

# RECON Online Working Paper 2010/20

## Social Models in the Enlarged EU

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RECON Online Working Paper 2010/20  
October 2010

URL: [www.reconproject.eu/projectweb/portalproject/RECONWorkingPapers.html](http://www.reconproject.eu/projectweb/portalproject/RECONWorkingPapers.html)

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RECON Online Working Paper Series | ISSN 1504-6907

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Issued by ARENA  
Centre for European Studies  
University of Oslo  
P.O.Box 1143 Blindern | 0318 Oslo | Norway  
Tel: +47 22 85 87 00 | Fax +47 22 85 87 10  
[www.arena.uio.no](http://www.arena.uio.no)

## **Abstract**

This paper considers the impact of the developments of the last 20 years on the nature of social models in the EU as categorized by the traditional Anglo-Saxon, Continental, Nordic and Southern regimes. It looks in particular at the impact of enlargement, globalisation and the pressures within the EU for harmonisation. In order to consider whether the addition of the new member states constitutes a further separate model it looks at the case of healthcare in Poland, the Czech Republic and Estonia. The conclusion is that neat categorisation is becoming increasingly difficult as countries adopt characteristics of other regimes and develop different parts of the social welfare system in different ways. While there is some element of increasing similarity, distinct regimes continue and it would not be realistic to talk about a single European social model in further research on the implications for democracy in the framework of the RECON project.

## **Keywords**

Czech Republic – Estonia – Health Policy – Poland – Social Policy – Welfare State



## Introduction

The purpose of this paper is to explore the way in which the developments of the last decade have altered the nature of the structure of European welfare systems. Up until recently it was accepted that welfare systems in the European Union (EU) could be characterised under four general headings: 'Anglo-Saxon', 'Continental', 'Scandinavian' and 'Southern' (Muffels et al. 2002; Sapir 2006), although the exact titles and countries included varied among studies.<sup>1</sup> The characteristics can readily be summarised under what is described as the 'welfare triangle' (see Figure 1). However, this neatness is being disturbed by three main factors.

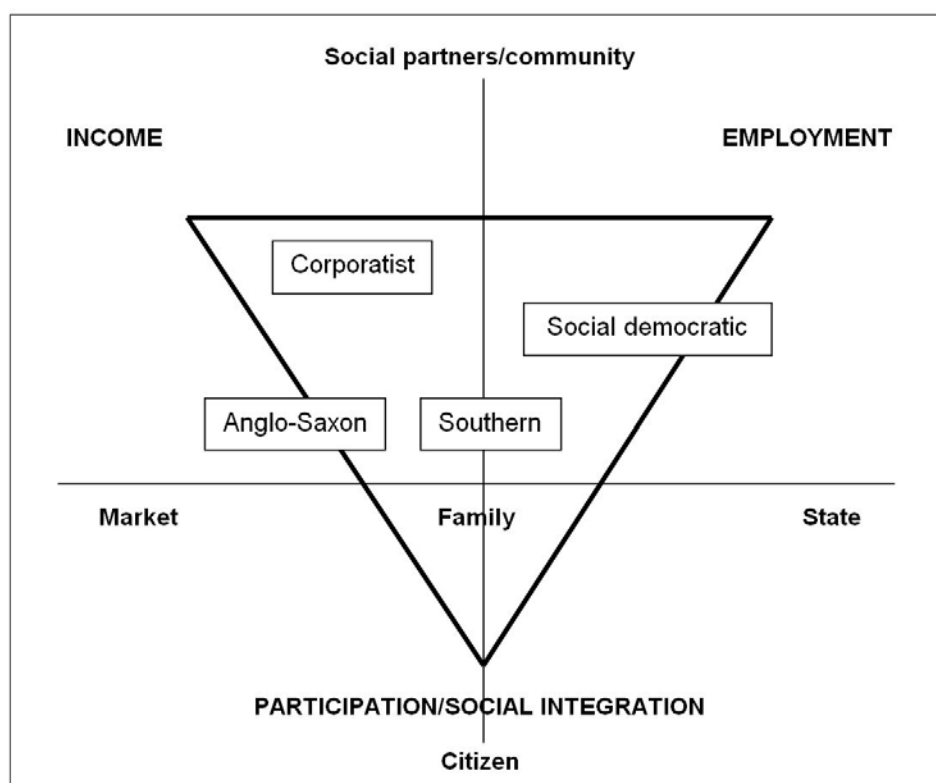


Figure 1: Welfare regimes and the welfare triangle.  
Source: the model is adapted from Muffels et al. 2002.

Most obviously there are 12 new member states, drawn primarily from Central and Eastern Europe, which might be thought to offer a fifth social model of their own. Second, welfare regimes have been subjected to the forces of globalisation and integration. Indeed, the EU has been encouraging a process of mutual learning through the Open Method of Coordination (OMC) that applies in this area, which has been a contribution to countries adopting some of the better ideas from the neighbours and hence blurring the boundaries. Last, as pointed out by Schelkle (2008), welfare systems are not homogeneous. Countries do not necessarily approach

\* The authors are grateful for the constructive comments from Agustin Menendez, Anna Michalski and Cris Shore.

<sup>1</sup> Arts and Gelissen (2002) provide a very helpful survey of the different studies that have been made since the original Esping-Andersen (1990) book on the issue and tabulate the various suggestions. Most opt for four regimes, with some remaining with three including Esping-Andersen himself and one suggesting five. However, the nature of the fourth regime differs quite a lot and in several cases is not equivalent in any sense to the Southern or Mediterranean regime, so five remains a possible set.

education and health in the same way that they approach employment, disability or old age. There is variety even within the provision of public services, such as libraries, transport and public open spaces in a single country. The relevance of the four model classification thus seems to be weakening.

It is therefore necessary to provide a reassessment of the position. It is not the purpose of this paper to provide a definitive reclassification but to ensure that the range of current approaches is clear. This paper is a contribution to the RECON project, which is investigating the implications of the whole range of public policy for the likely forms of democracy that may exist in the EU in the future.<sup>3</sup> Hence it seeks to set out the range of welfare regimes that need to be evaluated against the three models of democracy in RECON: a return to a more national basis for democracy; a move towards the supranational level; and the development of multi-level or 'cosmopolitan' democracy.

The paper is in three main parts. The first spells out the issues in more detail and the empirical approach that is employed. The second looks at a set of case studies for healthcare in Estonia, the Czech Republic and Poland, while the third sets out the implications for an assessment of the consequences for democratic processes in the EU.

## **The evolution of European welfare regimes**

### **A categorisation of welfare regimes**

There are many ways of categorising welfare schemes but a simple and a widely used example is the welfare triangle shown in Figure 1. The key element of this triangle is to establish what the principal objective of welfare is. The main choice has been over whether the system should seek to assist people to have employment or whether it should try to make sure simply that they have adequate minimum incomes to get by irrespective of whether they can find employment. Of course in practice no regime is at the extreme. Those countries that focus rather more on income support nevertheless are keen to see that people are employed, as this is essential to the viability of the scheme – people have to be earning and paying in. In the same way those schemes that are strongly weighted towards employment nevertheless have to handle those who are unable to work. The dichotomy can thus be readily exaggerated. It is also important to recognise that these classifications reflect the balance of the regime and are not a simple quantification of how much effort<sup>4</sup> is going in any dimension nor indeed on the extent of the result – whether or not the result of public sector intervention.<sup>5</sup> The role of the state in the economy in terms of taxation and expenditure is greater in the UK than it is in Germany for example. Arts and

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<sup>3</sup> Social welfare is an inherently interesting topic in this regard as many of the main pressures on it come from the process of integration in the EU yet the policy area remains a national responsibility (Scharpf 2002). However, the powers that the member states have for exercising this responsibility have been eroded (Scharpf 2010).

<sup>4</sup> Interestingly the Anglo-Saxon literature on the subject tends to concentrate on 'how much' while the Continental literature tends to focus on 'how' (Arts and Gelissen 2002).

<sup>5</sup> Indeed it is important to recognise that where norms are widely shared in society there is little need for state intervention to ensure that they are followed.

Gelissen (2002: 137) conclude from a thorough survey of the literature 'that real welfare states are hardly ever pure types and are usually hybrid cases'. This does not devalue the usefulness of the classification, if only for heuristic purposes. Indeed Esping-Andersen (1997) argues that creation of these 'idealised' welfare types is more helpful to understanding if the actual states are more hybridised.<sup>6</sup>

The third principal objective set out in the figure is broader, namely the ability to participate and be fully included in society rather than simply to be in work or with sufficient income to avoid poverty. This approach focuses more strongly on 'capabilities', concentrating on the ability of people to perform a full role in society. Thus social welfare is thought of in much wider terms of social inclusion, going beyond having an adequate income and employment. Such inclusion is particularly important for minority groups and immigrants.

