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Hybridization instead of Clustering: Transformation Processes of Welfare Policies in Central and Eastern Europe

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Abstract

Welfare state theories tend to use concepts of clustering for defining the affiliation of national social security systems to overarching worlds of welfare. A closer look at the transformation processes of welfare policies in Central and Eastern Europe shows a great variability among those countries in approximating their welfare states to Western European standards. In the design of their pension systems, their health care provision and their unemployment protection, Central and Eastern European Countries (CEEC) follow different reform paths. Welfare clusters in Western Europe are used as reference models, but no single example applies to all sectors of social security. Thus, a generalizing picture of welfare provision cannot be drawn for Central and Eastern Europe. Instead of constituting a new individual type of welfare arrangement, a hybridization process is observable.

Keywords

Central and Eastern Europe; Social security; Transformation; Welfare state; Worlds of welfare

Introduction

Nearly two decades have gone by since the historic breaking down of the Berlin Wall and the ensuing liberation of the Central and Eastern European Countries (CEEC) from Soviet hegemony. Besides major changes in the political and economic sphere, the transformation of these societies is also responsible for modifications in their social policies. So far, the welfare systems of the ten CEEC, which joined the European Union in 2004 and 2007, have not been analysed sufficiently. Often, their social policy arrangements are regarded in an undifferentiated and simplified way as a monolithic bloc of one single Central and Eastern European type of welfare state.

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This article examines the similarities and differences in the welfare policies of the ten CEEC. The main focus is upon the central areas of public social security: the old-age pension, health care provision and social protection in case of unemployment. Each of these three areas of social policy will be analysed in a single section, stating the particular system's main components alongside the reform activities of the transformation process from a comparative perspective. In a last section, the argument of this article leads to the discussion of a possible classification of Central and Eastern European welfare systems into existing clusters of Western welfare state typologies.

The Old-age Pension Systems in the CEEC

Before 1989, retirement security systems in the socialist countries of Central and Eastern Europe were organized very similarly. The state was the central agency responsible for the systems, which were based on a pay-as-you-go scheme. The standard retirement age was – with the exception of Poland – lower than in the Western European countries. In 1990, the average retirement age in the CEEC was 58 years for women and 61 years for men, while the average ages were 60 and 62 years respectively in the OECD countries (Fultz and Ruck 2001: 21). The actual retirement age in the ten CEEC must have been even lower, since the qualification period for full pension entitlement in most countries only varied between 20 and 25 years. In addition, there were also extensive possibilities for early retirement. Besides the low eligibility, pension systems in the CEEC contained numerous special arrangements and privileges for certain groups of people, depending on their occupational category or other aspects such as their social standing. Pension benefits were intended to be very high, with replacement rates up to 100 per cent and adjustments between higher and lower income classes. As a matter of fact, the number of beneficiaries greatly exceeded the number of contributors. The emerging financing gap could not be balanced by the states' general budget. This limitation of the financing of old-age pensions as well as the non-adjustment of pensions to growing inflation rates led to low real pension benefits and thus meant the provision of only a minimum basic protection (Schubert 2005: 16 ff.). Exceptions existed in all the CEEC for individual status groups, who safeguarded their privileges in politically motivated special legislation and independent pension systems.

Radical versus gradual reform approach

The change from centrally planned to market-orientated economies in the CEEC had a fatal impact on the pay-as-you-go pension schemes. Already weakened by a disproportion between real contributions and intended benefits, the dependency ratio was worsened by the economic transformation crisis with its high unemployment rates, new early retirement programmes (due to close-downs of state-owned enterprises) and the increasing informal economy. In some CEEC, high inflation rates have been responsible for extraordinary diminutions in the value of pensions. In the first phase of transformation, new governments faced the growing finance problems of the

Table 1

Year of implementation of a mandatory funded pillar in the CEEC pension systems

BG	CZ	EE	HU	LV	LT	PL	RO	SK	SI
2000	–	2002	1998	2001	2004	1999	–	2005	–

Source: Baum-Ceisig *et al.* (2008).

pensions sector only in a selective way. At the beginning of the 1990s, numerous parametric reforms were enforced in all CEEC, dealing with:

- the disjuncture of pension funds, particularly social security budgets, from the states' general budget;
- the first broad participation of employees in the pension system's financing structure;
- an increasing linkage between pension benefits and individual earnings;
- new restrictions on the entry requirements through an increased retirement age and higher minimum contribution periods;[1]
- an indexation of the pensions according to inflation or wage growth development.

