small share of annual Assistance Allowance expenditure

Annual expenditure on Assistance Allowance by diagnosis, Sweden, 2020-2024



Note: Children aged 0-17. F84 refers to pervasive developmental disorders. “Children with other diagnosis” includes children with no diagnosis.
Source: Data provided by Sweden’s Social Insurance Agency (*Försäkringskassan*).

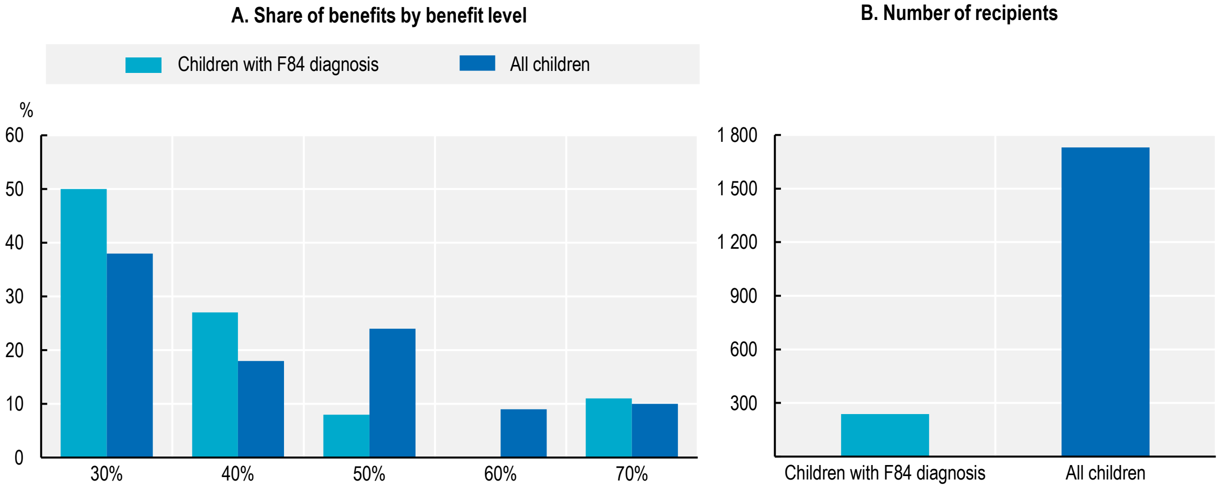
StatLink https://stat.link/31azpv

Additional Cost Allowance is granted far less frequently than Care Allowance

The Additional Cost Allowance, like the Assistance Allowance, primarily targets children with extensive support needs, specifically those who incur high additional expenses due to their disability. Recipient numbers are far lower than for the Care Allowance and comparable to the number receiving Assistance Allowance. In July 2025, 1 730 children received the Additional Cost Allowance (Figure 9.7), of which just 238 had an F84 diagnosis. Among these children with F84, roughly half received the lowest allowance level of 30%. The proportion of children with F84 in the lower allowance levels is higher than that of all children, suggesting that while some families of children with F84 may face substantial extra expenses related to their child’s disability, these additional costs tend to be lower than those incurred by the average child qualifying for the Additional Cost Allowance.

Figure 9.7. Very few Swedish children with F84 diagnosis qualify for an Additional Cost Allowance

Recipients of Additional Cost Allowance by allowance level and F84 diagnosis, July 2025



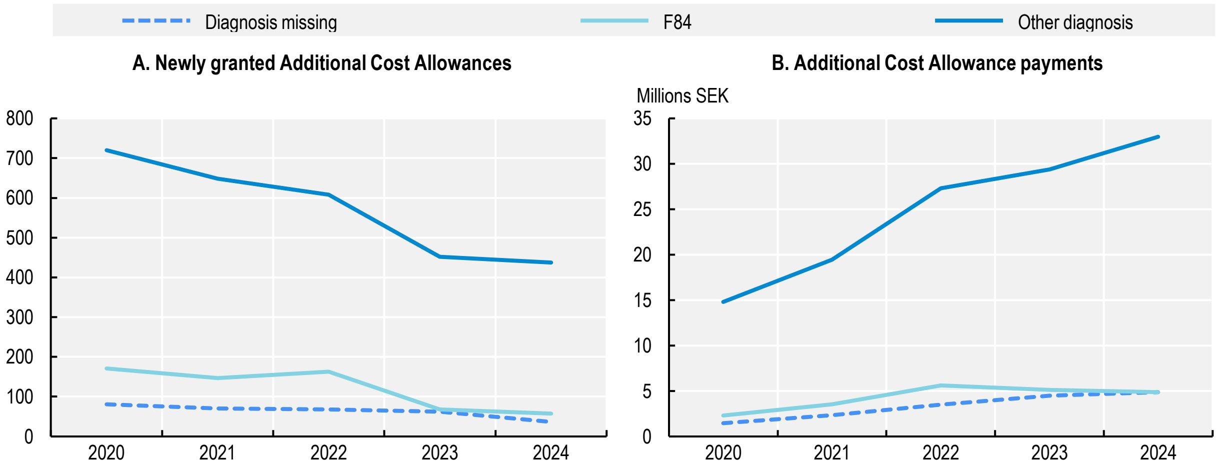
Note: Children are grouped according to their ICD-10 diagnosis code. Autism is classified under code F84 (pervasive developmental disorders). The share of children with an F84 diagnosis across allowance levels totals 96% rather than 100%. The remaining 4% likely fall into the 60% or above 70% levels, but their numbers are so small that they are excluded from the administrative data.
Source: Data provided by Sweden's Social Insurance Agency (*Försäkringskassan*).

StatLink https://stat.link/vdwg3p

Although there was a relatively high number of new Additional Cost Allowance claims in 2020 – shortly after the allowance was introduced in 2019 – the number of children newly granted the allowance has steadily declined in subsequent years. This trend is also observed among children with an F84 diagnosis. In 2024, children with an F84 diagnosis accounted for only a small portion of the total annual Additional Cost Allowance payments, receiving approximately SEK 5 million out of the total SEK 43 million (Figure 9.8).

Figure 9.8. New approvals of Additional Cost Allowance for children with F84 diagnosis have fallen

Newly granted Additional Cost Allowances and annual payments by ICD-10 diagnosis, Sweden, 2020-2024



Note: F84 refers to Pervasive developmental disorders.
Source: Data provided by Sweden's Social Insurance Agency (*Försäkringskassan*).

StatLink https://stat.link/2g167o

Educational support for children with ASD is comprehensive

Different schooling options are available for children with special educational needs

Children with SEN have several schooling options in Sweden, depending on the type and severity of their support needs. In principle, children with SEN are encouraged to attend mainstream classes in regular schools, where support is tailored to their individual needs. This may take the form of "Minor Adjustments", such as modified assignments or additional time, or more extensive "Special Support", which is documented in the child's individual Action Plan (*åtgärdsprogram*). "Special Support" can include measures such as access to a personal assistant, assistive technology, flexible timetables, or on-site therapies (Informationsverige, 2025[16]). Depending on the child's needs, "Special Support" may also involve placement in a special teaching group (*särskild undervisningsgrupp*). These groups resemble special education classes (Skolverket, 2025[17]). They are not standardised nationally but instead established at the discretion of individual schools and therefore vary across municipalities.

If inclusion in a mainstream school is not deemed suitable, children may attend specialised schools, depending on their disability:

- "Adapted schools" (*anpassade skolan*) are special education schools exclusively for children with intellectual disability. These are administered by municipalities, which hold overall responsibility for compulsory schools in Sweden (Stockholms Stad, 2025[18]).
- "Special schools" (*specialskola*) can be either regional or national, run by the National Agency for Special Needs Education and Schools (*Specialpedagogiska skolmyndigheten*, SPSM). Sweden has five regional "Special schools", which serve only children who are deaf or hard of hearing. Its four national "Special schools" target specific groups: one school is designed for children with congenital deaf-blindness and hearing impairment with severe learning disorders; one school targets children with visual impairments combined with other disabilities; and two schools are for children with severe developmental language impairments (SPSM, 2023[19]).

Unless a child with ASD also has one of the specific disabilities covered by "Adapted" or "Special schools", such as intellectual disability or severe developmental language disorder, they will attend a regular class in a mainstream school, supported by special education measures tailored to their needs.[3] Some municipalities may however arrange special classes for children with ASD where they benefit from lower student-to-teacher ratios, smaller class sizes, and specifically trained teaching staff.

Comprehensive assessments are carried out to determine most suitable school placement and support

When Minor Adjustments are deemed insufficient and the need for Special Support is suspected, whether raised by teachers, parents, or the child, the school principal is legally obliged to initiate a support needs assessment without delay. This process involves the class teachers, school health professionals, and, where relevant, external specialists. The assessment draws on multiple sources of evidence, such as school records, teacher observations, and psychological reports, complemented by in-school observations and interviews with both the child and parents. Although the precise format of assessments varies between schools, the perspectives of parents and their child are always central; by law, their views must be taken into account. Importantly, a formal medical diagnosis is not required for a child to qualify for Special Support. Once the assessment is complete, the school principal makes the final decision on whether and what kind of Special Support will be granted. The specific measures are then detailed in the child's individual Action Plan (Skolverket, 2025[17]).

When Special Support in a mainstream school is insufficient to ensure a child can learn on an equal basis with others, a child with an intellectual disability may instead be placed in an Adapted School. The municipality holds the legal responsibility for approving such placements. To initiate the process, the child's school principal must request a target-group investigation (*utredning om målgruppstillhörighet*) to determine whether the child has an intellectual disability meeting the criteria for Adapted School. This investigation includes pedagogical, psychological, medical, and social assessments, carried out by school and municipal professionals such as special education teachers, school psychologists, and physicians where needed. Evidence is gathered for example from school records, classroom observations, and interviews with the child and their parents. While, again, a formal medical diagnosis is not strictly required, psychological and medical evaluations are conducted, for which parents' consent is necessary. The child's own views are also taken into account. If the investigation confirms the eligibility of the child to attend an Adapted School, the municipality makes the formal placement decision. However, parental consent is always required to finalise enrolment in an Adapted School. Reassessments may be conducted if the child's condition or support needs change significantly (Stockholms Stad, 2025[18]; Skolverket, 2025[20]).

Placement in a Special school follows a slightly different procedure than placement in an Adapted School. In this case, it is the parents who must apply directly to the National Agency for Special Needs Education and Schools (SPSM), which makes the final admission decision. The application must be supported by a set of professional assessments tailored to the type of Special School sought. For instance, to apply for a Special School for children with severe language impairments, parents must submit (SPSM, 2025[21]):

- a speech and language assessment conducted by a speech therapist,
- a medical assessment from the child's treating doctor,
- a psychological assessment from a licensed psychologist,
- a pedagogical assessment prepared by a special education professional at the child's current school, and
- a social assessment conducted by a school counsellor.

For children with additional impairments, such as ASD, documentation confirming the diagnosis should also be included. If the SPSM determines that the child does not qualify for placement in a Special school, the child continues their education in either a mainstream compulsory school or an Adapted school within their municipality.

Funding for special education mixes different approaches

According to a classification framework initially proposed by the European Agency for Special Needs and Inclusive Education (European Agency for Special Needs and Inclusive Education, 2016[22]) and applied by the OECD (Brussino, 2020[23]), Sweden's system for funding special education combines elements of both input and throughput funding models (see Chapter 4). General education funding follows an input approach, with municipalities allocating resources to schools based on student numbers. Schools are then responsible for managing these funds and providing SEN support within their allocated budget (European Agency for Special Needs and Inclusive Education, 2023[24]).

For pupils with extensive support needs that exceed what can normally be provided through the child's Action Plan for Special Support, schools may apply for additional funding from the municipality. However, such supplementary funding is not standardised at the national level: while some municipalities may operate with detailed formulas to allocate extra support, others may have no formal mechanism in place. Both schools and municipalities can also apply for targeted grants from the SPSM for specific initiatives, such as adapting the learning environment or providing specialised training for teaching staff. Finally, when a child requires personal assistance at school, funding can be accessed either through the municipality (if the need is under 20 hours per week) or through the Swedish Social Insurance Agency (if the need exceeds 20 hours per week; see section on Assistance Allowance funds several hours of personal assistance per week) (European Agency for Special Needs and Inclusive Education, 2023[24]).

Adapted Schools are equally funded by municipalities, which allocate resources on a per-pupil basis, like is the case for mainstream schools. However, the per-pupil amount is typically higher in Adapted Schools to account for factors such as additional teaching staff, specialised pedagogy, and adapted infrastructure. Like mainstream schools, Adapted Schools can also apply for targeted grants – special interventions in schools – from the SPSM. By contrast, Special Schools are directly run by the SPSM and are therefore state-funded.

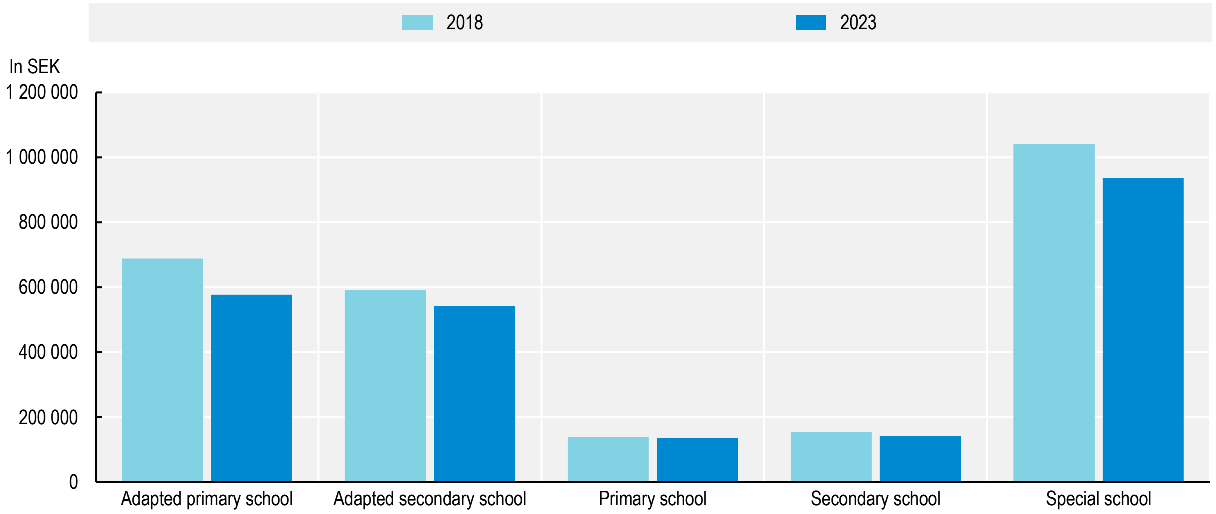
Per-child education expenditure in constant prices declined in recent years

Average per-child expenditure for the entire school population, including both children with and without SEN, is, unsurprisingly, far lower in mainstream primary and secondary schools than in Adapted and Special Schools, which exclusively serve children with SEN and therefore face much higher costs for specialised staff and equipment. On a per-child basis, Special Schools are the most expensive, with average expenditure of about SEK 1.04 million in 2018 and SEK 0.94 million in 2023 (Figure 9.9). However, because relatively few children attend Special and Adapted Schools, their total costs to the education system are far lower than that of mainstream schools (Figure 9.10).