The traditional characterisation of the four main regimes identified in Europe is also set out in Figure 1. The development of these types of regimes is ascribed to Esping-Andersen (1990) although he delineated only three regimes, the fourth, southern, regime being suggested by Liebfried (1992), Ferrera (1996) and Bonoli (1997). The general membership of the regimes is clear from the names. The Northern continental regimes belong to the corporatist/continental group, typified by Germany; the Nordic countries belong to the Nordic/social democratic regimes, the southern European countries to the Southern/Mediterranean regime and the UK and Ireland to the Anglo-Saxon regime (i.e. it is not a description of ethnic origin). In so far as there is a clear characterisation, the corporatist/continental regimes emphasise income replacement in the event of difficulty, reflecting their insurance base, whereas the social democratic/Nordic regimes emphasise employment.<sup>7</sup> There is thus more emphasis on trying to get people back into jobs in these regimes. A crucial fact here, for example, is the treatment of childcare. In the Nordic regimes it is thought important that both parents should be able to remain in full-time work as far as possible. Therefore there is a strong emphasis on the provision of childcare and kindergartens rather than the provision of assistance to enable one parent, or indeed both on a shared basis, if we consider the case of the Netherlands, to remain at home to look after the young children.

The social democratic regimes also place more emphasis on the inclusion of the individual/household in society than their corporatist counterpart. The Anglo-Saxon and Southern regimes both put more emphasis on a range of objectives, although the Anglo-Saxon regimes have a heavier emphasis on income preservation. However, it must be stressed that this characterisation represents the view of Muffels and

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<sup>6</sup> It is important to recall that Esping-Andersen (1990) does not cover all aspects of what are these days considered to be policies related to social welfare and hence some of the excluded areas do not fit well into his classification (Gough 2000).

<sup>7</sup> Arts and Gelissen (2002) suggest that the Esping-Andersen analysis uses a simple two dimensional classification according to 'commodification' (the degree to which a service is provided as a right) and 'social stratification' (the degree to which equalisation is promoted). If one divides each of these dimensions into 'high' and 'low' then this will give four and not three categories and hence a discussion of what might fill the missing box. Castles and Mitchell (1993) suggest that the Antipodean countries might form this fourth case as they combine a liberal regime with a culture of equality.

Tsakoglou (2002). Others held somewhat different views about the positioning<sup>8</sup> and, as the next section discusses, these positions have clearly changed since then.<sup>9</sup> One caution, for example, is that the UK system has been much more effective than its continental counterparts in maintaining employment and avoiding long-term unemployment. This must question where the balance of policy actually lies and something nearer the centre might make more sense.

A second problem is that the simple characterisation into a triangle does not reflect the nature of the differences fully. The figure shows a second overlay of where the responsibility lies for achieving the outcomes, represented by the horizontal and vertical axes bisecting the figure. On the horizontal dimension the balance between market and state is set out whereas on the vertical the balance is between responsibility of the individual and responsibility at a more aggregate level, represented by the social partners in the extreme or perhaps a wider view of society, which might be the case in a more tribal environment for example.<sup>10</sup> So, if the emphasis is on market solutions it is essential for the state to ensure that markets operate well, hence the emphasis in policy will be on trying to make sure that all participants are well informed and that transaction costs are low with vibrant competition so that it is easier to find a new job, that opportunities exist for working different numbers of hours, for a range of skills, etc. Where families are important, more of the solution is expected to be internal. This is particularly important in a regime based on insurance. In an individualistic environment each person has to arrange their own insurance. This inevitably involves a more intrusive system as a larger proportion will be exposed to a particular shock, their resources for handling such shocks will be more limited and external mechanisms will be required. Within an (extended) family arrangement there is already more opportunity for risk sharing.<sup>11</sup> Liebfried (1992) suggests that one of the characterising features of the Southern 'Latin Rim' countries is the lack of any clear concept of acceptable minima or a right to welfare. While this is not a description of present practice, the minima which now exist seem rather easier to roll back in hard times than those in the Continental or Nordic regimes.

## The evolution of welfare regimes in recent years

There is considerable debate about the degree to which countries belonged to the four types of welfare regime described in the previous section even at the beginning of the 1990s when the concepts were being promulgated. Since then there have been clear

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<sup>8</sup> The European Commission (2000: 6) has as one of its main conclusions that 'the standard (Esping-Andersen) paradigm for comparative analysis of social models needs review if it is to retain its usefulness for guiding policy development in contemporary Europe'.

<sup>9</sup> In 1997 the structure of the system in the UK reflected over 17 years of rule by the Conservative party, whereas by late 2009 it reflects over 12 consecutive years of Labour party rule.

<sup>10</sup> In the New Zealand case, for example, one might distinguish between the traditional responsibility of the individual *whanau* or extended families compared with the larger concept of *iwi*, which has achieved more political importance in recent years as governments have sort to get agreement on a broader scale across Maori.

<sup>11</sup> It is surprising (to the authors at any rate) how much countries differ in their willingness to share family risks. In the United States, for example, the family is a common source of finance for small scale enterprise, whereas this is less common in some European countries where banks will normally be the prime lender. It is not clear that this difference stems from experience in risk exposure or clear differences in risk appetite.



changes in regimes. Muffels and Fouarge (2002) argue for example that the Netherlands has moved from being in the corporatist/continental group to adopt many of the characteristics of the social democratic and liberal/Anglo-Saxon groups, with its adoption of active labour market policies and a strong move towards getting people into employment and off welfare. Dependency ratios among people of normal working age in the Netherlands had reached the position by the late 1980s that the system was unsustainable.

This move away from passive regimes and a much stronger requirement on people to seek work and reskill has also characterised the Nordic group and such ideas that would once have been attributed largely to the 'liberal' group are becoming universal. Esping-Andersen (1996) himself is rather reluctant to admit that these changes represent a shift from one category to another as he places a strong weight on history in defining the general approach. Thus adopting some 'liberal' approaches in some areas does not make the Nordic countries any less 'Nordic'.

Perhaps the concept that typifies the change is 'Flexicurity' (Madsen 2008; Wilthagen 2008). This concept, promoted particularly in Denmark and the Netherlands, but adopted more generally, seeks to draw a distinction between offering people security in a particular job as opposed to offering them the security of having *a* job, albeit one that may change quite frequently. It thus seeks to encourage flexible labour markets, where firms can adjust rapidly to new opportunities and new firms with innovations can enter and older firms that have become uncompetitive can exit at relatively low cost, thereby leading to a faster rate of economic growth. However, at the same time it seeks to ensure that the individual employee can move smoothly from one job to another and not endure extended periods of unemployment between jobs. In practice most job changes occur without unemployment. Indeed people leave before they are fired or made redundant.

Making this happen requires good information in the labour market about opportunities, a cutting of the search costs for new jobs, increasing the ability of families to move to new locations (which also involves a framework for replacing the social capital lost in such moves)<sup>12</sup> and providing ready opportunities for reskilling. It also requires good incentives for people to find new jobs and skills and avoid unemployment. Thus this is a mixture of the market approach favoured by the liberal regimes and the employment focus of the social democratic regimes.<sup>13</sup> However, it does not necessarily imply that all parts of the welfare system have changed in the same way, education and pensions may be treated differently for example. The EU has now adopted the ideas of flexicurity explicitly (Wilthagen 2008), becoming part of the European Employment Strategy in late 2007, which is bound to encourage social policy in all of the member states to show more of these characteristics.

Muffels and Fouarge (2002) also argue that it is probably not appropriate to treat Italy as a single country. Southern Italy is clearly in the 'southern' cluster but Northern Italy might be better described as being part of the corporatist cluster, much more akin to France for example.

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<sup>12</sup> The collapse in house prices in a number of countries in the present crisis inhibits movement when a household has negative or near negative equity.

<sup>13</sup> The generosity of the unemployment benefit and its terms might be the only distinguishing feature between a social democratic and an Anglo-Saxon regime following this approach.

Much of the driving force for these changes has come through the EU itself, although each individual country, whether inside the EU or not, faces similar challenges. Not only has the whole process of opening up markets increased competition but the EU actively encourages policy-learning among its members. In the field of social policy, the principal process is through the Open Method of Coordination (Hodson and Maher 2001).<sup>14</sup> Under the OMC, the member states, with the assistance of the Commission, determine a series of objectives that are desirable in each field and share experience on best practice.<sup>15</sup> The Commission monitors progress, although there is a substantial element of self-assessment. Although initially annual, a longer-term view and review are now taken. While there is no compulsion for uniformity and a variety of ways of achieving any given objective, such an arrangement is bound to encourage a measure of convergence. The actual convergence may be exaggerated by the measured degree of convergence as this tends to list measures applied rather than an evaluation of what is achieved by them. Nevertheless because the member states are compared there will inevitably be peer pressure to act and to improve performance.