After the end of the 1990s these reforms were considered not to go far enough in eight of the CEEC. Except for Slovenia and the Czech Republic, all the CEEC converted their pay-as-you-go schemes into multi-pillar models with capital-funded components (see table 1). In many states, the implementation of two new funded pillars was supplemented by an ongoing alteration of the first pay-as-you-go pillar. Many redistributive elements of the old socialist system were eliminated. In most of the CEEC, what defined the amount of a pension shifted from the collectively possible benefits of the system (*defined benefit scheme*) to individually achieved contributions in the sense of actuarial fairness (*defined contribution scheme*). The rates of contribution in the pay-as-you-go as well as in the funded pillars differ considerably among the countries.[2]

The reforms of the pay-as-you-go scheme have been most radical in Poland and Latvia. In both these countries, the political heritage of a defined-benefit scheme was converted into a *notional defined contribution scheme*, in which the principle of equivalence between contributions and later benefits is stressed. The rules applied in this system comply to a great extent with the *financial defined contribution schemes* of the funded second pillar (Müller 2002, 2006; Chłón-Domińczak 2004). The first country of the CEEC to move towards a multi-pillar pension model was Hungary, in 1998. All persons who have entered the labour market since then are covered mandatorily in the pay-as-you-go first pillar and in the funded second pillar. Under defined circumstances elder employees are allowed to join the second pillar on a voluntary basis. The retirement pension systems in Bulgaria, Estonia, Latvia, Poland and

Slovakia are organized in a similar manner. The age of the insured person serves besides the new entrance to the job market as a qualifying condition to the funded pillar. Only in Lithuania is participation in the funded pillar voluntary for everyone, but irreversible after joining the scheme (Lazutka 2006). Romania enacted the introduction of a mandatory funded pillar in the year 2000, but has not implemented it yet. While eight of the CEEC changed their pension systems fundamentally, only Slovenia and the Czech Republic did not follow this path of privatization and increased individualization of old-age risks. Both countries reformed their pension systems in a sustainable, but gradual, way without radically abolishing all the inherited redistribution elements from the socialist period (Baum-Ceisig *et al.* 2008: 239 ff.).

A voluntary, capital-funded old-age provision is possible in all ten CEEC. It is organized on a private basis in the so-called third pension pillar. Public subsidies and tax advantages support these voluntary private pension schemes in most countries.

Sustainability and adequacy of pensions still at risk

Unlike in many western European countries, the pension reforms conducted in the CEEC have been less an adequate answer to future demographic challenges than a reaction to the altered economic conditions brought about by the transformation process. On the one hand, one can see the implementation of radical reform strategies, leading to more privatization and individualization of old-age risks. But on the other hand, there can be observed in the same countries a strong persistence of privileges for single status groups, which were able to preserve their special pension arrangements all through the reform process. This issue can be seen particularly in Poland and Romania. In both countries considerable independent pension schemes for farmers still exist as a heritage from socialist clientele policies. Attempts to integrate these special schemes into the general pension system have not yet been successful. In the Baltic States and Slovakia the pension reforms led to a considerable reduction in public pension expenditures. With values around 7 per cent of GDP, pension expenditures in these countries are below the European average of 10.6 per cent of GDP. With the exception of Latvia this is reflected in low net replacement rates. In Estonia pensioners receive, with 41 per cent of average income, the lowest net replacement rate in the whole of the EU. The picture gets even worse when one looks at the projections of public pension expenditure, age-dependency ratio and estimated replacement rates until 2050, and one can realize the long-term implications of the recently implemented reforms. Notwithstanding its liberal reform strategy in 1999, Poland still spends above the average for old-age protection (14 per cent of GDP) and still has a high net replacement rate (78 per cent of the average wage). This situation will radically change in the future. For 2050 a reduction of public pension expenditure to 8 per cent and a replacement rate of only 44 per cent are forecast. Besides the liberal Polish reform strategy, a rapidly growing age-dependency ratio can account for these figures. As in many Western European countries, the demographic forecasts show societies ageing at above the average rate also in Bulgaria, the Czech Republic,

Table 2

Projected old-age pensions data in the CEEC, 2004–2050

	Public pension expenditure as % of GDP		Age-dependency ratio, persons aged 65+ to persons aged 15–64		Net replacement rate as % of average wage	
	2004	2050	2004	2050	2004	2050
BG	*	*	24.9	60.9	*	*
CZ	8.5	14.0	19.7	54.8	79	70
EE	6.7	4.2	23.8	43.1	41	43
HU	10.4	17.1	22.6	48.3	102	98
LV	6.8	5.6	23.6	44.1	78	72
LT	6.7	8.6	22.3	44.9	55	51
PL	13.9	8.0	18.6	51.0	78	44
RO	*	*	20.9	51.1	*	*
SK	7.2	9.0	16.3	50.6	63	64
SI	11.0	18.3	21.4	55.6	82	60
EU-25	*10.6*	*12.8*	*24.5*	*52.8*	–	–

* No data for BG, RO.
Source: ISG (2006); EPC (2006); Eurostat (2008).

