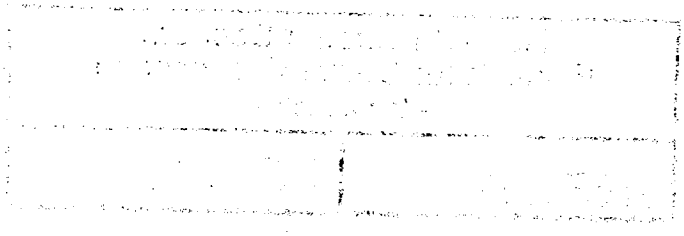
Stefan Immerfall · Göran Therborn
Editors

# Handbook of European Societies

## Social Transformations in the 21st Century



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# Chapter 19
# Welfare State

**Thomas Bahle, Jürgen Kohl, and Claus Wendt**

## 19.1 Introduction

The welfare state is at the heart of the institutional structure of all European societies. Yet there are major variations across countries due to different historical developments. The origins of social policy date back more than 120 years, but the real expansion of the welfare state did not take place until the end of World War II. In the 1950s, social programmes in most western European countries entered into a historically unique period of growth, which lasted until the 1970s (Flora 1986–1988). Since the early 1980s, however, the dominating issues of the welfare state debate have been crisis and retrenchment (Pierson 2001). Today, the expansion of state welfare has come to an end in most countries, but the core institutions and features of the welfare state have survived (Kuhnle 2000) and even been stabilized and consolidated. After more than 20 years of crisis debates and retrenchment policies, the welfare state has successfully adapted to domestic as well as international pressures (Castles 2004) and is supported by the vast majority of citizens in all European nations. The role of the state in social security, on the other hand, has changed during this time.

This chapter comparatively investigates the institutional structure and development of the welfare state in Europe, analysing trends and major variations between countries. The chapter is divided into six sections: The first provides a brief overview of major historical developments, the second maps major structural variations by discussing typologies of welfare regimes, and the third outlines social expenditure developments and structures since the 1980s. In the following sections, we more thoroughly analyse institutional variations in three areas of welfare: pensions (Section 19.5), healthcare (Section 19.6), and family policy (Section 19.7).

Pensions and healthcare belong to the historical core of the welfare state and represent its two most important spending areas. The role of the state has changed significantly in both fields: Private pensions have become more important, and forms of public (state) regulation have changed considerably. These developments have had a major impact on the role of the state in welfare provision. As a more recent element of the welfare state, family policy is less important in terms of spending, though growing in relevance. It is therefore a good contrasting case for studying the state's changing role in social welfare.

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## 19.2 Historical Developments

This section provides a concise overview of the historical development of European welfare states. While numerous comparative and individual country studies on this topic exist, hardly any that take both Western and Eastern Europe (after 1945) into account are available. The mainstream comparative welfare state research, such as the typological approaches following the seminal study of Esping-Andersen (1990), has focused on Western Europe and the OECD world. Therefore, this chapter discusses developments in Eastern European countries only to a limited extent.

The welfare state is both an element and a product of modernization related to industrialization and the rise of both the nation-state and democracy (Flora et al. 1977). The growth of industrial society has formed new social groups and social risks that need to be addressed. Furthermore, the development of both the nation-state and democracy has provided for the politicization of social problems. Welfare policies have thus become a battleground for social and political conflicts. Variations within these processes explain major differences in the timing and structure of welfare state policies and institutions. The welfare state has become a major element in the institutionalization of class conflicts (Dahrendorf 1957; Korpi 1983) and part of the social compromise that has characterized Western Europe since World War II (Crouch 1999).

Girvetz (1968) defines the welfare state as "the institutional outcome of a society's assumption of legal and therefore formal and explicit responsibility for the basic well-being of all its members" (521; cited in Kaufmann 2001: 17). The welfare state is thus characterized by institutionalized social rights, which are effectively realized by actual social policies (Flora et al. 1977: 707). This state assumes responsibility for the welfare of its citizens by devoting a large share of economic resources to social purposes (Alber 1982).

The welfare state interacts with other institutions and forces within a complex system of welfare production in society. The state was neither the first nor the most obvious resort for solving social problems deriving from industrialization and social change. Organizations and institutions such as private charities, local communities, the Church, and mutual benefit organizations (organized, for instance, by the labour movement) had played important roles in social security before the state entered this field. Yet, the institutionalization of social rights distinguishes the welfare state from other social welfare actors (Marshall 1964; Kaufmann 2003). The scope and character of these rights has structured modern societies in a fundamental and long-lasting way (Therborn 1995; Offe 2003).

The following overview presents the main variations in Europe with respect to timing (year of introduction of social programmes), basic structure (character of social rights) and size (measured in terms of population coverage and social expenditures). This section is purely descriptive and shall not consider explanations for differences between countries. As our focus is on social policy programs, we shall exclude the analysis of industrial relations and the regulation of labour markets and education, which are broader elements of the welfare state, for these fields are covered by other chapters in this handbook.

### *19.2.1 Institutional Foundations*

In the literature, the history of welfare state development is often presented as a typical cycle spanning from early formation and institutional foundation via expansion and growth to crisis and reform. The historical periods which are usually associated with these stages are

the period before World War I (early formation), the interwar years until the end of World War II (institutional foundation), the golden years of post-war capitalism from 1950 to the early 1970s (expansion and growth) and the period since the 1980s (crisis and reform).

This cyclical description, however, is based on a narrowly European perspective, indeed a *Western* European view, because it does not take into account differences in developments between socialist Eastern and capitalist Western Europe. Yet even before 1945, historical and structural conditions varied a lot between West and East as well as between Northern, Central and Southern Europe. This is first of all due to the different impacts of industrialization and urbanization. Also political conditions varied substantially. In the Western part of the continent, the formation of nation-states was almost completed when the welfare state came into being in the late 19th century, whereas in the East the rule of the Austrian–Hungarian, Russian and Ottoman Empires lasted until 1917/1919. Thereafter most Eastern European countries went through a very short period of national independence that was soon ended by Nazi occupation and the following Soviet regime for a long time. Thus, in Eastern Europe, imperial power in various forms lasted virtually until the fall of Communism in 1989. Moreover, in the interwar period in most parts of Europe, the democratization process came to a halt and was even reversed with Britain, Switzerland and Sweden being major exceptions. These huge socio-economic and political variations across European countries are of importance for a better understanding of the historical development of welfare state institutions that are sketched in the following paragraphs.

Table 19.1 summarizes the historical periods when individual countries introduced their core old-age pension and unemployment insurance programmes. Data are predominantly taken from the seminal study on the historical development of welfare states in *Western* Europe by Alber (1982). The periods are roughly divided by the turn of the 19th and the 20th centuries and the two historical watersheds of World Wars I and II.

**Table 19.1** Introduction of old-age pensions and unemployment insurance

| | | Old-age pensions | | |
|---|---|---|---|---|
| | | <1900 | <1918 | <1945 |
| Unemployment insurance | <1918 | Denmark | France<br>United Kingdom (Ireland)[a] | Finland<br>Norway<br>Netherlands |
| | <1945 | Belgium<br>Germany | Sweden<br>Austria<br>Luxembourg<br>(Czechoslovakia)[b]<br>(Hungary)[b]<br>(Poland)[c] | Italy<br>Spain<br>Canada<br>USA<br>Russia |
| | >1945 | | | Greece<br>Portugal<br>Switzerland<br>Japan |

Sources: Own depiction based on Schmidt (2005: 182); Siegel (2007: 237); Alber (1987[2]: 28); Inglot (2008: 109); ILO (1925, 1933).
Unemployment insurance abolished or fundamentally limited after 1945 in Czechoslovakia, Poland, Hungary and Russia.
[a]Until 1922 part of the United Kingdom.
[b]Until 1918 part of the Austrian–Hungarian Empire.
[c]Until 1918 divided between Prussia, Russia and the Austrian–Hungarian Empire.

Three European countries (Belgium, Denmark and Germany) introduced public pension programmes before 1900. Two of them, the German and Danish cases, are often referred to as two paradigmatic different approaches to social security. The German system, the first in the world, introduced compulsory social insurance for workers in industry, financed out of social insurance contributions. Although pensions were low and only paid in case of incapacity to work due to old age, in the long run this programme led to an occupationally structured pension system with earnings-related benefits known as the social insurance type (see ILO 1942). The social insurance approach was a real innovation and meant a significant departure from the old European tradition of public poor relief that at that time characterized almost all social policies. This road was taken by most Continental European countries.

The Danish system by contrast introduced general flat-rate pensions for the whole population based on residence (citizenship) and financed out of general taxation. Still, entitlements to benefits were principally based on a means-test. Yet the system soon covered large population groups, indeed a higher proportion of the elderly than the German occupationally based system, because the means-test was more and more relaxed. By this development, the system paved the way for general flat-rate pensions for all elderly citizens. This road was later taken by other Nordic countries and the United Kingdom (See Section 19.5 on pensions).

Until 1918 the United Kingdom, Sweden, Austria and France had also introduced public pension programmes following one of these two main approaches. No Southern or Eastern European country was among these forerunners with the exception of the Czech lands, the lands of Hungary (both covered by Austrian legislation) and large parts of Poland which at that time had not yet achieved national independence. In Silesia, German legislation was in force and Austrian regulations in the SouthEastern parts. When Poland, Czechoslovakia, and Hungary gained independence after World War I, they kept the core elements of this former imperial social legislation (see Inglot 2008). During the interwar years, then, most European countries introduced public pension programmes, including Southern Europe.

The interwar years also experienced the biggest wave of legislation on unemployment insurance. Only few countries had introduced such programmes prior to World War I. In the beginning, unemployment insurance was often organized by trade unions and subsidized by the state. Since this form of public–private mix was first institutionalized in the Flemish city of Gent, it is known as the Gent system. In some countries, in particular in Scandinavia with strong labour movements, this system still constitutes the basis of unemployment insurance. In most other countries, however, a general state-organized scheme was established, following the British example of 1911. Generally, there is a positive association between the timing of pension and unemployment programmes. However, there are also considerable exceptions. Germany, for instance, being the pioneer in social insurance generally, introduced unemployment insurance not before 1927 because this was a politically highly contested area. Again, the laggards can be found in under-developed Southern Europe as well as in Switzerland.

Family policy started considerably later than social insurance programmes. In most countries, family allowances were introduced only in the period following World War II, long after the core social insurance programmes had been established (see Table 19.2).

Pioneers in family allowances are found among two groups of nations: the Catholic countries of Europe and the Anglo-Saxon world except Britain and Canada. Belgium and France undoubtedly were the most ambitious pioneers of family policy in the world, but also the economically less advanced Southern European countries Italy, Portugal and Spain played a role in this early phase. In the South, family policy was an integral part of

**Table 19.2** Completion of social insurance and introduction of family allowances

| | | At least three of four major social insurance systems in place[a] | | |
|---|---|---|---|---|
| | | <1918 | <1945 | >1945 |
| Family allowances | <1945 | Belgium<br>France | Italy<br>Portugal<br>Spain<br>The Netherlands<br>(USA)[c] | |
| | <1950 | United Kingdom<br>(Ireland)[b]<br>Norway<br>Sweden<br>Austria<br>Luxembourg | Finland<br>Japan | |
| | >1950 | Germany<br>Denmark | Greece<br>(Canada)[c] | (Switzerland)[c] |

Sources: Own depiction based on Schmidt (2005: 182); Siegel (2007: 237); Alber (1987[2]: 28); Inglot (2008: 109); ILO (1925, 1933).
[a]Accident, sickness, old age and unemployment insurance.
[b]Until 1922 under UK jurisdiction/legislation.
[c]No general family allowances systems.

nationalist population policies, implemented by authoritarian regimes. In France, the population policy motive was prominent as well, but it was amalgamated with a strong component of Social-Catholicism (see Schultheis 1988; Gauthier 1996).

The timing of core social insurance legislation gives a first impression of the historical development of the welfare state. This needs to be supplemented by information about the character of social rights and the size of the welfare state in terms of population coverage and resources spent on social expenditures.

Until the 1930s, there were basically two kinds of social programmes: social insurance and traditional social assistance (see ILO 1942). In the first type, entitlements are usually based on employment (or more narrowly on occupation) and earnings; in the second, on membership in society (or a specific population group) and need. The first kind of system has led to an occupationally fragmented system of particular social rights, the second (by gradually and eventually completely removing the means-test) to a general system of universal social rights, although according to Therborn (1995: 89–97) this only rarely happened in reality. Though there are manifold variations between countries and even within countries (between different programmes), the European landscape shows a relatively clear pattern of social rights (Therborn 1995: 96). In most countries, an occupationally differentiated system of (particular) social rights predominates. Only Scandinavia and partly Britain (after the Beveridge reforms) have taken the road to universalism.

Interestingly, all Eastern European countries under the Socialist regime are grouped by Therborn (1995) among the particularistic regime of rights. Indeed, their social security systems relied strongly on employment, sometimes even more than in the typical social insurance countries of Western Europe like Germany. One reason for this is that after 1945 most Eastern European countries retained the core of their old pre-war social insurance systems based on principles of Bismarckian occupational insurance. Another reason was that communism itself produced new categorical distinctions between different population groups. The Socialist system favoured politically and economically important

social groups. Moreover, in the Socialist economy the firm became the centre of welfare provision, especially for social and medical services. Therefore, social policy in the former Socialist countries can be classified as being even more employment-related than in Western Europe. This is supported by the fact that after the breakdown of Communism, most Eastern European countries did not follow the Scandinavian road to universalism but the Continental way of occupational social insurance (see Götting 1998; Inglot 2008).

### *19.2.2 Growth*

Until the 1950s, the institutional foundations of the welfare state had been established almost everywhere in Europe. Only in the less developed Southern countries and in the strongly decentralized Switzerland, this process was not yet completed. At the same time, the structure of welfare states widely varied in terms of both social rights and size of social programmes. Moreover, the post-war political order of Europe brought about a new major divide between East and West, which became crucial for differences in the welfare state.

Before presenting some basic data, the major differences between social policies in socialist and capitalist countries should be emphasized. In Western Europe the welfare state was combined with capitalism (market economy) and in most cases with democracy (Mishra 1990; Kaufmann 2003). This combination produced a rather competitive environment for the welfare state which in the long run proved to be quite successful. On the one hand, a dynamic market economy generated the economic resources necessary for social programmes. Not all of them had an equalizing effect, to be sure, because social insurance has often focused on income maintenance (security) rather than equality. On the other hand, the welfare state also served to stabilize mass consumption in growing economies. The combination with democracy also had largely positive effects on the dynamics of welfare state development, because social policy became a major issue in the electoral competition. This was especially so in countries in which two pro-welfare camps competed, the Socialists and the Christian Democrats, even though their actual policies differed (Wilensky 1975; van Kersbergen 1995).

In Socialist countries of Eastern Europe both of these institutional contexts were missing. It might be argued that this contributed to their falling behind compared to the welfare state development in the West. However, it also shows that in Eastern Europe the welfare state needs to be analysed in a different context. Despite some variations among them (Inglot 2008), all Socialist countries shared major structural features of the welfare system that clearly distinguished them from the West (see Deacon 1993; Fajth 1999; Tomka 2004). First of all, social policy was interwoven with economic policy. Social policy never reached the status of an institution independent of the economy. Employment and the firm were the crucial channels for access to welfare. Alternative channels did not exist, except in healthcare which sometimes was organized on a residence basis. There was basically no general welfare system, only a rudimentary social assistance scheme and no unemployment assistance. On the other hand, the population benefited from employment security and very high price subsidies for housing, transport, and basic goods such as food. Indeed, these were major elements of social policy in the socialist economy that nowhere in the Western capitalist world were matched.

Second, the strong employment-relatedness of social policy resulted in a benefit structure by which the active population was highly favoured. In the long run, especially pensioners suffered heavily from this structural bias, because in contrast to most Western European countries pensions were not automatically adjusted to rising living standards.

However, family policy was more developed in the East than in most of Western Europe. This is not only true for childcare services (in fact, in this area Eastern European countries differed a lot), but even more so with regard to family allowances. Their value relative to average (national) wages was, at least since the 1970s, usually higher than in Western Europe (Voirin 1993: 42).

These crucial differences between capitalist and socialist welfare states should serve as a template when interpreting the following figures on the quantitative development of welfare states in Western and Eastern Europe. The size and social significance of social security programmes can be measured by the share of the population covered and by social spending as a proportion of national income.

Table 19.3 shows the long-term development of social insurance coverage in selected European countries.[1]

One can clearly identify four historically leading countries with respect to coverage: Germany, Sweden, Great Britain and Denmark. In these countries, the proportion of the economically active population covered by the four major social insurance programmes by far outnumbered figures in the other countries at least until 1935. It is noteworthy that some of those countries that were identified as welfare state pioneers on the basis of the timing of social legislation are lagging far behind in this indicator. This is particularly true for France, Austria and Belgium. The reasons for this discrepancy are different. In France, for example, old-age pension insurance was not fully implemented until after World War II. In Austria, the occupationally segregated social security programmes covered only small parts of the population, because the country was not yet heavily industrialized.

Table 19.3 also shows that by 1955 social insurance programmes covered the majority of the workforce in most countries. Only in Italy and Finland still less than half of the economically active population was covered. Coverage rates grew further until the

**Table 19.3** Social insurance coverage rates[1] in selected countries,[2] 1915–1975

| | 1915 | 1935 | 1955 | 1975 |
|---|---|---|---|---|
| Germany[3] | 42.8 | 57.8 | 73.3 | 81.8 |
| Sweden | 37.0 | 47.8 | 78.9 | 86.8 |
| United Kingdom | 36.3 | 71.8 | 90.0 | 86.8 |
| Denmark | 30.8 | 70.8 | 74.8 | 81.0 |
| Norway | 17.8 | 24.5 | 74.5 | 91.5 |
| Belgium | 17.5 | 34.8 | 60.8 | 87.0 |
| Austria | 13.0 | 39.8 | 62.8 | 82.0 |
| France | 11.5 | 31.5 | 54.5 | 86.8 |
| Switzerland | 10.8 | 34.5 | 67.8 | 71.3 |
| The Netherlands | 7.3 | 38.5 | 62.0 | 85.0 |
| Italy | 4.8 | 36.0 | 45.0 | 71.3 |
| Finland | 2.0 | 8.3 | 39.5 | 83.3 |
| Ireland | (...) | 33.3 | 58.5 | 75.3 |

Source: Own depiction based on Alber (1987[2]: 152).
[1]Percentage of economically active persons covered by accident, sickness, old-age pensions and unemployment insurance (average).
[2]Countries ranked by coverage rate in 1915.
[3]From 1955 Federal Republic of Germany.

[1]Figures are taken from Alber (1982) who, however, provides no information on Eastern Europe.

mid-1970s when most countries practically reached full coverage. In this respect, the Western European countries converged to their "limits to growth". In 1975 only Italy, Switzerland and Ireland still had coverage rates lower than 80% (note that Southern European countries are not included in the table, except Italy).