Social policy also forms part of the Lisbon Agenda and as such is associated with the achievement of a structure that will encourage an increase in productivity. Schelkle (2008) argues that, despite these factors leading to common features, the national systems are likely to retain strong elements of their own simply because of the forces of history and how embedded their particular approaches are. However, she goes on to point out that the components of welfare systems need to be considered rather than trying to label the systems as a whole because each of these components is not necessarily dealt with in the same way. She suggests that there are three common features to European social models in that they address encouraging productivity, income maintenance and basic security through some form of Beveridge style, generalised insurance. Nevertheless, since these dimensions can pull in different directions, a country has to decide on their balance. It cannot simply try to improve in all three dimensions in the light of the contradictions. In a detailed assessment of the Dutch social security system, Bannink and Hoogenboom (2007) show that policies can be assigned to all four welfare models as providing the best description even within narrow categories such as disability or old age. They argue that such different approaches are inherent as the 'risks' involved are different. The provision of libraries or sports halls does not face the same concerns as child care or old age pensions. These characteristics are at the heart of whether universality or selectivity should be applied to a particular service.

As the EU has opened itself up internally and externally, social welfare regimes have come under pressure. Sapir (2006) argues that some regimes are *prima facie* unsustainable in a competitive environment whereas others are not. He uses a simple two-way classification according to efficiency and equity shown in Figure 2 that implies that the regimes that are associated with inefficiency will have to change. (The regimes that are currently efficient may also need to keep evolving to maintain that efficiency.) Thus, in his view it is the Continental and Mediterranean regimes that need to change. The former because the nature of its labour laws make its labour markets inflexible and reduce the sustainable growth rate and in the latter case the

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<sup>14</sup> Social policy was taken into the open method as a result of the agreement in the Lisbon Council of 2000 – it covers, in particular, actions to eradicate poverty and to tackle social exclusion.

<sup>15</sup> Within the social area the OMC has focused on four areas: full employment, social inclusion, pensions, health and long-term care (Henstenberg 2009).

inflexibility has a wider cause across the public sector. Hence it is not equity per se that matters, that choice is still available to the European countries, but having an efficient system that can cope with the demands of a competitive market. The Anglo-Saxon regime puts more emphasis on allowing market forces to operate in the welfare field than does the Nordic regime, where the state has a much stronger role to play. That choice is therefore also open.

Whether one agrees with Sapir's particular characterisation or not, it is clear that market pressures have led to the evolution of welfare regimes, particularly with regard to labour markets. What is more difficult to argue is the degree to which there is an implication for the size of the public sector. Using the example of 22 countries in the Organisation for Economic Co-operation and Development (OECD), Mayes and Viren (2002) suggests that there is some prima facie evidence that, beyond a certain point, an increasing share of the public sector in the economy has a detrimental effect on overall output. Furthermore the evidence suggests that most of the old member states are beyond that point (whereas as most of the new member states are not [yet]).

		Efficiency	
		Low	High
Equity	High	Continental	Nordic
	Low	Mediterranean	Anglo-Saxon

Figure 2: The sustainability of welfare regimes.

Source: Sapir 2006.

However, the observance of this relationship does not in itself imply any particular causation and hence third factors could be at work, contributing to the finding. There is no need for us to enter this controversial debate or form a view of the validity of concepts, such as the Laffer curve, but the pressure that governments feel from these problems and indeed the disquiet that lenders feel and hence the price they impose on increasing debt beyond a certain point are tangible influences on social policy.

The recent financial crisis has added new problems for social welfare systems from two directions. The first is simply that like any adverse shock to the economy, it puts strain on social welfare systems as incomes fall and the demands on the systems rise. This creates the normal dilemma of how far this difficulty should be borne by the present generation and how much by the future. In a properly designed system the answer should be future generations because the system is balanced (normally around a growth path). Adverse shocks today will be offset by favourable shocks tomorrow and a cushion will be available today from previous surpluses. Finland is a case in point. Despite having an adverse shock in 1992-95, worse than the 1929 depression in terms of loss of GDP, it had returned to a sustainable position within 10 years and hence can weather a shock which is larger than that in most EU countries. Regrettably this is not true of most member states whose welfare systems have been based on optimistic views of growth rates and an absence of severe shocks.

The more direct impact of the financial crisis for several countries has been that it has placed a major demand on public finances that was not planned for. Someone has to pay. It could be relatively neutral for the welfare system if both the current and future

extra revenues are extracted from those who are not and do not become increased beneficiaries from the system. Where the effects have been dramatic, as in the UK, Latvia, Ireland, etc., this outcome is unlikely. While pensions and other insurance systems, including health and unemployment, can be self-financing, a substantial proportion of public services will be financed through taxation rather than through direct revenues in the form of user charges. Hence the problem cannot be avoided, although its incidence will vary considerably according to the structure of the regime.

The problem of sustainability in welfare systems is thus accentuated and brought forward in many countries but not changed in its fundamental nature. Thus the impact of recent events is likely to increase the pace of evolution of welfare systems and existing characterisations of systems within the welfare triangle will become increasingly outdated. There is no obvious way this representation can be turned into a dynamic framework but the present concerns are clearly dynamic in character and the question is how well they can cope with shocks.

In her study of the changes in social welfare systems in the UK, Germany, Sweden and Greece in recent years, Schelkle (2008) suggests that while there has been increasing communality in trying to focus on structures that benefit the productivity and hence the standard of living of society, the member states have gone about it in clearly different ways. Thus we can avoid getting into discussions about what constitutes the 'European Social Model'. Such classifications as do exist tend to describe a very broad model and are primarily concerned to set out what features distinguish European models from that in the US.<sup>16</sup> Classifying the UK and the US as both being 'liberal' regimes as in Esping-Andersen (1990) puts two very different approaches in the same basket – one only has to think about US complaints about 'socialised medicine' in the UK to realise the extent of the difference.

### **The new member states**

The welfare regimes for the 'old' member states were mainly long-standing. However, the collapse of the Soviet Union, and along with it the political and economic structures in the rest of the Council for Mutual Economic Assistance (CMEA), meant that new social welfare systems had to be built. By and large the physical infrastructure and skills for the operation of such systems still existed and in some cases were more pervasive than in some OECD countries but the financing framework did not. Hence those based entirely on financing, such as pensions, got into serious difficulty immediately as the source of funding dried up and inflation eroded the value of what could be paid. In areas such as health care the infrastructure in the form of hospitals and their staff remained in place but deteriorated rapidly as it became difficult to keep them in good condition, pay the staff, provide the necessary materials, medicines, etc. and cope with the exit of those whose skills were much more valuable abroad. Education faced similar challenges. The basic systems were good, especially in encouraging the talented, but they faced attrition.

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<sup>16</sup> Golinowska et al. (2009: 15-16) offer a typical description of the characteristics of such a European model: (1) simultaneous and proportional economic and social development; (2) emphasis on innovation and a knowledge based economy; (3) active employment policy; (4) decent and equalised living standards; (5) common values: equality, solidarity, subsidiarity; (6) social dialogue and social participation (7) social inclusion, and (8) the significant role of state social policy. Some countries clearly match this better than others and in many respects it is an aspiration rather than a description.

At the same time it was necessary to refocus the systems to a market economy. Many of the state enterprises in which people had been employed disappeared; the way the labour market operated changed. Thus the route of financing many operations changed as they could not be financed by the sale of goods and services but through taxation. Setting up such a system was not easy and yields were initially low. The position in Poland was particularly difficult where by the end of the 1990s only half of the population of working age were in employment (Golinowska 2009) and by 2002 20 per cent were unemployed – all this despite the significant emigration of the workforce. The consequence was that although new, well structured systems could be designed their scale could only be modest initially. However, it was also thought that the transition process would be less demanding initially and hence many schemes were over ambitious. The new schemes were therefore subject to revision, especially after the Russian crisis and default which provided a major adverse shock to what was a relatively fragile recovery. It is thus not until the turn of the century that more enduring schemes could be seen. The loss of a decade meant that in effect many systems were being operated as if there were little history.

As a result many of the new welfare systems in the new member states have characteristics that are rather different from those in the group they joined. A simple example is the nature of the tax system. Flat income taxes at relatively low rates have proved relatively popular as these tend to get both good compliance and provide strong incentives to work, work longer and seek better jobs as much of the benefits of higher pay are retained by the earner. At the same time this results in a strong element of contributions to social insurance also being income related. Not surprisingly therefore education is seen by many as a corner stone in the system providing both human capital and social justice (Henstenberg 2009).

The new member states thus have welfare systems that are in many respects different from those of the older member states. It is not obvious that they should be classified together as a single group as, just as in the old member states, there is considerable variety. Simply because of the lack of income and newness the systems will provide more limited benefits than their old member state counterparts, except where the infrastructure continues to operate as it has in areas of education.