Romania, Slovenia and Slovakia. Only the Baltic states show a below-average increase in the ratio between persons aged over 65 and persons aged between 15 and 64 until 2050 (see table 2).

The transformation process in the CEEC produced two different models of pension reform: a gradual reform path followed by Slovenia and the Czech Republic and a radical alteration of old-age security with a liberal strategy, followed by the other eight CEEC. The projected pensions data offer a modified classification of groups: Estonia, Lithuania and Slovakia appear as the forerunners of welfare retrenchment in old-age security. By 2050, Poland will have gone a long way down the same road – the preconditions have been set in place with the pension reform of 1999. Whether these states will be able to keep up with a policy of low replacement rates, or whether they will face massive problems with old-age poverty, cannot be predicted yet. But already today the at-risk-of-poverty rates for persons aged 65 years and over in the Baltic States are among the highest in the EU (Eurostat 2008). The data projections for Hungary are surprising. Despite its liberal pension reform, which has to be judged as a clear break with the traditional path of pension policy (Baum-Ceisig *et al.* 2008: 119), the country's public pension expenditures are located today near the average of the EU and it disposes of the highest net replacement rate in the CEEC. As projections show a massive aggravation of the systemic dependency ratio, but also a

continuance of the replacement rate at nearly 100 per cent, Hungary might face strong financing problems with its pension system in the future. Both gradual reformers Slovenia and the Czech Republic will also experience a large increase in their public pension expenditures. Besides Bulgaria and Romania, for which no projected pensions data are available yet, there remains only Latvia among the CEEC, the only state seeming to achieve a balance between the financial sustainability of the pension system and the adequacy of benefits in the long run. Projections until 2050 estimate a continuing high replacement rate of 72 per cent of average income, while public pension expenditures will be reduced to 5.6 per cent of GDP (see table 2). The reasons for this single positive outlook are to be found in a relatively positive demographic development, employment rates above the average and a pension reform strategy which shifted a major part of pension entitlements to the privately financed second pillar.

Health Care Systems in the CEEC

Before 1989, all ten CEEC suffered from the same problematic experiences with the bureaucratic and hierarchically structured Soviet model of health care provision (the 'Semashko model'[3]) that had to fit into the requirements of the state-directed economy. The health situation of the population was defined as a public interest. Therefore health care was carried out only by central planning forces. Provision was completely free of charge and founded on citizenship. Financed only by the general state budget, the health care system soon reached its financial limits. As a result, it produced long waiting lists, antiquated or non-existent medical equipment and an enduring market for illegal payments by the patients for receipt of provision of a higher medical quality (Mossialos *et al.* 2003: 99 f.). While the general financing and organization schemes of the CEEC health care systems have been changed fundamentally in the transformation period, the basic principle of universal coverage was preserved to a large extent. In most CEEC the right of free access to health care provision is fixed in the constitution.

Western reform concepts in an inadequate infrastructure

To cover the enormous financing needs of a nationwide modernizing programme for their medical infrastructure, in the 1990s the CEEC reformed firstly the revenue side of their health care systems. The new predominant organization principle for financing health care was the Bismarckian statutory insurance, based on contributions from both employers and employees (see table 3). Even Latvia and Lithuania, where the health care systems are partly financed by taxes, implemented organization schemes with health care insurances close to the organization principles of contribution-based health care funds. The contributions collected by the health insurances do not constitute in all of the CEEC the highest share of the general revenues for the health care sector. In contrast, the general revenue is split into public insurance contributions, tax revenues, additional insurance premiums, and official and informal out-of-pocket payments by patients. Between the CEEC

Table 3

Year of change to Bismarckian health insurance in CEEC health care systems

BG	CZ	EE	HU	LV	LT	PL	RO	SK	SI
1998	1992	1992	1991	–	1997	1999	1998	1994	1992

Source: Baum-Ceisig *et al.* (2008).

considerable differences in the breakdown of these capital sources exist: While the tax-financed share is 69.2 per cent in Bulgaria, social security insurance contributions account for 81.5 per cent of the general health care expenditures in the Czech Republic (Koulaksazov *et al.* 2003: 29; Rokosová and Háva 2005: 34). In all ten CEEC, health care is provided on a universal basis, depending on citizenship, place of residence or occupation. Because contributions from the non-active population are covered by the state, coverage rates between 90 and 100 per cent of the respective populations are common.