Unfortunately, no comparable figures are available for Eastern Europe. It can be assumed, however, that most employed persons were covered by social insurance, except in the agricultural sector which was particularly large in Poland and Hungary. Moreover, agriculture was not everywhere as strongly collectivized as in the German Democratic Republic. In particular, in Poland and Hungary, self-employed peasants remained a large group with fewer social rights than other occupational categories, especially compared to workers in heavy industries.

Few studies have tried to compare social expenditure in Eastern and Western Europe. In addition to the caveats mentioned above with respect to the different context of welfare states in capitalist and socialist economies, it should be noted that these figures are not directly comparable, because the national accounting systems differed. Yet some basic variations and trends can be found in Table 19.4.

In relative terms, measured as a percentage of GDP or NMP, the size of welfare states in East and West shows a mixed picture in the mid-1960s. The leading country in this respect was Czechoslovakia, closely followed by Austria and Western Germany. In a historical perspective, one might say that the pioneers of social insurance in the 19th century still took the lead in the 1960s. The Scandinavian countries still ranked behind the Continental social insurance countries including the Netherlands, Belgium, France and Italy. Except Czechoslovakia (being on top), Central Eastern European countries generally occupied positions in the middle of the overall distribution. At the bottom, the economically less developed countries of Southern Europe and the "liberal" welfare state laggards USA and Switzerland were assembled.

By 1975 the picture looked rather different. In almost half of the Western European countries, social spending had increased to more than 20% of the GDP. This level was never reached in any of the Socialist countries.[2] In the most advanced Socialist countries, the German Democratic Republic and Czechoslovakia, growth was slow (in the former) or even stagnated (in the latter case). Only Hungary had a significant growth comparable, for instance, to Finland which was, however, by Western European standards, still a welfare laggard by the early 1980s.

Thus, in most Western European countries, the welfare state expanded strongly in relative as well as in absolute terms due to high economic growth during the "golden age" of welfare capitalism. Especially the Scandinavian welfare states together with the Netherlands, Belgium and France went through a phase of extraordinary welfare growth. Compared to that, even the former leading welfare spenders, Germany and Austria, fell back.[3] Data for 1986, that is shortly before the fall of Communism, support this general impression of stagnation in welfare spending in Eastern European countries. However, the less developed Southern European countries still ranked behind the more advanced Eastern European welfare states.

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[2]It should be kept in mind that social and economic conditions were rather different in capitalist and socialist economies. In the latter, for example, unemployment did not exist officially. Hence, there is no need for unemployment compensation. Also, for instance, basic goods such as food, housing and transportation were heavily subsidized which does not show up in the figures.

[3]The more recent developments in social spending are analysed in Section 19.3, although on a different data basis.

**Table 19.4** Total social security expenditures in selected countries, 1965–1990

| | 1965 | 1970 | 1975 | 1980 | 1986 | 1990 |
|---|---|---|---|---|---|---|
| *As % of NMP* | | | | | | |
| Czechoslovakia | 18.0 | 18.0 | 17.2 | 18.9 | 21.5 | 16.0[a] |
| GDR[1] | 12.7 | 12.3 | 14.3 | 16.0 | 14.2 | |
| Yugoslavia | 12.2 | 13.1 | | 11.1 | 11.7 | |
| USSR | 11.6 | 11.9 | 13.6 | 14.2 | 15.5 | 10.4[aa] |
| Hungary | 10.9 | 11.0 | 14.9 | 18.3 | 16.2 | 18.4[a] |
| Bulgaria | 10.0 | 13.7 | 16.0 | 12.2 | 13.4 | 16.5[a] |
| Poland | 9.3 | | | 15.5 | 17.1 | 18.7[a] |
| *As % of GDP* | | | | | | |
| Germany[2] | 16.6 | 17.1 | 23.7 | 24.0 | 23.4 | 25.5[a] |
| Austria | 16.6[c] | 18.8[b] | 18.3[b] | 21.4[c] | 24.4[a] | 24.2[a] |
| France | 15.8 | 15.3 | 23.7 | 24.0 | 28.6 | 26.7[a] |
| The Netherlands | 15.5 | 18.9 | 25.5 | 28.3 | 28.6 | 29.7[a] |
| Belgium | 14.6[c] | 18.1[b] | 20.9[b] | 24.5[c] | 27.5[a] | 25.6[a] |
| Italy | 13.8[c] | 16.3[b] | 20.7[b] | 16.3[c] | 21.6[a] | 23.1[a] |
| Sweden | 13.3[c] | 18.8[b] | 24.4[b] | 31.2[c] | 31.1[a] | 32.2[a] |
| Denmark | 11.9[c] | 16.6[b] | 21.0[b] | 26.2[c] | 25.9[a] | 28.7[a] |
| UK[3] | 11.7 | 13.7 | 16.0 | 17.3 | 20.4 | 19.6[a] |
| Norway | 10.5[c] | 15.5[b] | 17.6[b] | 19.8[c] | 20.0[a] | 27.1[a] |
| Finland | 10.2[c] | 13.1[b] | 15.2[b] | 18.0[c] | 23.4[a] | 25.2[a] |
| Ireland | 9.8[c] | 11.6[b] | 15.6[b] | 20.6[c] | 22.9[a] | 19.2[a] |
| Greece | 9.2 | 10.8 | 10.8 | 12.2 | 19.5 | 19.8[a] |
| Switzerland | 8.0[c] | 10.1[b] | 13.2[b] | 12.8[c] | 17.4[a] | 20.1[a] |
| USA | 6.5[c] | | | 12.2[c] | 13.4[a] | 14.1[a] |
| Portugal | 5.2 | 5.6 | 11.0 | 9.7 | 10.4 | 14.6[a] |
| Spain | 3.6 | | 11.7 | 16.0 | 18.1 | 19.6[a] |

Sources: Own depiction based on the following sources: data given without footnote: Voirin (1993: 44); [a] ILO (2000: 1–5); [aa]Data refer only to Russian Federation in 1996; [b]Flora et al. (1983: 456); [c]Castles (1986: 217).

Notes: All figures in the table refer to total social security expenditures as defined by the ILO in "The Cost of Social Security", which basically includes income maintenance and health. The figures, however, are taken from different sources which slightly deviate from each other, for instance with respect to the inclusion/exclusion of administrative expenses. In all cases in which multiple data were available for one date and country, the deviance between the different sources was less than 1 percentage point.

Figures for (former) Socialist countries are given as percentages of Net Material Product, which is not exactly comparable to Gross Domestic Product (GDP) used as reference value for capitalist market economies.

More recent figures on social expenditures will be given in Section 19.3. These data refer to the EUROSTAT definition which is more encompassing than the one used here.

[1]German Democratic Republic; [2]Federal Republic of Germany; [3]United Kingdom.

To conclude, the Eastern European welfare states which were among the most developed in the 1960s fell back dramatically compared to most Western countries during the following decades. This finding is further accentuated if one considers real spending levels. Thus, the Socialist welfare states which had started with high aspirations and strong social institutions were dismantled in the end. Yet also in the Western part of Europe, the growth of the welfare state came to a halt in the early 1980s (Flora 1986–1988). Pierson (2001) argues that by that time a "new politics of the welfare state" has emerged that entails the logic of retrenchment and replaced the former long-lasting mechanism of expansion.

The next sections explore whether this new stage in welfare state development together with the historical watershed of 1989/1990 has resulted in new welfare state trends and assess variations between European countries. In this context, the question whether the Eastern European countries form a separate "world" of welfare remains a crucial one. During the transition phase, they have partly kept or revived their old social insurance traditions. Partly they have also installed new systems of social protection, particularly in pensions and social assistance. Overall, it seems that this kind of historical institutional "layering" in Eastern Europe has produced complex welfare systems, which do not easily fit into the typologies developed on the basis of variations across Western Europe.

## 19.3 Welfare Regime Types

When comparing a larger number of countries, it is necessary to reduce the complexity of existing social policy programmes by concentrating on their main characteristics. This can be done by distinguishing, within the broad definition of the welfare state referred to above (see Section 19.1), different types of welfare states or welfare regime types.

The probably most prominent and influential, though not undisputed, typology of welfare states has been developed by Esping-Andersen in his book *The Three Worlds of Welfare Capitalism* (1990). He suggests "to move from the black box of expenditures to the content of welfare states" and to distinguish "categorically different types of states" (1990: 20 f.).

Although Esping-Andersen does not explicitly refer to the Weberian method of ideal types in his 1990 volume, in his earlier work he clearly states that his *Three Worlds* are based upon Weber's methodology: "The objective of such 'regime analyses' is not to provide exhaustive comparisons across either time or societies, but rather to identify 'ideal-typical' cases (in the Weberian sense)" (Esping-Andersen 1987: 7). The concept of "welfare regimes" "seeks... to specify the welfare state's relative position within the broader welfare mix – in particular in relation to market and family provision of welfare" (Hicks and Esping-Andersen 2005: 518).

In order to capture the most important aspects of welfare states, Esping-Andersen (1990: 21 ff.) has suggested the concept of decommodification, which reflects the level of social entitlements and citizens' degree of insulation from market dependency. [4] Its theoretical basis is formed by T.H. Marshall's theory of social citizenship (1964). According to this theory, individual social risks are recognized as a common public responsibility. Therefore, citizens' well-being should at least partly be made independent of the market, of charity or of the family. It is this *social right element* that distinguishes welfare *state* involvement from support by family members, employers, charity and further actors in this field.

With regard to the characterization of welfare state regimes, Esping-Andersen has also been strongly influenced by Titmuss (1958, 1974), who distinguished a "residual welfare model", an "industrial achievement-performance model" and an "institutional redistributive model" of social policy. As Esping-Andersen's work demonstrates, the aims and

[4] As a second approach to characterize different welfare regime types, Esping-Andersen uses the concept of "stratification" by arguing that "the welfare state is not just a mechanism that intervenes in, and possibly corrects, the structure of inequality; it is, in its own right, a system of stratification. It is an active force in the ordering of social relations" (Esping-Andersen 1990: 23). It should be noted that the two methods of identifying clusters of welfare states lead to similar but not identical classification of countries (Kohl 1999).

virtues of using the ideal-typical method lie especially in its ability to highlight – by way of comparison between ideal types and real historical cases – the various differences existing between cases, as well as to identify institutional changes taking place over time. Moreover, the construction of welfare regime types implicitly contains hypotheses on the causes and effects of welfare states, according to the following logic:

- similar socio-political conditions result in similar institutional patterns of welfare states;
- similar institutional characteristics of welfare states have similar effects on the living conditions in a society, for instance with regard to social rights.

In an effort to explain the historical emergence of different institutional designs of welfare states, Esping-Andersen (1990) primarily builds on the power resource theory, as developed by Korpi (1978, 1980), who argues that working-class mobilization is the major determining factor with regard to distributive effects of social policy measures. Depending on the distribution of power resources, class conflicts produce different levels of redistribution and institutional set-ups. These, in turn, produce long-standing vested interests, and this perpetuates the once-established structure of the welfare state.

In the following we will not reiterate at length the welfare regime debate (see, for instance, Leibfried 1992; Kohl 1993, 1999; Abrahamson 1999; Arts and Gelissen 2002; Bambra 2005). Instead, we will discuss how welfare states can be classified on the basis of this concept, whether changes have taken place over time and what effects can be attributed to different types of welfare regimes. In a recent consolidating article, Hicks and Esping-Andersen (2005) select the following criteria for constructing different welfare regimes: "population coverage", "role of private market", "target population", "decommodification", "defamilialization", (re-)commodification", "redistribution" and "poverty reduction" (Table 19.5).

**Table 19.5** Welfare state regimes and welfare policy indicators

| | Regimes | | |
|---|---|---|---|
| Regime Elements and Outcomes | Conservative | Liberal | Social Democratic |
| Population coverage | Occupational | Selective | Universal |
| Role of private market for welfare | Low | High | Low |
| Target population | (Male) employed | The poor | All citizens |
| Decommodification | Medium | Low | High |
| Defamilialization | Low | Low | High |
| (Re-)commodification | Low | Medium | High |
| Redistribution | Low | Low | High |
| Poverty reduction | Medium | Low | High |

Source: Hicks/Esping-Andersen (2005: 513).

*"Social democratic" welfare states* are characterized by universal coverage, a residual role of the private market, high level of decommodification (social benefits are largely independent of the market), high defamilialization (low dependence on support from family members), high (re-)commodification (employment of all citizens is facilitated), high redistribution and successful poverty reduction.

*"Liberal" welfare states* predominantly focus on the poor by using strict criteria for eligibility and allow only modest social benefits. Market solutions (for instance, individual saving plans) are preferred for improving income security. Hence, levels of

decommodification and defamilialization are low, and redistribution is neither aspired nor achieved.

*"Conservative" welfare states* give families the main responsibility to see after their own, combined with a continued adherence of the traditional "male breadwinner model". Employed persons are in general covered by various social insurance schemes. The high dependency of social benefits on labour market participation makes for a medium level of decommodification, and since social benefits are related to income, the level of (vertical) redistribution is rather low.

Several authors have tested the empirical robustness of the *Three Worlds*. Kangas (1994), for instance, found some support for the existence of three types of welfare states. Other authors distinguish the Southern European countries from the conservative type due to their highly fragmented income protection, a high degree of familialization, developing NHS systems, patchy minimum income schemes and generous pension systems (Leibfried 1992; Ferrera 1996). Obinger and Wagschal (1998) tested Esping-Andersen's classification by using cluster analysis. In addition to the original three types, they distinguished a "radical" and a "hybrid" European cluster. Wildeboer Schut et al. (2001), finally, collected data for 58 characteristics of labour markets, tax regimes and social protection schemes and, by using principal component analysis, largely confirmed Esping-Andersen's three worlds of welfare states. Instead of widening the number of subgroups by adding further criteria, it might therefore be advisable to accept the existence of hybrid cases and that no particular real case perfectly fits in any particular ideal type (Kohl 1999; Arts and Gelissen 2002).

In the following, we will investigate whether (and if so, in which direction) welfare states have changed. When comparing the level of decommodification for 18 countries in 1980 (provided by Esping-Andersen, 1990) with data for 1998/1999 (provided by Bambra 2005a,b), the high stability of cluster affiliation, indicating a high level of path dependency, becomes evident (see Table 19.6). However, there are four "exceptions from the rule": we see Canada changing from the "Liberal" to the "Conservative" world, Japan from the "Conservative" to the "Liberal" regime, Finland from the "Conservative" to the "Social Democratic" regime and, finally, Denmark taking the opposite direction from the "Social Democratic" towards the "Conservative" regime cluster. Thus, 4 out of 18 countries have changed their regime type affiliation between 1980 and 1998/1999.

Scruggs and Allan (2006a,b) replicated Esping-Andersen's data and made annual data available on the programme characteristics which are included in the decommodification index. When adjusting the classification of countries according to the replication by Scruggs and Allan (2006a: 61), Japan would have to be placed in the "Liberal" cluster and Canada in the "Conservative" cluster already in 1980. Without discussing the various differences between Esping-Andersen's original version and the reanalysis done by Scruggs and Allan (2006a,b), existing welfare states might be said to have experienced an even stronger process of path dependency than suggested in Table 19.6.

However, neither Esping-Andersen's original version nor the discussed replication provide clear guidance how the formerly socialist countries of Central and Eastern Europe can be classified. Are CEE (Central and Eastern European) countries part of the "Liberal", the "Conservative" or the "Social Democratic" world? Due to the high emphasis on social insurance after 1990, CEE countries adapted, for instance, major characteristics of the "Conservative" regime type. At the same time, still existing comprehensive childcare facilities indicate a high level of defamilialization (and therefore characteristics of the "Social Democratic" type). In some countries, more recent pension reforms have both strengthened the link between earnings and pension benefits, on the one hand, and introduced strong

**Table 19.6** Degrees of decommodification, 1980 and 1998/1999

| Country | Decommodification, about 1980 | Welfare regime type, 1980 | Decommodification, 1998/1999 | Welfare regime type, 1998/1999 |
|---|---|---|---|---|
| Australia | 13.0 | Liberal | 13.5 | Liberal |
| USA | 13.8 | Liberal | 14.0 | Liberal |
| New Zealand | 17.1 | Liberal | 11.5 | Liberal |
| Canada | 22.0 | Liberal | 27.9 | Conservative |
| Ireland | 23.3 | Liberal | 22.1 | Liberal |
| UK | 23.4 | Liberal | 15.4 | Liberal |
| Italy | 24.1 | Conservative | 27.6 | Conservative |
| Japan | 27.1 | Conservative | 18.3 | Liberal |
| France | 27.5 | Conservative | 31.5 | Conservative |
| Germany | 27.7 | Conservative | 27.7 | Conservative |
| Finland | 29.2 | Conservative | 34.6 | Social Democratic |
| Switzerland | 29.8 | Conservative | 29.7 | Conservative |
| Austria | 31.1 | Conservative | 31.1 | Conservative |
| Belgium | 32.4 | Conservative | 31.9 | Conservative |
| The Netherlands | 32.4 | Conservative | 28.0 | Conservative |
| Denmark | 38.1 | Social Democratic | 29.0 | Conservative |
| Norway | 38.3 | Social Democratic | 34.0 | Social Democratic |
| Sweden | 39.1 | Social Democratic | 34.7 | Social Democratic |

Sources: Adapted from Esping-Andersen (1990: 52); Bambra (2005: 203); Schmidt (2005: 222).

incentives for additional private pension insurance on the other, thus decreasing levels of decommodification and emphasizing characteristics of the "Liberal" type (e.g. in Poland, Estonia and Latvia, see Standing 1996: 239ff; Müller 2000). By using cluster analysis, Fenger (2007) demonstrates that the post-communist welfare states cannot be reduced to any well-known type of welfare state, and Cerami (2006) argues that Central and Eastern European countries show characteristics of a new European welfare regime.

## 19.4 Social Expenditures

The comparative quantitative analysis of European welfare states over the past 25 years reveals two major findings. First, the years of the so-called welfare state "crisis" (OECD 1981) have in fact been a period of surprising overall stability in social spending. Second, the historically developed variations between different country groups or "families of nations" (Castles 1993) have also remained relatively stable. Even in the years of retrenchment policies and political attacks on the welfare state, it is above all stability that characterizes its development.

This can be seen from aggregate social expenditure figures. Social expenditure measures the overall "size" of the welfare state, but not its specific role within the mixed economy of welfare. Data include expenditures on old age and survivors' benefits, health and invalidity, unemployment, the family, housing and social exclusion. Both social transfers and social services (including benefits in kind) are covered; not included are education and tax

benefits. This might lead to some distortions in the findings for individual countries, but does not change the whole picture. Data are taken from the two most important international data sources EUROSTAT and OECD, which partly deviate from each other. In the following analysis, long-term developments of overall social spending over the past 25 years are based on OECD, recent cross-sectional data on EUROSTAT. OECD data distinguish between public and private social spending, which allows studying the overall size of the welfare state in a more differentiated way. However, it should be noted that private social spending is often mandatory and strongly regulated by the state. Therefore OECD distinguishes between mandatory and voluntary private spending.