The older member states have gone through two main phases. State provided welfare systems were introduced because existing privately provided systems, whether on a user pays or a charitable basis were thought inadequate. In some areas, such as education and healthcare, they largely supplanted the private sector system. As time has gone by, both the demand for these services and the ability to pay for them has increased to the extent that private provision has grown again. In the transition countries the problem has been different. There has been an urgent need for the services in a period when the state was unable to provide properly. Thus shadow systems have grown up. Where there are skilled personnel eager to work and be paid they are happy to provide some level of service outside the official system. In the older member states the problem is that the best (and more entrepreneurial) can be bid away from the state sector.

The market is becoming increasingly international, in part because of the deliberate efforts of the EU to make freedom of movement of labour and services a reality. Thus skilled people move from the lower income countries. While some of the movement is clearly temporary – moving without families and remitting as much of their income

home as they can before returning when they can afford the lifestyle they want – movement of the skilled may often be more permanent as they can afford to bring their families with them.

It is thus important to differentiate the provision of services through the public sector from the provision of income support, whether in the form of benefits for the young, disabled, sick and unemployed or in pensions for those who are beyond what is regarded as normal working age. Transfers, whether among individuals or across time, can be more directly financed. However, the transition economies faced exactly the same problem as the older member states in that at the time they introduced the schemes it was not possible for many of those in need to build up their own resources. This pushes countries towards a pay as you go system, where the current contributions go towards the financing of others' current expenditures rather than the building up of funds that can be used to support the individual's own future needs. The latter such schemes are essentially compulsory saving.<sup>17</sup> However, the system will nevertheless be described as insurance as the expectation is that future incomes will meet future claims.

Several countries have introduced 'two pillar' systems where the first pillar is pay as you go (PAYG) with a strong element of state funding to provide minimum levels of benefit to those who are unable to make contributions themselves, such as the disabled and those who are already retired. The second, funded pillar will rise in increasing importance until all the working population are full members – in many cases this will not be for another 30 years. The evolution of the system in Poland, paid for by employer contributions, is of particular interest (Erdmann 1998). Initially the old system continued, with a rise in social benefits as a proportion of GDP. This was then replaced by a new and less generous universal system, to which employees also contributed, which sought to provide such benefits on an affordable basis,<sup>18</sup> before the second funded pillar could be added as incomes rose far enough to make it plausible.

It thus appears that there are two characteristics to the social welfare regimes in the new member states that are of particular relevance to the present analysis. First, while the regimes in these states have many similar features as a result of the common problems that they faced, they also have many differences. Second, these regimes run across the existing four group classification of the old member states. While some may be near enough to one or other model many cannot well be classified as belonging to any specific group. The case of Poland, as described by Golinowska (2009; see Table 1), has elements of three of the four regimes. According to Golinowska, Ksiezopolski (2004) labels this a 'paternalistic-market hybrid'.

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<sup>17</sup> There are limits even within these systems to the degree in which the future income can be assured, as the beneficiary can always borrow against that future income stream if they can find a willing lender.

<sup>18</sup> The contribution rate to cover this was approximately 50 per cent, a much higher burden than in most other countries.

Table 1: The Position of Poland according the features of the Esping-Andersen welfare state regimes

Welfare state regimes	Decommodification	Defamilisation	Private-public mix	Social ties and social capital	Inequalities
<i>Liberal</i>	X				X
<i>Conservative</i>		X			
<i>Social democratic</i>					
<i>Southern European</i>			X	X	

Thus it is not really so that the new member states form a coherent fifth model that should be added to the existing four but that the changes among the older member states and the variety of the new member states mean that the neatness of classification is breaking down. While there has been some convergence, it is not at present reasonable to suggest that the four models can be replaced by a generic European model, of which the 27 member states have various varieties. The position is simply more complex with a degree of cross fertilisation. One irony, noted by Golinowska et al. (2009), is that non-governmental institutions are usually not very well developed in the new member states and hence collective action has to be more state based than in the older member states.

## Some examples from health care systems

Health care systems in the new member states have had to undergo major changes in structure - 'Big R' reforms in the terminology of Berman and Bossert (2000). We illustrate what this implies by taking the cases of Poland, the Czech Republic and Estonia, which between them cover large, medium and small-sized countries. However, our choice of countries is in part driven by the availability of the data. While these countries have clearly different systems, they faced a common problem and each of the solutions has many common features, which help illustrate how the new member states have welfare characteristics which make them have a place of their own in the welfare triangle rather than obviously joining one or other of the pre-existing groups.

### Poland

In the communist era, Poland's state system was highly centralised with a welfare system that provided a uniform framework. There was little scope for tailoring the system at the local level for individual's needs and priorities. Following the collapse of that regime, Poland underwent massive reforms of the state that covered public administration, the judicial system, education, social insurance and security, and the welfare system. The Polish pension system is primarily based on defined contributions, where both employees and employers contribute 16.26 per cent of salary divided 9.76 per cent and 6.5 per cent between a pension scheme and a social

insurance scheme for disability and survivor benefits. This is subject to minimum pensions, where any shortfall (based on contributions) is paid by the state. The schemes are not funded and work on a PAYG basis. However, this has been subject to the introduction of an additional new, funded pension scheme in 1999, voluntary for those between 30 and 50 years of age and compulsory for those workers 30 years and under at the date of its introduction. The resulting system with its two components is similar to that which was introduced in Sweden in the 1990s (somewhat contradicting the precepts of the traditional Scandinavian model). The funds are held in some 15 different private funds (originally 21 when the scheme was introduced but the three largest have 55 per cent of the total between them (Wiktorow 2007)).

In general terms, the current Polish public health care system follows the model of universal provision but attempting to produce an element of choice for the individual and competition among providers. The system in many respects resembles those in the UK and New Zealand for example.

Poland initiated its health care reforms effectively on 1 January 1999. The previous health care system suffered from lack of financing, bureaucracy and centralised administration and low rewards for medical personnel (Regulski 1999). Poland also suffered from a growing 'grey market', reflecting the expanding distance between the need for medical services and the actual possibility of getting the service through the public system (*ibid.*). The initial development of the new regime reflected clear differences of view among the political parties. Health care reforms in 1990, immediately after the collapse of the communist regime, were mostly crafted by the minority social democratic wing of the liberal party – the Freedom Union (UW). The liberals' 1992-93 reform proposal included establishing regional health care bodies responsible for financing and planning, contracting with regional health care providers, restricting privatisation of health care providers, and combining hospital and ambulance care. Solidarity, on the other hand, proposed greater roles of small independent insurance institutions, privatisation of health care providers and decision-making empowerment of physicians and a clear separation between hospital services and the ambulance service (Bossert and Wlodarczyk 2000). Solidarity's proposals were supported by the post-Communist and peasant parties. However, when the post-Communist and peasant parties won the election in 1993, they implemented the liberals' proposals but introduced market competition and de-emphasised the integration of hospital and ambulatory care provision. The Solidarity-liberals coalition, which won the 1997 election, rejected the acts passed by the previous government and adopted health care reforms plans much closer to the ones they suggested in 1992-93. The health care system after the 1997 election still reflected the liberals' proposals because of the intervention of the then liberal finance minister, Leszek Balcerowicz. Solidarity's proposed fully independent health care funds were predicted to lead to state debts and the government resorted to establishing large regional health care institutions, instead of small independent ones. The regional institutions have no powers over funds and premium collections. Funds were transferred to these regional health care funds through the state's social insurance system. Doctors and physicians did not possess bargaining mechanisms with the Funds and fee-for-service. The boards of the Funds were assigned by regional assemblies rather than general election, which was what were initially proposed. In summary, the Solidarity government deviated from the initial reform initiatives. The 1999 reform resulted in 16 regional insurance funds and one overlooking insurance



funds for uniformed services. The 2004 reform exercise in the country established the National Health Fund, with 16 regional departments.

### The increasing role of private health care providers

Poland's health care system before the 1990 reforms was defined by highly centralised and hierarchical administrative bureaucracy (McMenanim and Timonen 2002). Market mechanisms were introduced into the health care system in the 1990 reform plan to try to ensure increased quality and efficiency in the national health care services. The increasing role of private sector health care providers was intended to create market competition between health care providers and, in turn, improve the quality of health care services. Some private hospitals were set up in combination with public and black market practices (*ibid.*). Rising direct payments in health care, primarily to private healthcare providers in Poland after the fall of the Berlin Wall, were linked to the health care reforms in the country (Maarse 2006). The private health care providers are thought to be more able to provide rapid and better health care services, compared to public ones.