Across all school types, per-child expenditure in constant prices fell between 2018 and 2023, even as nominal spending continued to rise (Figure 9.9). At the same time, total costs in constant prices remained relatively stable across most school forms, with the notable exception of Adapted Primary Schools. In these schools, total costs (in constant prices) increased from about SEK 6.58 billion in 2018 to SEK 8.12 billion in 2023 (Figure 9.10). Given that this rise in total costs coincided with a decline in per-child expenditure, it suggests that enrolment in Adapted Primary Schools grew substantially over this period.

Figure 9.9. Special schools are the most expensive school type in per-child expenditure

Average expenditure per child (in 2023 constant prices) by school type, Sweden, 2018 and 2023

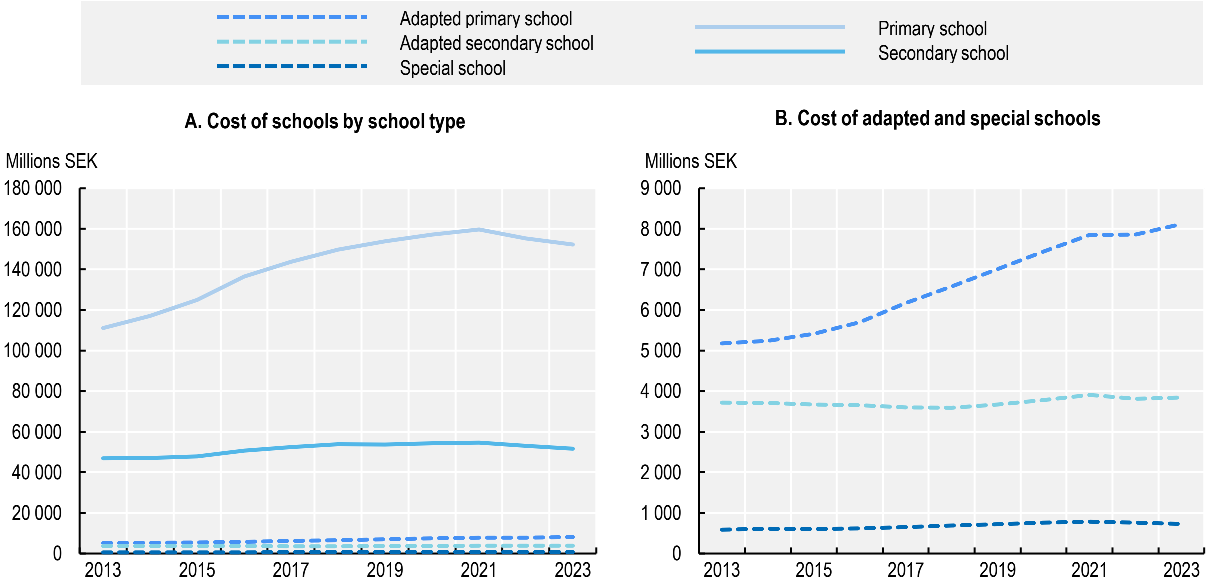


Note: Primary and secondary municipal schools only, i.e. excludes independent and regional schools and *sameskola*.
Source: Statistikmyndigheten SCB (n.d.[25]), Statistikdatabasen, https://www.statistikdatabasen.scb.se/pxweb/sv/ssd/.

StatLink https://stat.link/4i51lw

Figure 9.10. Special education settings account for only a small share of total school spending

Costs per school type (in 2023 constant prices), Sweden, 2013-2023



Source: Statistikmyndigheten SCB (n.d.[25]), Statistikdatabasen, https://www.statistikdatabasen.scb.se/pxweb/sv/ssd/.

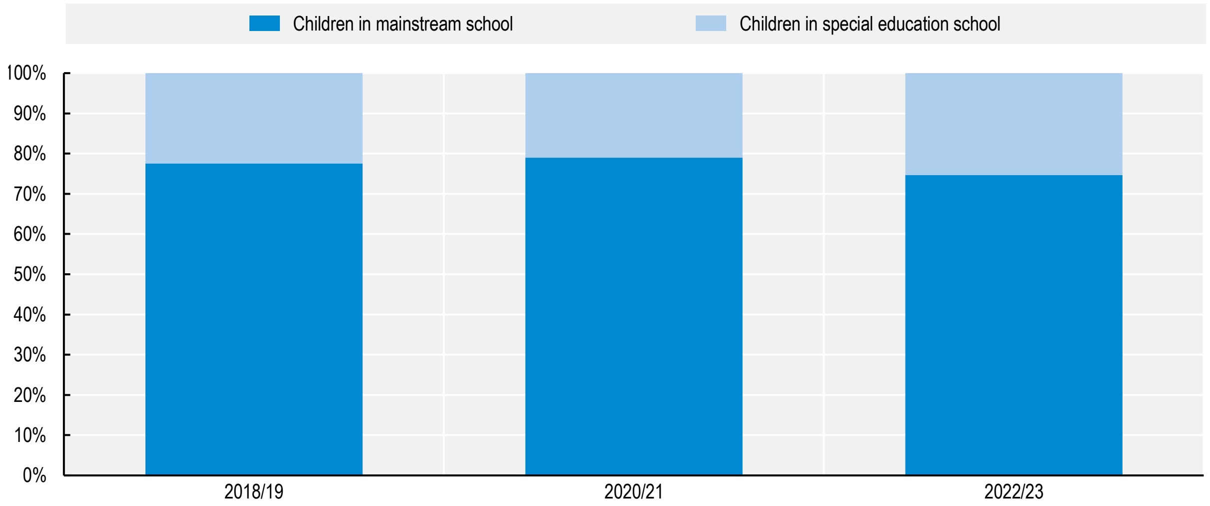
StatLink https://stat.link/yodz1e

Placement of children with SEN in mainstream classes is common

The distribution of children with SEN between mainstream and special education schools remained relatively stable from 2018 to 2023, with around 75-80% of children with SEN enrolled in mainstream schools – a notably high share by international standards. Between 2018/19 and 2020/21, there was a modest increase in mainstream school attendance, followed by a slight decline between 2020/21 and 2022/23 (Figure 9.11).

Figure 9.11. Distribution of children with SEN across school types has remained relatively stable

Distribution of children with SEN across school settings, Sweden, 2018/19-2022/23



SEN: special educational needs.
Note: The category “special education school” includes adapted primary schools, adapted secondary schools and special schools.
Source: Based on European Agency for Special Needs and Inclusive Education (2025[26]), Data tables and background information, https://www.european-agency.org/activities/data/data-tables-background-information.

StatLink https://stat.link/91sv57

Sweden offers generous social and therapeutic services

Early intervention is a priority for Sweden

Sweden’s 2024 National Guideline on ADHD and Autism (*Nationella riktlinjer 2024: Adhd och autism*) places strong emphasis on early intervention, particularly for children with suspected or diagnosed ASD. The Guideline highlights early support as a top priority, aiming to prevent secondary difficulties such as anxiety, behavioural challenges, or school-related problems. Early intervention is recommended to involve a multi-disciplinary team, including psychologists, occupational therapists, speech-language pathologists, and educators, working together to address the child’s needs. Importantly, the Guideline stresses that support should be offered to all children showing signs of ASD, even before a formal diagnosis is established, basing eligibility on observed needs rather than waiting for the completion of a full neuropsychiatric assessment (Socialstyrelsen, n.d.[27]).

Access to paramedical therapy is determined by needs and availability

Children with disability most often receive therapy, such as speech and occupational therapy, at Habilitation Centres (*habiliteringscenter*). These are regional, publicly run clinics that provide multi-disciplinary support to both children and adults with congenital disability. Their services range from assessments and therapeutic interventions to broader support, including guidance for caregivers. As part of Sweden’s public healthcare system, Habilitation Centres are free of charge. Children with disability, including children with ASD, can access them through referrals from a GP, school nurse, child health centre (*barnavårdscentralen*), or, in some regions, via self-referral. Some centres may require a formal medical diagnosis. Once referred, the child is assessed by a multi-disciplinary team at the centre that develops an individualised intervention plan, which may include speech and language therapy, among other supports.

The type, frequency, and intensity of therapy ultimately depend on several factors, including the child's specific needs as well as the staffing and resources available at the centre (Region Stockholm, 2024[28]; Habilitering, n.d.[29]).

Another pathway for children to access therapy, particularly speech therapy, is through their school. Children who receive Special Support or attend an Adapted or Special School may, depending on availability, resources, and their specific needs, have therapies integrated into their school day. Such interventions are considered special education measures and are included in the child's Action Plan, which does not require a formal medical diagnosis (see section on Comprehensive assessments are carried out to determine most suitable school placement and support for details on the SEN assessment). Adapted and Special Schools are generally more likely than mainstream schools to provide therapy on-site (SPSM, 2024[30]).

Therapists, such as speech and language, occupational, or physiotherapists, are rarely employed directly by individual schools. Instead, they are typically employed by the municipality's school health service or by regional health authorities (through habilitation centres). As a result, therapists are often shared across several schools and daycare centres.

Sweden also offers a broad range of social services

As noted earlier, the LSS law (*Lagen om stöd och service till vissa funktionshindrade*) is one of the most important frameworks through which people with disability can access essential daily supports. The law defines ten categories of support services available to eligible individuals: 1) counselling and other personal support; 2) personal assistance; 3) companion service; 4) contact person; 5) relief service; 6) short-term stays away from home; 7) short-term supervision for schoolchildren over 12; 8) accommodation in a family home or special housing for children and young people; 9) special housing for adults; and 10) daily activities. Children with ASD are covered under Target Group 1 of the LSS law (Region Stockholm, 2023[14]).

Beyond these core social services stipulated by the LSS law, Sweden provides some additional supports. Parents of a child covered by LSS are entitled to up to ten days of paid leave per year (Contact Days), funded by the Swedish Social Insurance Agency, to allow participation in activities such as parent training or school visits. This right applies until the child turns 16. Parents may also access special counselling and training programmes offered by Habilitation Centres or municipalities. In addition, municipalities arrange free school transport for children whose disability prevents them from travelling safely on public transport.

Conclusion

Sweden's experience illustrates a comprehensive and rights-based approach to supporting children with autism within a universal welfare system. Over the past decades, the country has made substantial progress in aligning disability policy with international standards, expanding access to inclusive education, and ensuring that families receive financial and practical support according to assessed needs. Sweden's approach to financial assistance is particularly notable: support is differentiated according to the level and nature of children's and families' needs, rather than tied solely to a medical diagnosis. This tiered system – comprising several allowances for care, assistance, and additional costs – enables families to access support that more accurately reflects the intensity and complexity of their circumstances. The introduction of national guidelines for ADHD and autism represents an important step toward greater consistency and quality in service provision. Moving forward, strengthening implementation of these guidelines, ensuring equitable access to supports across regions, and maintaining a strong focus on inclusion and participation will be critical to sustaining Sweden's progress in meeting the needs of children with ASD and their families.

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Notes

[1] The guideline uses the word "neuropsychiatric disorder", which is a different categorisation used to describe disorders such as ADHD and ASD. Since the term "neurodevelopmental disorder" is more broadly accepted, this is the term this report uses.

[2] Note that the level of diagnostic detail varies depending on how precisely case administrators record this information. For example, diagnostic information was missing for a substantially larger share of cases in 2020 than in 2024.

[3] "For the purposes of the Education Act, people with autism or autism-like conditions shall not be equated with people with intellectual disabilities unless they also have an intellectual disability or intellectual disability due to brain injury as described above." (Sveriges Riksdag, 2010[31])

Annex A. Evolution of autism diagnosis criteria in DSM and ICD (1952-2022)

Table A A.1. Autism as a subtype of schizophrenia (1952-1980)

Diagnostic manual	Diagnostic and Statistical Manual: Mental Disorders (DSM-I)	Diagnostic and Statistical Manual, 2nd edition (DSM-II)	International Classification of Diseases, 9th edition, Clinical Modification (ICD-9)
Year	1952	1968	1977
Type	Schizophrenia	Schizophrenia	Psychosis with origin specific to childhood
Subtypes	Schizophrenic Reaction, Childhood Type (manifesting primarily as autism)	Schizophrenia, childhood type (may be manifested by autistic behaviour)	Infantile autism

Source: APA (1952[1]), *Diagnostic and Statistical Manual: Mental Disorders (DSM-I)*; APA (1968[2]), *Diagnostic and Statistical Manual of Mental Disorders, Second edition (DSM-II)*; WHO (1977[3]), *International Classification of Diseases, 9th edition (ICD-9)*.

Table A A.2. Autism as pervasive developmental disorder (PDD) (1980-2013)

Diagnostic manual	Diagnostic and Statistical Manual, 3rd edition (DSM-III)	Diagnostic and Statistical Manual, 3rd edition, Revised (DSM-III-R)	International Classification of Diseases, 10th edition (ICD-10)	Diagnostic and Statistical Manual, 4th edition (DSM-IV)
Published	1980	1987	1992	1994
Type	Pervasive developmental disorder (PDD)	Pervasive developmental disorder (PDD)	Pervasive developmental disorder (PDD)	Pervasive developmental disorder (PDD)
Subtypes	1. Infantile autism (onset before age 30 months) 2. Childhood-onset PDD (onset after age 30 months) 3. Atypical PDD (autistic-like condition) 4. Residual infantile autism	1. Autistic disorder (roughly corresponds to infantile autism) 2. Pervasive developmental disorder, not otherwise specified (PDD-NOS)	1. Childhood autism 2. Atypical autism 3. Rett syndrome 4. Other childhood disintegrative disorder 5. Overactive disorder associated with mental retardation and stereotyped movements 6. Asperger syndrome 7. Other PDDs 8. PDD-NOS	1. Autistic disorder 2. Rett's disorder* 3. Childhood disintegrative disorder 4. Asperger's syndrome 5. PDD-NOS (including atypical autism)

Note: *In the text revision of the DSM-IV, Rett's disorder was classified as a separate genetic disorder, distinct from autism (APA, 2000[4]).
Source: APA (1980[5]), *Diagnostic and Statistical Manual, Third edition (DSM-III)*; APA (1987[6]), *Diagnostic and Statistical Manual, Third edition, Revised (DSM-III-R)*; APA (1994[7]), *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*; WHO (1992[8]), International Classification of Diseases, 10th edition (ICD-10).