The relatively low economic productivity of the CEEC in comparison to their Western European neighbour states and the shortcomings in the acquisition of contributions caused by organizational problems and corruption led to insufficient financial revenues. Consequently, it was not possible to modernize the medical infrastructure in a comprehensive way, nor could the entitlement to a state-guaranteed, universal high level of provision be kept up. Hence, the CEEC modified, in a second reform approach, the expenditure side of their health care systems. Like the already-reformed revenue design, governments in the CEEC oriented their strategies for cost reduction on models of Western origin. They contained:

- an increasing decentralization of responsibilities for the acquisition and allocation of financial resources by autonomous acting regional health insurance funds;
- a trend towards contract-based agreements between insurance funds and health care providers in the primary health care sector, mainly on a private basis;
- the implementation of general practitioners as gatekeepers to all other forms of secondary and tertiary treatment;
- a reduction of hospital bed capacity in favour of an expansion of treatment in the community by general practitioners;
- new cost-efficient allowance and accounting systems through the implementation of capitation fees, fees-for-service and diagnosis-related groups.

A closer look at these modern and efficient structures shows quite different attendant circumstances in the CEEC compared to Western Europe. It is still the basic infrastructure of the health sector which is at stake. The modernizing

of hospitals and polyclinics, the renewal of the technical equipment, the build-up of the primary ambulant care provision outside the hospitals and a better remuneration of the medical personnel are massive cost drivers. These finance-intensive challenges cannot be resolved in a short time period. Compared to the situation at the beginning of the 1990s progress is obvious, for example in the reduction of hospital beds. In the Czech Republic the concentration of hospital beds could be reduced from a peak value of 11 per thousand inhabitants in 1989 to 8.5 in 2004 (EU-15 = 5.7). It was possible to increase the number of physicians per thousand inhabitants from 2.7 to 3.5 (EU-15 = 3.4) in the same time period (WHO 2007).

However, many specific problems remain unresolved. The autonomy of regional health insurances has created significant complications in the allocation of financial sources as they are needed in practice. Thus, in 2003 Poland recentralized its 17 autonomous health insurances created in 1999 under the common umbrella of a national health insurance fund (Kuszewski and Gericke 2005: 99). The socialist heritage of the Soviet health care system can be seen very obviously at the interfaces of insurers and providers on the one side and physicians and patients on the other. In communist times it was common in all of the CEEC that patients were treated directly in hospital. The supply of oversized hospitals created its own demand at the expense of quality of provision. It is difficult to change the traditional habit of the population of walking directly to hospital, no matter what they suffer from. The introduction of more general practitioners should help to change the situation. However, in some cases the modern allowance and accounting rules led to unintended consequences: In Hungary the application of diagnosis-related groups led to a reduction of the patients' duration of stay in hospital, but at the same time it led to an increase in newly admitted cases. General practitioners had been motivated by capitation fees to keep their patients healthy. But as soon as the patients felt ill there was no financial incentive to treat them any longer, so general practitioners transferred them to a higher level of provision – to the hospital (Mossialos *et al.* 2003: 135; Gaál 2004: 115).

Abandonment of universal health care in favour of privatization?

The CEEC have been very cautious in implementing private elements in their health care systems. The average private financing share in the ten CEEC amounts to about 29 per cent and shows an increasing trend (see table 4). This latter fact cannot be ascribed to a huge market of private insurances, but to a strong increase in fees and official out-of-pocket payments. In Bulgaria, Estonia, Latvia, Slovakia and Slovenia patients have to pay a mandatory fee for a consultation with a physician or for staying in a hospital. In all ten CEEC patients have to co-finance prescribed medicaments. Between the states different tariffs and reimbursement rules apply. Specifically to fight corruption, many states implement or increase out-of-pocket payments (Baum-Ceisig *et al.* 2008: 265 ff.). In addition, in most countries a considerable share of total health expenditure consists of a historical system of informal out-of-pocket payments. One reason for their persistency is the low wages of physicians and other medical personnel (Mossialos *et al.* 2003: 110).

Table 4

Health care expenditure and life expectancy in the CEEC

	Share of total health care expenditure in % (2004)		Out-of-pocket payments as % of total health care expenditure (2004)	Health care expenditure per capita in PPS (2004)	Life expectancy at date of birth in years (2005)	
	public	private			M	F
BG	57.6	42.4	41.6	671	69.0*	76.3*
CZ	89.2	10.8	10.3	1,412	73.0	79.3
EE	76.0	24.0	21.3	752	67.3	78.2
HU	71.6	28.4	25.0	1,308	68.8	77.2
LV	56.6	43.4	42.7	852	65.4	76.6
LT	75.0	25.0	24.2	843	65.4	77.4
PL	68.6	31.4	28.1	814	70.7*	79.3*
RO	66.1	33.9	31.7	433	68.3*	75.6*
SK	73.8	26.2	19.2	1,061	70.3	78.2
SI	75.6	24.4	9.6	1,815	74.0	81.0
EU-15	76.3	23.7	16.0	2,729	76.5*	82.3*
EU-27	75.0	25.0	18.4	2,334	75.1	81.4

* Data from 2004.
Source: WHO (2007).