The number of private health care providers increased rapidly over the reform period. Tyszko et al. (2007) report that no private outpatient health care institutions existed prior to 1999 in neither urban nor rural Poland. In 1999, 2248 non-public outpatient clinics emerged (2047 in urban areas and only 201 in rural areas). By 2005, the number of non-public outpatient clinics increased to 9015 (7151 in urban areas and 1864 in rural areas, a 75 per cent increase over the 1999 to 2005 period. A similar trend was observed for non-public medical practices in the urban and rural areas. The current trend within the health care provision is to combine private practices with part-time public sector employment (Maarse 2006) so that both institutions and individuals provide a combination of privately and publicly funded services. Privatisation of hospitals, on the other hand, was not as rapid as for outpatient clinics. In 1995, there were only nine private hospitals, 0.07 per cent of the total number of hospitals in the country. The number increased to 72 in 2003, and 147 in 2004 (Tyszko et al. 2007). However, the emergence of private health care providers in Poland should more accurately be defined as the re-introduction or reconstruction of the practice, rather than a novel incident. Private health care providers existed during the pre-Communist period in the country until such practices were banished when the Semashko-type of health care system<sup>19</sup> was introduced. Nonetheless, the re-emergence of private health care providers in Poland can be considered as demand-led privatisation.<sup>20</sup>

### Financing and funding

The first aspect of the health care system to be reformed was the financing methods. State ownership of hospitals and other medical institutions was also abolished, except for teaching medical institutions. Under the first insurance bill, employees paid a contribution rate of 10 to 11 per cent. In 1998, the contribution rate was reduced to 7.5

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<sup>19</sup> Nikolai Aleksandrovich Semashko (1874-1949) was a medical doctor and a politician, The Semashko-type of health care system was introduced in the Central and Eastern European and Commonwealth of Independent States (CIS) countries after the second world war, and was defined by state-financed, publicly owned health care services (Saltman et al. 1998).

<sup>20</sup> It is interesting that despite the fact that most practitioners had spent all their working lives in the communist system that the previous arrangement should be so quickly reinstated.

per cent as part of personal income tax (hypothecated tax). In 2000, the contribution rate was raised to 7.75 per cent due to intensive pressures from several groups, especially medical representatives, who had envisaged the 1999 health care reform as bringing increases in the sources of public health care finances. In 2003, the contribution rate increased again to eight per cent and later to nine per cent in 2007. Premium fees are collected by the Social Insurance Institutions (ZUS) *Kasy Chorych* (or Patients' Funds) and then distributed to 16 regional Patients' Funds, each covering an administrative region. The fund was set up to be managed by a board chosen by each regional council. The fees that people pay do not reflect the level of their health risks, just their income.

Each working person in Poland selects a Patients' Fund to which he or she would contribute, normally following the area of residence. However, everyone would be allowed to move their contributions to another fund as they see fit, especially when another fund delivers better medical service than the ones they were subscribed to. Each person has a signed contract with his/her selected fund, and is allowed to choose a family doctor and a preferred medical institution. Only certain medical services are fully covered for the insured and any excess has to be covered out of his/her own pocket or private health insurance. There were disruptions to the health care funding reforms. Distribution of funds was delayed, and the government resorted to giving loans to the health funds just to keep the new system going; funds were insufficient to cover health care expenditures (McMenamin and Timonen 2002).

Health care premiums for those on low incomes and specialised medical treatments are to be borne by the state. Thus the national health insurance system covers all citizens and their dependents. Hospitals and other medical health care institutions receive payments for their services according to the contracts, and those that deliver better medical services would be able to attract more clients. This would in theory create healthy competition among health care providers and help improve health care service quality in the country. However, as other countries have found, reality is more challenging.

Three main competition-enhancing mechanisms exist within the health care system:

1. Competition between purchasers. People residing in a particular region are automatically subscribed to the regional patients' fund, but they are allowed to change funds even to those outside their region, according to their level of services. Because premiums paid by workers are not paid according to their health risks, this competition creates equity problems because those with low health risks pay for others with serious medical conditions.
2. Competition between health care providers for contracts. The reform efforts allowed private and public health care providers – hospitals, clinics, and labs – to bid for contracts to service the funds.
3. Competition between health care providers for patients.

In practice patients do not have a real choice for their health care providers. Patients may be allowed to choose their own general practitioners (GP), but only GPs who have signed contracts with their health funds. Only those who are prepared to pay extra out of their own pockets have the real choice of their own preferred GPs. Those who are willing to pay extra, in effect jump the queue for free medical services, and unREFERRED treatment.

The state also contributes to the financing of the health care system through allocating funds for public health programmes, training and developing medical care personnel and medical research, setting standards and quality for the medical services, funding the national health care investments and generally overlooking the entire performance and services of the medical institutions. Medical education in Poland was not up to (EU) standards, especially in family medicine. Efforts were made to re-energise GP practices in Poland by retraining medical professionals and building a dedicated family medicine department at the Jagiellonian University in Krakow.

With the introduction of market mechanisms within the health care industry in Poland, the remuneration and wages of medical personnel and practitioners remained low (McMenamin and Timonen 2002). However, the practice of informal payments to medical practitioners increased their average income to above that of the population average (Chawla et al. 1998). This bypassing of the system results in unequal medical services and access to health care services (McMenamin and Timonen 2002; Scully 2007). Those who are willing to pay for unreferred medical services out of their own pockets are institutionalising the informal payment practices within the health care system. However, by permitting the low wages it does mean that the basic system can be more affordable.

The increase in health care spending in Poland after the fall of the Berlin Wall and the reforms that followed came mainly from the increase in direct private payments to health care providers (Maarse 2006), with the result that the burden for the average Polish household increased rapidly after the reforms. The role of family doctors was initially to act as gatekeepers to specialised treatment but also to the overall primary health care services. The outpatient treatment and hospital admission rate in Poland was considerably higher than those in countries with similar level of wealth (Berman 1998), reflecting their greater emphasis in preference to GP facilities.

## Summary

The Polish Ministry of Health has been criticised for placing greater emphasis on developing and refining the grand reform efforts of the health care system, while doing very little to implement the proposed changes (McMenamin and Timonen 2002). A study of citizens' perceptions of the health care reform in 2000 revealed that 77 per cent of the respondents thought the current system was worse than that prior to reform (Kocinska 2000). Patients were uncertain regarding which hospitals they can go to and how payments for the health care services are made. This dissatisfaction with the health care reforms was worse than that with the government. Furthermore, the introduction of market mechanisms into the health care system was insufficient without the fundamental changes to support market forces (Berman 1998). The separation between the authorities that fund/finance health care and those that provide health care created an 'illusory' bargaining system, because in effect local government members are those who sit on health funds and own the public health care providers (McMenamin and Timonen 2002). The health funds were not adhering to the constrained health care budgets, as what the reforms intended to. The introduction of private health care practices in the system was not successful in improving health care services according to McMenamin and Timonen (2002). Moral hazard also arose when public hospitals felt obliged to accept more patients just to secure more state funding (ibid.). There remain disparities in the level of health care delivery services between areas, with big cities like Warsaw having far bigger

capacities for health care services than smaller, less densely populated cities. The current health care system suffers from system inefficiencies and inadequate resources, while the demand for health care rises with the ageing population. The current reform efforts also did not pay close scrutiny to the issues of medical personnel's remuneration and incentive system.

Political problems attached to the health care reform exercised are said to pose an even greater challenge. Low salaries of health care practitioners and professionals threatened the health care system. Protests by health care professionals increased, with demands for a pay rise of over 30 per cent in 2006 and a rise of over 100 per cent in 2007 (Komorovsky 2006). Doctors in Poland worked more than 100 hours a week, while earning only 1400 to 1550 zloty monthly (350 to 390 Euros). The government's delayed response to the demands of the health care professionals added to the low regard in which medical professionals were held in the country.

The EU enlargement has also contributed to some challenges of to the Polish health care system. Free movement of health care professionals can contribute to an even acute shortage of the already in-crisis system. On the other hand, the potential increased flows of health care professionals from other EU states into Poland can bring competition into the provision of health care services and in effect, increase the quality of health care services (Zajac 2004); however, these potential immigrants would face the same incentives to go to higher income countries. Those who choose to leave Poland to seek opportunities in the larger EU states are most likely the young and best qualified ones, which further deprives Poland of good medical practitioners.

The monopoly of the National Health Fund can also be a cause for concern. The National Health Fund has already been heavily criticised for its inefficiency in solving the fundamental problems of the Polish health care system (Krajewski-Siuda and Romaniuk 2008).

The lack of political consensus in Poland has been argued to be the single most important contributor to the delayed implementation and execution of health care reforms in the country. The direction of Poland's health care reforms and other social structures is dictated by the principles of the ruling government (*ibid.*). The frequent changes of Ministers of Health (six ministers over the period from 2001 through 2005) further added to the complications of the reforms process (Kozierkiewicz et al. 2005).