A first indicator is public social spending measured as a percentage of the GDP. In the Nordic countries, public social spending has always been well above the OECD average (see Fig. 19.1).

At the same time, there has always been wide variations among the Nordic countries. They have never been such a homogeneous group as is sometimes assumed (see Kolberg 1992). Sweden and Denmark have always been top social spenders. Their social expenditure ratios have only exceptionally fallen below 25% of the GDP since the 1980s. There was a peak in the early 1990s, more pronounced in Sweden than in Denmark, followed by a decrease until 2000 and a slight recovery since then. This development reflects the impact of the severe economic crisis that hit Scandinavia and particularly Sweden (and Finland). The welfare state reacted to this development with a certain time lag. As Sweden was more affected by the economic shock, it shows less continuity in social spending than Denmark. The Finnish development deviates from this pattern. Still in the 1980s, Finland was a laggard in welfare state development, but caught up to the leading Scandinavian nations rapidly until 1990 when it was hit very hard by the economic crisis. Since then, Finnish social spending figures went down significantly and fell to a level much below the Swedish or Danish figures. The two other Nordic countries, Iceland and Norway, have always been outliers within this group. Norway has always been a moderate social spender that was able to keep its welfare state at a relatively modest level due to its special economic position and wealth. Iceland, on the other hand, never had a sizeable welfare state and in many respects looks more like countries of the liberal welfare regime where social spending has always been comparatively low (Eydal 2000).

In all countries of the liberal type social spending has been below or close to the OECD mean with Britain being mostly on top and the USA being on the bottom of this group. Over time, the most significant changes occurred in Ireland which moved from a position close to Britain to one near the USA. However, this development is not due to social retrenchment policies in Ireland. It is rather the result of the economic miracle in this country with strongly rising national income since the 1990s. Switzerland moved the other way round, so to speak. At the beginning of the period, it was close to the USA, but the size of social spending increased continuously since then, and in 2003 with slightly above 20% it has reached the OECD average. The Swiss welfare state was a laggard but has slowly moved towards the more developed European welfare states. In contrast to the USA where the federal system has set strong limits on welfare state expansion, the Swiss combination of federalism and direct democracy has unfolded a more positive dynamic for social spending (Obinger 2005).

In the advanced Continental European countries, public social spending has been well above the OECD average over the whole period. Moreover, there has been a moderate tendency of growth from slightly below 25% in the early 1980s to a little above 25% at the beginning of the new millennium. The variation between countries in this group has been very small generally. There are only two exceptions: France and the Netherlands.

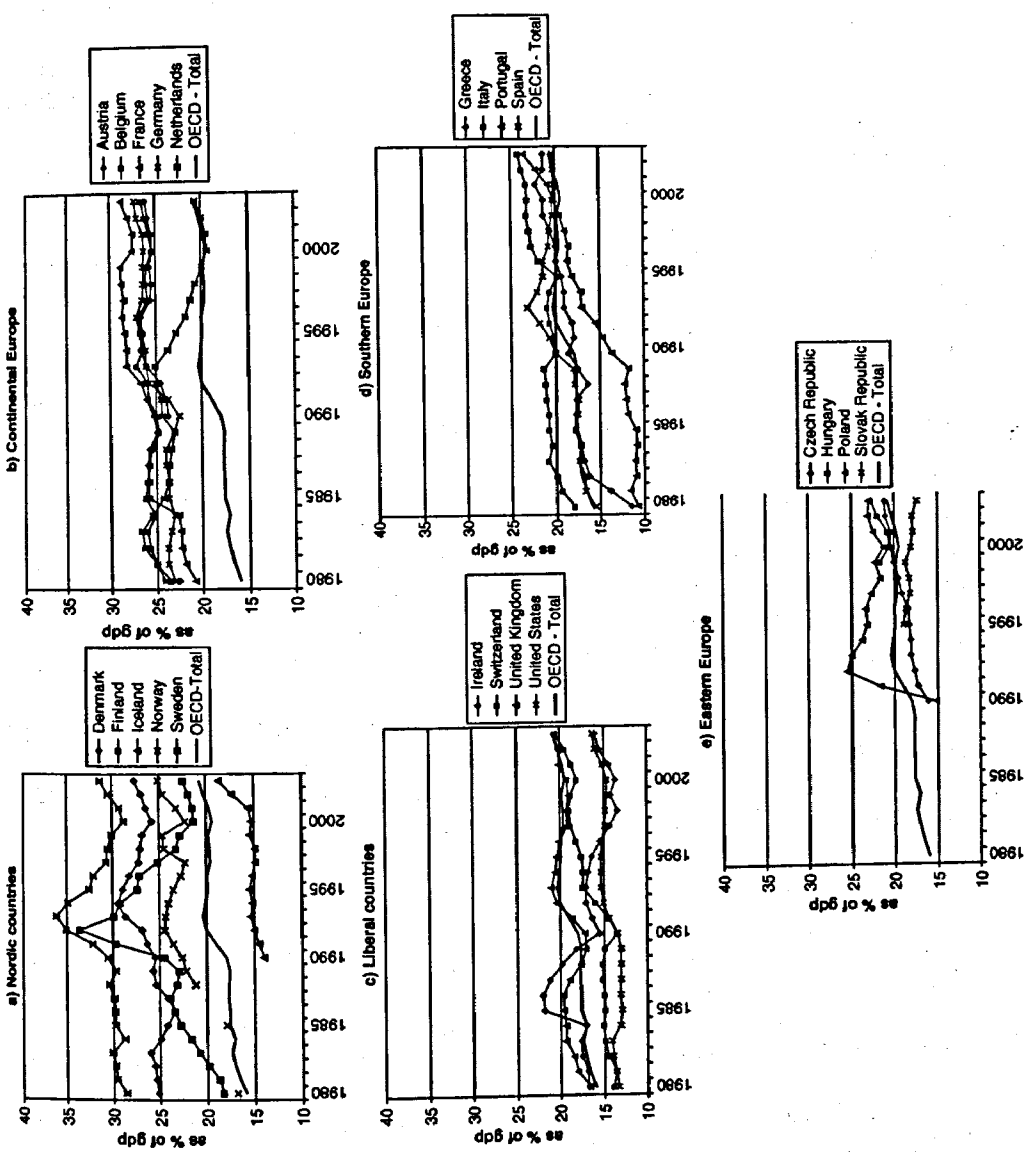


Fig. 19.1 Public social expenditures, 1980–2003

In 1980 the French welfare state was very moderate compared to the other countries in this group, but since then social spending has increased steadily and today France has the highest social expenditure ratio of this type of welfare state and is also close to the European top. The Netherlands exhibits the reverse development. They started from the highest expenditure ratio in this group in the 1980s, but have cut down the relative size of their welfare state significantly to the OECD mean and therefore well below the other Continental countries since the mid-1990s. In this respect, one might speak of a veritable "path departure" in the development of the Dutch welfare state.

The Southern European countries were latecomers in welfare state development. In 1980 their social spending relative to national income was rather low except in Italy that has always been more advanced than the other Southern countries. Yet Greece and Spain soon caught up and by 1990 had reached the Italian spending level of about 20% of GDP. Since then the Italian and Greek figures have increased moderately and continuously, whereas the Spanish rate of social spending reached its peak in the mid-1990s and since then levelled off. As in the case of Ireland this is mainly due to an exceptional economic growth that has surpassed social welfare expenditures by far. If Southern Europe can be regarded as a laggard in welfare state development in general, Portugal may be characterized as the latecomer among the latecomers. Until 1990 Portuguese social spending remained at a modest 10–12% of the GDP, but then a fast increase set in that has brought this country to the second position in social spending in this group, closely behind Italy.

In the Eastern European countries social spending is currently at about the same level as in Southern Europe and close to the OECD average. Due to varying economic fluctuations after the fall of Communism, the development in the individual countries was different. In the Czech Republic there has been a moderate increase since 1990 whereas social spending in Poland went up suddenly in the first years of the transition and then declined strongly since 1992 when the big shock of the first transition period was absorbed. Yet due to high unemployment in Poland compared to the other Eastern European countries, social spending remained relatively high.

The picture of variation between countries slightly changes if one adds to public expenditure also mandatory and voluntary private social expenditure (Adema 2001). Besides public social programmes of the welfare state there are various social benefits which are delivered by non-public actors under private law either mandatorily (that is required by the state) or voluntarily. It makes good sense to include mandatory private social expenditure under the rubrics of the welfare state, because such policies often are functional equivalents to public programmes. For example, the welfare state may grant sickness benefits in case of temporary incapacity to work, but employers may also be legally obliged to continue wage payment for a certain period of time. It also makes some sense to include voluntary private expenditure, because though the state does not legally enforce these measures it most often subsidizes them, for example, through tax concessions. A good example is occupational pensions provided by employers.

Figure 19.2 shows the size of total social expenditure, including mandatory and voluntary private expenditure for 1980 and 2003.

The significance of private benefits has generally grown over this period, but the inclusion of private social expenditures in the total has not changed the differences between countries dramatically. There are only four cases where they really make a big difference and bring these countries closer to the high social spenders: Switzerland, the Netherlands, the UK and the USA. In Switzerland the welfare state expanded both in its public and its mandatory private form. This development is mainly due to mandatory occupational pensions and to the reform of the health insurance system in 1996, which introduced

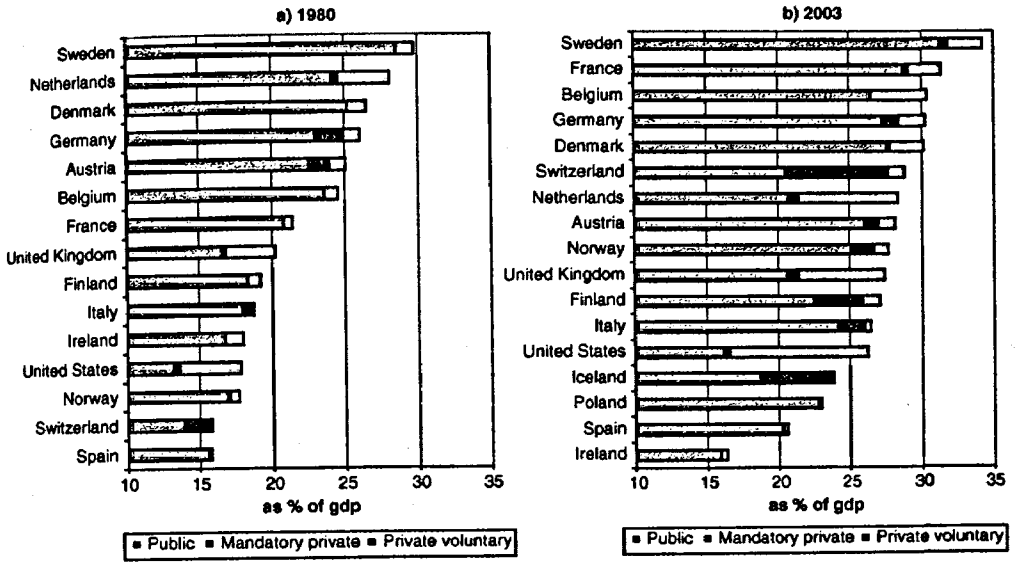


Fig. 19.2 Total social expenditure, OECD

compulsory subsidized private health insurance. Taking into account these expenditure items, the Swiss welfare state expanded strongly over the past 25 years. In the USA and the UK, by contrast, it is voluntary private expenditure that counts most. This means that it is up to private actors whether and which benefits they provide to whom. If they provide benefits, however, the state grants them generous tax concessions. This is the case, for example, with employer-based health insurance in the USA and with part of the large occupational pension system in the UK. If one takes into account private social expenditures, USA moves up its position significantly and comes close to Italy and Finland (Adema 2001).

Interesting is also the case of the Netherlands. As we have argued above, public social expenditure in this country went down as a percentage of the national income since the mid-1990s (see Fig. 19.1b). But this has largely been offset by a growth in private voluntary social expenditure. One should therefore not speak of a general decline of the welfare state, but of a shift in the welfare mix: the Netherlands have thus "privatized" large parts of social welfare and thereby moved towards the liberal welfare regime type.

All countries are increasingly affected by population ageing which leads to problems of securing a decent income in old age and to growing costs in health and social care systems. Yet although in all countries social expenditures on old age (including survivors) and health (including disability) represent by far the largest proportions of the total, there is significant variation in this respect (see Fig. 19.3).

In Ireland spending on old age and health makes up for less than 70% of the total whereas in Italy both items account for about 90%. In Italy and Poland roughly 60% of total social expenditures go to old-age pensioners and survivors alone; in Norway and Iceland only about 30%. In general, the Southern European countries tend to spend the highest proportions of their totals on old age, the Scandinavian countries the least. Continental and Eastern European countries are in between. The more "gerontocratic" (Alber) welfare states are typically found in the South and a little bit less in the East, the more family- and child-oriented welfare states are located in the North and West of Europe. This clearly

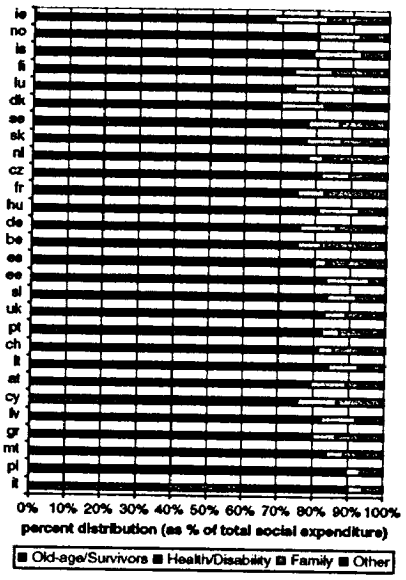


**Fig. 19.3** Structure of social expenditure, Europe 2004

shows the rudimentary character of the Southern European welfare states where only the core institutions, mainly pension systems, are well developed.

This is also reflected in the share that benefits in kind represent among total social expenditure (see Table 19.7).

In 1990, all countries with a strong social service component were found in the North and West of Europe; only Portugal was an exception. The low-service welfare states were typically found in the South, in the rudimentary welfare states. Yet also some "big" social spenders like Austria, Belgium and the Netherlands spent low shares on social services. Together with Luxembourg, Italy and Germany these three "advanced" countries represented the well-developed, but mostly transfer-oriented welfare state typical for the Christian democratic world, respectively, Continental welfare states (see van Kersbergen 1995) that was strongly influenced by the ideas of Social Catholicism.

In 2004 we still find that the Scandinavian and the English speaking countries of Northern and Western Europe had the highest shares of expenditure on services in Europe, but in the middle and at the bottom of the distribution the picture has become blurred and individual countries have more or less erratically changed positions in the rank order. The Netherlands, for example, has clearly become more service-oriented whereas Belgium has remained relatively low near the bottom. This again shows that the Dutch welfare state since the 1990s has changed significantly whereas Belgium has remained relatively stable. The general tendency across Europe has been a moderate expansion of social services.

The last dimension of variation in European welfare states addressed here is the structure of financing. The methods and sources of financing the welfare state have been major areas of conflict during the ongoing reform debates in recent years. Whereas in the 1970s and 1980s the most visible political conflicts occurred in countries which depended on high proportions of general tax revenues, the situation has become reversed today. The tax-welfare backlash of the 1970s, for which Denmark was the outstanding example, was replaced by heavy conflicts over social security contributions paid by employers and employees, because they add to high overall labour costs and hence are often regarded

as one of the main reasons for high unemployment. Today it is the conservative welfare regime type in Continental Europe that has come under severe attack from economists and interest groups, because these countries have traditionally relied most on social security contributions as a method of financing.

Table 19.7 shows the share of social contributions as a source of financing social welfare for 1990 and 2004. In 2004 the Northern and Liberal countries relied least on social contributions as a source of financing. Yet with respect to the other families of nations the picture is somewhat blurred. Most of the advanced Continental welfare states like Austria, Germany, France, Belgium and the Netherlands still rely heavily on social contributions. The share of general government revenues in these countries is lower than 40% or even 30%. It seems therefore that the two classical welfare state models, Bismarck versus Beveridge, can still be seen in the structure of financing in highly developed welfare states. The Southern European and the Eastern European countries, however, do not show such a clear pattern. On the one hand, we find countries like Poland and Portugal in which the welfare state is heavily financed by general tax revenues. On the other hand, Spain and

**Table 19.7** Spending and financing patterns: social services and social contributions, Europe 1990 and 2004

| | Spending on social services as % of total social spending | | | Financing by social contributions as % of total financing | | |
|---|---|---|---|---|---|---|
| Country group | 1990 | 2004 | Difference | 1990 | 2004 | Difference |
| *Northern countries* | | | | | | |
| Denmark | 36.1 | 38.9 | +2.8 | 13.1 | 29.8 | +16.7 |
| Finland | 36.2 | 35.9 | −0.3 | 52.1 | 50.3 | −1.8 |
| Iceland | 50.0 | 51.5 | +1.5 | 32.2 | 34.0 | +1.8 |
| Norway | 38.6 | 39.9 | +1.3 | 36.4 | 43.7 | +7.3 |
| Sweden | 38.4 | 41.1 | +2.7 | 40.6 | 49.4 | +8.8 |
| *Continental Europe* | | | | | | |
| Austria | 26.4 | 29.1 | +2.7 | 64.1 | 64.0 | −0.1 |
| Belgium | 21.7 | 28.1 | +6.5 | 67.0 | 71.1 | +4.1 |
| France | 33.0 | 34.9 | +1.9 | 79.5 | 66.0 | −13.5 |
| Germany | 28.8 | 29.8 | +0.9 | 72.1 | 63.8 | −8.3 |
| Netherlands | 23.6 | 32.7 | +9.1 | 59.0 | 68. 7 | +9.7 |
| *Liberal Countries* | | | | | | |
| Ireland | 36.7 | 47.1 | +10.4 | 40.0 | 37.6 | −2.4 |
| Switzerland | 27.6 | 28.8 | +1.2 | 64.7 | 62.3 | −2.4 |
| United Kingdom | 33.4 | 40.2 | +6.8 | 55.0 | 48.7 | −6.3 |
| *Southern Europe* | | | | | | |
| Greece | 30.7 | 35.4 | +4.7 | 59.0 | 60.8 | +1.8 |
| Italy | 26.3 | 26.9 | +0.5 | 70.3 | 56.0 | −14.3 |
| Portugal | 35.1 | 33.2 | −1.9 | 61.7 | 47.5 | −14.2 |
| Spain | 26.7 | 31.8 | +5.1 | 71.3 | 67.2 | −4.1 |
| *Eastern Europe* | | | | | | |
| Czech Republic | x | 35.0 | x | x | 79.2 | x |
| Hungary | x | 35.7 | x | x | 59.0 | x |
| Poland | x | 16.9 | x | x | 51.7 | x |
| Slovenia | x | 33.0 | x | x | 67.0 | x |
| Slovak Republic | x | 33.1 | x | x | 698 | x |

Source: EUROSTAT Social expenditure and financing data.

the Czech Republic seem to follow the Bismarck model with a high share of social security contributions.