The rise of individual responsibilities through direct patient fees and charges seems to promise the strongest impact on reducing costs in the health care sector. For politicians the out-of-pocket payments offer a comfortable way to slowly reduce the once unlimited range of medical treatment to an ever-smaller basic package of state-guaranteed benefits, free of charge. Through the back door this increasing individualization of risk necessitates the establishment of private provision systems. In most CEEC, out-of-pocket payments account for considerably more than 20 per cent of the total health care expenditures, while they are 16 per cent in the EU-15. In Poland and Romania the share of out-of-pocket payments amounts to around 30 per cent of all health care expenditure; in Bulgaria and Latvia it even surpasses 40 per cent. This extensive use of self-financing by patients changes profoundly the universal general principle of the CEEC health care systems (see table 4). In particular, a large proportion of people living in poor conditions are being gradually excluded from access to health care provision. Officially, comprehensive private insurance does not exist to a great extent in CEEC, except in Poland and Slovakia, where this option is open to patients who are not covered by the mandatory public system (Mossialos *et al.* 2003).

The governments have resisted the emergence of dual health care systems, like those in Germany for example. Instead, they have maintained the universal

public insurance system. Additional private health care insurances on a voluntary basis do exist in all ten CEEC, but their share of overall expenditures is, with the exception of Slovenia (12 per cent) and Latvia (3 to 4 per cent), only minimal (between 0.1 and 2 per cent). This situation might change in the future. Although private health insurances are introduced more as supplementary than as substitutive measures to public health insurances, a growing role for private health insurances is to be observed throughout the region (Waters *et al.* 2008). This development may be fostered by the growing sector of occupational welfare as a substitutive element in the CEEC (Greve 2007: 154 ff.; Waters 2008: 485). After the universal health care provision principle had already been undermined by reforms on the revenue and the expenditure side, political discussions arose in the CEEC about a possible break with the politically inherited entitlement to all-round provision. The recent massive resistance against privatization plans for the health care sector, set out by the Hungarian government (Tóth and Neumann 2008), testifies to the awareness of the CEEC that they are at a crossroads between the maintenance of high public influence on the health care sector with equal benefits for everyone and a loss of control by the state in the case of the development of two-tier health care provision. Already the enormous impact of illegal out-of-pocket payments has led to the *de facto* establishment of a two-tier system of medical treatment. Growing risk individualization by official out-of-pocket payments, allowing the implementation of a dualistic insurance market, would make permanent the unattainability of universal health care in the CEEC (Baum-Ceisig *et al.* 2008: 294 ff.).

The evolution of the health care systems in Slovenia and the Czech Republic makes clear that the observed general trend of growing risk individualization and privatization is by no means an unavoidable path. In both countries physicians earn relatively good money so that informal payments by patients are irrelevant. Moreover, the official out-of-pocket payments are relatively low. With a share of around 10 per cent of the total health expenditure in each state they mark the lowest values of all the CEEC. To cover these extra payments, Slovenia created a system of additional health care insurances, which is used by 94 per cent of the population (Laursen 2005: 202). Furthermore, both countries have the best rates of life expectancy and infant mortality in the CEEC and score well in health care criteria in a gender dimension (Hacker 2008). Their high economic growth seems to be the central precondition for Slovenia and the Czech Republic to dispose of health care expenditures per capita close to the respective values of their Western European neighbours and considerably ahead of the rest of the CEEC group (see table 4). In contrast, the economically less developed countries Bulgaria, Romania and the three Baltic States stand out through low per capita health care expenditures and persistently negative health indicators.[4]

Unemployment Insurances in the CEEC

The transformation from state-directed economies to functioning market economies did not run smoothly. At the start of the 1990s there was a remarkable decline in production, which was accompanied by a strong increase in unemployment rates. While under the communist regimes unemployment,

by definition, did not exist, the CEEC had to implement new systems to absorb the upcoming social risks after 1989. The new governments moved towards unemployment insurances of Western European provenience. The social intention of these insurances is the temporary payment of wage replacement benefits in the event of a loss of employment. In half of the CEEC, the unemployment insurances are financed solely by the contributions of employers and employees. In Latvia, Lithuania, Poland, Slovakia, Slovenia and Romania a mixed financing, with participation by the state, is applied. Initially, Estonia developed a pure tax-financed system, but changed in 2001 to a contribution-based unemployment insurance. In Slovenia the financing is almost entirely organized by the state, which covers 90 per cent of the costs (Baum-Ceisig *et al.* 2008: 300 ff.).