Table A A.3. Autism spectrum disorder (ASD) (2013-current)

Diagnostic manual	Diagnostic and Statistical Manual, 5th edition (DSM-5)*	International Classification of Diseases, 11th edition (ICD-11)
Published	2013	2019
Type	Neurodevelopmental disorders (NDD)	Neurodevelopmental disorders (NDD)
Subtypes	Autism spectrum disorder (ASD) (severity levels 1, 2 and 3)	Autism spectrum disorder (ASD)

Note: *The text revision of the DSM-5 added elements related to culture and sex and gender, as well as co-occurring conditions (APA, 2022[9]).
Source: APA (2013[10]), *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596; WHO (2019[11]), *International Classification of Diseases, 11th edition (ICD-11)*, https://icd.who.int/browse/2025-01/mms/en.

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Annex B. Detailed autism assessment guidelines

Table A B.1. Autism assessment guidelines and regulations in selected OECD countries

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
Australia	National Guideline for the assessment and diagnosis of autism in Australia (2023)	Autism CRC	1) Health practitioner (typically GP) makes a referral within the assessment and diagnostic process. 2) Comprehensive Needs Assessment a. Assessment of functioning b. Medical evaluation 3) Diagnostic evaluation (e.g. ADOS)	The assessment can be done by either one professional (A) or through a multi-disciplinary team evaluation (B) 1) Lead Practitioner Diagnostic Evaluation: can be conducted by one or more relevant practitioners, which can be: a. A paediatrician, a psychiatrist, a neurologist b. A GP with at least 6 years of experience in the assessment and diagnosis of neurodevelopmental conditions c. A psychologist specialised in clinical psychology, clinical neuropsychology, and/or educational/developmental psychology 2) Consensus Team Diagnostic Evaluation: should include at least one additional practitioner in addition to what's been defined under lead practitioner, which can be: a. A paediatrician, a psychiatrist, a neurologist b. A GP with at least 6 years of experience in the assessment and diagnosis of neurodevelopmental conditions c. A psychologist specialised in clinical psychology, clinical neuropsychology, and/or educational/developmental psychology d. An occupational therapist	• DSM-5-TR (2022) • ICD-11 (2019)

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
				e. A speech pathologist f. A registered nurse, which can be: a nurse practitioner, mental health nurse practitioner, or a registered nurse with relevant experience as a clinical nurse specialist/consultant g. A social worker	
Canada	Standards of diagnostic assessment for autism spectrum disorder (2019)	Canadian Paediatric Society	1) Children with suspected ASD are first identified by a paediatrician, family physician, parent, or another caregiver and then referred to a diagnostic assessment 2) ASD diagnostic assessment may include: a. Developmental, medical, and social history b. Information from school, childcare, community c. Audiology, vision assessment d. Direct clinical observation of the child e. +/- ASD diagnostic tool, which can be a behavioural observation tool e.g. ADOS-2, CARS-2; and/or a questionnaire based on parent/caregiver interview e.g. ADI-R, SRS-2, DISCO, 3di.	In most provinces and territories only physicians or psychologists are licensed to diagnose ASD. In some communities, appropriately trained nurse practitioners may also make the diagnosis. A. When a child's symptoms clearly indicate ASD, an experienced or trained sole paediatric care provider can independently diagnose ASD (Approach 1). B. Shared care model: when a child's symptom presentation is milder, atypical, or complex, or a child is under 2 years of age, a paediatric care provider may use information from an ASD diagnostic assessment tool, and consult with another healthcare professional with specialised knowledge (e.g. a psychologist) to inform a diagnosis (Approach 2). C. Team-based approach[1]: diagnostic assessment by healthcare professionals in an interdisciplinary or a multi-disciplinary team (Approach 3).	- DSM-5 (2013)
Denmark	National clinical guideline for the treatment of autism spectrum disorders in children and adolescents (2021)	Danish Health Authority (*Sundhedsstyrelsen*)	- Assessment for ASD is a specialist task and should include: - Interview with primary caregivers, including information about early development, difficulties and co-morbid conditions. - Observation of the child/young person's environment and/or obtaining additional information from institutions (school, nursery, etc.) - Autism-specific observation (ADOS) and parent interview (ADI-R)	n/a	- ICD-10 (1992)
France	Autism spectrum	French Health	1) Screening is recommended in children with warning	The diagnostic process should fall under a specialised	- DSM-5 (2013)

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
	disorder: Warning signs, detection, diagnosis and assessment in children and adolescents – Best Practice Guideline (2018) Instruction No. DGCS/SD3B/DGOS/SDR4/CNSA/2014/221 of 17 July 2014 on the national framework for detection, diagnosis and early interventions for children with autism or other pervasive developmental disorders provided for in the autism plan (2013-2017) (2014)	Authority (*Haute Autorité de santé*, HAS)	signs or who have a high risk of ASD (e.g. children born prematurely, siblings of children with ASD, etc.). Recommended tools for a comprehensive clinical assessment: a. For children aged 16-30 months: M-CHAT b. For children aged 48 months and above: SCQ c. In children and adolescent with co-occurring intellectual developmental disorder: ASSQ, AQ and SRS-2. 2) Referral: If the risk of ASD is confirmed during the dedicated screening consultation, the child should immediately be referred to a specialised neurodevelopmental disorders diagnostic consultation with a paediatric psychiatrist and/or a paediatrician. 3) Autism assessment should include at minimum the following: a. Detailed developmental history b. Standard screening tests (hearing, vision) c. Complete clinical paediatric exam (weight, height, head circumference, neurological exam) d. Clinical observation based on DSM-5 criteria, which can be structured using tools, such as CARS, ADOS, ECA-R. e. Language and communication assessment f. Cognitive assessment g. Adaptive skills assessment h. Psychomotor functions assessment i. Sensory integration processes assessment Diagnosis of co-occurring conditions should also be considered.	local team, namely a second-line team comprised of professionals specifically trained in neurodevelopmental disorders and autism spectrum disorder: • Paediatric psychiatry team (children's psychiatry departments including medico-psychological centres – *Centre medico-pédagogique,* CMP) • Paediatrics departments • Centre for early medico-social action (CAMSP) • Medico-psycho-pedagogical centres (*Centre médico-psycho-pédagogique,* CMPP) • Networks of specialised care in the diagnosis and assessment of autism or private practitioners co-ordinated by a doctor For complex cases, consultation at a third-line facility is recommended, which can be: • Professionals practicing at autism resource centres (CRA), or • Professionals practicing at hospital centres for additional specialised opinions, namely in paediatric neurology, clinical genetics and medical imaging	• Pending ICD-11 (2019)
Germany	S3[2] Guideline on autism spectrum disorders in childhood, adolescence and adulthood (2016)[3]	Association of the Scientific Medical Societies (*Arbeitsgemeinschaft der Wissenschaftlichen*	1) Screening is recommended in children with a pre-defined risk factor (genetic findings with increased rate of ASD, drug exposure during pregnancy, viral infection during pregnancy, birth weight under 1500g, premature birth, neonatal seizures, siblings with ASD) and at least one additional symptom indicating ASD.	The assessment should be conducted by one or more healthcare professionals who are knowledgeable and skilled in mental and developmental disorders, as well as in the screening instruments used and their evaluation and interpretation.	• ICD-10 (1992) • DSM-IV-TR (2000) • DSM-5 (2013)

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
		Medizinischen Fachgesellschaften, AWMF)	Recommended tools for screening (optional): a. For toddlers: M-CHAT b. For preschool and elementary school-aged children: SCQ c. For primary school aged children and adolescents that are high-functioning: MBAS d. For children and adolescents with intelligence impairment: SEAS-M 2) Referral to a centre specialising in autism spectrum disorder diagnostics should be made if clinically and ASD seems likely and/or parents/caregivers/affected person also report corresponding symptoms. 3) Diagnostic procedure should include: a. Detailed medical history b. Autism-specific diagnostic testing i. A standardised instrument (interview with parent or guardian) should be used for clinically complex questions. The ADI-R is recommended for children. ii. A semi-standardised behavioural observation should be conducted. Recommended instruments are CARS and ADOS-2. c. Assessment of cognitive abilities and skills d. Assessment of strengths and weaknesses based on autism-specific diagnostic testing e. Complete internal neurological examination f. Assessment of hearing and visual disturbances g. The presence of co-morbid disorders should be considered.	The diagnosis of children and adolescent should be made by a professional with the following competence: - Skills in the use of specific diagnostic tools - Differential diagnostic skills regarding all psychiatric and somatic co-morbidities - Skills in performing an internal medicine-neurology examination and correctly interpreting the results. - Skills in the test psychological investigation of language development and cognitive development. - Skills in professional counselling with regard to therapeutic, educational and social issues The diagnosis should be made in consultation with: - a specialist in child and adolescent psychiatry and psychotherapy, or - a specialist in child and adolescent medicine who is specially qualified for this purpose	
Israel	Circular No. 15/13 of 10 November 2013, of the Director General of the Ministry of Health on diagnosing children on the autism spectrum (2013)	Ministry of Health	1) The diagnosis of a child with suspected autism should include a physical, neurological, developmental and emotional examination. a. Developmental assessment using MULLEN or BAILEY-II/BAILEY-III until the age of 3. b. Cognitive assessment using WPPSI-III between ages 3 and 7 and WISC-IV between ages 6 and 7.	The diagnosis needs to be co-signed by at least two professionals: 1) A specialist conducting the physical, neurological, developmental and emotional assessment, i.e. one of the following: - Child and adolescent psychiatrist - Developmental paediatrician	- DSM-5 (2013), including detailed criteria and breakdown of the

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
			c. Functional assessment using VINELAND-II or ABAS-II. 2) Assessment of autism symptoms using: a. Parent questionnaires e.g. SRS-2, SCW, CARS-2 b. Kindergarten teacher/educator questionnaire e.g. SRS-2 c. Also recommended: ADOS and ADI-R (if necessary and if the diagnosing professional is trained in their use)	- Child development specialist - Expert in neurology and child development 2) A professional trained in autism diagnostic evaluation, i.e. one of the following: a. Clinical psychologist with training in child or development psychology b. Rehabilitation psychologist or education psychologist with training in autism diagnosis Additional health professionals may also participate in the diagnosis if needed.	severity levels
Netherlands	Autism spectrum disorder in children/young people (2025)	Dutch Association for Psychiatry (*Nederlandse Vereniging voor Psychiatrie*, NVvP)	1) Information gathering (medical history) is recommended to gain full understanding of the child's development and concerns, including information on: a. Early development, including pre- and perinatal factor and course of development to date b. Functioning of the child within the family c. Previous diagnoses and interventions d. Relevant family history 2) Combined with medical history, a physical examination is recommended to rule out underlying medical conditions, including: a. Assessment of current and past physical health b. Vision and hearing test c. Genetic testing 3) Developmental assessment may include: a. General developmental test b. Intelligence test c. Language test 4) Assessment of autistic traits should be done through: a. Direct interaction with the child b. Information collected from parents, teachers and caregivers c. Behavioural observation d. Observation of the child's functioning in different settings	- Diagnosis should be done by a specialist multi-disciplinary team. - Behavioural observation should be done by a child psychiatrist, psychologist or developmental educationalist.	- DSM-5-TR (2023) or the Dutch equivalent DC:0-5

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
			Recommended standardised tools can be used as support for the clinical diagnostic process, including: • CARS, SCQ, AQ-child, SRS, VISK/CSBQ and ASV. • For children with intellectual disability, the appropriate modules of ADOS/ADOS-2 and ADI-R should be used.		
Sweden	National guidelines 2024: ADHD and autism	National Board of Health and Welfare (*Socialstyrelsen*)	1) First line services offer early intervention for children and young people with suspected neuropsychiatric disorders. 2) Neuropsychiatric assessments are conducted focussing on either ADHD or autism, if healthcare or social services staff have a well-founded suspicion of a neuropsychiatric disability.	A team with at least one doctor and one psychologist should complete the neuropsychiatric assessment and diagnosis. The following professionals should always be included: • Licensed psychologist • Specialist doctor or a resident in psychiatry with training in child and adolescent psychiatry or paediatrics (including paediatric neurologist). The following professionals should be included in the assessment, as needed: • Occupational therapist • Speech therapist • Physician with experience of addiction disorders • Social worker • Physiotherapist • Special needs teacher • Counsellor • Dietitian • Specialist nurse (e.g. midwife, paediatric nurse or psychiatric nurse)	• DSM-5 (2013)
England (United Kingdom)	Autism spectrum disorder in under 19s: recognition, referral and diagnosis – Clinical guideline 128 (2017) Autism spectrum disorder in under 19s:	National Institute for Health and Care Excellence (NICE)	1) Screening is recommended if there are concerns about the development, or behaviour of the child, and/or if there is an increased risk of autism e.g. sibling with autism, born prematurely, birth defects associated with central nervous system malformation, etc. 2) Referral is recommended: a. To the "autism team" for children younger than 3 years, if there is a regression in language or	A multi-disciplinary "autism team" composed of the following professionals: • paediatrician or paediatric neurologist (core team) • child and adolescent psychiatrist (core team) • psychologist with training and experience in working with children and young people with autism (core team) • psychologist with training and experience	• DSM-5 (2013) • ICD-11 (2019)

Country	Guideline or regulation	Issuing authority	Diagnostic process	Professional(s) involved in the assessment	Diagnostic criteria
	support and management – Clinical guideline 170 (2021)		social skills. b. To a paediatrician or paediatric neurologist (who can refer to the “autism team” if necessary), if: i. The child is older than 3 years, with regression in language ii. A child has regression in motor skills 3) Diagnostic assessment should include: a. Medical history, including prenatal and perinatal and family history b. Developmental history c. Information gathered from pre-school or school, parents’ and carers’ about the child or young persons’ experiences of home life, education and social care d. Physical examination e. Assessment of social and communication skills and behaviours (using an autism-specific tool) f. Consideration of differential diagnosis and systematic assessment for conditions that may coexist with ASD g. Assessment of the child’s strengths, skills, impairment and needs h. The following assessments should also be considered: i. intellectual ability and learning style ii. academic skills iii. speech, language and communication skills iv. fine and gross motor skills v. adaptive behaviour (including self-help skills) vi. mental and emotional health (including self-esteem) vii. physical health and nutrition viii. sensory sensitivities ix. behaviour likely to affect day-to-day functioning and social participation x. socialisation skills	complementary to the psychologist in the core team • speech and language therapist (core team) • occupational therapist	

Note: The table includes information on guidelines and regulations for countries, for which information was available at the time of writing. 1. In some Canadian jurisdictions, only a team-based diagnostic approach is accepted for accessing specialised services. 2. S3 guidelines are the most rigorous type of medical guidelines issued by the Association of the Scientific Medical Societies in Germany (AWMF). They combine evidence-based systematic analysis and structured consensus by the steering committee. 3. The guideline is currently being revised.