Though there are still big differences between European welfare states in this respect, there has been a slight convergence in financing structures over time. Countries which in 1990 had a very high share of social contributions have moved towards increased tax financing in 2004. This is above all true for France, Germany and Italy. France, for example, which in 1990 had the highest share of social contributions of more than 75% reduced it to less than 65% in 2004. Thus, the old "Bismarck"-type welfare states have at least partly shifted financing and put more burdens on taxpayers. On the other hand, the Scandinavian countries have increased the share of social contributions in this period. Denmark in particular, which in 1990 was the opposite case to France and had with less than 15% the lowest share of social contributions, increased this source of financing to more than 25% in 2004. By these developments the extremes of the spectrum moved closer to each other and the European countries have converged somewhat, although the major structural differences have remained.

One may thus conclude that there seems to be an astonishing overall continuity of the European welfare states. At the same time the historically developed differences between the various families of nations in Europe tend to persist. In fact, there have only been rare cases of fundamental changes. Indeed, in the strict sense only the Netherlands might be a real case of path change. Though in most countries there have certainly been significant reforms in many social policy areas, the overall architecture of the welfare state as a whole has shown great stability.

## 19.5 Pensions

### *19.5.1 The Historical Evolution of (Public) Pension Schemes*

Historically, public pension schemes in Europe (and elsewhere in the Western world) have evolved along two basic models almost diametrically opposed to each other – commonly referred to as the Bismarckian vs. the Beveridgean tradition.

Typically, these models can be characterized as follows:

In the Bismarckian tradition, pensions are provided in the framework of social insurance schemes. The insured population is typically restricted to workers and employees, sometimes to all those in gainful employment (including the self-employed). The main (distributive) goal is to provide earnings replacement in case of old age, invalidity and, in the case of death, for their survivors.

This implies that pension benefits have somehow to be related to former income from employment. Thereby, for the insured population as a whole, the structure of benefits is bound to preserve the hierarchical pattern of income inequality generated during their employment careers. From this basic idea, later the goal has evolved to upgrade benefit levels so as to allow the maintenance of living standards attained in working life. According to the principles of social insurance, these earnings-related benefits have to be financed by earnings-related contributions so that there is a fairly strong contribution–benefit linkage, usually referred to as the (structural) equivalence principle. Contributions are usually shared between employers and employees and, as a rule, there are also state subsidies to total public pension expenditures. Historically, compulsory old-age

pension schemes have sometimes been preceded by state-subsidized voluntary schemes (see below).

In the Beveridgean tradition, the dominant goal of public pensions is to provide a minimum level of income to all elderly citizens, effectively protecting them against the risk of poverty in old age. The Beveridgean system stems from the even older "poor law" tradition where, however, benefits were subject to a means or income test. It departs from the "poor law" tradition in that it grants an entitlement to these minimum benefits "as of right", i.e. as a social citizenship right, without recourse to a means test. It follows from this dominant distributive goal of providing basic security that benefits should be "flat rate", i.e. not related to former income or contribution but to social needs.

In the liberal spirit of Lord Beveridge, state responsibility with regard to pensions should be restricted to providing minimum benefits and should leave room to, indeed encourage, private initiative to secure adequate living standards. Therefore, public pension schemes should be complemented by occupational and private pension schemes.

According to the original "poor law" tradition, but to some extent deviating from Beveridge's own plan, basic pension schemes are typically financed by taxes, be it from general state revenues or from ear-marked taxes. Consequently, these schemes imply a fair amount of redistribution from the upper to the lower income strata and almost no linkage between contributions or taxes paid and the entitlement to benefits.

The Bismarckian tradition, first instituted in Imperial Germany in 1889, has also been adopted by the Austrian–Hungarian monarchy and has later been followed by Luxembourg and the Netherlands. Some other Continental European countries (France, Belgium, Italy and Spain) first started with the public subsidization of voluntary schemes, but later also changed to compulsory social insurance schemes (France 1910/30, Italy 1919, Belgium 1924/25).

The precursors of the Beveridgean model, namely tax-financed, usually means-tested flat-rate pensions were introduced as early as 1891 in Denmark and Iceland and later in the United Kingdom and Ireland in 1908. The Scandinavian countries have also built their first old-age pension schemes in this tradition (Sweden 1913, Norway 1936, Finland 1936). Flat-rate pensions according to the Beveridgean principles, i.e. without a means test, have been introduced shortly after World War II in the United Kingdom and Ireland (1946), in Sweden (1948) and also in the Netherlands (1956/1957) (Fig. 19.4).

Later developments have, however, shown a tendency towards convergence from the original "pure" forms, so clearly opposed in their basic principles (see Wilensky 2002: 216 ff.). In the countries following the Bismarckian model, the road to convergence consisted of two elements: First and most importantly, minimum benefits were introduced in the basically earnings-related schemes so as to provide better protection against poverty in old age for those with low earnings and/or shorter and interrupted employment records. Second, the coverage of schemes, originally restricted to industrial workers, was extended to include other segments of the working population (such as salaried employees, farmers and craftsmen). Yet groups without an employment career at all (in particular housewives) remained excluded from compulsory membership in these schemes.

Germany is the only clear case that stuck to compulsory earnings-related schemes without a minimum pension component. However, it is only a partial exception, because it strengthened the legal entitlement to (means-tested) social assistance for pensioners with low pension benefits.

In the countries following the strategy of minimum income protection, first the early means-test requirements were relaxed or abolished. More importantly, in addition to the

| Strategy I: Secure minimum protection | | Strategy II: Secure income maintenance | |
|---|---|---|---|
| 1. Tax-financed means-tested minimum pensions | | 2. Tax-subsidized voluntary pensions | 3. Compulsory earnings-related pensions |
| Denmark (1891)<br>Iceland (1891)<br>New Zealand (1898)<br>Australia (1901/1908)<br>United Kingdom (1908)<br>Ireland (1908)<br>Canada (1927)<br>Sweden (1913)<br>Norway (1936)<br>Finland (1936) | | France (1895)<br>Belgium (1900)<br>Italy (1898)<br>Spain | Germany (1889)<br>Austria (1906)<br>Luxembourg (1911)<br>The Netherlands (1913)<br>USA (1936) |
| | | | |
| 1. Stuck to minimum pensions | 2. Introduced (additional) compulsory earnings-related pensions | 1. Introduced minimum pensions | 2. Stuck to compulsory earnings-related pensions |
| Denmark<br>Ireland<br>Australia<br>New Zealand<br>The Netherlands (1956) | Sweden (1959)<br>Norway (1966)<br>United Kingdom (1975)<br>Finland (1961)<br>Iceland<br>Canada | France<br>Belgium<br>Italy<br>Spain<br>USA<br>Austria<br>Switzerland (1946) | Germany |

**Fig. 19.4** Pension policy trajectories in the long run: convergence towards a mixed system of income security for the aged in OECD countries
Source: Adapted from Wilensky (2002: 219, Figure 5.1) and Alber (1982: 232ff., Table A2).

flat-rate basic pensions for all citizens, compulsory earnings-related supplementary pension schemes for the employed population were introduced in the late 1950s and 1960s in the United Kingdom as well as in the Scandinavian countries. As a result, in these countries dual pension systems emerged, consisting of a universal flat-rate minimum pension component and an earnings-related, usually contribution-based component for the working population.

In institutional terms, however, considerable variation remained among the original Beveridgean countries.

Strictly speaking, only the Scandinavian countries (Sweden 1959, Finland 1961, Norway 1966) and Canada (1965) "established a second *public* pillar, which was contribution-based, unfunded (at least in principle), yielded an earnings-related supplementary pension and included redistributive provisions in varying degrees" (Hinrichs 2000: 81).

A second group of countries sought to attain the goal of income maintenance by topping up their basic flat-rate scheme by *occupational* pension schemes that were either mandated

by law (Switzerland 1985, Australia 1991) or were established through collective agreements (Netherlands, Denmark). "In these four countries the second pillar is funded and private, but. . .publicly regulated and controlled" (Hinrichs 2000: 81).

The United Kingdom constitutes a special case in that it set up a State Earnings-Related Pension Scheme (SERPS) in 1978, but allowed for contracting-out into employer-sponsored occupational schemes or into tax-subsidized private pension plans (PPP), both of which are usually funded schemes. Currently, the latter *non-public* forms of pension provision clearly outweigh in importance the *public* PAYG scheme.

In a functionalist interpretation, this move towards convergence may be seen as the result of the inherent shortcomings of the "pure" ideal-typical models: The Bismarckian model, although geared to secure income maintenance, does not provide an effective protection against poverty in old age (in particular, for those social groups with marginal employment careers or those outside the labour market). The Beveridgean model, while it may provide a better minimum protection for all elderly citizens, does not secure adequate living standards for the larger part of the working population. Put in another way, the trend towards convergence can be interpreted to reflect the growing political recognition among citizens as well as policymakers in European countries that providing basic security for all older citizens and securing adequate income maintenance for the working population are both legitimate and desirable goals of public pension schemes.

### *19.5.2 Typologies of Contemporary Pension Systems*

In addition to the priority goals of pensions provision – poverty alleviation vs. income maintenance – the resulting levels of benefits provided by public pension schemes should be taken into account. For instance, a universal flat-rate pension may be so low that it will not effectively protect against poverty in old age. Or in order to achieve adequate income maintenance, an earnings-related scheme should not fall short of a 50% net replacement rate. Combining these two aspects, the institutional characteristics and the level of (minimum and standard) benefits, Palme (1990: 73 ff.) has distinguished four models of public old-age pension schemes:

- a *basic security* model, with universal coverage (based on citizenship) and a minimum pension of at least one-third of an average production worker's wage, net of taxes;
- an *income security* model, with earnings-related benefits and a net replacement rate for a standard worker's pension of at least 50%;
- an *institutional* model, which combines a basic pension based on citizenship with an earnings-related supplementary pension meeting the criteria of the income security model; and
- a *residual* model which meets neither the criteria of the basic security model nor those of the income security model.

Based on these operational criteria, pension schemes in OECD countries around 1985 can be classified as in Fig. 19.5.

The OECD has suggested a different typology of pension systems which, at first sight, bears some resemblance to the "three-pillar" classification suggested by the World Bank (1994):

| | | Basic Security | |
|---|---|---|---|
| | | No | Yes |
| Income Security | No | **Residual**<br>Australia<br>USA<br>Switzerland<br>Ireland<br>United Kingdom | **Basic Security**<br>New Zealand (1947)<br>Denmark (1960)<br>Netherlands (1965)<br>Canada (1980) |
| | Yes | **Income Security**<br>Austria (1950)<br>Belgium (1960)<br>Germany (1960)<br>Italy (1970)<br>Japan (1975)<br>France (1985) | **Institutional**<br>Finland (1965)<br>Sweden (1975)<br>Norway (1980) |

**Fig. 19.5** Classification of OECD countries according to models of old-age pensions
Source: Palme (1990: 90, Table 4.2).
Note: Year of entry indicated in parentheses.

– a publicly managed system with mandatory participation (first pillar),
– a privately managed mandatory savings system (second pillar), and
– voluntary savings (third pillar).

This classification is, however, rightly criticized because "it is a prescriptive rather than a descriptive typology" (OECD 2005: 22).

Leaving aside the third pillar of *voluntary* provisions and focusing on the *mandatory* parts of pension arrangements, two tiers are distinguished according to their objectives or functions: the first tier is called the redistributive part and the second one the insurance part. The redistributive components of the first tier "aim to prevent poverty in old age" (OECD 2007: 21) by ensuring that "pensioners achieve some absolute minimum standard of living" (OECD 2005: 22). The insurance components of the second tier aim "to ensure that retired people have an adequate replacement rate (retirement income relative to earnings before retirement)" (OECD 2005: 24).

The two basic objectives or functions of pension schemes can be performed by different institutional arrangements. Therefore, within these tiers schemes are classified further by their institutional form: public or private, defined benefit or defined contribution. In this way, the overall pension system of a country is not assigned to a single type, but can be characterized by the mix of its constituent parts (see Fig. 19.6).

The first-tier redistributive schemes can be of three different types:

– In *basic pension schemes*, the benefits are flat rate, i.e. the same amount is paid to every retiree, and additional income from other sources does not change the entitlement to the basic pension. This sub-type clearly conforms to the original Beveridgean concept.

| | First tier | | | Second tier | |
|---|---|---|---|---|---|
| | Universal coverage, redistributive | | | Mandatory, insurance | |
| | Public | | | Public | Private |
| | Resource-tested | Basic pension | Minimum pension | Type | Type |
| | | | | | |
| Austria | X | | | DB | |
| Belgium | X | | X | DB | |
| Czech Republic | X | X | X | DB | |
| Denmark | X | X | | | DC |
| Finland | | | X | DB | |
| France | X | | X | DB | |
| Germany | X | | | DB | |
| Greece | X | | | DB | |
| Hungary | | | | DB | DC |
| Iceland | X | X | | | DB |
| Ireland | X | X | | | |
| Italy | X | | | NDC | |
| Luxembourg | X | X | X | DB | |
| The Netherlands | | X | | | DB |
| Norway | | X | X | DB | DC |
| Poland | | | X | NDC | DC |
| Portugal | | | X | DB | |
| Slovak Republic | | | X | DB | DC |
| Spain | | | X | DB | |
| Sweden | | | X | NDC | DB + DC |
| Switzerland | X | | X | DB | DB |
| United Kingdom | X | X | X | DB | |
| | | | | | |
| Australia | X | | | | DC |
| Canada | X | X | | DB | |
| Japan | | X | | DB | |
| New Zealand | | X | | | |
| USA | X | | | DB | |

**Fig. 19.6** The structure of pension systems in OECD countries
Source: OECD (2007: 23, Table 1.1).
Notes: DB = defined benefit, DC = defined contribution, NDC = notional defined contribution.
Mandatory private schemes include quasi-mandatory schemes with broad coverage.

- *Resource- or means-tested programmes* are targeted at low-income earners, i.e. they pay higher benefits to poorer pensioners and reduced benefits to better-off retirees. In the calculation of benefits, they may take into account at least other retirement income or, more often, other sources of income and assets.
- *Minimum pensions* also aim to prevent pensions from falling below a certain level, not by means-testing, but by setting a floor in an otherwise earnings-related pension scheme. In other words, they constitute the redistributive parts of earnings-related social insurance schemes.

It is important to note that all of these programmes with a redistributive character are provided by the public sector. On the other hand, the insurance programmes designed to provide retirees with an adequate income relative to previous earnings, while mandatory, may be publicly or privately organized. A further distinction can be drawn between defined-benefit schemes (DB) and defined-contribution schemes (DC). In DB schemes, the target benefit (usually an earnings replacement rate) is defined first, and the contribution

rate is set accordingly. This type most closely conforms to the Bismarckian model. Thus, the amount a pensioner will receive depends on the number of years of contributions and on some measure of individual earnings from work.[5] In DC schemes, on the other hand, the contribution rate is defined first, and the benefits the pensioners will receive depend on the accumulation of individual contributions and investment returns. Consequently, in a DC scheme, replacement rates cannot be guaranteed in advance, but will vary considerably by age cohorts. As a rule (but not necessarily), DB schemes are financed on a pay-as-you-go basis while DC schemes are funded.

Finally, there are so-called notional defined-contribution (NDC) schemes which are some kind of hybrid between DB and DC schemes, and which have received increasing attention in recent pension reform debates. On the one hand, these schemes mimic the principles of a DC scheme, i.e. benefits are calculated according to accumulated individual contributions and an assumed rate of return, but they are "notional" in the sense that both the contributions and the rate of return applied to them exist only on the books of the managing institution. That is to say, in these NDC schemes, actually no capital is accumulated, but they are financed on a pay-as-you-go basis.

The classification of countries according to their combination of first- and second-tier schemes presented in Fig. 19.6 can be summarized as follows.

Concerning the first-tier schemes with the goal of poverty prevention in old age, 8 out of the 22 European countries listed have a basic pension scheme and 13 have instituted a minimum pension in their basically earnings-related social insurance schemes. Germany and Austria are among the few European countries that have neither a basic nor a minimum pension. But even in these countries, as in most others, there exists a safety net for the elderly poor in the form of means-tested social assistance schemes.

Concerning the second-tier schemes with the goal of maintaining living standards relative to previous earnings, public defined-benefit schemes are the most common form of pension insurance provision. In 15 out of 22 European countries such schemes of the Bismarck type are in force. Three more countries (Sweden, Italy and Poland) have implemented, in the course of recent pension reforms, notional defined contribution plans under the guidance of the public sector. The next most common form of mandatory pension insurance provision is defined-contribution schemes, organized either as occupational schemes or as private pension plans. In six European countries, mandatory insurance is now organized in this way, operated by private sector institutions. Four countries (Netherlands, Switzerland, Iceland and Sweden) have private occupational defined-benefit plans. In these countries, the contribution rate as well as the minimum rate of return and a mandatory annuity rate is set by government regulation so that the system, although it looks like a DC scheme with capital funding, has strong elements of a DB plan.

This evidence confirms the trend towards convergence described above. With a few exceptions, almost all countries in Europe and even the overseas OECD countries pursue the goals of prevention of poverty in old age and of adequate income maintenance of the

[5]The method of calculating, "pension points", used in some countries, is just a variant of a defined benefit scheme.

pensioners simultaneously.[6] This does not mean, however, that they perform these functions equally well, for instance, ensure effective protection against poverty in old age or attain similar levels of earnings replacement (see below).

In many countries private pensions have become a significant part of old-age security. Though there seems to be a trend towards privatization, countries differ a lot with respect to their public–private mix. Moreover, the role of the state in private pensions widely varies. The distinction between mandatory and voluntary private schemes is fundamental in this respect, but also voluntary schemes can be more or less regulated or subsidized by the state or both.

**Table 19.8** The composition of total pension expenditures (as % of GDP) in 2003

| | Public | Mandatory | Voluntary | Total |
|---|---|---|---|---|
| Austria | 12.8 | a | 0.6 | 13.4 |
| Belgium | 7.2 | 0.0 | 2.3 | 9.5 |
| Czech Republic | 7.8 | 0.2 | a | 8.0 |
| Denmark | 7.2 | a | 2.2 | 9.4 |
| Finland | 5.8 | 2.7 | 0.2 | 8.7 |
| France | 10.5 | 0.1 | 0.1 | 10.7 |
| Germany | 11.3 | a | 0.7 | 12.0 |
| Greece | 11.5 | a | 0.5 | 12.0 |
| Hungary | 7.5 | a | a | 7.5 |
| Ireland | 2.9 | a | a | 2.9 |
| Italy | 11.4 | 1.2 | 0.2 | 12.8 |
| Luxembourg | 4.5 | 1.6 | a | 6.1 |
| The Netherlands | 5.4 | 0.0 | 3.2 | 8.6 |
| Norway | 7.0 | a | 0.7 | 7.7 |
| Poland | 11.4 | a | a | 11.4 |
| Portugal | 8.8 | a | 0.1 | 8.9 |
| Slovak Republic | 6.4 | 0.1 | 0.3 | 6.8 |
| Spain | 7.9 | a | 0.0 | 7.9 |
| Sweden | 10.1 | a | 2.0 | 12.1 |
| Switzerland | 6.8 | 4.5 | 0.0 | 11.3 |
| UK | 5.9 | 0.5 | 4.2 | 10.6 |
| Australia | 3.9 | 0.5 | 2.5 | 6.9 |
| Canada | 4.0 | a | 4.2 | 8.2 |
| Japan | 8.0 | 0.6 | 2.6 | 11.2 |
| New Zealand | 4.4 | a | a | 4.4 |
| USA | 5.5 | a | 3.8 | 9.3 |

Source: OECD Social Expenditure Data; data extracted from OECD.
[a]Data do not exist.