Health funds are linked to the local government authorities and have been posing problems for the efficiency of the entire system. Health care reforms in Poland were executed much later and are lesser market oriented compared to other transition economies such as the Czech Republic and Hungary (Bossert and Wlodarczyk 2000). Nevertheless it is possible to be overcritical. Healthcare outcomes, such as life expectancy improved during the 1990s (Golinowska 2009). However, this could be attributable more to an improved diet and access to better medicines on the opening up to the west and later to the growth in incomes.

## **Estonia**

Health system reform efforts in Estonia started in 1991, when the government introduced a social health insurance system (Habicht and Kunst, 2005). The system was fundamentally based on the solidarity principle. The intended outcome of the

health system reform in Estonia was to provide health care services to citizens, regardless of their income or financial situation. People are covered through health insurance funds collected as an earmarked payroll tax. The previous health care system was funded by the state and the reform efforts shifted to a compulsory health insurance system with an employers' contribution of a flat 13 per cent rate on monthly income. (There is also a 20 per cent contribution towards pensions, making a total 'social tax' of 33 per cent.) Among adults, only students, pensioners and some part-time employees are exempt although there is a cap on the contribution of sole traders. Unemployment insurance is separate, funded by a combination of employer and employee contributions.<sup>21</sup> The state provides for those who are not able to participate in employment, through old age or disability as such people have had no ability to build up insurance before the new regime started. At present the emphasis is still very much on this state provision given the number of pre-existing pensioners and the lack of time for new pensioners to build up much finding.

Prior to the reforms, the health care system in Estonia was described as 'inefficient' and was mainly focused on institutional care (Koppel et al. 2003). Primary health care was almost non-existent because family medical care was provided by different specialists in different polyclinics. The main aims of primary health care reforms in Estonia were twofold: to introduce family medicine in the Estonian health care system and to reform remuneration packages for primary care doctors and practitioners.

In the first half of the 1990s, there was a second wave of health care reforms along with a decentralised system of health care planning and delivery (Habicht and Kunst 2005). During these reform efforts, 95 per cent of Estonia's population were free from financial barriers for health care coverage. The Estonian Health Project (1995-1999) was launched with financial support from the World Bank. The national and local health promotion projects are financed by the Estonian Health Insurance Fund. Estonia's Ministry of Social Affairs was established in 1993, merging several previous ministries – Health, Social Welfare and Labour. The ministry is responsible in developing health care policies and health care development plans.

In 1997, a third wave of health care reforms was launched. The primary health care reform was introduced and general practitioners were introduced to function as gatekeepers for increased quality of primary health care services (Habicht and Kunst 2005). The incentive system of primary care doctors was also reformed. Changes to the family doctors' incentive system was introduced in 1997 and implemented in 1998.

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<sup>21</sup> Estonia has a flat income tax system, at a rate of 24 per cent in 2005, with a substantial exemption for those on low incomes and a larger exemption for those receiving state pensions. With a VAT rate of 18 per cent the tax take was divided in 2005 into 34.1 per cent social tax and unemployment insurance, 18.3 per cent income tax and 28.1 per cent VAT, i.e. over 80 per cent of central tax revenues (Staehr 2009). Estonia developed a second pension scheme, whereby those who were new to the labour force had to join, those who were already in work but less than 50 years old could join, and those 50 and over could not, in order to create an element of a funded scheme (Casey 2004). Similar but rather more extensive plans have been implemented in the other Baltic States. It is difficult to ascribe such schemes as being 'European' rather than of any other origin. In recent years New Zealand has also introduced a new voluntary pension scheme called KiwiSaver to which people may commit 2.4 or eight per cent of their income. (It is actually rather more than a simple pension scheme as withdrawals can be made for purchase of a first home or in the event of illness or hardship; <http://www.retire.co.nz/KiwiSaver---early-withdrawal.htm>)

The reform efforts of the primary health care system were intended to achieve its desired results in 2003. All residential areas in the country should receive continuous primary health care from well-trained family doctors. Family doctors function as gatekeepers to more serious health care services and treatments. People are required to register with a primary care doctor – primary doctors are independent doctors contracted by the state/Health Insurance Fund. Prior to these reforms, family doctors earned monthly salaries, but post reform in 1998, family doctors are paid on capitation payments, with additional minor payments and fees-for-service. The state allocated funds for primary health care to counties based on the population – the capitation fee was 15 Estonian kroons (EEK) per person in 1998. The weights were readjusted in 1999 to be 20 EEK for children below the age of two, 16 EEK for persons aged 2-69, and 18 EEK for people above 70.

The final wave of health care reforms in Estonia was in 2001, when a centralised system for acute in-patient care and high technology medicine was introduced to improve the quality of hospital services. A modern and all-inclusive long term nursing care system was also introduced as part of the final wave of reforms in the country. The Health Care Board was established in 2002 to ensure health care quality and improvements. This is a governing authority responsible for issuing licenses and registering and administering private health care practices, governing patients' complaints and appraisals of the quality of health care services, and coordinating the roles and responsibilities of the board of health care professionals.

The Estonian Health Insurance Fund provides funding for disease prevention and health promotion activities in 2005. In line with the aim of the Estonian health care reform to introduce family medicine in the system, family medicine courses and retraining programmes were introduced in 1991. Later in 1993, the family medicine postgraduate training programme was upgraded to a medical specialty (Koppel et al. 2003). Estonians on higher incomes now face a choice of publicly or privately provided health care (Aidukaite 2009).<sup>22</sup>

### Achievements of the health reforms

Since the health system reforms 1993-1995, several improvements to the population health are evident. Life expectancy increased for men (from 65 years in 1990 to 67 in 2005) and for women (from 75 years in 1990 to 78 in 2005), infant mortality per 1000 live births decreased from 11.9 in 1992 to 3.3-5.6 in 2005 (Polluste et al. 2005) and this was attributed to the improvement and better access of health care services in Estonia (O'Connor and Bankauskaite 2008). However, inequalities of health care service utilisation can still be observed (Habicht and Kunst 2005). Differences in health care utilisation in Estonia were by far the largest in the socio-economic dimensions (income, education level and employment) (ibid.). Estonians with higher socio-economic status were more likely to use health care services compared to those of lower socio-economic status (ibid.). Differences in terms of the use of GPs were also found among rural and urban residents, with the rural residents being more likely to use telephone consultation and GP visits. Urban residents were more likely to use outpatient medical services.

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<sup>22</sup> This also applies to an extent in education.

## The Czech Republic

Historically, the Czech Republic practised a Bismarckian system of social and health insurance, inherited from the health care system of the Czechoslovak Republic, which covered the modern day Czech Republic before the division of the Czech and Slovak lands.<sup>23</sup> These health policies derived from the Austro-Hungarian Empire of which Czechoslovakia was part before independence after the First World War and the onset of the communist regime in 1948. Universal coverage, tax financing, and state-owned and controlled health care facilities defined the old health care system in the Republic (Výborna 1995; Oswald 2000) but the Bismarckian approach has appeared rather more strongly in the Czech Republic than in the other Visegrad countries (Potucek 2004).

The Czech pension scheme is largely defined benefit in nature, with employees contributing 6.5 per cent of earnings and employers 28 per cent. The payments take the form of a flat rate sum plus an earnings related element based on 1.5 per cent of the earnings base for each year worked (Aspalter et al. 2009). The social insurance scheme, which has separate cash sickness and maternity benefits, and medical benefits elements, is financed by employees (5.6 per cent of earnings) and employers (12.3 per cent of earnings). It is administered by the state through the Ministry of Labour and Social Affairs (ibid.).

The Czech Republic's health care system underwent dramatic reforms and liberalisation beginning in 1990 (Vepřek et al. 1995; Výborna 1995; Oswald 2000). Democratisation of the state was in place and the principle of free choice of health care facility commenced. The process saw the end of the large regional and health authorities. The General Health Insurance Fund Act and the Act on the General Health Insurance Fund (GHIF) were approved in 1991. With the introduction of the Acts, the health care system in the Czech Republic moved to compulsory health insurance model that practices contractual health care provision by a number of insurers (Rokosová and Havá 2005). In summary, the new system is characterised by compulsory universal coverage.

The 1990s saw more changes and improvements being implemented into the Czech Republic's health care system. The health care facilities and authorities experienced a major overhaul and a new system of home care was set up. Privatisation of primary health care, the pharmaceutical industry, pharmacies and health support firms were also well under way.