3di: Developmental, Dimensional and Diagnostic Interview; ABAS-II: Adaptive Behaviour Assessment System, Second edition; ADI-R: Autism Diagnostic Interview – Revised; ADOS: Autism Diagnostic Observation Schedule; AQ (-child): Autism-Spectrum Quotient (child module); ASSQ: Autism Spectrum Screening Questionnaire; ASV: Autisme Spectrum Vragenlijst [Autism Spectrum Questionnaire]; CARS: Childhood Autism Rating Scale; DISCO: Diagnostic Interview for Social and Communication Disorders; ECA-R: Échelle d'évaluation des comportements autistiques révisée [Autistic behaviours evaluation scale, revised]; MBAS: Marburg Assessment Scale for Asperger's Syndrome; M-CHAT: Modified Checklist for Autism in Toddlers; SCQ: Social Communication Questionnaire; SCW: South Central Wisconsin (from Group Health Co-operative of South Central Wisconsin, GHC-SCW); SEAS-M: Scale for the Assessment of Autism Spectrum Disorders in the Less Abled; SRS: Social Responsiveness Scale; VISK/CSBQ: Vragenlijst voor Inventarisatie van Sociaal gedrag van Kinderen [Children's Social Behaviour Inventory Questionnaire]; WPPSI-IV: Wechsler Preschool and Primary Scale of Intelligence, Fourth edition.

Source: Goodall et al. (2023[1]), *National Guideline for the assessment and diagnosis of autism in Australia*, https://www.autismcrc.com.au/best-practice/assessment-and-diagnosis; Brian, Zwaigenbaum and Ip (2019[2]), *Standards of diagnostic assessment for autism spectrum disorder*, https://doi.org/10.1093/pch/pxz117; Sundhedsstyrelsen (2021[3]), *Behandling af autismespektrum-forstyrrelser hos børn og unge [National clinical guideline for the treatment of autism spectrum disorders in children and adolescents]*, https://www.sst.dk/media/fuvlzofd/nkr-for-behandling-af-autismespektrumforstyrrelser-hos-boern-og-unge.pdf; HAS (2018[4]), *Trouble du spectre de l'autisme: Des signes d'alerte à la consultation dédiée en soins primaires*, https://www.has-sante.fr/jcms/c_468812/fr/trouble-du-spectre-de-l-autisme-signes-d-alerte-reperage-diagnostic-et-evaluation-chez-l-enfant-et-l-adolescent; Ministère des affaires sociales et de la santé (2014[5]), *Instruction No. DGCS/SD3B/DGOS/SDR4/CNSA/2014/221 of 17 July 2014 on the national framework for detection, diagnosis and early interventions for children with autism or other pervasive developmental disorders provided for in the autism plan (2013-2017)*, https://www.legifrance.gouv.fr/download/pdf/circ?id=38551; AWMF (2016[6]), *S3-Leitlinie Autismus-Spektrum-Störungen im Kindes-, Jugend- und Erwachsenenalter, Teil 1: Diagnostik [S3 Guideline for Autism Spectrum Disorders in Childhood, Adolescence, and Adulthood. Part 1: Diagnostics]*, https://register.awmf.org/assets/guidelines/028_D_G_f_Kinder-_und_Jugendpsychiatrie_und_-psychotherapie/028-018l_S3_Autism_spectrum_disorders_in_childhood__adolescence_and_adulthood_2021-09_abgelaufen.pdf; Ministry of Health (2013[7]), *Circular No. 15/13 of 10 November 2013 of the Director General of the Ministry of Health on diagnosing children on the autism spectrum*, https://www.gov.il/he/pages/mk15-2013; NVvP, (2025[8]), *Autismespectrumstoornis bij kinderen/jeugd [Autism spectrum disorder in children/young people]*, https://richtlijnendatabase.nl/richtlijn/autismespectrumstoornis_bij_kinderen_jeugd/startpagina_-_autismespectrumstoornissen_kinderen_en_jeugd.html; Socialstyrelsen (2024[9]), *Nationella riktlinjer 2024: Adhd och autism [National guidelines 2024: ADHD and autism]*, https://www.socialstyrelsen.se/contentassets/9477556cf0ce4c9e9ee8310a5f52b642/2024-3-8958.pdf; NICE (2011[10]), *Autism spectrum disorder in under 19s: recognition, referral and diagnosis*, www.nice.org.uk/guidance/cg128; NICE (2013[11]), *Autism spectrum disorder in under 19s: support and management*, https://www.nice.org.uk/guidance/cg170.

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Annex C. Detailed financial benefits and services tables

Table A C.1. Carer allowances in comparison

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
ALLOWANCE 1	• **Name** • **Responsible institution** • **Levels** • **Means-testing**	• Carer Allowance • Services Australia • Fortnightly payment of AUD 159.30; set rate – does not vary based on individual circumstances • Partially means-tested (max. income AUD 250 000 annual)	• Compensation for Lost Earnings (*Tabt arbejdsfortjeneste*) • Local municipalities • Compensation for lost earnings is determined on the basis of the previous gross income, however, at a maximum of DKK 36 622 per month. Parents receive a percentage of their lost income. • Partially means-tested (income-based)	• Caregiver’s Allowance for Parents (*hooldajatoetus*) • Local municipalities • Municipalities determine the exact amount on a case-by-case basis; on average EUR 90 per month. • Usually not means-tested	• Education Allowance for Disabled Children (*Allocation d’éducation de l’enfant handicap, AEEH*) • Department for the Disabled (*Maison Départementale des Personnes Handicapées, MDPH*) • AEEH is made up of a monthly basic allocation (EUR 151.80) plus a complementary amount that varies	• Care Allowance (*Pflegegeld*) • Long-term Care Insurance (*Pflegekasse*) • *Pflegegrad* levels 1-5 depending on the child’s care dependency 1) not eligible 2) EUR 347 3) EUR 599 4) EUR 800 5) EUR 990 • Not means-tested	• Care Allowance (*Omvårdnadsbidrag*) • Swedish Social Insurance Agency (*Försäkringskassan*) • Four levels depending on child’s care needs: 1) SEK 3 063 2) SEK 6 125 3) SEK 9 188 4) SEK 12 250 • Not means-tested	• Carer’s Allowance • Department for Work and Pensions (DWP); Social Security Scotland • Flat rate of GBP 81.90 per week • Means-tested: working carers earning more than GBP 196 per week after deductions are ineligible for the benefit	• In-Home Supportive Services (IHSS) Program • California Department of Social Services (CDSS) • Financial assistance based on the number of authorised service hours, which are determined through an assessment of the child’s needs. The payment to caregivers is calculated by multiplying the

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
					depending on parents' capacity to engage in work: 2) EUR 460.14 (total) 3) EUR 588.22 (total) 4) EUR 828.11 (total) 5) EUR 1 016.15 (total) 6) EUR 1 439.94 (total) • Not means-tested				authorised hours by the applicable hourly wage, which varies by county. • Means-tested
	Eligibility assessment	Formal medical diagnosis required. Eligibility is determined by considering both the medical diagnosis and the support needs. A medically documented disability alone is not sufficient; the child's daily care needs and the impact on the carer's capacity to engage in employment are also crucial factors.	Entirely based on an assessment of the child's support and care needs, and limitations in daily life. Formal medical diagnosis is not required but parents usually provide supporting medical evidence – such as reports from healthcare professionals.	Primarily based on an assessment of the child's daily support and care needs. Formal diagnosis not required; supporting medical documentation (e.g. specialist reports) is necessary to determine the severity of the child's disability. Assessment procedures vary by municipality;	AEEH eligibility requires that the child's impairment be acknowledged as causing a disability; allowance is not automatically granted based on a diagnostic label alone. Benefit decisions are based on an assessment of the child's support needs and subsequent disability severity. MDPH evaluates	Medical documentation is necessary, but a formal medical diagnosis is neither mandatory nor does it alone guarantee entitlement. Eligibility is determined by the assessed level of care dependency. The Medical Service of the Long-term Care Insurance assesses the child's abilities and	Does not require a formal medical diagnosis. The child must demonstrate needs for extra care or supervision due to disability or a medical condition. Parents complete an application form indicating their child's care and supervision needs. Additionally, the treating doctor completes a medical report.	No separate assessment of the child for Carer's Allowance. Eligibility is based on the child's Disability Living Allowance (DLA) status: To qualify, the child must be receiving DLA at the middle or highest rate for the care component, which indicates significant care needs. Additionally, the carer needs to	A medical diagnosis is required to establish the child's disability. Additional medical documentation from healthcare providers that details the child's need for in-home supportive services is required. An IHSS social worker conducts an in-person assessment to evaluate the child's functional

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
		However, conditions on the List of Recognised Disabilities are automatically guaranteed access to the Carer Allowance, pending an official diagnosis. ASD features on that list.		usually relies on assessment conducted by the Social Insurance Board.	the child and assigns a *taux d'incapacité* (disability rating) reflecting how much ASD limits daily life of the child and what support is required. Complementary allowance level depends on the child's care needs and subsequent care burden on parents.	practical support needs in daily life (usually in-person visits).		spend at least 35 hours a week caring for the child.	limitations and the level of assistance required. This assessment focusses on the child's ability to perform activities of daily living.
	Further details	• The child's care needs are assessed through the Disability Care Load Assessment (Child) (DCLA) • The DCLA covers the following three domains: behaviour, functional abilities, and special care needs • Typically, no in-person assessment; decisions are	• Assessments vary by municipality • Assessment relies both on documentary evidence (e.g. school reports, medical certificates…) and an in-person evaluation (often conducted by the *Pædagogisk Psykologisk Rådgivning, PPR*)	• Assessments focus on the child's care needs in everyday life and the carer's ability to provide adequate care • Evaluation is primarily based on documentary evidence but may include an in-person assessment by the Social Insurance Board (or local municipalities) • Usually only granted to	• Assessment includes an evaluation of the child's support needs in daily life and its impact on carer's capacity to engage in employment • Assessment carried out by a multi-disciplinary team from the MDPH, typically using a standardised evaluation tool (e.g. GEVA guide)	• Activities assessed: mobility, cognitive and communicative abilities, behaviour and psychological issues, self-care, managing illnesses and therapies, social participation and structuring daily life • A standardised evaluation conducted by the Medical Service • No age	• Parents describe their child's needs across key areas of daily life, including practical everyday support, communication and social interaction, and school-related needs • Case administrator typically schedules a follow-up call with the parents to discuss the	• For children, the allowance is linked to the child receiving DLA which typically applies to those under 16 • After age 16, if the child transitions to receiving Personal Independence Payment (PIP) at the relevant care rate, the carer may continue to claim Carer's Allowance	• Targets low-income families (receipt of SSI means automatic eligibility) • Assessment relies on documentary evidence, as well as in-person evaluation of the child • IHSS is available to individuals of all ages • Annual reassessments by a social worker

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
		made based on completed application form and supporting medical evidence • For children under 16 years of age • No periodic reassessments • Child Disability Assistance Payment: an annual lump-sum payment of AUD 1 000 if carer receives the Carer Allowance for a child under 16 years of age on 1 July		parents of children with severe or profound disability • Usually for children aged three – 18 years • Regular reassessments (usually after six months – three years)	• Involves both in-person evaluation and review of documentary evidence • Level 6 is equivalent to full-time care • For children under 20 years of age • Periodic reassessments (typically every two to five years) • For single parents, a supplement is available	restrictions; available to individuals of all ages • Periodic reassessments; frequency depends on individual circumstances (typically every two years for children) • An additional Relief Amount (*Entlastungsbetrag*) is available for all care levels (1-5); it is not paid out directly but rather reimburses up to EUR 131/month for extra daily support or short-term care • Individual federal states might provide supplements (e.g. Bavaria EUR 1 000 annually for care need Level 2 and higher)	child's needs in detail • Available for children up to and including June of the year in which the child turns 19 • Reassessments are normally carried out every two years		

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
ALLOWANCE 2	• **Name** • **Responsible institution** • **Levels** • **Means-testing**	• Carer Payment • Services Australia Fortnightly payment with maximum at: - AUD 1 149 for a single carer - AUD 1 732.2 for a couple if both care full-time. Benefit is income-tested, it begins to be reduced once the adjusted family net income exceeds a specified threshold; benefit can be reduced gradually down to AUD 0. • Means-tested	• Care Leave Scheme (*Pasning af nærtstående*) • Local municipalities • Carer is entitled to leave from work. During the leave, the carer will be employed by the municipality and receive a salary of DKK 27 033 per month. However, this amount cannot be greater than the salary the carer would receive from their employer. • Partially means-tested (income-based)	• Care Allowance for Temporary Incapacity for Work (*hooldushüvitis*) • Estonian Health Insurance Fund (*Tervisekassa*) • 80% of the previous labour income • Partially means-tested (income-based)	• Leave Allowance (*Allocation Journalière de Présence Parentale, AJPP*) • Family Allowance Fund (*Caisse d'Allocations Familiales, CAF*) • Full day: EUR 65.80 Half day: EUR 32.90 Plus possible monthly supplement: EUR 126.20 • Partially means-tested (daily allowance No; monthly supplement Yes)		• Assistance Allowance (*Assistansersättning*) • Swedish Social Insurance Agency (*Försäkringskassan*) • Benefit is calculated based on the approved number of assistance hours and a standardised hourly rate. Standardised hourly rate is SEK 342.60 per hour. • Not means-tested	• Universal Credit – Carer's Element • Department for Work and Pensions (DWP) • Flat rate of GBP 198.31 per month • Means-tested	

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
	Eligibility assessment	Formal medical diagnosis required. Eligibility is determined by considering both the medical diagnosis and a support needs assessment that considers the child's daily care needs and functional impairments. The extent of care required and how it impacts the carer's capacity to engage in employment are critical. Child's care needs have to require full-time care.	Based on an assessment of the child's support and care needs, and limitations in daily life. Formal medical diagnosis is not required but parents usually provide supporting medical evidence – such as reports from healthcare professionals. An additional condition: the alternative to home care is a 24-hour stay outside the home or the need for care is equivalent to a full-time job.	Primarily based on an evaluation of the child's need for continuous care (including details of diagnosis and severity). Requires a medical certificate from a healthcare professional that explains the nature of the impairment, its impact on daily functioning, and the expected period during which care is required.	Formal diagnosis not strictly required but a medical certificate from the child's treating physician is needed. The certificate must state that the child's disability necessitates continuous parental presence and specify the care required. CAF evaluates whether child's condition requires sustained care, justifying the parent's temporary cessation or reduction of work. Assessment does not involve a detailed support needs evaluation like that used for the AEEH.		Does not necessarily require a formal medical diagnosis. Child must meet eligibility criteria under LSS Act. To qualify under eligibility group 1 of LSS, the child would need a medical diagnosis of ASD. The child's impairment must cause significant difficulties in daily life to receive the allowance. Eligibility depends on whether their support needs require assistance for more than 20 hours per week.	No separate assessment of the child for UC Carer's Element. Eligibility is based on the child's DLA status: To qualify, the child must be receiving DLA at the middle or highest rate for the care component, which indicates significant care needs. Additionally, the carer needs to spend at least 35 hours a week caring for the child.	