Table 19.8 shows pension expenditure as percentages of the GDP, broken down by public, private mandatory and voluntary schemes in 2003. Countries already differ a lot in overall pension expenditures summing up the different schemes. This "pension effort" varies from about 3% in Ireland to more than 13% in Austria. Higher shares of private systems can be found in three country groups: in the Nordic welfare states of Denmark, Finland and Sweden (but not Norway); in liberal Britain; and in the Continental countries Belgium, the Netherlands and Switzerland. With the exception of Belgium, all of these

[6]There is only one country (Hungary) that does not have any of the three variants of minimum protection, and only two countries (Ireland, New Zealand) do not have some form of mandatory second-tier pension, be it public or private.

countries can be subsumed under the Beveridge an legacy with strong flat-rate first pension pillars. Here private pensions are a necessary supplement in order to secure the standard of living of pensioners. This is not the case in countries with a Bismarckian system, because here already the first pillar is meant to fulfil this purpose.

Yet countries with strong private pensions differ with respect to the mandatory character of these schemes. In Finland and Switzerland, private pensions are required by law (for employed persons) while in the others they are largely voluntary. Thus the role of the welfare state is very different, although most voluntary schemes are also strongly regulated and heavily subsidized by the state.

### *19.5.3 The Performance of Pension Schemes*

The performance of pension systems can be measured with respect to the two major goals: maintaining the standard of living and preventing poverty in old age. A good indicator for measuring to what degree the first goal has been achieved is the earnings replacement rate. More precisely, it is the *net* earnings replacement rate, i.e. "individual *net* pensions relative to individual *net* earnings, taking account of personal income taxes and social security contributions" (OECD 2005: 51 ff.), which seems to be the most appropriate indicator to measure the maintenance of previous living standards.

Most often, the ratio of average (net) pensions to average (net) earnings is used to characterize the generosity of a pension system. This may be misleading for it neglects the impact of the benefit *structure* of a pension scheme. As a result, the earnings replacement rate may not be uniform for all pensioners, but different at different earnings levels. For instance, a flat-rate pension will lead to high replacement rates for low-income earners, but to low replacement rates for high-income earners. Only a pure earnings-related pension scheme will yield the same uniform replacement rate at all (gross) earning levels. Taking account of the usually lower taxation of pensions, compared to earnings, such an earnings-related scheme would, indeed, imply gradually higher *net* replacement rates at higher earning levels.

Table 19.9 presents net replacement rates of mandatory pension programmes[7] at different earnings levels[8] based on a complex modelling of pension entitlements developed by the OECD (see OECD 2005, Chapter 3). Thus, benefits from all schemes detailed for the respective countries in Fig. 19.6 are included and aggregated. To interpret the comparative evidence correctly, one should be aware of the methodological rules: In principle, *future* pension entitlements are calculated on the basis of the *current* pension legislation and *current* pension system parameters (concerning pensionable age, indexation procedures, etc.) and on the assumption that these pension rules remain unchanged.

The results are partly as expected, but also reveal some interesting unexpected features: On average, for all OECD countries, net replacement rates are highest at low earning levels and are gradually diminishing with increasing levels of income. This suggests that the need for compulsory public or mandated private provision is felt most urgently for low-income earners, while at higher income levels, more choice is left to individuals to make private provisions for old age.

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[7] These include public plus private mandatory schemes. Systems with near-universal coverage (as occupational schemes in the Netherlands and Sweden) are also included, provided they cover at least 90% of the employees.

[8] For reasons of comparison, earnings levels are standardized, ranging from 50 to 250% of average earnings.

Table 19.9 Net replacement rates by earnings level, mandatory pensions, men (percent of individual pre-retirement earnings)

| | Individual earnings, multiple of average | | | | | |
|---|---|---|---|---|---|---|
| | 0.5 | 0.75 | 1.0 | 1.5 | 2.0 | 2.5 |
| Austria | 91.2 | 93.4 | 93.2 | 93.5 | 79.3 | 63.2 |
| Belgium | 82.7 | 63.8 | 63.1 | 53.3 | 42.7 | 36.0 |
| Czech Republic | 88.3 | 68.3 | 58.2 | 42.9 | 35.3 | 31.0 |
| Denmark | 95.6 | 68 | 54.1 | 42.5 | 35.5 | 30.8 |
| Finland | 90.7 | 78.8 | 78.8 | 79.2 | 78.3 | 79.3 |
| France | 98.0 | 70.8 | 68.8 | 62.6 | 59.2 | 57.0 |
| Germany | 61.7 | 66.6 | 71.8 | 79.2 | 67 | 54.2 |
| Greece | 99.9 | 99.9 | 99.9 | 99.9 | 99.9 | 99.9 |
| Hungary | 86.6 | 90.9 | 90.5 | 99.1 | 92.6 | 81.8 |
| Iceland | 95.8 | 77.1 | 65.9 | 54.1 | 57.2 | 55.1 |
| Ireland | 63.0 | 47.0 | 36.6 | 27.4 | 21.9 | 18.3 |
| Italy | 89.3 | 88.0 | 88.8 | 88.4 | 89.1 | 89.0 |
| Luxembourg | 125.0 | 115.0 | 109.8 | 105.6 | 104.2 | 100.1 |
| The Netherlands | 82.5 | 88.2 | 84.1 | 85.8 | 83.8 | 82.8 |
| Norway | 85.5 | 73.1 | 65.1 | 58.2 | 50.1 | 42.8 |
| Poland | 69.9 | 69.7 | 69.7 | 69.8 | 70.5 | 71.0 |
| Portugal | 115.9 | 79.8 | 79.8 | 84.4 | 86.3 | 86.9 |
| Slovak Republic | 58.2 | 59.4 | 60.2 | 63.1 | 65.7 | 67.8 |
| Spain | 88.7 | 89.4 | 88.3 | 88.4 | 83.4 | 68.8 |
| Sweden | 90.2 | 76.4 | 68.2 | 70.1 | 74.3 | 75.0 |
| Switzerland | 71.4 | 68.9 | 67.3 | 53.0 | 41.4 | 34.3 |
| United Kingdom | 78.4 | 57.7 | 47.6 | 38.2 | 29.8 | 24.7 |
| Australia | 77.0 | 61.2 | 52.4 | 43.1 | 36.5 | 31.3 |
| Canada | 89.4 | 67.6 | 57.1 | 39.5 | 30.6 | 25.1 |
| Japan | 80.1 | 66.3 | 59.1 | 51.9 | 44.3 | 35.8 |
| New Zealand | 77.1 | 52.0 | 39.5 | 27.9 | 22.0 | 18.1 |
| USA | 61.4 | 54.6 | 51.0 | 44.9 | 39.0 | 35.5 |
| **OECD average** | **84.1** | **73.2** | **68.7** | **64.3** | **59.4** | **54.5** |

Source: OECD: Pensions at a Glance 2005: 52.

This pattern is most visible for countries in the Beveridgean tradition of flat-rate pensions (UK, IRE, NZ, AUS), but also – to a lesser degree – for countries with earnings-related schemes that have instituted minimum pensions for low-income earners and ceilings on pensionable earnings for high-income earners (like CH, BE, FR).

While this pattern holds true for most countries, there are some significant exceptions from the rule in earnings-related schemes, most significantly in Germany. Because of the mechanism of lower taxation for pensioners outlined above, the individual net replacement rates actually increase which seems counterintuitive to any social policy logic. In some other countries (GR, NL, IT), the net earnings replacement rate remains practically uniform across all income levels. In Sweden, surprisingly, the replacement rate is lowest for the average earner, but higher both for low- and high-income earners.

Because of the impact the benefit structure (flat-rate vs. earnings-related) of a pension system has on the replacement rates, the rank order of countries changes considerably if one compares the replacement rates at various earning levels. While in the upper income brackets, the highest replacement rates can be achieved by earnings-related schemes, this

does not apply to below-average income earners. Here, some of the countries with universal flat-rate pensions perform equally well as earnings-related schemes (or even better), depending on the minimum benefit level.

While the individual earnings replacement rate shows best to what extent the *previous personal* standard of living can be maintained, it does not answer the question of whether an *adequate* standard of living, relative to the average income situation in a given country, can be sustained. Individual replacement rates may be quite high (for instance, 100% for a low-income worker), but his pension benefits may still amount to 50% or less of the economy-wide average earnings. Therefore, pension adequacy is better measured by the relative pension level which shows "what benefit level a pensioner will receive in relation to the average wage earner in the respective country" (OECD 2005: 45). "Only for an average wage earner, the replacement rate and the relative pension level will be the same" (ibid.).

In countries with "pure" flat-rate (or resource-tested) pension benefits, the relative pension level is virtually independent of previous incomes (UK, IRE, CAN, AUS, NZ, DK, CZ). On the other hand, in "pure" Bismarckian earnings-related schemes, the relative pension levels increase with individual earnings in an almost linear way. There are six countries with a very strong link between relative pension levels and pre-retirement earnings (GR, HU, NL, IT, PL, SK) and six more countries with a strong link (AUT, GER, FIN, SW, LUX, ESP).

The protection against (or the alleviation of) poverty in old age is the second central goal of pension policy about which there is a broad political consensus. The "success" of pension policies in this respect can best be measured directly by the incidence of poverty among the elderly population. Of course, the incidence of poverty among the elderly does not depend solely on the retirement income provided by public pension programmes. It is also affected by the degree of income inequality prevailing in society at large (or, more specifically, by the distribution of market income among the working population). Likewise, it must be taken into account that retirement income is only part of the "total income package"[9] of pensioners (households), albeit in most cases the most important item. It may be supplemented by continued, though reduced, income from work and by interest income from capital assets. In addition, the pooling of resources within households and support from other household members may reduce the risk of pensioners to fall into poverty.

Table 19.10 presents some comparative information on the evidence of poverty among the elderly in 15 EU countries, as of 1999.[10] A total of 50% of the national median equivalent income has been adopted by the EU as the quasi-official poverty line in its research programmes to combat poverty. A total of 60% of median income has come into use as a "milder" poverty line, also including those groups "at the risk of poverty". It makes sense to use both poverty lines in conjunction as a sensitivity test of how a change of the baseline by 10 percentage points affects the poverty rates measured.

Using these yardsticks, about 10% of the elderly in the EU are living in poverty (at the 50% threshold) and about 17% at the 60% threshold. In Greece and Portugal, relative poverty rates are higher than 20%, that is, more than two times the EU average. Also in

[9]The "total income package", i.e. net equivalent household income, is the basis for setting the relative poverty lines which are used for calculating the poverty rates.

[10]These data are based on the European Community Household Panel (ECHP) 1999. There are certain methodological problems associated with the ECHP (e.g. the non-imputation of rents in case of home ownership) which do not allow drawing definite conclusions.

**Table 19.10** Poverty rates and risks among the elderly 1998

| | Relative poverty rates among the elderly (65 years and over) | | | | | |
|---|---|---|---|---|---|---|
| | 50% of median | | | 60% of median | | |
| | Men | Women | Total | Men | Women | Total |
| Austria | 8 | 12 | 10 | 15 | 29 | 24 |
| Belgium | 11 | 12 | 12 | 20 | 22 | 22 |
| Denmark | 10 | 14 | 12 | 26 | 35 | 31 |
| Finland | 1 | 8 | 6 | 9 | 23 | 17 |
| France | 8 | 12 | 10 | 16 | 21 | 19 |
| Germany | 5 | 6 | 6 | 9 | 13 | 11 |
| Greece | 24 | 25 | 25 | 34 | 33 | 33 |
| Ireland | 7 | 19 | 14 | 26 | 41 | 34 |
| Italy | 7 | 9 | 8 | 12 | 16 | 14 |
| Luxembourg | 3 | 4 | 4 | 6 | 10 | 8 |
| The Netherlands | 4 | 5 | 4 | 7 | 7 | 7 |
| Portugal | 18 | 25 | 22 | 30 | 36 | 33 |
| Spain | 7 | 7 | 7 | 16 | 16 | 16 |
| Sweden | 2 | 3 | 3 | 6 | 10 | 8 |
| United Kingdom | 7 | 13 | 11 | 17 | 25 | 21 |
| **EU-15** | **7** | **10** | **9** | **15** | **19** | **17** |

Source: European Commission (2003: 28, Table 2).
Source of data: ECHP, 6th wave, 1999.

Ireland and the United Kingdom and, surprisingly, in Belgium and Denmark, poverty rates of the elderly are above the EU average. At the other end, poverty among the elderly is lowest in Sweden, the Netherlands and Luxembourg, followed by Germany, Finland, Spain and Italy. At the 60% threshold, the pattern among EU countries remains largely the same, but the differences concerning the risk of poverty among pensioners seem to be even more pronounced. More than 30% of pensioners live at the risk of poverty in Ireland, Greece, and Portugal (and, again surprisingly, in Denmark), while in Sweden, the Netherlands and Luxembourg, the respective rates are below 10%.

Additional analyses on the basis of ECHP data show that the risk of poverty increases with age and is highest among the very old (75+). On the EU average, the poverty rates and risks are somewhat higher for elderly women than for men, but here two groups of countries emerge: one group where the poverty risks of elderly women are at least 50% higher than for men (POR, IRE, UK, FIN, FR, AUT) and another group where the gender difference is far less significant (BE, NL, ESP, GER, LUX, GR).

Furthermore, it is interesting from a social policy point of view to examine whether pensioners suffer from higher risks of poverty than the younger age groups and whether the range of income inequality prevailing among households of working age is reduced (or perhaps even widened) during the retirement phase. On the EU average, pensioners have only slightly higher risks of poverty than younger households (of working age) nowadays, but there are again two distinctly different groups of countries: in Ireland, Greece, Portugal and Austria, pensioners (and among them, in particular women) still have significantly *higher* poverty risks, while in Luxembourg, Italy, the Netherlands, Spain and Sweden, poverty risks among pensioners are actually lower than among households of younger age, or for that matter, among the population at large.

Finally, while on the EU average, income inequality among pensioners is somewhat less pronounced than in the working-age population, this general tendency holds no longer true for all member countries: in Germany and the Netherlands, there is virtually no difference, and in Greece, Austria, Belgium and Denmark, inequality among pensioners seems to be more expressed than among younger age cohorts.

### *19.5.4 Trends of Pension Reform*

In the last two decades, most pension systems in Europe and the Western world have come under increasing strains, above all, from the demographic pressures of ageing populations and by economic pressures arising from mass unemployment and slow economic growth, exacerbated by processes of globalization. These pressures have led to increasing imbalances between the revenues and expenditures of pension systems and thus have challenged the stability and future viability of existing pension schemes. Governments have responded to these real and/or perceived challenges by a variety of reform and adjustment strategies. In general, it can be hypothesized that the scope and direction of reform strategies is determined:

– by the institutional set-up of existing schemes ("path dependency") and
– by the interests of the political actors involved ("pension politics").

Since both factors vary cross-nationally, it can be expected that the political and administrative measures will also vary considerably. Indeed, a large variety of measures have been taken to stabilize the expenditure and/or the revenue side of public pension schemes.

Nonetheless, certain common trends of reform can be identified in most countries (see Hinrichs 2000; Schludi 2005):

First, "reforms have strengthened the equivalence principle in social insurance-type pension schemes and have thus reduced elements of interpersonal redistribution" (Hinrichs 2001: 85). Such measures usually imply lower pension benefits for those with a less than full employment record.

Second, "the reforms are aimed at increasing the age of entry into retirement, be it by gradually raising the standard retirement age or by blocking pathways into early retirement" (ibid.: 87). In particular, attempts have been undertaken to reverse the trend of ever lower employment rates in the upper age brackets.

Third, "increased tax financing ... can be identified as a further trend" (ibid.: 87). The purpose of this measure has mostly been to contain or even reverse increases in the contribution rate to the schemes which would have otherwise added to non-wage labour costs and thus have been detrimental to the international competitiveness of the national economy.

This trend seems to be at odds with the principle of contribution financing of social insurance schemes, and also with the first trend mentioned above, of strengthening the equivalence principle. Both trends can, however, be rendered compatible if tax financing is used for the redistributive parts of social insurance schemes while the insurance parts continue to be financed by contributions. In this way, the schemes can even be made more transparent and acceptable for the citizens.

Fourth, in almost all countries "unpaid family work was incorporated into benefit calculation" (ibid.). In contrast to tightening eligibility criteria and strengthening the equivalence principle, this obviously is an expansionary and, moreover, a redistributive element in

recent reforms. But insofar as child-bearing and -rearing are recognized by such measures, they may also be justified as extended "equivalence in real terms" which goes beyond equivalence in monetary terms (i.e. of contributions).

Finally, and perhaps most importantly, a major trend of reform can be observed in most countries: shifting the balance in the public/private mix in pension provision in favour of the latter, by giving more weight to occupational schemes and personal pension plans. By the same token, pay-as-you-go financing prevailing in public schemes is gradually shifting towards capital funding which is the predominant mode of financing in non-public schemes.

It is sometimes argued by the proponents of such a shift that in this way the reduction of entitlements and benefits in public schemes can be compensated by increased benefits from non-public schemes. It must be questioned, however, whether such a shift is socially desirable because of the negative distributional consequences it entails. First, the redistributive elements of the pension income package will be further reduced and, second, the tax advantages usually given to companies and individuals as incentives for making private provisions tend to benefit the upper income brackets and may turn out to be very expensive for the public budget.

Just because "the non-public components are not completely private, but are shaped by public regulation and fiscal welfare" (Hinrichs 2000: 80), the regulation of the non-public forms of pension provision will probably become a crucial issue in future pension reform debates.

## 19.6 Healthcare

Healthcare systems form a major part of modern welfare states and alongside pensions are the biggest consumers of resources. Furthermore, they are among the largest employers in countries where most health services are offered by public providers. Healthcare systems provide security against a major life risk, and access to healthcare services is highly valued in all developed countries (Mossialos 1997; Kohl and Wendt 2004). Therefore, even in countries without National Health Service or nation-wide compulsory insurance, the state guarantees access to basic healthcare for all citizens. Due to the high importance of health and healthcare, the medical profession has obtained a special role in modern societies and – with respect to healthcare reforms – has a strong veto power (Immergut 1992). While for many years healthcare systems have expanded, from the early 1990s onwards cost pressures have increased, and in a context of permanent austerity (Pierson 2001) healthcare systems are increasingly confronted with structural reforms.