Adjustment to economic realities through benefit cutbacks

Faced with the growing unemployment rates in the 1990s, the initially comprehensive benefits of the unemployment insurances put a heavy burden on insurance systems and state budgets. As a consequence, many of the CEEC enacted broad benefit cutbacks. They affected:

- the level of the wage replacement rate;
- the duration of the reference period to receive unemployment benefits;
- an increase in the necessary minimum period of insurance and the entitlement period;
- a reduction of the initially high employers' share of financing of the unemployment insurance.

For example, in Poland no time ceiling was intended for receiving unemployment benefits. Today, the unemployed person has to exhibit a minimum of one year of employment during the 18 months prior to the loss of his/her job. In Hungary the reference period was shortened from 48 to 9 months; the same happened in Slovakia from 36 to 6 months. In the Czech Republic at the beginning of the 1990s, the unemployed received for the first three months of their unemployment 60 per cent and then for the six following months 50 per cent of the reference salary. Today these replacement rates amount to 50 and 45 per cent, respectively. In 2005 the contribution rate for employers to the Romanian unemployment insurance fell from 5 to 2.5 per cent; today it lies at only 2 per cent (Baum-Ceisig *et al.* 2008: 310 ff.).

The eligibility criteria for receiving unemployment benefits differ significantly between the CEEC. In Slovakia it is necessary to prove 36 months of insurance in the last four years of employment; in Romania the unemployed must have worked for six months during the year prior to the loss of the job. The reference period of the unemployment benefits is organized differently as well, and equated to the criteria of years of income, duration of individual contribution period, and age. In Poland the regional level of unemployment is an additional criterion for defining the reference period. Only in Latvia, Hungary and Slovakia is a single fixed reference period in force for all persons concerned. The replacement rates are normally determined as a percentage share

of the individual gross income over a certain period before unemployment.[5] In four countries the rules vary: In Poland a fixed amount, currently €132, is paid, plus additional benefits, depending on the length of the qualifying period. Similarly, in Lithuania the unemployment benefit is made up of a fixed amount, currently €59, and a complicated calculated variable rate out of individual and national average income. In Romania the national minimum wage is the main reference parameter. A share of 75 per cent of the minimum wage makes up the main part of the unemployment benefit and is supplemented by up to 10 per cent of the individual gross income. The minimum wage is also used for reference in the Hungarian unemployment insurance: For the first 91 days without a job, 60 per cent of the individual average gross income in the last four quarters is paid, but not less than 60 per cent of the national minimum wage. From the 92nd day of unemployment onwards, this share of the minimum wage constitutes in any case the general replacement rate.

It is striking that in most of the CEEC the wage replacement rates in the case of unemployment are very low, are time-limited and restricted through preconditions. Unemployment benefits do not serve as an instrument for status maintenance but as a guaranteed basic amount to tide people over for a strictly limited time period. In the Czech Republic, Estonia, Hungary and Slovenia the benefits are reduced to a significant extent, the longer the period of unemployment lasts. In Poland and Romania the replacement rates increase considerably, dependent on the duration of employment or insurance. In Latvia both directions apply: benefits increase according to the length of time the unemployed has paid insurance contributions, and decrease if joblessness is continued. After the expiration of all entitlements to receive an unemployment benefit, only in Estonia, Hungary and Slovenia may the people concerned receive a small financial allowance of unemployment assistance. In all other CEEC the unemployed are referred directly to social assistance (Baum-Ceisig *et al.* 2008: 318).

The social allocation of unemployment

Since the mid-1990s, economic growth rates have increased significantly in the CEEC. In most states they surpassed the average growth rates of Western Europe. This development helped to reduce the high unemployment rates in the first phase of the transformation process. Only in Poland and Slovakia does unemployment remain high, with rates at 13 to 14 per cent of the working population. In contrast, the European average unemployment rate is 8.2 per cent. Moreover, within the CEEC group, both these countries have the highest rates of unemployment among young and older people, as well as for the long-term unemployed. A look at the activity rates in the CEEC tarnishes the positive impression of low unemployment rates. Apart from Poland and Slovenia, also Bulgaria, Hungary and Romania have low activity rates, at fewer than 60 per cent of the total population (see table 5). These three countries all exhibit moderate total unemployment rates, but dispose of above average rates for young people and long-term unemployment. This shows that unemployment in the CEEC is distributed very unequally across society.