		Australia	Denmark	Estonia	France	Germany	Sweden	United Kingdom	United States (California)
	Further details	• To be eligible, the carer must provide constant care, which is roughly equal to a normal working day and stops the carer from working full time • Carer may still get allowance when they do paid work or are self-employed for up to 100 hours in a four-week period • The child's care needs are assessed through the Disability Care Load Assessment (Child) (DCLA) • The DCLA covers the following three domains: behaviour, functional abilities, and special care needs • Carer Supplement: an annual lump-sum payment of AUD 600 if carer receives the Carer Payment or Carer Allowance on 1 July	• Assessments vary by municipality • Assessment relies both on documentary evidence (e.g. school reports, medical certificates…) and an in-person evaluation (often conducted by the *Pædagogisk Psykologisk Rådgivning, PPR*) • Maximum duration: up to six months; if special circumstances warrant it, period may be extended for another three months • Care Leave Scheme can also be shared by several people	• Assessment relies almost exclusively on medical documentation; normally no in-person evaluations conducted • For children under 19 years of age: up to 60 days of paid leave from work	• Purpose: support parents that are forced to temporarily leave work to care for their child (max. 22 days per month) • Eligibility is based primarily on a medical certificate confirming that the child's condition requires sustained parental presence • Evaluation relies exclusively on documentary evidence • For children under 20 years of age • Benefit is granted for a maximum period (typically up to three years), with renewal possible if the need persists • Not compatible with the top-ups of the AEEH		• Parents complete a form specifying the number of assistance hours needed and, if possible, the types of activities for which support is required • Child must need assistance for at least 20 hours per week to meet severity threshold for eligibility • Case administrator typically schedules a follow-up call with the parents to discuss the child's needs in detail • Parents can be hired as their child's assistant • Available also for adults up to age 66 • Reassessments are triggered by significant changes of the child's needs	• Carer's Element is provided as a flat rate addition to a claimant's Universal Credit award • Universal Credit is a means-tested benefit for low-income individuals; income affects eligibility and the overall amount awarded, including the Carer's Element	

Source: Information collected by the Secretariat and verified in discussions with national autism organisations.

Table A C.2. Disabled child allowances in comparison

		Canada (Ontario)	Estonia	France	Israel	Netherlands	United Kingdom	United States (California)
ALLOWANCE 1	• **Name** • **Responsible institution** • **Levels** • **Means-testing**	• Child Disability Benefit (CDB) • Canada Revenue Agency • Eligible families can receive up to CAD 3 322 per year (or about CAD 276.83 per month) for each child who qualifies for the Disability Tax Credit (DTC) (June 2025). Benefit is income-tested, it begins to be reduced once the adjusted family net income exceeds a specified threshold; benefit can be reduced gradually down to CAD 0. • Means-tested	• Disabled Child Allowance (*Puudega lapse toetus*) • Social Insurance Board (*Sotsiaalkindlustusamet*) • Three levels depending on severity: 1) moderate disability: EUR 138 2) severe disability: EUR 161 3) profound disability: EUR 242 • Not means-tested	• Education Allowance *for Disabled Children (Allocation d'éducation de l'enfant handicap, AEEH*) • Department for the Disabled (*Maison Départementale des Personnes Handicapées, MDPH*) • AEEH monthly basic rate is at EUR 151.80. Top-ups (six levels) are determined by assessing additional expenses related to the disability and whether the child's care needs compel parents to reduce or stop working. • Not means-tested	• Disabled Child Allowance (*קצבת ילד נכה*) National Insurance Institute (*Bituach Leumi*) Five levels 1. 50% – NIS 1 880 2. 100% – NIS 3 694 3. 112% – NIS 4 352 4. 188% – NIS 6 947 5. 235% – NIS 8 828 Child with ASD automatically entitled to 100% but can receive higher rate (up to 235%) if has co-morbidities and/or high dependency on others. Family with two children with disability or more is entitled to a benefit increased by 50% for each child • Not means-tested	• Double Child Benefit (*Dubbele Kinderbijslag*) • Dutch Social Insurance Bank (*Sociale Verzekeringsbank, SVB*) • Quarterly payments; three levels according to child's age: 1. 0-5 years: EUR 583 2. 6-11 years: EUR 708 3. 12-17 years: EUR 833 • Not means-tested	• Disability Living Allowance (DLA) • Department for Work and Pensions (DWP); Social Security Scotland; Department for Communities (DfC) • Weekly rates; two components; rates based on the child's support needs. Care component: ○ Lowest GBP 28.70 ○ Middle GBP 72.65 ○ Highest GBP 108.55 Mobility component: ○ Lower GBP 28.70 ○ Higher GBP 75.75 • Not means-tested	• Federal Supplemental Security Income (SSI) & California State Supplementary Payment (SSP) • Social Security Administration (SSA) • Eligible families can receive up to USD 747.20 per month (SSI + California SSP). Benefit is income-tested, it begins to be reduced once the family income exceeds a specified threshold; benefit can be reduced gradually down to USD 0. • Means-tested

	Canada (Ontario)	Estonia	France	Israel	Netherlands	United Kingdom	United States (California)
Eligibility assessment	A formal medical diagnosis is not strictly required. To qualify for CDB, the child must be assessed by a health professional who documents that the child has a severe, prolonged impairment on Form T2201 (Disability Tax Credit Certificate). This form details the diagnosis, support needs in daily activities, and the expected duration of the disability.	Formal medical diagnosis is not mandatory if the submitted medical documentation sufficiently demonstrates the disability and its severity. Child must undergo an official disability assessment by the Social Insurance Board. An expert panel reviews medical information and the child's support needs in daily life to determine degree of severity of disability. ASD is evaluated under the category of mental or neurodevelopmental disorders for this purpose.	AEEH eligibility requires that the child's impairment be acknowledged as causing a disability; allowance is not automatically granted based on a diagnostic label alone. Benefit decisions are based on an assessment of the child's support needs and resulting disability severity. MDPH evaluates the child and assigns a *taux d'incapacité* (disability rating) reflecting how much the impairment limits the daily life of the child and what support is required.	Formal ASD diagnosis required ("double diagnosis"): a) medical diagnosis from a qualified physician (child psychiatrist, developmental paediatrician, or neurologist) b) psychological assessment from a qualified psychologist (clinical, developmental, or educational) ASD diagnosis leads to automatic entitlement. Care needs assessment conducted by NII's Medical Board only to determine higher than standard rate because of high dependency on others.	Eligibility for the benefit depends on whether the child's care requirements are intensive. This must be confirmed through a formal evaluation by the Care Needs Assessment Centre (CIZ). The child must either hold an existing long-term care indication (Wet langdurige zorg, Wlz), as determined by the CIZ, or meet the eligibility threshold in a care and supervision assessment. In this assessment, the CIZ applies a two-component framework – care and supervision – each divided into five functional domains. Parents must hand in documentation from the child's treating physician confirming the child's diagnosis. They also complete a questionnaire describing their child's everyday care and supervision needs.	Entirely based on an assessment of the child's support needs. Formal medical diagnosis is not required but parents usually need to provide supporting evidence – such as reports from healthcare professionals. The eligibility evaluation process involves completing a detailed questionnaire that assesses the child's care and mobility needs.	Medical documentation of a condition is necessary, but a formal medical diagnosis alone does not guarantee an allowance. The medical condition has to cause "marked and severe functional limitations". Disability Determination Services (DDS) review all documentary evidence to assess how the impairment impacts the child's daily functioning.

		Canada (Ontario)	Estonia	France	Israel	Netherlands	United Kingdom	United States (California)
	Further details	• Assessment focusses on whether child's impairment severely limits essential activities; however, the process does not include a detailed needs assessment but is based on a physician's assessment • For children under 18 years of age • Allowance can be paid retroactively for the current and up to ten previous benefit years • Benefit amount is recalculated annually (every July) using updated income information, and the child's DTC status must remain current • Some provinces offer additional allowances (some specific to autism); provincial programmes require proof of ASD diagnosis from a specialist; some, like Ontario Autism Program, use needs-based assessments to determine funding amounts	• Assessment covers amongst others: child's overall state of health and operational capacity, need for personal assistance or supervision, child's living environment and extra expenses caused by the disability • Assessment relies primarily on documentary evidence (e.g. from psychologist, social worker, teacher) and may include an in-person visit if needed • Allowance is paid until 16 years of age (note: recent proposal to extend the age limit to 18 from Feb 2027) • The degree of severity of a child's disability is determined for fixed periods (e.g. six months, one year, two years, or three years) and is subject to periodic reassessment when that period expires	• Assessment covers amongst others: daily living, communication skills, social interactions, cognitive development • Assessment carried out by a multi-disciplinary team from the MDPH typically using a standardised evaluation tool (e.g. GEVA guide) • Involves both in-person evaluation and review of documentary evidence • Base AEEH is awarded based on the child's disability level (minimum disability rating of 80% or 50-79% with additional conditions) • For children under 20 years of age • Periodic reassessments (typically every two to five years)	• A child with ASD is entitled to allowance from the age of 91 days to 18 years and three months • Allowance is paid retroactively for up to one year prior to the date of claim submission • Assessment relies almost exclusively on documentary evidence but may include an in-person visit/or third doctor's evaluation if needed • Child diagnosed before three years old: will be granted eligibility until age ten when a re-assessment will be needed • Child diagnosed after three years old: will be granted automatic and permanent eligibility up to age 18 and three months • Standardised NII tool for care needs assessment available	• Care: personal hygiene, toileting, eating and drinking, mobility, medical care • Supervision: behaviour, communication, being home alone, supervision outside the home, engagement and guidance • Assessment relies primarily on documentary evidence and may include an in-person visit if needed • Periodic reassessments are typically not conducted • Extra, means-tested payment for children with extensive care needs (paid once a year ~ EUR 2 702) available if receive Double Child Benefit for a full year	• Assesses the child's care and mobility needs, with specific focus on how child's impairment affects their ability to carry out daily activities • Primarily based on a detailed claim form/questionnaire completed by the parent/carer • Supporting documentary evidence (e.g. medical reports, school records) is required to detail the child's needs • In some cases, in-person assessment with a healthcare professional • For children under 16 years of age • No regular reassessments (only if there is a significant change in circumstances)	• SSI is foremost a federal benefit for low-income individuals • California's SSP adds a state supplement to SSI recipients • Max. benefits for a child with disability living with parents: SSI USD 644.67 + SSP USD 102.53 • SSA/DDS review of medical records, diagnostic reports, educational records, etc. to determine whether/how the medical condition limits the child's daily functioning (communication, self-care, mobility…) • Assessment relies primarily on documentary evidence; may include an in-person visit if needed • Allowance is paid until 18 years of age • Periodic reassessments every few years (usually every three

		Canada (Ontario)	Estonia	France	Israel	Netherlands	United Kingdom	United States (California)
								years)
ALLOWANCE 2	• Name • Responsible institution • Levels • Means-testing						• Universal Credit (UC) – Disabled Child Element • Department for Work and Pensions (DWP) • Two levels: 1. Lower Rate Addition: GBP 156.11 per month 2. Higher Rate Addition: GBP 487.58 per month (if child receives the highest rate of DLA care component) • Means-tested	
	Eligibility assessment						Eligibility is based on the child’s DLA status, with rates corresponding to the level of DLA received. It does not require the carer to provide a specific number of care hours.	
	Further details						• Disabled Child Addition is provided as a flat rate addition to a claimant’s Universal Credit (UC) award • UC is a means-tested benefit for low-income individuals;	

		Canada (Ontario)	Estonia	France	Israel	Netherlands	United Kingdom	United States (California)
							income affects eligibility and the overall amount awarded, including the Disabled Child Addition • A child receiving any rate of DLA (care or mobility component) qualifies for the lower rate of the UC Disabled Child Addition • A child receiving the highest rate care component of DLA qualifies for the higher rate of the Disabled Child Addition • If a child is registered blind, they also qualify for the higher rate	

Source: Information collected by the Secretariat and verified in discussions with national autism organisations.