In this section we discuss different types of healthcare systems and the variations between them regarding expenditures, financing and service provision. With respect to expenditure and financing it is asked whether processes of convergence can be detected and whether "laggard countries" have increased expenditures faster than "pioneer countries". This would support Peter Flora's "growth to limits" thesis. In addition, the structure (public–private mix) of financing is addressed. This includes a discussion of "the role of the state" in healthcare systems: Do healthcare systems face a retreat of the state from financing and an increase of private funding? With respect to service provision, the development of various sectors (in-patient [hospital treatment], out-patient, pharmaceutical and dental healthcare) is analysed. Since out-patient services are mostly offered by private providers while in-patient services are still dominated by public ones, a shift from in-patient to

out-patient services would also result in a privatization of healthcare (Tuohy et al. 2004). The section concludes with an overview of healthcare reforms and reflects on processes of convergence or divergence among European countries.

### *19.6.1 Types of Healthcare Systems*

Healthcare systems have never been a major issue in the distinction of different welfare state models (see above). Only data on sickness benefits, but not institutional structures of service provision have been taken into account (Esping-Andersen 1990; Korpi and Palme 2003; Scruggs and Allan 2006). The analytical focus has been on cash benefits whereas healthcare and social services have been largely ignored in developing welfare state models (Alber 1995; Bambra 2005a,b).

Healthcare systems are mainly grouped by their way of organization and funding: the Social Insurance (SI) type on the one hand and the National Health Service (NHS) on the other (see, for instance, Freeman 2000; Wendt 2009; Wendt et al. 2009). The first compulsory health insurance system for workers was established in Germany in 1883. This system was developed by the German chancellor, Bismarck, at that time, and in the following decades was adopted by other European countries. Even countries that are today known for their National Health Service, for instance Great Britain or Denmark, had first introduced health insurance for selected population groups and changed their systems only decades later. The main idea of health insurance is that the state has to organize compulsory insurance against the risk of sickness for those parts of the working population that are considered to be unable to fend for themselves by private means. At a later stage, additional population groups like dependent family members, pensioners, handicapped persons and students gained access to social insurance. Some of these groups were covered even without paying own insurance contributions (especially dependent family members). Today, most social insurance systems cover nearly the whole population. Thus in most European countries the original character of a worker's insurance was gradually replaced by the idea of a citizen's insurance.

After World War II the second type of healthcare system was installed. In 1948, Great Britain implemented the National Health Service. Since the NHS widely followed the recommendations made by the 1942 Beveridge Report, it is also known as the Beveridge type of healthcare system. The main characteristics of NHS systems are tax financing, universal coverage, and a major role of the state in organizing and providing healthcare services. The Scandinavian countries also finance their healthcare systems mainly out of taxes and offer healthcare as a "social citizenship right". Therefore, they can also be included among the NHS type of system, but in contrast to the hierarchical structure of the British NHS, in Scandinavia healthcare is mainly organized and financed at the regional or even local level.

In principle, a third type of healthcare system can be distinguished. In some countries, neither a NHS nor compulsory insurance has been implemented. In these cases people either have to rely on private insurance or finance healthcare to a large extent out of pocket. In the early 1960s, in a number of countries less than 60% of the population was covered by a NHS or compulsory health insurance (Belgium, Finland, Portugal, Spain, USA; see OECD Health Data 2006). Today, however, only in the USA the majority of the population relies on private insurance. Private healthcare systems are characterized by a high share of

private funding and service provision and are mainly coordinated by market mechanisms (see Table 19.11).

In some countries a system shift took place. Italy, for instance, replaced social insurance by a NHS in 1978. Other Southern European countries, too, implemented NHS systems in the 1970s and 1980s (Portugal in 1979; Greece in 1983; Spain in 1986). Since they are characterized by a comparatively high level of private funding, these "late developing" NHS systems can be distinguished from earlier developed ones.

In the 1990s, a substantial number of CEE countries established social insurance systems (Dubois and McKee 2004), which from the beginning have been confronted by rising costs and a growing share of private funding. In contrast to Western Europe, private health insurance has not gained ground in CEE countries. If these later implemented social insurance schemes are separated from the "pioneer" systems of Western Europe, five "real" types of healthcare systems can be distinguished (see Table 19.12).

In Table 19.12, 22 European countries for which data are available in the OECD Health Data are grouped according to the 5 types of healthcare systems. Additionally, the USA and Japan have been included to compare European countries with two countries from other world regions. Due to the large share of private funding and the great importance of market mechanisms we classify Switzerland and the USA as private healthcare systems. Since the introduction of general compulsory insurance in 1996 the Swiss system certainly contains many characteristics of a social insurance system, but without departing from the traditional high level of private out-of-pocket funding.

### *19.6.2 Health Expenditure and Financing*

When analysing those European countries which have been members of the OECD already in 1970 (without Central and Eastern Europe, CEE), we see on average an increase of *total health expenditure* from 5.0% of GDP in 1970 to 9.2% in 2005. Health expenditure has increased at a high rate in the 1970s, followed by a more stable development in the 1980s, and again by a rapid increase from the early 1990s onwards.

Switzerland has been the country with the highest level of total health expenditure in 2005, followed by Germany and France. Luxembourg, Finland and Ireland are at the other end of the scale. While countries with a social health insurance in general show a higher level of total expenditure, nearly all countries below the OECD Europe average have a National Health Service. When comparing 1970 and 2005, it becomes evident that the rank order of European countries has changed remarkably. Today, we find Sweden and especially Denmark, "big spenders" in 1970, below the OECD Europe mean. Southern European countries which had implemented National Health Services only in the 1970s or 1980s, on the other hand, have experienced a high increase of total health expenditure between 1970 and 2005. While Japan has experienced a similar expansion as European countries and today is close to the European mean, USA has doubled its health expenditures relative to GDP since 1970 and is today by far the biggest spender in healthcare (15.3% of GDP in 2005).

The hypothesis that countries with a higher GDP per capita spend a greater share of their GDP for healthcare services (Alber 1988; Castles 2004) has been confirmed in many empirical studies. It is also supported when using OECD data for 1970. In 2004, however, the correlation between the wealth of a country and the percentage of GDP spent on healthcare has declined remarkably (see Fig. 19.7).

**Table 19.11** (Ideal) Types of healthcare systems

| Type | Underlying values and principles | Financing | Service provision | Regulation |
|---|---|---|---|---|
| National Health Services | Equity: Equal access to services for everyone | Public: taxes according to income (direct taxes) and consumption (indirect taxes) | Public providers | Hierarchy; encompassing planning and tight control by the state |
| Social Insurance system | Solidarity: Equal access to services for all members of insurance funds | Societal: social contributions according to income | Private and public providers | Collective bargaining; legal framework and some control by the state |
| Private (insurance) system | Principle of equivalence: service with respect to ability to pay | Private: premium according to individual risk | Private providers | Markets; limited control of insurance and service provision by the state |

Source: Rothgang et al. (2005).

**Table 19.12** "Real" types of healthcare systems

| Private health systems | Social Insurance systems: Western Europe | Social Insurance systems: CEE countries | National Health Service systems: Western and Northern Europe | National Health Service systems: Southern Europe |
|---|---|---|---|---|
| Switzerland | Austria | Czech Republic | Denmark | Greece |
| *USA* | Belgium | Hungary | Finland | Italy |
| | France | Poland | Iceland | Portugal |
| | Germany | Slovak Republic | Ireland | Spain |
| | Luxembourg | | Norway | |
| | Netherlands | | Sweden | |
| | *Japan* | | United Kingdom | |

Note: USA and Japan have been included to compare European healthcare systems with examples from outside Europe.

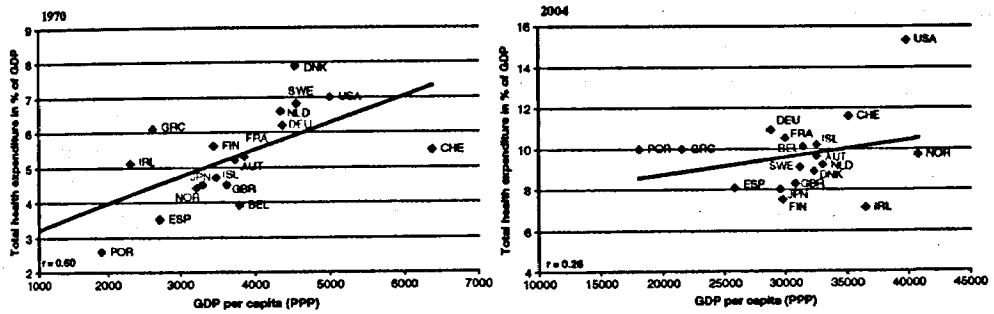


Fig. 19.7 GDP per capita and THE in % of GDP (without CEE region)
Source: OECD Health Data (2006).

When CEE countries are included (Fig. 19.8), it is possible to identify different groups of healthcare systems. The CEE countries at the bottom are characterized by both a low

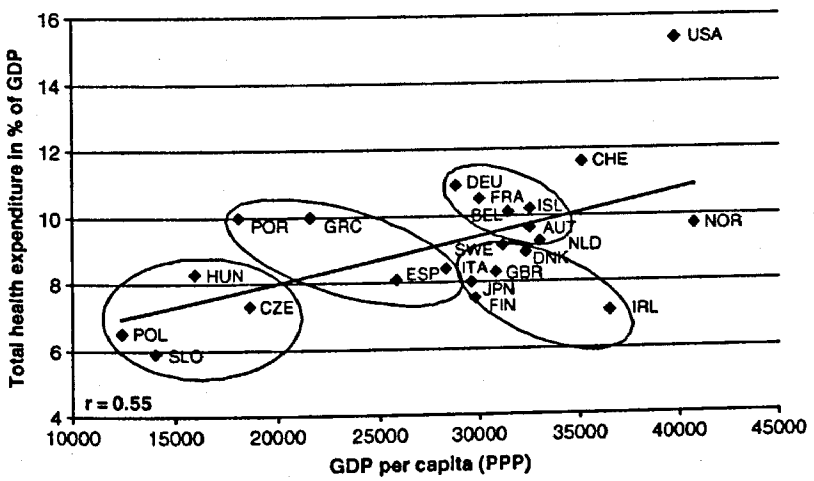


Fig. 19.8 GDP per capita and THE in % of GDP, 2004 (CEE region included)
Source: OECD Health Data (2006).

GDP and a relatively low level of total health expenditure. Within the Southern European group, we find countries with a relatively high level as well as with a lower level of total health expenditure. The Social Insurance systems of Western Europe generally spend a higher share of GDP on healthcare than the "mature" NHS systems of Western and Northern Europe. The type of healthcare system, therefore, has a strong influence on the level of health expenditure. Especially NHS systems proved to be successful in stabilizing healthcare costs.

With respect to processes of convergence or divergence the following developments can be outlined:

- Due to the strong increase of total health expenditures in "late developing" NHS systems and the more stable development in "pioneer NHS countries" from 1970 to 2005 a convergence has taken place in Western Europe. The coefficient of variation decreased from 28.8 to 13.4 in this period (OECD Health Data 2006, own calculation).
- When comparing NHS systems and Social Insurance systems, due to the catching up of Southern Europe, today NHS countries are more similar to each other and experienced a stronger convergence than Social Insurance-type countries.
- Besides the institutional setting of the respective healthcare systems, the European Union seems to have a positive impact on convergence. Convergence in countries which have been members of the EU for a longer period of time (EU 12) and divergence in non-EU 12 countries lend some support to the European Integration thesis (Wendt et al. 2005).

When analysing the share of public financing as a percentage of total health expenditure, no general retreat of the state can be detected. On average, the share of public funding has remained quite stable in European healthcare systems from 1970 to 2005 (OECD Health Data 2006). In certain healthcare sectors, however, changes in the public-private mix turned out to be more far-reaching than in the healthcare system in total. While in-patient healthcare is still funded by more than 80% by public sources in nearly all OECD countries, public financing for dental services has been reduced, and in 2005 only in Germany, Luxembourg and Japan the public share exceeded 50%. In countries like Spain, Switzerland and the USA, on the other side, public financing is almost absent in dental healthcare.

The differences with respect to the financing of healthcare systems become even more evident when public funding is subdivided in to tax financing and social insurance contributions and private funding in private insurance and private out-of-pocket payments. The NHS systems of Sweden, Denmark and the United Kingdom are still financed by more than 80% out of taxes whereas healthcare systems in Luxembourg, Germany and France are overwhelmingly financed from social insurance contributions. In Switzerland, compulsory health insurance for the total population was introduced in 1996, followed by an increase of social insurance financing which in 2005 exceeded private funding. Yet still the Swiss system is financed to a large extent by private out-of-pocket payments. It therefore represents a mixed model of healthcare financing. Today the CEE countries belong to the group of systems which are financed mainly out of social insurance contributions. In the Czech Republic and the Slovak Republic, the respective shares are even higher than in the "traditional" Social Insurance systems of Germany or France. In Hungary and Poland, the level of social insurance financing is also comparatively high, but supplemented by a high share of private out-of-pocket payments. Private insurance, on the other hand, is of hardly any importance in CEE countries.

Taking the share of public funding as an indicator for the interventionist power of the state, Alber has argued that in times of austerity, countries with a higher share of public funding are more successful in controlling total health expenditure (Alber 1988). While in 1970 (in a period of welfare state expansion) nearly no correlation between public financing and the level of health expenditure could be identified, the data provided for 2004 in Fig. 19.9 support this hypothesis with a strong negative correlation between the share of public funding and the relative level of total health expenditure.

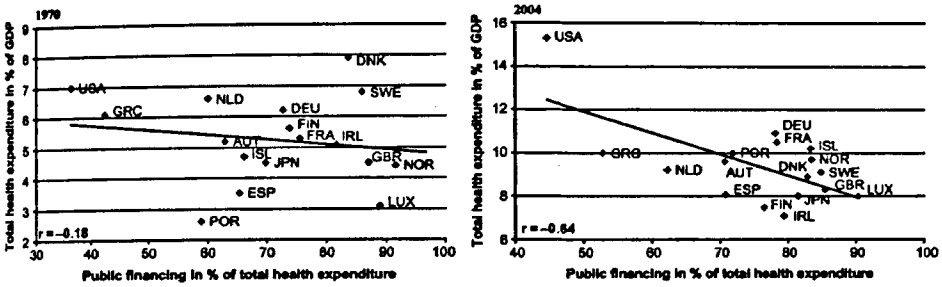


Fig. 19.9 Public financing in % of THE and level of THE in % of GDP
Source: OECD Health Data (2006).

## *19.6.3 Health Service Provision*

Healthcare systems represent the "service heavy" part of the welfare state. The lion's share of resources is spent on healthcare personnel while financial transfers today are of minor importance. Healthcare services can either be measured as "monetary inputs" or as healthcare personnel. Due to differences in income and prices, important distinctions concerning the development of monetary and non-monetary resources can be identified. The analysis of health service provision will therefore be based on both "inputs".

When calculating the share of monetary resources for different healthcare sectors, it becomes evident that some countries (especially Iceland and Switzerland, also Italy, Austria and Norway) give in-patient healthcare by far the highest importance while in Luxembourg, Sweden, Denmark and Spain less than one-third is spent on this sector (see Fig. 19.10). In Sweden and Spain, out-patient healthcare is even of higher relevance than in-patient healthcare. CEE countries, too, spend a relatively low share on in-patient healthcare. Especially the Slovak Republic, Poland and Hungary can be distinguished from the other countries by their comparatively high share for pharmaceuticals. In most European countries, the relative importance of in-patient healthcare has decreased in recent years.

When focusing on healthcare personnel, we find an increase of the number of healthcare providers per 1,000 inhabitants in almost all European countries (OECD Health Data 2006). This trend indicates that even in times when welfare states are facing enormous cost containment pressures, growing needs have pushed service supply.

In contrast to health expenditure, no convergence with regard to healthcare providers can be identified (Wendt et al. 2005). This heterogeneity is indicated by the remarkable differences in the numbers of healthcare personnel in European countries. In 2004, the total number of health service providers varied from 59.4 per 1,000 inhabitants in Switzerland to 13.5 in Portugal. At the top we find the UK and Iceland, where most service providers are employed in hospitals, and Germany and Norway, where most providers work outside

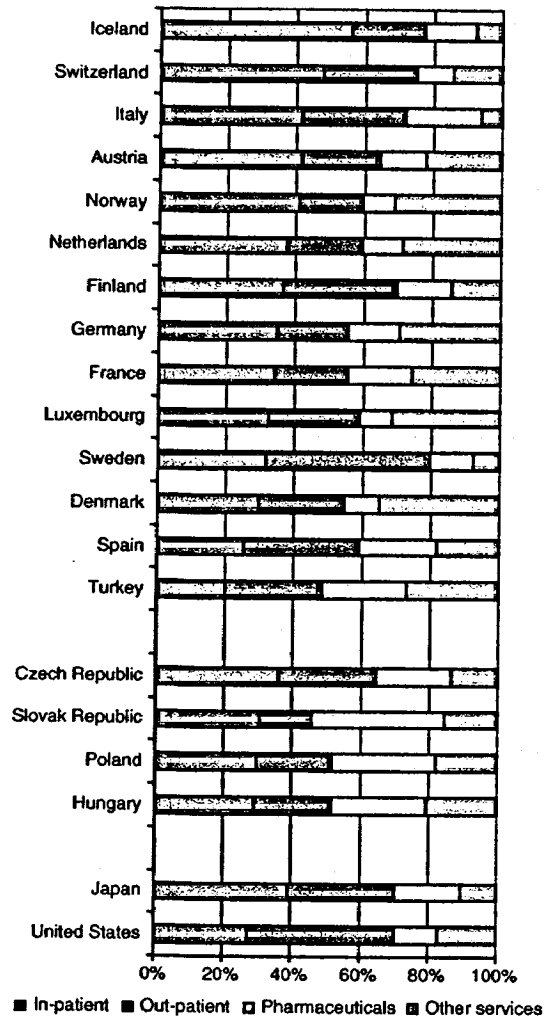


**Fig. 19.10** Monetary resources for healthcare sectors, 2004
Source: OECD Health Data (2006).

hospitals. In countries with a low overall number of healthcare personnel, however, provision is primarily inside hospitals. The number of healthcare personnel in CEE countries is higher than in most Southern European NHS systems, but much lower than in Western Europe.

Since at the top we find Social Insurance-type systems (Switzerland, Germany), NHS systems (Norway, Iceland, United Kingdom) as well as the privately dominated US system, it is not the *type of healthcare system* that can be considered as the main factor for different service levels.