Table 5

Labour market data, CEEC, 2006

	Unemployment rate as % of active population				Employment rate as % of total population
	In total	Long-term*	Under 25 years	Over 25 years	
BG	9.0	5.0	19.5	7.9	58.6
CZ	7.1	3.9	17.5	6.2	65.3
EE	5.9	2.8	12.0	3.5	68.1
HU	7.5	3.4	19.1	6.5	57.3
LV	6.8	2.5	12.2	6.0	66.3
LT	5.6	2.5	9.8	5.2	63.6
PL	13.8	7.8	29.8	11.7	54.5
RO	7.3	4.2	21.4	5.7	58.8
SK	13.4	10.2	26.6	11.7	59.4
SI	6.0	2.9	13.9	5.0	66.6
EU-15	7.7	3.2	15.7	6.6	66.2
EU-27	8.2	3.7	17.1	7.0	64.5

* 12 and more months of unemployment.
Source: Eurostat (2008).

In addition, a strong variation in respect of the regional distribution of unemployment is observable. Rural areas are more affected than urban areas. In many of the CEEC an east–west divide is identifiable, whereby the eastern regions suffer from higher unemployment rates. The unemployment data for Romania have to be evaluated with caution. The country maintains an extensive black economy and subsistence farming, which is unique in the EU. Approximately 5 million people are occupied within these two sectors. Considering that Romania possesses 9.8 million employable persons in total, these figures change the labour market indicators significantly (Hacker 2007: 69).

In the last few years all of the CEEC have followed a general European trend to strengthen active and activating labour market policies instead of offering passive unemployment benefits. These new labour market programmes are still at an early stage and the financial resources provided are not noteworthy compared to Western European benchmarks. Often they do not reach the target group of persons most capable of being integrated into the labour market, but serve the best-qualified people as a complementary support (Baum-Ceisig *et al.* 2008: 319 ff.).

Conclusions

The developments of the central social security systems during the transformation process shed some light on the current arrangements of the Central and Eastern European welfare states. The sectoral as well as the intra-sectoral

variance of social arrangements and models between the ten new EU members shows clearly that the existence of a single post-socialist welfare state type cannot be shown. For the time proximate to 1989 it is indeed possible to identify a turn throughout the area to Bismarckian social insurances as a basic principle for the organization of old-age security, health care provision and unemployment protection. But the reform activities of the CEEC in the following transformation years implemented a variety of elements.

In the pensions sector one can speak of an obvious dichotomy. On one side there is the majority of the CEEC, which followed through a far-reaching elimination of redistribution elements and the installation of mandatory private insurances as a way to increase risk individualization. On the other side is situated the minority of Slovenia and the Czech Republic, which were successful in adapting their pension systems to a changed socio-economic environment by gradual reform steps. The reasons for the radical path breaks in most of the CEEC are, for example, insufficient parametric reforms in the 1990s, wrong policies of early retirement as a reaction to mass unemployment, the persistence of privileges for single occupation and status groups, as well as the influence of the dominating ideological model of market-driven solutions after the end of the Cold War. The projections of pension data until 2050 suggest that under the current political conditions the radical reformers are moving with different speeds towards the old-age security systems which we know from classic liberal welfare states, e.g. Great Britain. The public pay-as-you-go schemes will little by little change into a basic protection provision and all old-age security beyond that will have to be organized individually and on a private basis. Some states will be confronted with massive problems of old-age poverty. The prevention of poverty will thus in the long run replace the principle of securing living standards. On the other side, the pension systems in Slovenia and the Czech Republic, often referred to as 'sustainable', will increasingly face old-age dependency ratios above the average, which could lead to severe financing problems. Thus, both states are confronted with similar challenges like, for example, the conservative welfare states of Germany and France.

The development of the CEEC unemployment insurance systems shows similar tendencies to those of Western Europe. Because the old systems were not constructed to cover mass unemployment, the CEEC had to cut back generous wage replacement rates and entitlement criteria in the face of the high unemployment rates of the beginning of the 1990s. Despite current all-time low unemployment rates, the CEEC continue to tighten benefit preconditions and to cut back benefit periods and replacement rates. This policy can be explained along with socio-economic factors – as in the pension system reform process – by an imported paradigm of supply side economic philosophies. These identify inflexible labour markets as the central obstacle to higher economic growth and the creation of more jobs (Baum-Ceisig *et al.* 2008: 442). The benefit cutbacks in the unemployment insurance systems of the CEEC and the tendency to move from passive to activating labour market measures are in line with similar reform strategies in many Western European states as well as with the European Employment and the Lisbon Strategy. The low replacement rates in most of the CEEC indicate a

more radical retrenchment of social security than in Western Europe. They testify to the decision in favour of a certain policy direction which leads away from the general securing of status in the event of unemployment towards a basic protection strictly limited in duration and scope.