Table A C.3. Additional cost allowances in comparison

		Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
ALLOWANCE 1	• **Name** • **Responsible institution** • **Levels** • **Means-testing**	• National Disability Insurance Scheme (NDIS) • National Disability Insurance Agency (NDIA) • No standardised levels; amount varies depending on individual support needs; in 2025, average annual NDIS budget of AUD 24 000 for a child with ASD • Not means-tested	• Ontario Autism Program (OAP) • AccessOAP, an independent intake organisation – previously Ontario's Ministry of Children, Community and Social Services • OAP's funding for Core Clinical Services and Supports is divided in four age groups (0-3 years; 4-9 years; 10-14 years; 15-17 years) and three levels of support needs ranging from limited, to moderate, to extensive. Children aged 15-17 with limited support needs receive the smallest annual budget (CAD 6 600), while children aged 3-9 with extensive support	• Additional Expenses Allowance (*Merudgiftsydelse*) • Local municipalities • Allowance covers necessary additional costs directly attributable to the child's disability. The specific amount is determined based on documented additional expenses and must exceed the annual minimum threshold of DKK 5 718 to qualify. • Not means-tested	• Education Allowance for Disabled Children (*Allocation d'éducation de l'enfant handicap, AEEH*) • Department for the Disabled (*Maison Départementale des Personnes Handicapées, MDPH*) • AEEH is made up of a basic allocation (EUR 151.80) plus a complementary amount that varies depending on additional expenses caused by the disability: 1. EUR 265.65 (total) 2. EUR 460.14 (total) 3. EUR 588.22 (total) 4. EUR 828.11 (total) • Not means-tested	• Integration Assistance (*Eingliederungshilfe*) • Typically Youth Welfare Office (*Jugendamt*) • No predefined levels; funding is tailored individually based on assessed support needs. Options: either services or a Personal Budget (*Persönliches Budget*) – a full-choice, self-managed monthly cash allowance • Partially means-tested	• Personal Budget (*Persoonsgebonden Budget, PGB*) • Typically local municipalities • Allocated budget depends on assessed support needs and individual municipality rates. Benefit allows parents to arrange customised care and other assistance (material or personnel) • Not means-tested	• Additional Cost Allowance (*Merkostnadsersättning*) • Swedish Social Insurance Agency (*Försäkringskassan*) • Five levels – amount depends on actually incurred additional costs: 1. Costs are at least SEK 14 700 per year: receive SEK 1 470 per month. 2. Costs are at least SEK 20 580 per year: receive SEK 1 960 per month. 3. Costs are at least SEK 26 460 per year: receive SEK 2 450 per month. 4. Costs are at least SEK 32 340 per year: receive SEK 2 940 per month. 5. Costs are at least SEK 38 220 per year: receive	• Direct Payments • Local authorities • No standardised payment amount; amount depends on individual care needs and the cost of services required • Means-tested

		Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
			needs receive the biggest annual budget (CAD 65 000). • Not means-tested					a maximum amount of SEK 3 430 per month. • Not means-tested	
	Eligibility assessment	To enter the NDIS system, a formal medical diagnosis is not strictly required. A child must have an impairment that is likely to be permanent and causes a substantial reduction in functional capacity. Early intervention supports can also be provided for eligible children with likely permanent impairment or children younger than six with developmental delay, where the supports are likely to benefit the person and reduce the impact of their impairment. Children with a diagnosis of ASD at Level 2 or 3 have so far had easier	A formal medical ASD diagnosis is required. After registering with the required diagnostic documentation through AccessOAP, an OAP care co-ordinator (often a clinical professional or programme advisor) reviews the submitted materials and carries out a Determination of Needs assessment. This process involves interviewing the child's parents and reviewing relevant documents, such as diagnostic evaluations and school reports, to assess the child's support needs and determine the corresponding level of funding.	Entirely based on an assessment of the child's support and care needs, and limitations in daily life. Formal medical diagnosis is not required but parents usually provide supporting medical evidence – such as reports from healthcare professionals.	AEEH eligibility requires that the child's impairment be acknowledged as causing a disability; allowance is not automatically granted based on a diagnostic label alone. Benefit decisions are based on an assessment of the child's support needs and resulting disability severity. MDPH evaluates the child and assigns a *taux d'incapacité* (disability rating) reflecting how much the impairment limits the daily life of the child and what support is required. The complementary allowance level depends on the amount of extra	A formal medical diagnosis is required. Additionally, the responsible agency (e.g. Youth Welfare Office) carries out a participation and needs assessment. It is a collaborative assessment and planning process in which social workers, the child (and family) review all evidence (medical/psychological reports, school reports, etc.) to map out the child's functional needs. The assessment is person-centred, based on the WHO's ICF framework, and looks at how the impairment affects daily life (self-care, mobility, communication, learning, social interaction) and	Depending on the child's situation, the responsible authority is either the local municipality or the Care Needs Assessment Centre (CIZ). Evaluation involves reviewing medical reports and professional assessments. The process focusses on evaluating the child's care needs rather than the specific diagnosis – a formal medical diagnosis is not necessarily required.	A formal medical diagnosis is not required but the treating doctor must complete a medical report. Eligibility depends on whether the family incurs extra costs because of the child's disability or medical condition, compared to a child without disability of the same age.	While a formal medical diagnosis can support the assessment, it is not strictly required. Eligibility focusses on the child's support needs in daily life. Assessment evaluates the child's abilities and challenges in daily activities; it also considers the family's needs as a whole, not just the child's needs.

		Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
		access to the NDIS, as these two levels of ASD are on the NDIS' Access List A.			costs parents incur because of the child's disability.	what supports are required.			
	Further details	• NDIS provides individualised funding packages which are used to purchase supports and services such as therapies, equipment, personal care, and training • Eligibility is based on reduced functional capacity in one or more of the following areas: moving around, communicating, socializing, learning, or undertaking self-care or self-management tasks • To determine funding package: NDIS planners/local area co-ordinators evaluate the	• OAP's services and funding fall into five core categories: 1) foundational family services, 2) caregiver-mediated early years programmes, 3) core clinical services, 4) entry to school programme, 5) urgent response services • In some of these categories, services are provided completely free of charge, in other categories, parents purchase services privately (such as therapy sessions under Core Clinical Services) and are reimbursed	• Conditions: additional costs must be attributable to the child's disability and additional costs could not be avoided	• Assessment includes an evaluation of the child's support needs in daily life and the resulting extra expenses • Assessment carried out by a multi-disciplinary team from the MDPH typically using a standardised evaluation tool (e.g. GEVA guide) • Involves both in-person evaluation and review of documentary evidence • E.g. Level 4 = child's disability results in expenses equal to or greater than EUR 828.11 per month • For children under 20 years of age • Periodic reassessments	• Allowance covers a wide range of participation services: medical (e.g. therapy), educational (e.g. school aides), vocational (e.g. workshops), mobility services, social-assistive services (e.g. personal assistants) etc. • Individuals can choose a personal budget instead of direct services. In that case, they receive a cash budget or vouchers to purchase services themselves • Needs assessments rely on documentary	• PGB is regulated under four separate legal frameworks, with the applicable law depending on the nature and intensity of the care required (Youth Act, Social Support Act, Health Insurance Act, Long-term Care Act) • Purpose: budget to buy care, assistive devices, etc. to meet the child's care needs • Evaluation centres on the child's support and care needs, such as assistance with daily activities, supervision, and medical support • Relies on documentary	• Parents must complete an application form, in which they detail all additional expenses directly linked to their child's disability and explain how these costs arise from the disability • Case administrator typically schedules a follow-up call with the parents to discuss the child's needs in detail • Reassessments are normally conducted every four years	• Direct Payments provide funding to arrange and manage personalised care and support services • Typically, local authorities conduct in-person assessments to evaluate the child's needs and the family's circumstances; although procedures vary across local authorities • Regular reassessments are foreseen

		Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
		child's needs • Children diagnosed with Level 2 (Requiring substantial support) or Level 3 (Requiring very substantial support) ASD considered likely to meet eligibility criteria (see List A) • Support needs and functioning evaluation relies mostly on documentary evidence provided by the applicant • Children aged 0-9 years can also access NDIS support through an "early childhood approach" • NDIS is available to all Australians under 65 years of age	for the approved expenses with the child's allocated annual budget • Determination of Needs covers the following ten key domains: communication, social interaction, play and leisure, activities of daily living, motor skills, cognitive skills, sensory system, interfering behaviours, mental health, and adaptability and resilience • For children under 18 years of age • Annual reassessment of child's support needs by OAP care co-ordinator		(typically every two to five years) • For single parents, a supplement is available	evidence (therapy reports, school evaluations, etc.) and in-person interviews or home visits • No age restrictions; available to individuals of all ages • Person's income and savings beyond thresholds are taken into account when calculating co-payments. However, parents' income is generally not considered for children • Periodic reassessments, latest every two years	evidence, as well as an in-person assessment • Reassessments are triggered by any significant changes in the child's care needs		

		Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
ALLOWANCE 2	• **Name** • **Responsible institution** • **Levels** • **Means-testing**		• Ontario's Assistance for Children with Severe Disabilities (ACSD) • Ministry of Children, Community and Social Services (MCCSS), administered by regional MCCSS offices/family support units • Monthly benefit ranges from CAD 25 to CAD 646, based on: - Household income (max CAD 76 200 / year) - Family size - Severity of the child's disability - Extraordinary disability-related costs • Means-tested		• Disability Compensation Benefit (*Prestation de compensation du handicap, PCH*) • Department for the Disabled (*Maison Départementale des Personnes Handicapées, MDPH*) • 100% of extra expenses linked to the disability are reimbursed if the household's annual income is EUR 30 398.54 or below. If annual household income is above, 80% of expenses are reimbursed • Partially means-tested (income-based)				

	Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
Eligibility assessment		Child must have a formal medical statement or psychological assessment confirming a severe impairment that significantly limits daily function (e.g. mobility, communication, personal care). Parents complete an Expense Report listing actual or expected disability-related costs (e.g. travel, equipment, respite). A Special Agreements Officer evaluates the severity of the disability, functional limitations, and extraordinary costs to determine eligibility and benefit level.		Eligible if already receives the AEEH.				
Further details		- ACSD blends a medical-functional assessment (diagnosis & functional limitation) with a cost-based evaluation		- The PCH comprises five forms of aid: Human assistance; Technical assistance; Accommodation adjustments or				

		Australia	Canada (Ontario)	Denmark	France	Germany	Netherlands	Sweden	United Kingdom
			- For children under 18 years of age - Reassessments only if there are significant changes in household income, disability status, or extraordinary costs		transportation costs; Specific or exceptional charges; Animal assistance - Each form of aid has a ceiling amount				

Source: Information collected by the Secretariat and verified in discussions with national autism organisations.

Table A C.4. Special educational support for children with SEN across countries

Country	General system structure	Assessment & decision making		Further details
		Who	How	
Australia	- Most children with SEN attend regular schools where they receive additional support, such as additional resources and assistance tailored to their needs, including learning support staff. - Children may also have the option to spend only part of their school day in a mainstream classroom, and the rest working in smaller groups or one-to-one with learning support staff. - Some special education classes are offered specifically for children with ASD (though they may also include children with other neurodevelopmental or intellectual impairments). - Usually, only students with intellectual disability and very intensive support needs opt for special schools.	Parents together with school/teachers ultimately decide on the child's school placement – usually choice limited by school district.	A formal medical diagnosis is typically required to access specialised educational supports, including specialised classes and specialised schools. School administrators and specialised professionals (such as educational psychologists, special education teachers, and the child's therapists) provide recommendations and advise parents based on their assessment of the child's needs. There is no standardised assessment procedure. School decides on the concrete support measures for the child and details them in the child's Individual Learning Plan.	- Default option is to send a child with ASD to the local school (regular school); however, these may not always be well equipped to adequately support children with ASD - Educational support is provided based on the individual needs of every child - Four levels of adjustment for students with disability: a) support within quality differentiated teaching practice (QDTP) b) supplementary c) substantial d) extensive - Certain schools have introduced Specialised Autism Learning Programs (SALP) - Parents can also decide to homeschool their child
Canada	- Most children with SEN attend regular schools where they receive additional support, such as access to therapies, additional resources, assistive technologies, and educational assistants. - An Individual Education Plan (IEP) or an Individualised Program Plan (IPP) outlines personalised goals, accommodations, and modifications needed. - Most provinces (especially Ontario) offer specialised classes and programmes specifically for children with ASD. - Only few special education schools exist in Canada.	Provincial/territorial level committees (e.g. Ontario's Identification, Placement and Review Committee which consists of at least three members) or even school-based multi-disciplinary teams which usually involve school representatives, special education experts, and parents.	A formal medical diagnosis is frequently required while placement and support decisions also consider the child's support needs. These committees or school-based teams assess the child's support needs through a review of primarily documentary evidence and subsequently decide on the child's school placement and services package – the assessment typically culminates in an IEP or IPP that formalises the placement decision. The scope and reliance on diagnostic labels of these assessments may vary a lot across provinces. Parents usually play a key role in identifying their child's needs and necessary special education services.	- Schooling options may vary by province – e.g. in Ontario, there are five options: a) Regular class with indirect support b) Regular class with resource assistance c) Regular class with withdrawal assistance d) Special education class with partial integration e) Full-time special education class - Usually regular reassessments, e.g. in Ontario, the Identification, Placement and Review Committee reviews the child at least once per school year

Country	General system structure	Assessment & decision making		Further details
		Who	How	
Denmark	- Most children with SEN attend mainstream public schools (*Folkeskole*) where they can receive additional, individualised support which may include supplementary lessons, assistive technologies, one-on-one assistance, or adapted teaching materials. - Some municipalities also offer integrated classes (NEST) for children with and without ASD – small class size and taught after special pedagogical principles. - Many municipalities have special education classes (*specialklasser*) within regular schools. - Students may attend part of their school day in a specialised class and the rest in a regular classroom. - Some municipalities offer specialised classes specifically for children with ASD. - Usually, only students with very extensive support needs enrol for special schools. - A particular form of specialised school are the so-called Treatment and Special Education schools (*behandlings- og specialundervisningstilbud*) which are specialised day-school programmes that combine therapeutic treatment and intensive special-education supports in a single, cohesive setting.	The main stakeholders involved are: child's current school, Municipal Council, and municipality's Educational-Psychological Counselling (*Pædagogisk-Psykologisk Rådgivning, PPR*) which may include psychologists, pedagogues, health professionals, and special education experts.	A formal medical diagnosis is not required – placement and support decisions are entirely based on a support needs assessment of the child. Municipal PPR undertakes the educational-psychological assessment (PPV) of the child, evaluating the child's academic, personal and social skills and needs. It also proposes specific educational support services. The current school's head teacher is then consulted to decide whether the child's needs exceed what the current school can provide; if so, the Municipal Council (via a special committee) reviews the PPV and authorises to place the child in a special education class or school. Parents are involved in all these stages. Assessments typically rely on documentary evidence, as well as in-person evaluations of the child.	- Special education classes and schools are usually reserved for children that require more than nine hours of extra-support per week - Many municipalities provide specialised after-school programmes for children with significant support needs. These are tailored environments with trained staff and structured routines, sometimes co-located with special schools - Therapies (e.g. speech or occupational therapy) are typically offered at specialised schools and classes but less frequently offered on-site at mainstream schools - Usually, annual reassessment of the child
Estonia	- Special education classes (*Eriklass*): only students with enhanced and special support needs may attend a specialised class. Some of these special education classes are ASD-specific. - Special education schools (*Erikool*): only students with very extensive support needs attend these schools.	The main stakeholders involved are: school director, parents, specialised school support team, and a regional counselling committee under municipal co-ordination. Each counselling committee (at regional centres, called *Rajaleidja*	A formal medical diagnosis is not necessarily required – placement and support decisions are primarily based on an assessment of the child's support needs. Multi-disciplinary school support team (pedagogue, psychologist, speech therapist, etc.) carries out a pedagogical-psychological assessment of the child's learning, social and self-care needs and prepares recommendations, which the municipal *Rajaleidja's* counselling committee then reviews	- Special education system based on a three-tier support system: a) General Support (includes e.g. teaching assistant, extra time for completing exams, and individual curriculum) b) Enhanced Support (includes e.g. special education teacher, and therapies) c) Special Support (includes e.g. adjusted learning environment, specialised equipment, and intensive support sessions) - Students with SEN can follow either:

Country	General system structure	Assessment & decision making		Further details
		Who	How	
		(Pathfinder Centres)) consists of at least five members, including special educator, speech therapist, school psychologist, social worker, and representative of the county or city government.	(alongside medical certificates) to advise on school placement and support services; school director and parents together formalise the final decision. Parents must approve their child's placement. Student can only receive special education support (e.g. attend a special education school) following the above described assessment conducted by *Rajaleidja's* counselling committee.	a) Regular national curriculum, which is adaptable to those with mild support needs b) Simplified curriculum, designed for students with significant support needs and again divided in two specific curriculum options – the "Curriculum for Coping" and the "Curriculum for Care" - Students who follow simplified national curricula for coping or care may remain enrolled up to the age of 20
France	- Students receive an individualised education plan (*Projet personnalisé de scolarisation, PPS*) which outlines their educational support needs. - Special education classes (*Unités Localisées pour l'Inclusion Scolaire, ULIS*) typically offer teaching assistants, individualised learning plans, specialised instruction, allied health support (such as therapies). - Autism-specific classes/units are also available (usually reserved for children with severe support needs): UEEA (*Unité d'enseignement élémentaire autisme*) for ages 6-11. - France offers different so-called medico-social establishments for children with very extensive support needs which provide integrated schooling, care and therapy.	The main stakeholders involved are: Department of the Disabled (*Maison Départementale pour les Personnes Handicapées, MDPH*), Multi-disciplinary Evaluation Team (*Équipe Pluridisciplinaire d'Évaluation,* EPE), Committee of Rights and Autonomy (*Commission des Droits et de l'Autonomie, CDAPH*), and School Monitoring Team (*Équipe de Suivi de la Scolarisation, ESS*). The EPE may include physicians, paramedical staff, teachers, social workers, etc.	A formal medical diagnosis is typically required – however, placement and support decisions are primarily based on an assessment of the child's support needs. The Multi-disciplinary Evaluation Team (EPE) of the MDPH assesses these needs based on the GEVA/GEVA-Sco report (*Guide d'évaluation des besoins de compensation en matière de scolarisation*), which is prepared jointly by the School Monitoring Team (ESS) and the child's parents. The evaluation draws on the report and other documentary evidence and, where appropriate, may include in-person observations through home or school visits. On the basis of this assessment, the decision making body (CDAPH) of the MDPH determines the child's school placement and the educational support measures to be provided. Parents are typically most involved during the initial stages of the process, working with the school to compile the assessment report submitted to the MDPH.	- Annual reassessments with subsequent annual update of the personalised education plan (*Projet Personnalisé de Scolarisation, PPS*) through the ESS (*Équipe de Suivi de la Scolarisation*) - Children with disability may remain enrolled at school until 20 years of age
Germany	- Special education schools (*Förderschule*) are relatively common and may focus on a type of need (e.g. learning, emotional/social, physical).	The main stakeholders involved are: parents, the local school authority (*Schulaufsicht*), the SEN Service (*Sonderpädagogischer*	A formal medical diagnosis is not necessarily required – placement and support decisions are primarily based on an assessment of the child's support needs. Such an assessment of the child's educational support needs (*sonderpädagogischer*	- If the school is not able to provide the child with the necessary supports, e.g. an integration assistant, parents can apply for Integration Assistance (*Eingliederungshilfe*) to cover the associated costs - Integration Assistance (*Eingliederungshilfe*) may also fund additional therapy sessions and other

Country	General system structure	Assessment & decision making		Further details
		Who	How	
		Dienst) of the local school authority, and the school's teachers.	*Förderbedarf*) can be initiated by parents and teachers. A multi-disciplinary team (or individual) then reviews documentary evidence (reports, grades, medical records…) and conducts in-person observations and tests across functional domains (learning, communication, social-emotional, motor, self-care) to assess the child's needs. The local school authority (*Schulaufsicht*) then issues recommendations on school placement and educational support provisions. Parents usually make the final decision regarding school placement.	educational supports if the school cannot provide them sufficiently - At mainstream schools, school enrolment can be extended by up to two additional years, depending on the child's development and needs - At special education schools (*Förderschulen*), children can remain enrolled until age 21, and in some cases longer
Israel	- Children with SEN may attend regular classes in regular schools where they benefit from a personal basket of service hours for extra support. - Special education classes typically offer smaller class sizes, specialised equipment and assistive technologies, special education teachers and assistants, on-site therapy, personalised curricula, etc. - Special education classes are always dedicated to one specific type of disability, e.g. children with Down Syndrome, ASD, or Cerebral Palsy & Severe Physical Disabilities (REB).	Eligibility and Characterization Committee for Special Education: operate at local level (approx. 369 in Israel), composed of five members: representatives of the Ministry of Education, the local authority, and the superintendent of Special Needs Education, a parent of a child with special educational needs, and an educational psychologist. These Committees have the authority to determine the student's eligibility for special education. The parents, student, student's teacher, and other professionals may be invited to join the meeting of the	A medical diagnosis of the disability is required. Eligibility and Characterization Committee evaluates the child's support needs to determine eligibility for special educational support, recommends a suitable schooling option, and decides on the scope of the service basket available to the child. A Multi-disciplinary Team subsequently decides on the precise composition of the child's services basket (e.g. what therapy and teaching materials) and creates the child's Individual Education Program (IEP). Normally, the child's teacher(s) complete a functioning questionnaire (RAMA) for the Committee's consideration, however, the questionnaire is no longer consistently used. The Committee relies primarily on other documentary evidence from the child's parents, psychologist, and teachers.	- Specialised classes and specialised schools integrate therapies (such as occupational, speech, and psychotherapy) into school day - Support needs divided in four levels of severity (level four = extensive support needs) - Committee reassessments take place every three years - Multi-disciplinary Team reassessments of the IEP take place annually

Country	General system structure	Assessment & decision making		Further details
		Who	How	
		Committee. A Multi-disciplinary Team (including child's teachers, parents, specialists, such as their therapists) decides on the composition of the services basket for the child.		
Netherlands	- Children with disability are encouraged to attend regular schools where they receive additional, individualised support. - There are two different types of special education schools depending on a child's level of support needs: a) Special Primary Education (*Speciaal Basisonderwijs, SBO*) which offers the curriculum of regular primary schools, but class sizes are smaller, and children get more attention and support. This type of school is meant for children with learning and behavioural difficulties. b) Special Education Schools (*Speciaal Onderwijs, SO*, and *Voortgezet Speciaal Onderwijs, VSO*) which offer specialised teaching staff, adapted curricula and teaching methods, etc. They are divided in four clusters: Schools of Cluster 4 focus on behavioural and psychiatric disorders (such as ASD, ADHD, etc.).	The main stakeholders involved are: parents, teachers, independent experts, and regional school partnership groups (*samenwerkingsverband*) which include regional regular and special education schools.	A formal medical diagnosis is not necessarily required – placement decisions are primarily based on an assessment of the child's support needs. If the regular school cannot provide the child with the support needed, the child can be referred to a special education school. For Cluster 3 and 4 special education schools, access is determined through a Declaration of Admissibility (*toelaatbaarheidsverklaring, TLV*) issued by the regional school partnership group (*samenwerkingsverband*). The assessment is primarily document-based (medical certificates, school reports, etc.), with in-person evaluations conducted if clarification is needed.	- Children enrolled at SBO schools can attend those until age 14 (normally 12 years limit) - SO/VSO are divided in four clusters: a) Cluster 1: Visual impairments b) Cluster 2: Hearing impairments and speech-language difficulties c) Cluster 3: Physical disabilities and chronic illnesses d) Cluster 4: Behavioural and psychiatric disorders - TLVs are granted for a fixed term (often two years) and specify how long placement in SO schools is approved - When the TLV nears expiry, the school must review the child's progress and support needs and decide whether to request a new TLV from the regional school partnership group
Sweden	- Children with disability are encouraged to attend regular schools where they benefit from either a) Minor Adjustments, such as modified assignments, extra time, etc. or b) Special Support, individually specified in an Action Plan (*åtgärdsprogram*), which may include a personal assistant, assistive technology, flexible timetables, access to therapies, etc. - Adapted Schools (*anpassade skolan*) are	The main stakeholders involved are: parents, school director, municipality, school's teaching staff, and independent experts, such as psychologist and special education teachers.	A formal medical diagnosis is generally not required – placement and support decisions are based on an assessment of the child's support needs. There are essentially three assessment procedures: one to determine the child's need for special support at a regular school, one to determine the child's need to attend an Adapted School, and one for attendance at a Special	- Access to special education schools (adapted schools): "For the purposes of the Education Act, people with autism or autism-like conditions shall not be equated with people with intellectual disabilities unless they also have an intellectual disability or intellectual disability due to brain injury as described above." (Sveriges Riksdag, 2010)

Country	General system structure	Assessment & decision making		Further details
		Who	How	
	dedicated to children with intellectual disability and offer adapted curricula, specialised teaching staff, lower student/teacher ratio, allied health support (such as therapies), etc. - Special Schools (*specialskola*) target specific groups: one school is designed for children with congenital deafblindness and hearing impairment with severe learning disorders; one school targets children with visual impairments combined with other disabilities; and two schools are for children with severe developmental language impairments.		School. Assessment 1: When Minor Adjustments seem not to suffice and a need for Special Support is suspected – raised by teachers, parents or the child – the school principal must immediately commission a needs assessment (*utredning av behov av särskilt stöd*) led by special-education staff in collaboration with class teachers, school health professionals and, where relevant, external specialists. The assessment relies on both documentary evidence (e.g. school records, teacher observations, psychological reports) as well as in-school observations and interviews with the student and parents. The school principal makes the final decision on the provision of special support. Special Support measures are then specified in an individual Action Plan. Assessment 2: Before a child can be placed in an Adapted School, the municipality must carry out a Target-Group Investigation (*utredning om målgruppstillhörighet*). This investigation typically comprises four assessment parts – pedagogical, psychological (by a licensed psychologist), medical (by a physician) and social (by a school counsellor or equivalent) – and relies on documentary evidence as well as in-person observations and interviews with the student and parents. Once the multi-disciplinary report confirms the child meets the criteria (e.g. intellectual disability or equivalent severe needs), the municipality formally decides on placement in the Adapted School. Parents play a crucial role at all stages of the assessments and decision making.	

Country	General system structure	Assessment & decision making		Further details
		Who	How	
United Kingdom	- Some schools offer specialised classes for specific types of SEN, e.g. specifically for children with ASD. - Special education classes are usually meant for children with an Education, Health, and Care Plan (EHCP) but may also include children with SEN Support. - Usually, only students with extensive support needs attend special schools – they are generally reserved for children with an EHCP.	The main stakeholders involved are: parents, school's Special Educational Needs Co-ordinator (SENCo), the local authority, and independent experts.	A formal medical diagnosis is not required – placement and SEN support/EHCP decisions are entirely based on an assessment of the child's support needs. There are two assessment procedures, one to determine the child's need for SEN support and one for an EHCP for children with extensive support needs. SEN support: The school's SENCo in partnership with teachers, parents and, where necessary, local-authority specialists (e.g. educational psychologists or health professionals) assess the child's support needs. They assess the child against four broad areas of needs and subsequently draft a SEN support plan, detailing the special educational measures that the child is entitled to. Assessment relies on documentary evidence and may also include in-person evaluations. EHCP: EHCP needs assessments are carried out by the local authority, which must gather information on the child's educational, health and care needs from a range of professionals (parents, school's SENCo, educational psychologist, healthcare practitioners, social worker, etc.). The assessment relies primarily on documentary evidence (e.g. school reports, medical and therapy records) but may also include in-person evaluations. Based on the gathered information, the local authority then decides whether the child requires an EHCP and, if so, drafts one which details the most suitable school setting and educational support. Parents play a crucial role at all stages, such as the finalisation of the EHCP.	- Children can receive paramedical therapy, e.g. speech and language therapy, even without an official SEN support plan or EHCP if a teacher recommends it - Annual reassessment and update of the EHCP - Termly (i.e. every four months) reassessments and update of the SEN support plan - Local authority may place a child in an independent (private) special education school if there is no availability in a public one - Local authorities only initiate an assessment for an EHCP if there is sufficient evidence that existing interventions are not effective

Country	General system structure	Assessment & decision making		Further details
		Who	How	
United States (California)	- Separate Classes or Special Day Classes: usually, only children with significant support needs attend those. - Many such specialised classes are offered for specific types of SEN – some are specifically designed for children with ASD. - Typically, only children with extensive support needs attend special education schools. There are some non-public (private) special education schools specifically designed for children with ASD.	Individualised Education Program (IEP) Team which includes the parents, special education teacher, regular education teacher, and a qualified representative of the school district.	A formal medical diagnosis is required – additionally, a comprehensive assessment of the child's support needs is conducted to determine placement and support measures. Only children that meet one of the 13 disability categories in the Individuals with Disabilities Education Act (IDEA) (e.g. intellectual disability, visual impairment, deaf-blindness, autism, etc.) can be found eligible for special-education and receive IEP services. Decisions on school placement and services are described in the child's Individualised Education Program (IEP), which is developed and reviewed by an IEP Team. Eligibility requires both (a) a formal disability determination (medical diagnosis) and (b) a multi-disciplinary needs assessment. A parent or teacher referral initiates a written request for assessment. The assessment covers a broad range of areas of the child's life and relies on both documentary evidence (medical records, school reports, etc.) and in-person evaluations (e.g. standardised tests, interviews, observations). Parents play a crucial role at all stages of the assessment and IEP creation.	- Child may be placed in a non-public (private) special education school if there is no availability in a public one - Some schools offer ASD-specific support programmes and services, such as ABA therapy and ASD-specialised teaching staff - Placement and services are reviewed at least annually, with full re-evaluations every three years - All children with special educational needs must obtain an IEP that details educational support and school placement

Source: Information collected by the Secretariat and verified in discussions with national autism organisations.