In general, there is a positive correlation between total health expenditure (in US$ per capita) and total health employment per 1,000 population. Again, certain groups of healthcare systems can be identified. Figure 19.11 shows that especially CEE Social Insurance systems as well as Southern European NHS systems form rather homogeneous clusters. Within the group of Western European social insurance systems, however, Germany offers a much higher level of health employment than France at a similar level of health expenditure (in US$ per capita). Likewise, within the group of "mature" NHS systems

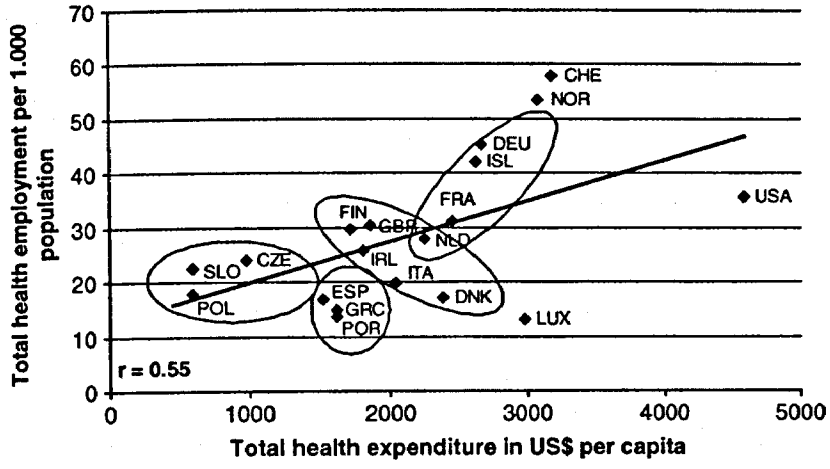


Fig. 19.11 THE in US$ per capita (ppp) and total health employment per 1,000 persons, 2004
Source: OECD Health Data (2006).

Finland has reached a higher level of health employment than Denmark although the costs are much lower. Denmark can be taken as an example for a close cooperation between in-patient and out-patient healthcare with in-patient social care and home care services. This close cooperation is considered to be one reason why patients can be transferred earlier from hospitals to social care facilities. Therefore the number of healthcare providers in Denmark can be lower than in most other countries (see Wendt 2009).

### *19.6.4 Reform Trends*

In response to growing cost pressures, health reforms have been implemented at an accelerating rate. While for many years strong veto groups succeeded in defending the established structure of healthcare systems, from the 1980s onwards health politicians increasingly implemented structural reforms (Giamo and Manow 1999; Freeman and Moran 2000). The increasing role of policy learning and the orientation at "best practice" may have had the effect that countries have to a greater extent left their traditional reform path and implemented new elements into their systems (Marmor et al. 2005).

This can be demonstrated by the dawn of market mechanisms especially in NHS systems. Referring mainly to ideas introduced to the health policy debate by Enthoven (1985), a so-called internal market was implemented in the British NHS in 1991 where money would follow the patient. A purchaser–provider split was introduced with general practitioners (GPs) being allowed to hold their own budget which would cover in-patient treatment as well as all out-patient referrals and all diagnostic tests. Hospitals were given the opportunity to become NHS trusts and thus to compete with one another on the basis of performance to secure purchaser contracts and replace the existing hierarchical command-and-control system.

Other NHS systems followed the British example. For instance, in Sweden, Finland and Italy (less extensive) experiments with internal markets to stimulate competition between healthcare providers and thus improve efficiency were undertaken. In Sweden a series of planned market models were implemented in the 1990s. The reforms sought to enable

patients to choose between different health centres or hospitals. A purchaser–provider split within the county council's administrative apparatus was intended to generate incentives for competition and for more entrepreneurial behaviour (Saltman and Bergman 2005).

NHS-type systems thereby changed their character by implementing instruments that used to be more common in private systems. In recent years, however, the British NHS experienced changes that might better be described as "devolution". In 2001, Primary Care Trusts had been established in Great Britain. Within these entities, cooperation between service providers is of major importance and therefore the utilization of market elements has lost ground. One important effect can be seen in a convergence within the NHS type. Healthcare provision in Sweden, Denmark and Finland is traditionally organized at a local or regional level (Saltman and Bergman 2005), and the process of devolution brought the British system closer to the Scandinavian countries.

While Southern European countries have approached the level of health expenditure of earlier developed NHS systems, major differences remain with regard to the organizational structure. Especially in Greece and Portugal part of the former, social insurance schemes continue to operate in parallel to the NHS (Davaki and Mossialos 2005; Oliveira and Pinto 2005). The NHS systems of these countries have not yet obtained characteristics of a universal system. Patients, for instance, face much higher direct costs than in most other NHS systems. There have also been debates on implementing a purchaser–provider split, but this was barely implemented in Southern Europe. On the other side, the healthcare systems of Greece, Portugal and especially Spain also experienced processes of devolution. In Spain, for instance, the responsibility for healthcare provision has been transferred to the regional governments (Lopez-Casasnovas et al. 2005). These reform processes towards the regional or even local level might lead to convergence among NHS systems.

Social insurance systems, on the other hand, can be characterized by a high level of self-regulation. Especially in Germany, sickness funds and doctors' associations negotiate on budgets and conditions for healthcare provision. From the early 1990s onwards, however, the self-regulatory core came under pressure from two sides. The state improved its capacity for direct intervention and at the same time market mechanisms have been implemented, as some commentators argue, to bypass established veto positions (Tuohy 1999; Giaimo and Manow 1999). An important structural effect of this development is that the traditional strength of corporate actors within social insurance systems is losing ground.

The market-derived changes were different from those implemented in NHS systems. In Social Insurance systems, a separation of purchasers and providers exists almost by definition (Freeman 2000). In some Social Insurance systems (e.g. Germany, The Netherlands), however, competition between sickness funds has been strengthened in the belief that this would increase efficiency and quality (Saltman et al. 2004). Further, the distinction between sickness funds and private insurance has been reduced in the Netherlands and Switzerland while in other Social Insurance systems neither competition between insurance funds nor a convergence between public and private insurance has taken place. The group of Social Insurance countries is, therefore, today more heterogeneous than in the past.

The Social Insurance systems in CEE countries are still distinct from those of Western Europe. The reforms of the early 1990s were driven by the ideas of departing from the centralized state model, of liberalization of health service provision and of enforcing accountability of providers and consumers of healthcare (Dubois and McKee 2004). The concept of self-regulation, however, has not achieved such a dominant role like in Western European systems. Another prominent difference is the minor role of private health insurance in Central and Eastern Europe. In common with NHS systems of Southern

Europe, most CEE Social Insurance systems rely on a relatively high share of private out-of-pocket funding. In these countries, the risk of sickness is therefore to a larger extent "privatized" than in "mature" NHS or Social Insurance systems.

Since in most Social Insurance systems compulsory coverage has been extended to the total population, these systems today contain certain elements that used to be typical for NHS systems. Further examples are the introduction of global budgets by the state and of "gate keeping" models in many Social Insurance systems. Healthcare system types are today therefore not as "distinct" as they used to be. Examples for the increasing importance of "policy learning" are the introduction of Diagnosis Related Groups (DRGs), a system that intensifies competition between hospitals (Rothgang et al. 2005). Thereby the integration process of the European Union seems to have hardly contributed to these developments (Freeman and Moran 2000). Yet it has been argued that the common European market and the open method of coordination (OMC) provide ground for an increasing importance of market mechanisms and competition in the field of healthcare (Gerlinger and Urban 2006). In this context, international hospital groups or pharmacies have gained access to the healthcare market in many European countries. These processes can be seen as an indicator for a general "economization" of healthcare provision.

## 19.7 Family Policy

Family policy is one of the "youngest" and still less developed parts of the welfare state and has often been initiated by "private" actors rather than the state. The Catholic Church, for instance, was a major competitor of the state in the field of family law, but had a strong influence on social services and particularly childcare as well. Local communities, especially the notables and representatives of the local bourgeoisie, played an important role in implementing the poor law and providing basic collective goods such as water supply, electricity and public transport. Employers and trade unions were major actors in income policies for families. Family allowances, for example, were first introduced voluntarily by Catholic employers rather than by the state. Most, if not all, state family policies were historically launched by civil society actors which emphasizes the strong intermediary structures in European societies.

This specific constellation was also the starting point for public family policy that can be defined as programmes by which the state intervenes into the family (as a social group and institution) or into the relationships among family members or both. The aims, instruments and degrees of state intervention vary between European societies.

### *19.7.1 The State and the Family: Family Policy Forms in Europe*

The historical development of family policy in OECD countries is analysed by Gauthier (1996). According to her, differences in family policy between countries can be explained by two major factors: the impact of pro-natalist movements and of the women's movement. The two major aims to stabilize/increase birth rates and to improve gender equality have certainly been among the major driving forces of family policy in Europe. The first motive is related to the competitive, conflict-ridden European nation-state system and to nationalism evolving in the 19th century, the second to the historically relatively favourable position of women in European societies which is one of the historical legacies

of Christianity. Yet a third major driving force for family policy was industrialization. Since its beginnings in the late 19th century, family policy has been closely linked to economic and social problems, in particular related to working-class families.

Kaufmann (1994, 2002) distinguishes five *Leitmotifs* for family policy that have shaped policies in different countries to varying degrees: the population motive, the individual rights motive (linked to gender equality and children's rights), the social motive (originally linked to the issue of living wages for working-class families), the anti-poverty motive and the social control/social integration motive. The mix of these motives and the degree to which they have been actually transformed into policies vary between countries.

Variations in European family policies do not exactly fit with Esping-Andersen's three worlds of welfare regimes discussed above, but there are some broad commonalities. One can broadly identify five models of family policy in Europe which are the result of long-term structural and institutional developments (Bahle 1995, 2008a).

The first is based on principles of universality and equality and aims at reconciling family and work. It is characterized by modest but universal child benefits and highly developed childcare services integrated with parental leave policies. This approach fits well with Esping-Andersen's social democratic welfare regime type.

The second model is based on the principle of subsidiarity in which the family is supported by the state as a social group and institution. There is also a preference for supporting large families or low-income families. A major characteristic of this form of family policy is that parental leave is developed better than public childcare services which means that childcare within families is preferred. This approach fits with Esping-Andersen's conservative welfare regime type.

In between these two models there is a "modernized conservative" model. Historically, the countries in this group have started from a conservative policy profile, but have added highly developed services and today come closer to the Scandinavian group. France and Belgium represent this "in-between form", but it seems that more recently also Germany is moving in this direction. This approach does not fit with Esping-Andersen's categories or it must be interpreted as a hybrid form or a path change.

The fourth group of nations can be characterized as the non-interventionist family policy model. These countries share the principles of universality and equality with the Scandinavian world, but do not actively support the compatibility of work and family life. By contrast, the concept of non-intervention into social relations is very strong. Thus, there is a lack of public social services. This approach fits with Esping-Andersen's liberal welfare regime type, although in family policy the Netherlands also belongs here.

Finally, there is a group of countries that does not follow any explicitly developed model. One can characterize this type as the "traditional approach" or the "no family policy" group (see Flaquer 2000). In these societies the family still performs many social functions without state support. These countries are characterized by a lack of coherent family income policy and a lack of social services. The family is also not supported in its care-taking function, for example, through generous leaves as in the conservative approach. These countries represent Stephan Leibfried's (1992) "latin rim" group.

Historically, that is before World War II, the Eastern European countries had been close to the conservative approach, but after 1945 they established the socialist model with its strong emphasis on work and population growth, albeit with variations. After the fall of Communism in 1989 it seems that most of these countries have returned to a conservative approach in which the family is an important social institution. Yet it is too early to say whether this is really a return to history or whether it simply reflects the difficulties

of the transition period in which the state cannot shoulder a higher level of care-taking responsibilities.

Kaufmann's (1994) "families of nations" nicely fit with the models described above, except that he did not classify the Socialist countries. Künzler (2002) and Fux (2007) have introduced similar typologies. Fux, for example, distinguishes between "etatistic", "familialistic" and "individualistic" approaches to family policy. The etatistic policy pattern fits with the social democratic approach, the familialistic one with the conservative and the individualistic pattern with the liberal approach. Yet Fux (2007) does not identify a "traditional" Southern European approach – rather he sees it as an underdeveloped conservative model – and he treats the former Socialist countries of Eastern Europe as a group of their own.

In the following empirical part it is analysed to what extent these historically developed "families of nations" can be identified in present family policies. The analysis is based on comparative quantitative indicators such as social spending on families and the value of child benefits.

## *19.7.2 Family Policy Patterns*

Total social spending on the family is the most encompassing indicator to quantify family policies and shows total effort in supporting the family (see Fig. 19.12).

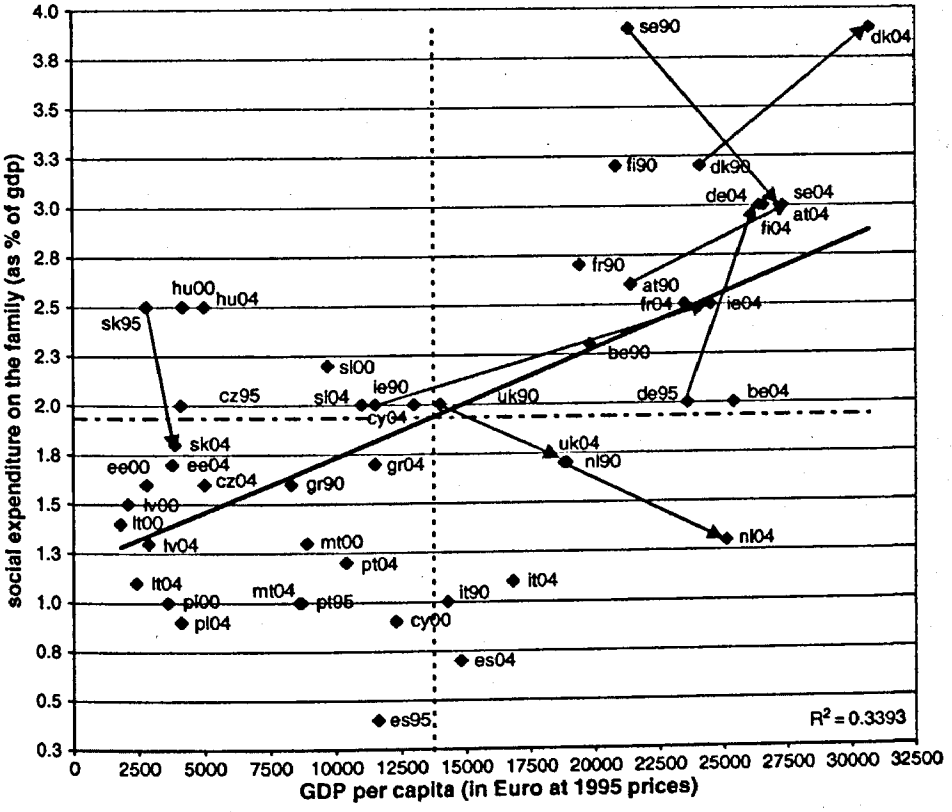


Fig. 19.12 Social expenditure on the family, Europe 1990 and 2004

Comparing total social spending on the family in Europe at two points in time, 1990 and 2004, reveals sizeable variations across countries. Generally there is a slightly positive relationship between a country's wealth and its social spending on the family. Yet one can roughly identify four different groups of countries in this respect. There are first the wealthy countries that spend a high level of their income on the family. These are the Scandinavian countries (with Denmark being on top) and the three Continental countries Austria, France and Germany. Belgium and Ireland are also close to the high family policy spenders. There are, second, a few wealthy countries with low social spending on the family: the UK, the Netherlands and also Italy and Spain, although at different levels. Less wealthy countries tend to spend less on the family, but again two different groups can be identified. The Southern European countries are generally wealthier than the former Socialist states, but they have less developed family policies. The Eastern European countries are all among the poorest EU countries, but their efforts in family policy vary. For example, Poland and Lithuania spend about 1% of the GDP on the family whereas Hungary and Slovenia spend more than 2%; Hungary's spending level is (in relative terms) in fact as high as in France.

Looking at developments over time, the general pattern has not changed significantly between 1990 and 2004, but some individual countries have "moved" a lot (as demonstrated by the arrows in Fig. 19.12). In all countries real wealth has increased, indicated by a growth in GDP per head of population (in Euro at constant prices as of 1995). But the size of this growth varies a lot. The most spectacular rise in real income occurred in Ireland which now belongs to the richest countries in Europe. Also in the Netherlands, Denmark and the UK increases in wealth have been strong. Compared to this, most Southern European countries have fallen back. Italy was surpassed by the UK and today, after the spectacular rise of Ireland, all poorer "old" EU member states are located in the South. In most Continental and Northern European countries real incomes have risen. Only France and Germany are exceptions with moderate changes between 1990 and 2004. In Eastern Europe, the development was different. After the fall of Communism these countries suffered from a strong decline in real income, but by 2004 all are on the increase, although at a modest level.

With respect to family policy one can observe different developments. In most "old" EU member states social spending on the family (measured as a percentage of the GDP) went up closely in line with the (moderate) increase in real wealth whereas in most new member states spending on family policy declined. Overall, there is no sign for a strong family policy boom in Europe since the 1990s. But there are exceptions to these trends. Denmark has increased its family policy spending strongly and has now clearly moved on top position in Europe whereas over the same period Sweden's family policy declined. Also in the UK and in the Netherlands family policy is currently on a (relative) decline despite significant increases in real income. In Germany and Austria family policy increased at a higher rate than the European mean whereas in the pioneer countries of family policy, France and Belgium, spending declined. Both Germany and Austria now have surpassed France and Belgium in family policy spending. In Germany the rise was strongest among all countries.

There is also a strong correlation between real income and the value of the average child benefit which in most countries is a core element of income policies for families (Fig. 19.13).