Among the sectors of the welfare state analysed here, the health care systems of the CEEC still contain the most inherited elements from the socialist period. With the change to the Bismarckian insurance model and gradual reforms, CEEC governments established the foundations for modern drafted health care systems which should include all citizens at a high provision level. This could not be achieved, however, because of the cost-intensive but indispensable reorganization and adjustment of the Soviet health provision model to Western standards and the relatively low economic performance of the CEEC. This is attested by the below-average state of health of the populations of some states, the ongoing important role of public hospitals, the low remuneration of physicians, gaps in the medical infrastructure and the persistence of informal out-of-pocket payments. No state among the CEEC wants to denounce the inherited universal principle of health care provision. However, there are increasing limits on the provision of free services, and official out-of-pocket payments have risen to be an important source of financing. A possible countermovement is – as with the design of reformed pension systems – shown by Slovenia and the Czech Republic. Their positive economic development allowed higher public investments and modernization measures in the health care sector. Generally, the CEEC are at the point of making a fundamental decision over the future balance between the existing public provision and a possible new private health care provision. Even though the gap between the claim and the reality of a universal health care provision widens steadily, the still comprehensive systems of today feature – also through their high tax-financed share – a certain closeness to the health care policies of the welfare states of social-democratic provenience, e.g. Sweden.

Besides borrowings from all three classic worlds of welfare states (Esping-Andersen 1990, 1999; Arts and Gelissen 2002), the CEEC also show close similarities with the Mediterranean world of welfare (Leibfried 1992; Ferrera 1996). The important role of the family in social care and the often insufficient financial resources of many insured persons, as well as the growing distribution inequalities and high poverty rates, represent the proximity to states with only rudimentary welfare systems. This is true especially for Romania, where a legally modern designed welfare state cannot fit into the context of the obvious socio-economic deficits of the country.

Because of their variable orientation and the amalgamation of different social policy models, a classification of the CEEC into the four main welfare worlds is not feasible. Moreover, there is no such thing as a Central and Eastern European welfare state model. The heterogeneous social security systems do not result in a generalizing picture, which would allow the establishment of an independent welfare model as a new category. In contrast, an increasing assimilation to Western welfare state archetypes is observable, but the CEEC do not follow one single example. On the one hand, this implies an increasing hybridization of the common welfare state clusters (Baum-Ceisig *et al.* 2008: 436; Schubert and Brazant 2008). On the other hand, some of

the identified sectoral convergence processes in social policies follow, in Central and Eastern Europe, the same liberal tendencies as in Western Europe.

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Notes

1. Today, the average retirement age in the CEEC is 63 years for men and 61 years for women. The qualification period ranges from 10 years for men and women in Slovakia to 25 years in Poland for men. In the majority of the CEEC, 15 years is the period for both sexes (MISSOC 2007).
2. For example, the contribution rate as a percentage of the gross income for the funded pillar in Bulgaria is only 2 per cent, while the rate of the pay-as-you-go scheme in the first pillar is, at 27 per cent, still high. In contrast, in Latvia contributions to the second pillar constitute 10 per cent, but only 19.1 per cent are earmarked for the first pillar. The highest contributions in the pay-as-you-go schemes are to be paid in countries without a funded scheme – Slovenia, the Czech Republic and Romania – as well as in Bulgaria and Hungary (between 24 and 28 per cent); the lowest rates can be found at 12.22 per cent in Poland and 9 per cent in Slovakia (MISSOC 2007).
3. Nikolai Aleksandrovich Semashko (1874–1949) was the first Commissar of Health in the Soviet Union from 1918 to 1933. After him is named the centrally organized health care system, financed solely by the state budget, which was introduced in all ten CEEC.
4. Men have the lowest life expectancy in Latvia and Lithuania with 65 years, which marks a difference of 10 years from the EU-27 average. Women have a life expectancy of only 76 years in Bulgaria and Romania, while the EU-27 average is 81 years (see table 4).
5. It is difficult to compare the rates of unemployment benefits among the CEEC, because of the use of different reference earnings. Even so, many states use the individual average gross income, and replacement rates differ considerably. For example, the Estonian unemployment insurance pays between 40 and 50 per cent of the average gross income; in Latvia, the unemployed receive between 50 and 100 per cent (MISSOC 2007).

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