Table A C.5. Access to paramedical therapies for children with ASD/disability across countries

Country	Institution / Programme	Eligibility Criteria	Access Pathway	Therapy Hours / Limits	ASD-Specific
Australia	- National Disability Insurance Scheme (NDIS) - Medicare (limited coverage) - Mainstream community health services or hospital-based community health - Education system (depends on individual schools)	- NDIS: permanent impairment that substantially reduced functional capacity OR likely permanent impairment or children younger than six with developmental delay, where the therapies are likely to benefit the person and reduce the impact of their impairment - Community services: access varies considerably across regions - In educational setting: formal medical diagnosis typically required	- NDIA determines eligibility based on documentary evidence; subsequently parents meet with an NDIS Local Area Co-ordinator to develop an individualised NDIS plan which determines therapy hours (NDIS budget management options: self-managed, NDIS-managed, or plan-managed) - Medicare: GP referral - Community services: access varies considerably across regions - In educational setting: school evaluates child's needs and decides on support services (incl. therapies)	- NDIS budgets are individualised, i.e. no fixed hours - Average NDIS budget of a child with ASD approximately AUD 24 000/year (buys about two h/week of therapy) but can vary widely - Medicare: usually capped at ten h/year of psychotherapy	- No ASD-specific programme - For every child: therapy hours based on individual needs
Canada (Ontario)	- Children's Treatment Centres (CTCs) - Ontario Autism Program (OAP) (parents purchase privately and get reimbursed) - School-Based Rehabilitation Services (SBRS) via CTCs in partnership with school boards - Ontario's Preschool Speech and Language Program (PSLP)	- CTCs: for children up to 19 years of age (or 21 years if in publicly funded school) with physical, developmental, communication challenges - OAP: formal ASD diagnosis required; must register and undergo "Determination of Needs" assessment to receive a Core Clinical Services budget - SBRS: formal medical diagnosis typically required	- Families contact local CTC directly (no formal referral needed); waiting lists tend to be long - For OAP: registration for OAP with an official ASD diagnosis, with subsequent "Determination of Needs" assessment facilitated by local care co-ordinator, in order to receive fixed annual funding for Core Clinical Services (ABA, speech/occupational therapy, mental health services) - SBRS: school referral to local CTC partner to provide speech/occupational/psychotherapy - PSLP: for children from birth until they start school; parents register their child through the local PSLP provider	- CTCs: no fixed hours; allocation according to available resources and child's needs - OAP: Core Clinical Services budget varies by child's age and intensity of support needs; no predefined number of therapy hours but fixed budgets - SBRS & PSLP: no fixed hours; allocation according to available resources and child's needs	- OAP is ASD-specific; children with other disabilities cannot access OAP - CTCs, SBRS, and PSLP serve all children with disability

Country	Institution / Programme	Eligibility Criteria	Access Pathway	Therapy Hours / Limits	ASD-Specific
Denmark	- Municipalities (primarily in educational setting)	- Comprehensive PPR (Pedagogical Psychological Counselling) assessment determines eligibility - No formal medical diagnosis required	- Parental or school request initiates process: PPR (in each municipality) conducts a comprehensive educational, psychological assessment of the child's needs through observations, interviews, and tests - Once child's needs are determined, municipality allocates special education support (which includes speech/occupational therapy) - Therapies are typically integrated into educational setting or offered at specialised institutions (e.g. day treatment centres (*dagbehandlingsskoler*))	- No fixed number of therapy hours; allocation according to available resources and child's needs as determined by PPR	- No ASD-specific programme - For every child: municipalities allocate therapy hours based on individual needs
Estonia	- Estonian Health Insurance Fund (Tervisekassa) - Municipalities (for therapies in educational setting) - Social Insurance Board (*Sotsiaalkindlustusamet*) for Social Rehabilitation Centres	- Health insurance: family doctor or specialist referral - In educational setting: formal medical diagnosis not necessarily required; municipal Pathfinder (*Rajaleidja*) Counselling Committee assessment - Social Rehabilitation Centres (SRC): official "degree of disability" (moderate/severe/profound) issued by Social Insurance Board	- Health insurance: doctor's referral to contracted therapist - In educational setting: multi-disciplinary school support team assesses child's needs and issues recommendations, which the municipal Pathfinder Counselling Committee reviews (along with medical certificates) to advise on support services; speech therapy (if availability permits) then integrated into child's school day - SRC: application for an official "degree of disability" to the Social Insurance Board; subsequent application for SRC to the Social Insurance Board; once application approved, a multi-disciplinary team from SRC establishes a tailored therapy plan for the child	- Health insurance: no fixed number of therapy hours; allocation according to child's needs - In educational setting: no fixed number of therapy hours; allocation according to available resources and child's needs - SRC: no fixed number of therapy hours but services are funded up to an annual limit of EUR 2 695 until the child turns 16	- No ASD-specific programme - For every child: therapy hours based on individual needs

Country	Institution / Programme	Eligibility Criteria	Access Pathway	Therapy Hours / Limits	ASD-Specific
France	- Kindergarten/Elementary School Autism Units (UEMA/UEEA) - Early Medical and Social Action Centres (*Centres d'Action Médico-Sociale Précoce, CAMSP*) - Special Education and Home Care Services (*Services d'Éducation Spéciale et de Soins à Domicile, SESSAD*) - National Health Insurance (*Assurance Maladie*) (for individual therapies) - Early Intervention Package (*forfait d'intervention précoce*)	- UEMA (ages 3-6), UEEA (ages 6-11): formal medical ASD diagnosis & recommendation by CDAPH (via MDPH) - CAMSP (ages 0-6): early screening by CAMSP teams; medical diagnosis helpful but not strictly required - SESSAD (ages 0-20): formal medical diagnosis & recommendation by CDAPH (via MDPH) - Health insurance for individual therapies (speech/occupational therapy): doctor's prescription - Early Intervention Package (ages 0-12): doctor prescribes a course of assessment and early intervention	- Parents apply to departmental MDPH: multi-disciplinary evaluation team assesses the child's needs and CDAPH makes the decision; child then placed in UEMA/UEEA or receives SESSAD as appropriate - CAMSP: either direct access or referral by a paediatrician; to determine eligibility and therapy plan, child undergoes a comprehensive evaluation conducted by various specialists (a recommendation from MDPH becomes necessary beyond six months of care) - For individual therapies: doctor's prescription; family books therapist and health insurance reimburses (partially) - Early Intervention Package: doctor prescribes a course of assessment and early intervention, and refers the child to the co-ordination and guidance platform (PCO); PCO assesses whether child needs occupational therapists, psychologists or psychomotor therapists	- UEMA/UEEA: child spends several hours each school day in a partial-day programme with embedded therapy; no fixed number of therapy hours (but bound by staff availability and resources) - CAMSP: no fixed number of therapy hours, as based on individual needs - SESSAD: no fixed number of therapy hours, as based on individual needs - Individual therapies through health insurance: no fixed number of therapy hours, as based on individual needs - Early Intervention Package: no fixed number of therapy hours, as based on individual needs, but available for a maximum of 18 months	- Children with ASD have dedicated UEMA/UEEA units for early intervention - Early Intervention Package also serves exclusively children with neurodevelopmental disorders, such as ASD - CAMSP and SESSAD serve all children with disability: therapy hours based on individual needs - National Health Insurance also serves all children: therapy hours based on individual needs

Country	Institution / Programme	Eligibility Criteria	Access Pathway	Therapy Hours / Limits	ASD-Specific
Germany	- Statutory Health Insurance - Integration Assistance (*Eingliederungshilfe*) for non-regular services or ASD-specific supports (e.g. at autism therapy centres) - Education system (esp. special education schools typically integrate therapies in school day)	- Statutory health insurance: doctor's prescription and medical diagnosis - Integration Assistance: formal medical diagnosis + comprehensive assessment of the child's support needs - In educational setting: school/teachers evaluation (formal medical diagnosis may be required if costs are to be covered by health insurance)	- Statutory health insurance covers typical, doctor-prescribed therapies (speech/occupational/physio-/psychotherapy) - Integration Assistance: family applies to relevant authority (usually Youth Welfare Office) with a formal medical diagnosis; multi-disciplinary ICF-based assessment of the child's support needs (considering medical and non-medical reports); individual service package or personal budget granted - In educational setting: multi-disciplinary team at school typically assesses the child's needs, followed by the school authority making recommendations; individual support plan created by school (incl. therapies)	- Applies to all pathways: no standard number of therapy hours, as based on individual needs (but bound by staff availability and e.g. school's resources) - Health insurance: therapists can often decide on frequency and length of individual sessions	- No ASD-specific programme - For every child: therapy hours based on individual needs
Israel	- Public Health Insurance via Health Maintenance Organizations (HMOs) - Early Childhood Program - Education system (e.g. individual service baskets)	- Official ASD diagnosis - For 14 h/week early childhood programme: child with ASD aged 0-6 - For regular three h/week HMO services: ASD diagnosis and a doctor's referral	- HMO therapies (speech/occupation/physio-/psychotherapy): paediatrician/psychiatrist referral - Early Childhood Program: • Special daycare centres (<3 years): medical diagnosis and NII approval • Kindergarten (3-6 years): Eligibility and Characterization Committee assessment of child and approval for special kindergarten - Individual services basket at school: Eligibility and Characterization Committee assessment of child's support needs and approval	- Early Childhood Program: 14 h/week (10.5 h direct + 3.5 h indirect team) for children 0-6 with ASD - Beyond age seven: through HMOs up to three h/week + SEN hours at school	- Children with other disabilities get the same HMO three h/week basket of therapies but the Early Childhood Program offers up to 14 h/week of therapies exclusively for young children with ASD

Country	Institution / Programme	Eligibility Criteria	Access Pathway	Therapy Hours / Limits	ASD-Specific
Netherlands	- Health Insurance, especially for speech and language therapy - In-kind therapeutic services provided by municipalities - Personal Budget (PGB) via Youth Act (*Jeugdwet*) or Long-Term Care Act (*Wlz*), especially for behavioural therapy - Education system	- Health insurance: often with GP/specialist referral - PGB: medical diagnosis not necessarily required - In educational setting: no formal medical diagnosis required per se	- Health insurance: doctor's referral if non-contracted therapist - PGB: usually through municipality which assesses the child's specific needs - In educational setting: regular schools rarely offer therapy on-site; special education schools are much more likely to integrate therapeutic services into the child's school schedule	- Health insurance: no fixed number of therapy hours, as based on individual needs (some exceptions) - PGB: no fixed number of therapy hours, as based on individual needs - In educational setting: no fixed number of therapy hours, as based on individual needs (but bound by staff availability and resources)	- No ASD-specific programme - For every child: therapy hours based on individual needs
Sweden	- Public Health System - Municipalities and schools (speech/occupational therapists employed by municipalities and shared across schools or employed by individual schools)	- Public health system: Referral by GP, school nurse, or child health centre (*barnavårdscentralen*) - In educational setting: no medical diagnosis required; comprehensive support needs assessments	- Public health system: GP/child health centre/school nurse refers child to a habilitation centre where a multi-disciplinary team creates an intervention plan - In educational setting: student health team (school nurse, speech therapist, psychologist) and teachers assess the child's support needs and integrate therapy in school day accordingly	- No standard number of therapy hours, as based on individual needs	- No ASD-specific programme - For every child: therapy hours based on individual needs
United Kingdom	- Educational provisions of Education, Health & Care Plan (EHCP) funded by local authority - Health provisions of EHCP and individual therapies funded by National Health Service (NHS) - Direct Payments provided by local authorities (to purchase outside services)	- Through NHS: referral to NHS therapy services from GP or school staff - Through EHCP: medical diagnosis not required - Through Direct Payments: medical diagnosis not strictly required	- NHS: GP or school refers child to NHS therapy services; waiting lists tend to be long - EHCP process: local authority conducts comprehensive assessment of child's support needs based on medical and non-medical reports; if eligible, authority drafts an EHCP, including therapy entitlements; therapies are funded either through local authority or NHS - Direct Payments: local authority evaluates the child's needs and	- No standard number of therapy hours, as based on individual needs	- No ASD-specific programme - For every child: therapy hours based on individual needs

Country	Institution / Programme	Eligibility Criteria	Access Pathway	Therapy Hours / Limits	ASD-Specific
			family context; personal budget then used by parents to purchase therapies		
United States (California)	- Medi-Cal (California's Medicaid) under EPSDT (Early & Periodic Screening, Diagnostic & Treatment) - California Department of Education allocates funds to Special Education Local Plan Areas (SELPAs) which distribute resources to school districts for special education services, incl. therapies - California's Early Start Program (early intervention programme) administered by California's Department of Developmental Services and California's Department of Education through Regional Centres	- Medi-Cal: for children under 21 years old, covers medically necessary therapies; child qualifies if family income = 138% of federal poverty level OR possibly via Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) waiver regardless of income - In educational setting: formal medical diagnosis required - ES Program (ages 0-3): documented assessment demonstrating child's developmental delay	- Medi-Cal: primary care provider referral; Medi-Cal Managed Care Plan reviews the request to determine medical necessity and authorises therapies accordingly - In educational setting: school conducts a comprehensive support needs assessment of the child (typically completed by a school psychologist); if the child is found eligible, it receives an IEP, incl. speech/occupational therapies; school district usually co-ordinates and schedules therapy sessions - ES Program: One of California's Regional Centres either conducts multi-disciplinary assessment of child itself or forwards to relevant agency; if deemed eligible, child receives speech/occupational/physical therapy; review every six months	- Across all pathways: no fixed or standard number of therapy hours, as based on individual needs	- No ASD-specific programme - For every child: therapy hours based on individual needs

Source: Information collected by the Secretariat and verified in discussions with national autism organisations.

Policy Responses to Rising Autism Diagnoses in Childhood

Across the Spectrum

The number of children and youth diagnosed with autism spectrum disorder (ASD) has increased two to fourfold in just 15 years across OECD countries. Current evidence suggests that this is largely due to an increase in the detection and diagnosis of ASD, not in the underlying autism prevalence. The increase in ASD diagnoses has the potential to improve social, health and education outcomes for many young people, but has led to more demand for support, including for disability payments and specialised healthcare services. This report looks at benefits and services available in 11 OECD countries for children diagnosed with ASD. It finds large differences across countries in the level of support offered to different groups but also a general strong shift towards basing entitlement for support on the needs of individuals rather than just their diagnosis.

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