In 2004 the average child benefit (calculated by the average rate for the first, second and third child in a family) was highest in Germany and lowest in Poland and Greece. There is an outstanding group with high benefits including the Scandinavian countries, Ireland, Austria and Belgium, but also the UK and the Netherlands, two countries with low overall

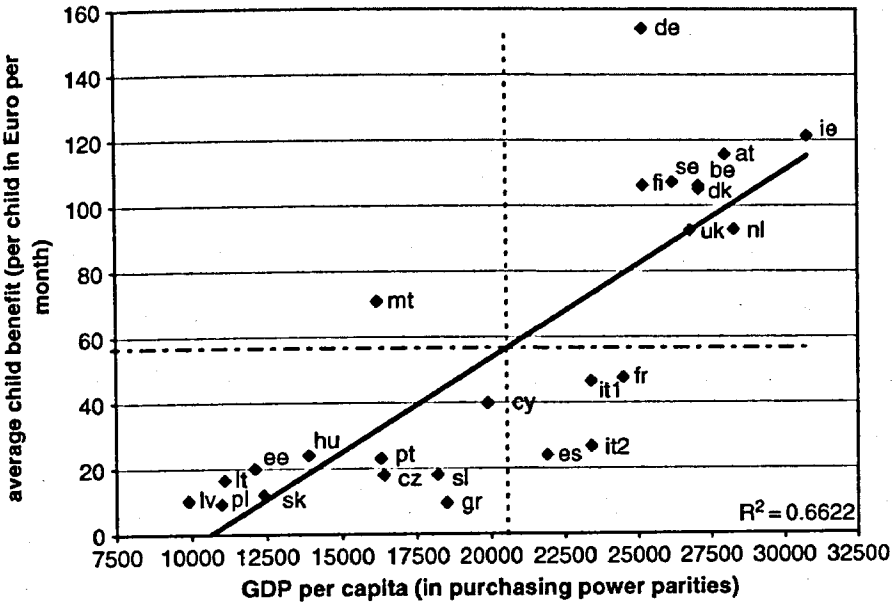


Fig. 19.13 Average child benefits, Europe 2004

spending on the family. "Real" child benefits in Eastern Europe are significantly lower, mainly due to the much lower level of national income in these countries. Yet also in Southern Europe child benefits are very modest compared to their more favourable income position. The case of France needs an explanation. France has a low average child benefit here, because it is the only European country in which the first child does not receive benefits. However, in France the biggest part of income support for families is granted through the tax system which is not included here.

Yet in childcare, France is clearly among the leading European nations (see Fig. 19.14).

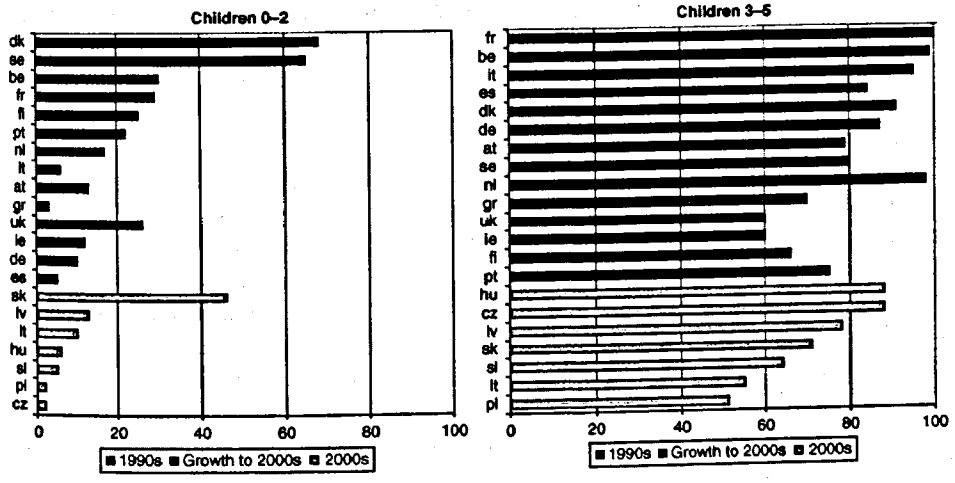


Fig. 19.14 Childcare enrolment rates, Europe 1990–2004

This is due to the long tradition of preschools that started in the 19th century (Bahle 2009). The strong competition between the liberal secular state and the Catholic Church

was a major factor for the expansion of this system, as in Belgium and other Catholic countries (Willekens 2009). Still today these countries have the highest coverage rates for children above the age of 3. The religiously mixed countries of Continental Europe and the Scandinavian countries follow behind.

Services for younger children below the age of 3 are generally less well developed. Here the Scandinavian countries, and once again France and Belgium, are the leading nations. In contrast to preschools which have been dominated by the aims of socialization and education, services for children below 3 have been closely linked to the rise of female employment. It is therefore not the position of the Church (vis-à-vis the state) which is important here, but the position of women in society. In the Scandinavian countries, but also in the French culture and society, women have had a more powerful position than in other European countries since long. The working mother in particular was not regarded with such suspicion as in many Continental European societies, in particular in German speaking nations, and in England.

In Eastern Europe the legacy of the Socialist system in which women were required to work is still visible. The Socialist countries had extensive services for children of all ages, although with some variation. After the fall of Communism, however, many of these institutions were abolished. In particular services for children below 3 declined significantly whereas the kindergarten institutions have remained more stable. It seems that during the difficult transition years with high unemployment the model of the working mother was partly replaced by the caring mother for very young children. In this sense, the Eastern European countries have come closer to the Continental European pattern, in a way returning to their historical traditions from before Communist times.

Looking at developments over time, from 1990 until the mid-2000s, one can see a mixed picture of varying growth in childcare services across Europe, with the exception of the former Socialist countries. For children 3–5 there were only minor changes since in most countries coverage rates were already high a the beginning of the period. There are only two exceptions, the Netherlands and Portugal, where services for this age group grew strongly and which at the same time saw a strong increase in female employment rates.

For the younger age group services grew strongly in most countries. In absolute terms the increase was strongest in Sweden and Denmark, the two countries that already had the most developed services at the beginning of the period. But also the UK saw a high increase in childcare facilities over the past 15 years. In relative terms the increase was also strong in Austria, Germany and Ireland, countries which had started from very low levels in the 1990s.

Though childcare services have been extended in most countries, with the exception of Eastern Europe, there was no convergence in general family policy effort and in policy patterns between European countries (Fig. 19.15).

General effort can be described by an index that includes a whole package of individual family policies, for example, income policies like child benefits, childcare services and paid parental leave. In 2004 there was only a modest positive relationship between a country's overall family policy effort and the size of the welfare state in general.

Yet one can identify different groups of countries in this figure. On the one hand there are the Scandinavian and some advanced Continental European countries (France, Austria, Germany and Belgium) which have not only a relatively large welfare state but also a strong commitment to family policy. This is the traditional group of family policy forerunners since the last century. Today Denmark is well ahead of all other countries and has probably the most developed family policy in the world. Compared to this group, the Southern European countries perform very badly in family policy. Not only in absolute

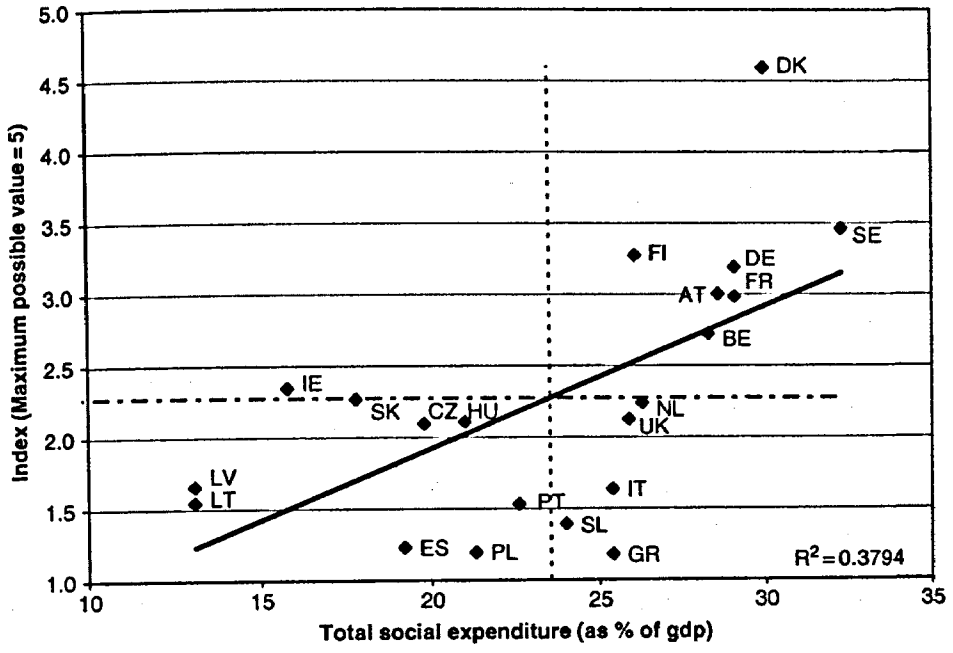


Fig. 19.15 Index of family policy, Europe 2004

terms, but even compared to the overall size of their welfare states, family policy is rudimentary. Interestingly, Slovenia, which is the most "Southern" of the former Socialist new member states, now also belongs to the Southern group whereas the other new member states have a more family-oriented welfare state. A little bit out of place in this pattern are the liberal countries UK, the Netherlands and Ireland. The UK and the Netherlands have advanced welfare states, but their family policy efforts are relatively modest. Ireland is at about the same level with respect to family policy, but has a more limited welfare state in general.

Family policies can further be characterized by different profiles. Countries with the same general "effort" may exhibit quite different forms and packages of family policies. One way to identify different family policy profiles is to compare policies supporting family income with policies aiming at a better balance of family and employment. Among the first policies would be tax deductions in favour of families and family allowances, among the latter childcare services and paid parental leave. Policies of the latter kind also tend to focus on young families in the phase of family formation whereas income policies are usually directed towards all families (see Fig. 19.16).

In Fig. 19.16 one can once more identify five country groups sharing similar family policy profiles. These groups of countries represent the five families of nations of family policies distinguished above. The first group is made up of the Scandinavian countries with a profile characterized by both high-income support and a high childcare policy index. This policy favours especially families with young children. Also France belongs to this group. A second group consists of "advanced" Continental European countries: Belgium, Austria and Germany. Here income policies are more developed than childcare policies. The UK, the Netherlands and Ireland are close to this group, but the UK and the Netherlands have less well-developed family policies in both dimensions than the other countries. On the left lower side of the figure are the Southern European countries with very weak policies in

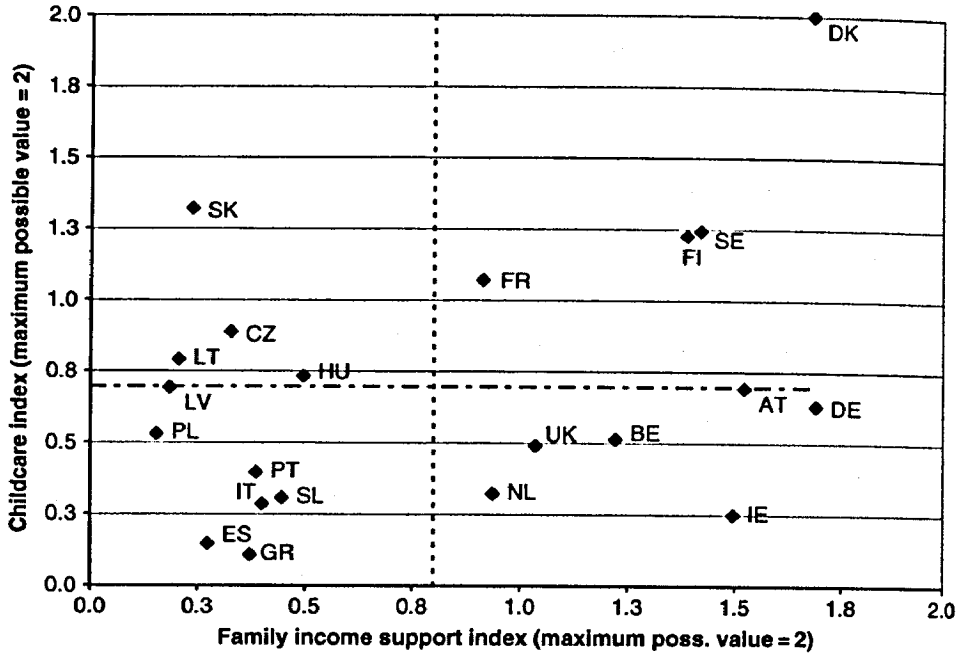


**Fig. 19.16** Family policy profile, Europe 2004

both dimensions. The former Socialist new member states have preserved a family policy profile that focuses more on childcare than on income policies.

In comparative perspective the Scandinavian policy pattern today is the most successful with persistently low child poverty rates and relatively high birth rates. This is the reason why some other European countries have partly adopted Scandinavian policies in particular with respect to childcare and the support of working families. France and Belgium did so already years ago, Britain and Germany have followed since the late 1990s. The least "successful" countries in terms of outcomes are found in Southern and Eastern Europe. In both areas, structural problems of the labour market and in welfare systems have a negative impact on the situation of families resulting in very low birth rates and high poverty among children. The major exception here is the Czech Republic which was able to keep poverty at a very low level, lower than in most Western European countries. The two Anglo-Saxon countries are characterized by high poverty rates, but also high birth rates. Yet Britain recently succeeded in lowering poverty among children significantly due to major policy changes introduced since the late 1990s. Finally, in Continental European countries both child poverty and birth rates are at a medium level within the Europe spectrum.

## 19.8 Conclusion

Although the "golden age" of welfare capitalism has undoubtedly come to an end, the welfare state has remained an integral part of the institutional structure in European societies.

In historical perspective, the "success" of the welfare state, i.e. the diffusion and adoption of its principles and core institutions and their long-term expansion in terms of

coverage and social expenditures, can be attributed to the multiple favourable effects it had on other spheres of modern societies (Kaufmann 1997, Ch. 4).

- *Economically*, welfare state institutions have rather successfully coped with major social risks of industrial societies and have contributed to improving human capital resources, for instance, by health and educational policies.
- *Socially*, the welfare state has played a major role in the (re-)distribution of "the wealth of nations" among social classes and thereby improved the living conditions of citizens on a large scale.
- *Politically*, the welfare state has contributed a lot to the mitigation of class conflicts through the institutionalization of new modes of conflict regulation and thereby increased the legitimacy of the social and political order.
- *Culturally*, the welfare state has emphasized values like social justice, social security and solidarity and has thereby contributed to the social integration of modern societies.

No doubt, since the late 1970s European welfare states are facing major challenges:

- *Demographic* challenges, arising from declining birth rates and increasing life expectancy, leading to ageing populations and demographic shifts, in particular between the economically active and non-active parts of the population, which give rise to issues of generational equity.
- *Economic* challenges, arising from declining economic growth rates and mass unemployment, accompanied by profound changes in employment patterns, which threaten to undermine the resource basis of the welfare state, in particular the established method of pay-as-you-go financing of social expenditures.
- Challenges from the *international* economy, arising from the globalization of markets and increased competition which eventually limit the feasibility of national economic and social strategies and even the political capacities of nation-states in general.
- *Social* challenges, arising from changing family patterns and life-styles which call for a better recognition of the role of private households and civil society associations in welfare production.
- *Cultural* challenges, resulting from changing value orientations and calling for a new balance between individual and collective responsibilities.

But it must also be recognized that in many countries major social policy reforms have been undertaken during the last three decades in order to meet these challenges and cope with the economic and fiscal strains on the welfare state. Although these reforms have taken different routes, they have by and large succeeded to adapt the welfare state to changing environments and conditions. If anything, one can conclude that the welfare state has relatively successfully survived its crisis.

These generalizing statements can be made, notwithstanding the variety of European welfare states. From the beginnings of modern social policy in the 19th century, different types of welfare states or welfare regimes have emerged due to different political traditions and power constellations. The development of national welfare states is characterized by a high degree of institutional continuity ("path dependency"), while at the same time allowing for expansionary trends concerning the scope of risks covered, the coverage of social groups, and benefit levels. In this sense, the European welfare states have always had to adapt to large-scale socio-economic and political changes and thus have proved to be dynamic rather than stable systems.

Despite the diversity of national welfare states, some distinctive features of European welfare states stand out when contrasting the European experience with that in other regions of the world. Therborn has aptly alluded to this aspect when calling Europe "the Scandinavia of the world" (1997). Compared with the OECD average, European welfare states are characterized by a higher degree of state interventionism and higher levels of social expenditures. All of the countries belonging to the social democratic regime type and almost all countries clustering around the conservative regime type are located in Europe, whereas most countries following the liberal regime type of welfare capitalism are found in the overseas areas of the OECD world.

Moreover, certain trends towards convergence between European welfare states can be observed. Castles (2004), for instance, has convincingly demonstrated that over the period from 1980 to 1998, the European welfare states (in different demarcations) have indeed grown more similar in terms of general government expenditure and social expenditure, in particular.[11] Convergence in institutional terms, however, is likely to proceed much more slowly, due to the inertia of established institutional arrangements and commitments.

Yet, since the 1990s, deliberate political efforts are undertaken by the European Union to forge a 'European Social Model'. The main instrument to initiate and facilitate a process of convergence of social policies among the member states is the so-called open method of co-ordination (OMC). The promising idea behind this new approach is to reach a political consensus about social policy *goals* to be achieved, but to leave the choice of instruments and strategies to the member states. Although at present the various European countries can still be grouped into different welfare regime types, the differences between them appear to be blurred. The reason is that there have been similar trends across Europe, in particular with respect to the role of the state in welfare production and distribution. In all countries one can observe the growth of mixed economies of welfare, but at different speeds and with very different mixes between public and private actors. The general trend, however, is one of less direct state involvement in welfare production. At the same time, this partial retreat of the welfare state is compensated for by more public regulation and control of "private" actors and institutions.

This can be seen foremost in pension policy where the public pillar has been limited in most countries whereas the private pillars have gained significance (see Section 19.4). This partial shift from public to private pensions does not, however, signal a fundamental retreat of the welfare state from the area of pensions, because most private pension systems are strongly regulated and often also largely financed (directly or indirectly through tax subsidies) by the state.

Also in healthcare one can observe some converging trends with respect to the role of the state. In most National Health Services systems, different forms of market mechanisms have been introduced, and in many Social Insurance systems, the regulating role of the state has been strengthened. Even in largely private insurance-based systems like Switzerland, the role of the state has become more important.[12] In particular in healthcare, complex forms of mixed economies of welfare have emerged in which the role of the state has been changed, but was not fundamentally dismantled.

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[11] Convergence has here been measured by the coefficient of variation of the respective expenditure ratios.

[12] The USA remains the big outlier among the developed industrialized nations with its mainly voluntary and incomplete private system.

Moreover, in the field of family policy (and also in social services) the welfare state has continued to expand over the past decades despite the general impression of "crisis" and retrenchment (Bahle 2008b). In these areas, the state has played a more "indirect" role from the beginning, in particular with respect to service provision. In most Continental European countries, non-profit welfare organizations rather than the state provided the majority of services. In Scandinavia and in Britain, the local communities were major providers. Thus, the mixed economy that has now emerged in the core areas of welfare state activities has always been present in these fields. Here, institutional re-formation was less dominant than the belated quantitative expansion accompanied by more public financing and control.

The evidence presented in this chapter leads to the conclusion that the development of European welfare states is characterized by great stability and a process of consolidation rather than decline or even breakdown. While there has undoubtedly been retrenchment and dismantling in some fields, others have expanded. Even in those policy areas from which the state has partially retreated as a direct welfare provider, increased private provision has been combined with more state regulation and control. Though the welfare state has altered its mechanisms and institutional features, the basic idea of politically regulating the social sphere has not been abandoned. The welfare state thereby maintains a flexible stability in which institutional arrangements have shown remarkable adaptive capabilities while the core principles of the welfare state have been maintained. The future character of the welfare state will certainly continue to be a contested issue, but there will be a future (to the) welfare state.

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