As in most of the new member states, the first step in the health care sector involved the decentralisation of previously state-owned health care institutions. The legal basis in the Czech Republic was the introduction of a new act – Health-Care in Nongovernmental Health-Care Facilities Act – in April 1992. The state-owned District Institutes of National Health were dismantled. Under the old health care system, the country has several regional authorities, and these regional authorities were further split into district authorities (Oswald 2000). Citizens were assigned a primary physician, who acted as the gatekeeper to specialised care. Doctors and medical personnel also received minimum wages (Oswald 2000; Lawson and Nemeč 2003)

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<sup>23</sup> Czech social policy has three main components of which the Bismarckian approach to insurance is only one. It also pursues an active labour market policy and provides a safety net for those in need who cannot insure themselves, e.g. because they are not able to enter the workforce (Potucek 2009).

Under the new system, health care is available to all permanent residents of the Czech Republic and non-residents of the country who work in companies, firms and organisations which are legally registered in the Czech Republic. All health insurance funds are legally bounded to accept any persons who meet the criteria for belonging to the health care system. Any person is allowed to change health insurance fund only once in a 12 month period. Those who do not meet the criteria for participating in the statutory health insurance fund can sign up with a contractual health insurance fund. Those who do not fulfil the terms and conditions of the statutory health insurance may take up voluntary ones with the GHIF.

Hospital administration and operations and specialised tertiary-care medical institutions in the Republic are under the Ministry of Health. Interestingly, however, the central government has not been able to secure legal authority over all hospital care; there are some hospitals that are owned by limited liability firms.

While the early period may have had a rather more market based element to it than in some of the other new member states, during the period 1998-2006 the various Czech governments were dominated by the Social Democratic Party. Nevertheless, the excess of demand over the ability to supply through the public sector led to both privatisation of health and social care facilities and the launching of voluntary social and health insurance schemes (Potucek 2009).

### Health care financing

Financing for the Czech Republic's health care systems after the reforms came from five different sources:

1. Payments to health insurance
2. Contributions from the state government
3. Contributions from the local government
4. Direct payments to health care providers, and
5. Others (such as donations)

Figure 3 illustrates health care financing structure in the Czech Republic. The state contributes for those citizens without taxable income. These groups of people include pensioners, children, women on maternity leave, registered unemployed, disabled citizens and those who are eligible to receive social allowance, soldiers and prisoners. The working population pays 4.5 per cent of their taxable income, while self-employed citizens contribute 13.5 per cent of 35 per cent of their taxable income. Employers' contributions to employees' health insurance make up nine per cent of taxable income.<sup>24</sup>

All citizens must be registered with an insurance institution. The General Health Insurance Fund and branch health insurance funds were set up in 1992 when the health insurance system was implemented (Rokosová and Háva 2005). The state is the

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<sup>24</sup> It is helpful to see the financing of healthcare in the context of the financing of the whole of compulsory social insurance in the Czech Republic. Over a third of the employee's contribution goes to healthcare (4.5 per cent out of a total of 12.5 per cent) whereas only a quarter of the employer's total contribution of 35 per cent of wages goes on healthcare. The difference is largely accounted for by pension contributions which take up over 60 per cent of the employer contribution but only half the employee one.



major shareholder of the GHIF (Výborna 1995). The GHIF accepts all people who are not registered with any regional or national health insurance institution.

In theory, the new health system was designed to ensure that all citizens of the Czech Republic received health care regardless of their incomes. Health care providers on the other hand, received a fee-for-service payment from the state government for health care services rendered. Under the old health care system, health care providers received state grants and budgets according to the number of staff employed, their service capacity and the type of health care institution.

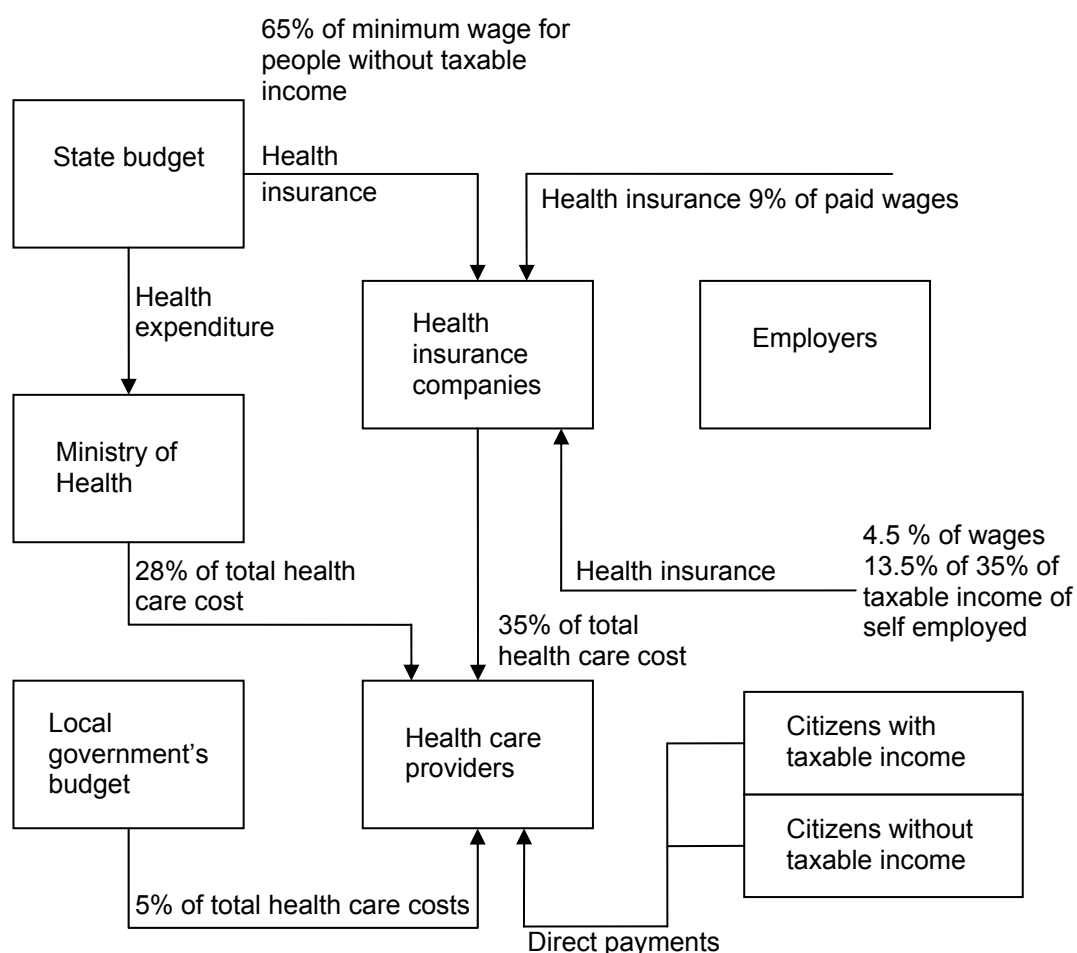


Figure 3: Health care financing in the Czech Republic.  
 Source: adapted from Výborna 1995.

In addition to the GHIF, the state introduced market competition into the health care system and, at one point, the Czech Republic had 19 health insurance companies (ibid.). Competition between the health insurance companies prompted some health insurance companies to target only those people with high incomes and low health risks. Private health insurance companies also used advertising campaigns that were criticised by the GHIF as wasting money that could have been spent on more efficient health care services. Another tactic by the private health insurance companies to maximise their profits was to encourage the insured to take out extra cover for drugs and services not otherwise listed under the Fee-for-Services and Drugs and Other Medications Price List. (Each medical service and operation was listed and valued according to a points system and an amount of direct material costs associated with

the service. The price (or points and costs) for each medical service was determined by GHIF. The points and costs for each service serve as the basis for fee-for-services rendered by health care institutions). While this expanded the cover for people it enabled the companies to move into areas where the GHIF could not compete.

This fee-for-service system of health care service payments motivated health care providers to increase their quantity of medical services to clients without much regard to the level of quality of the medical services (Vepřek et al. 1995). The price list was also initially established without comprehensive tests of its feasibility and was published in a rather rushed manner according to Vepřek et al. (1995). In the second stage of health care reform in the Czech Republic in 1997, more reforms were introduced and the fee-for-service and the price list were replaced by a weighted capitation system with increased health care regulations and policies in place (Lian 2008).

The state introduced a redistribution system for collected health insurance contributions. Health insurance companies were required to surrender 60 per cent of collected contributions and allocations from the state to a special account administered by the GHIF. These sums were then redistributed to health insurance companies according to the normalised health contributions (average contribution with those from 60 years of age and over counted three times) times the number of insured clients, with those over 60 years old, again counted three times (Výborna 1995).

Health care reforms in the Czech Republic were criticised by Výborna (1995) for increasing health care costs because there are increased administrative costs due to the set up of new health care insurance companies, and the weakness of the reimbursement system (for private health care providers) and the Fee-for-Service Price List which led to inflated high-priced services of health care (ibid.). Technicalities with the calculation of the newly introduced Fee-for-Service Price List and the reimbursement systems were blamed for this roadblock facing the reform exercise. The set up of the GHIF was also controversial. The institution's largely ambiguous dual roles, as health-care provider *and* regulator blurred the transparency of the entire health care system (ibid.). In theory the increased competition should have stimulated innovation and efficiency offsetting any increase in costs from the more complex system.

However, currently only nine health insurance companies have survived in the Republic, collectively holding only a 25 per cent market share (Oswald 2000; Lawson and Nemeč 2003). The demise of the private health insurance companies in the Czech Republic was attributed to the lack of experience in the health sector of these privately held insurance companies leading to an inefficient reimbursement system (Oswald 2000). The introduction of privately held insurance companies and subsequently competition into the health care system brought negative impacts on the health care system. Private health insurance companies targeted the young, healthy and rich populations, leaving the unemployed persons, the elderly, children and the poor, and those with the highest health risks insured under the GHIF. The situation has led the heavily-subsidised government agency to be responsible of the sickest and riskiest population in the country. The GHIF now operates almost as a monopoly, controlling more than half of the insured population in the Czech Republic.

## Overall analysis

Výborna (1995) suggests that the health care reforms were directed towards a market-based health care system, and to facilitating citizens' personal responsibility for their state of health. The health care system was dramatically reorganised only once (in 1990). However, even when the health care system was targeted for further reform (in light of other parts of the social system, such as, pensions and education), the reforms and national health policies were inconsistent. This is attributed to the turbulent political system, changing the Minister of Health 13 times from 1990 to the present. The frequent shift of the top-most position in the ministry led to inconsistencies and ambiguities in health care policies.

The current health care system of the Czech Republic is a step back towards some of the practices of the old communist regime. For example, the patients were excluded in the state's policy design and implementation throughout the reforms, which was largely the practice in the old regime (Lawson and Nemeč 2003). And the health care insurance system is a near monopoly by the GHIF (Oswald 2000).

The GP sector still operates on the list system, with a weighted capitation payment system. Informal payments are still practised (Lian 2008). Local managerial influence to the GP system remained unchanged and low, while systems for administering quality of GP services are weak (*ibid.*).

In summary, the Czech Republic has undergone massive reforms to its health care system and experienced one of the highest increases in health care spending among the new EU countries. Provision of health care has succeeded in meeting the needs of the wider population (Rokosová and Havá 2005). The recent accession to the EU also saw the adoption of new legal acts to keep abreast of other EU members.

The benefit system is of particular interest in that the changes of 1995 introduced an element of means testing which managed to make the system much more closely focused on benefits to children and to reduce its cost (Coutler et al. 1997). To try to make the various schemes more affordable, the retirement age has been increased incrementally and the average pension has fallen as a percentage of average income (although it has not fallen in absolute terms) (Potucek 2009).

## Implications

The analysis in this paper is only illustrative as a comprehensive study would be prohibitively expensive. Nevertheless it is possible to draw on other partial studies, such as that by Schelkle (2008) and some common features emerge.

The most important implication from the findings of this paper is that there is no single model that applies to welfare regimes. In many cases this applies not just among the EU countries but within each country because they do not treat each aspect of the welfare system in the same manner. Thus for example pensions may be based largely on the ability of the individual concerned to fund the pension during their lifetime, whereas schooling may be something that is fully funded irrespective of the means, current or past, of the parents. Even within education, treatment may not be uniform, with people expected to pay in full for their own vocational training and at least in part for the costs of university. To some extent this may reflect the relative

balance between public and private benefits. This entails that the size of community relevant for the decision-making over the system will itself vary from the individual to the whole of the EU where transfers are required across borders.

However, there has been a degree of convergence among the member states assisted by the forces of globalisation and the process of open coordination in the EU. This convergence has not been towards a single one of the four pre-existing regimes in the 'old' member states but it has moved them towards features that encourage efficiency and productivity. Thus there has been an increasing focus on active labour market measures and a move towards permitting increasing flexibility in the operation of labour markets. At the same time the focus of social policy has become wider, with an enhanced focus on trying to ensure inclusion in society and not simply income (poverty avoidance) and employment. Economic pressures from the inability to increase debt much further – emphasised by the recent financial crisis – and pressures from ageing have meant that the overall budget has had to be revised.

The new member states have also contributed to a change in the picture away from a relatively straightforward characterisation into four general regimes: Anglo-Saxon, continental/corporatist, social democratic/Nordic and Mediterranean/southern. They have faced extreme pressures because of the collapse of the funding mechanism for much of existing social welfare and the need to progress rapidly to an adequate new system that is financially viable. This has inevitably resulted in a greater weight on privately provided support and grey services outside official regimes as people have sought solutions, particularly in health care. These pressures have also affected mobility and labour markets, as skilled providers of public services and those who want them have sought employment opportunities and higher incomes elsewhere.<sup>25</sup> The focus in many of these new systems has been on incentives. Thus there has been a strong insurance element in pension and healthcare systems to encourage contributions from those who expect to be beneficiaries in the future. At the same time income tax rates have tended to have low and, in several cases, flat rates in order both to encourage people to work and to increase their skills as they will retain much of their earnings and to encourage them to declare their incomes.

There is some disagreement over the characterisation of the regimes in the new member states. Aspalter et al. (2009), for example, argue that the Czech Republic, Hungary, Poland and Slovenia can be classified as Continental/Corporatist regimes as they have a 'Bismarkian' approach to social insurance. Deacon (2000) on the other hand suggests that the social welfare systems of the European transition countries are a cross between the Continental and Nordic models. The Nordic dual earner model certainly seems apparent in Estonia, possibly reflecting the extent of help received from Finnish experts in getting the system operating (Aidutaike 2009).<sup>26</sup> Given the extent of means testing in some cases this would also introduce elements of the Anglo-Saxon system, suggesting that these regimes are something of a hybrid. This has been labeled a 'post socialist regime' by some (ibid.) and applied in particular to the Baltic States, where the low levels of income have meant that benefits have had to

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<sup>25</sup> The Polish workforce has been particularly mobile, although it has not been concentrated on the more skilled and covered all categories of workers. To some extent those on low incomes have been replaced by immigration to Poland from Ukraine, where conditions have been much worse.

<sup>26</sup> This is reflected in extensive childcare arrangements and encouragement for single parents to return to work.

be very modest. It is, however, worthy of note that in general they have not followed the advice of the World Bank to create funded systems and have bowed to the economic pressures by using a PAYG approach (Casey 2004). However, all such generalisations are subject to exception. Latvia, for example, has implemented a substantial funded pension scheme, which makes it far more like the Anglo-Saxon model, although there the terms are much less controlled.

Although the advent of the new member states has in some respects increased the competitive pressures, as incomes rise so the new member states have been able to expand their systems and convergence has been a clearly bi-directional process. Many of the pressures have come from outside the EU, either literally in the sense of competition, from China in particular, or because the forces are general, such as ageing and not dependent on the process of closer integration. In so far as there has been increased mobility, then this increases the complexity to which democratic processes have to respond. Although, some of the mobility has been decidedly temporary, as people have moved without their families and look to return when they can be assured of adequate income. In the same way this has meant that the migrants have not been a drain on the social welfare systems in the host countries as the point of their migration is work and if the job opportunity disappears then the people tend to return home rather than be unemployed and away from home.

There thus seem to be two forces at work, which are resulting in a more complex picture than the clear classification set out by Esping-Andersen. Member states have adopted some of the best features of other regimes encouraged by the deliberate policy learning mechanisms such as OMC in the EU. Moreover they have not necessarily applied it uniformly within the social welfare system, making their approach more of a hybrid. Second, while all member states have been stressed by the forces of globalisation that forces them to address sustainability, the new member states have had to develop systems that work in the short run but nevertheless take account of the lack of funding and lower income levels. While there is a temptation to label at least some of the new members as constituting a distinct fifth regime, perhaps a better characterisation is simply to suggest that the boundaries are no longer so distinct and there are now more overlaps but without an overarching structure that would enable them to be labeled as being all part of an identifiable and distinctive European Social Model in anything but a very general sense.

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RECON seeks to clarify whether democracy is possible under conditions of complexity, pluralism and multilevel governance. Three models for reconstituting democracy in Europe are delineated and assessed: (i) reframing the EU as a functional regime and reconstituting democracy at the national level; (ii) establishing the EU as a multi-national federal state; or (iii) developing a post-national Union with an explicit cosmopolitan imprint.

RECON is an Integrated Project financed by the European Commission's Sixth Framework Programme for Research, Priority 7 – Citizens and Governance in a Knowledge-based Society. Project No.: CIT4-CT-2006-028698.

Coordinator: ARENA – Centre for European Studies, University of Oslo.

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