fiscal basis of subnational authorities, particularly in Spain and Italy. Concern about redefining the activities and purpose of government is evident in all four countries through strategies of outright privatization of public utilities, recasting of various public bodies such as, for instance, the National Employment Services and establishment of a range of more or less autonomous agencies for planning, research and inspection functions in various policy areas. Devolution trends have also been prominent mainly in Spain and Italy. In the third part we briefly examined policy developments encouraging a wide scope of mixtures of public–private providers and new governance strategies (quasi-markets, contracting-out, performance criteria, etc.). The extent to which such strategies trigger wide-range and systematic reforms in welfare arrangements and embed regulatory mechanisms into everyday routines greatly varies among SE countries and regional jurisdictions. Moreover, the 'legalistic' administrative culture (particularly strong in Greece) is not fit for purpose, as the regulatory requirements of the changing welfare mix are increasing.

SE countries are facing a daunting task: to tackle extensive inequalities and inefficiencies of their old regimes and at the same time enter into unchartered territories of more diversified yet highly regulated welfare mixes. How successful this attempt will be in the future remains to be seen. At the current stage, however, concern is growing about the overwhelming influence in these countries by a discourse (and practice) that largely frames aspects of social welfare – previously expressed in the language of need, vulnerability and redistribution – in terms of workfare and market competition. In the absence of well-developed safety nets and universal guarantees, there is a danger that such an orientation may pre-empt equity and redistribution criteria with detrimental effects on social cohesion.

5
Metamorphoses of Welfare States in Central and Eastern Europe[1]

Martin Potůček

Introduction

This chapter deals with the protracted processes of social policy transformations in Central and East European post-communist countries. Parallel processes of political democratization, institutionalization of the market economy, globalization and Europeanization form the relevant context of genuine domestic decision making and implementation. From a scholarly point of view, the processes of their societal transformations have been – and still are – a series of exciting natural experiments. As Esping-Andersen (1996a, p. 267) remarked: 'East and Central Europe is clearly the most under-defined region, a virtual laboratory of experimentation'.

In the first part of this chapter, eight post-communist Central and East European states (CEEs) that became European Union (EU) Member States (the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia) in May 2004 are analysed with regard to welfare state financing, regulation and provision. In addition I will scrutinize some social policy outcome variables with regard to the recent transformations. In the second part, the development of the Czech Welfare State is analysed in greater detail.

Central and Eastern European welfare states

The core contextual changes that have influenced social policy-making since the fall of Communism were the abrupt shifts from a centrally planned economy to a market economy, and from authoritarian to democratic and pluralistic political systems. Correspondingly, the regulatory power of the state has diminished and that of the market has sharply increased. In the first part of this section, I will discuss the institutional changes of welfare state policies, before addressing the dimension of outcomes.

Institutional dimensions

The actors of the market economy spilled over to welfare provision both in a regulated and unregulated way. The regulated channels of provision include public as well as partially privatized health and social care facilities and various social security schemes. In addition, all countries allow insurance contracts between individuals and private providers alongside the publicly financed provision. The unregulated channels of provision are typical for dual two-tier systems of social and health care, where formally universally accessible services suffer from insufficient public resources, thus forcing people to pay bribes to professionals in order to get a service in time and of sufficient quality. The role of the civic (nonprofit) sector remains, for a whole set of reasons, rather marginal, though with an appreciable rise of its influence and scope of operation (Kendall et al., 2000).

There have been strong external factors influencing the various national social and health policies. Initially the European Union did not developed strong, clear-cut requirements in the field of social policy-making towards the future candidate countries (Potůček, 2004; Horibayashi, 2006), even though Orenstein and Haas (2003) identified positive effects for those post-communist countries that have joined the EU compared with post-communist countries without an immediate perspective of joining the EU. This initially rather reluctant policy approach by the EU provided considerable policy space for other international actors, namely the World Bank and the International Monetary Fund (Potůček, 2004).

Since the beginning of the new millennium, however, the situation has been changing slowly as the European Union has contributed to the increasing salience of social policy issues on the political agenda, and has provided support for institution building through the transfer of skills and money. The Open Method of Coordination (OMC) has become the main instrument for the 'Europeanization' of social policies in the New Member States (NMS). Nevertheless, the standard of preparing and implementing national programmatic documents was not very advanced. Poorly defined goals and responsibilities, lacking programme evaluation, poor inter-departmental coordination, and missing links to budgetary resources provide plenty of room for further improvements (cf. Atkinson et al., 2005).

Taking a closer look at labour market developments, the general tendency in the region has been towards a steady decline in the number of employed people and rising unemployment. The centrally planned economies inflated the labour force by creating an artificial demand. Thus, unemployment was virtually an unknown phenomenon in the region prior to 1989. Transition brought about a sharp rise of unemployment – from close to zero to two-digit rates in some countries. The current unemployment rates have decreased below the average of Old Member States (OMS), with the important exceptions of Poland and Slovakia, which have significantly higher unemployment rates, and Hungary.

Table 5.1 Unemployment rates in New Member States

Country	*2000*	*2007*
Slovenia	6.7	4.8
Czech Republic	8.7	5.3
Slovakia	18.8	11.1
Hungary	6.4	7.4
Poland	16.1	9.6
Estonia	12.8	4.7
Lithuania	16.4	4.3
Latvia	13.7	6.0
OMS	***7.7***	***7.0***

Source: Eurostat, 2008.

Table 5.2 Public expenditure for labour market policies

Country	*Public expenditure for labour market policy measures, % of GDP, 2004*	*Expenditure on active labour policies, % of all public labour market policies expenditures*
Czech Republic	0.39	34.0
Slovakia	0.39	18.4
Hungary	0.59	35.3
Estonia	0.23	19.0
Lithuania	0.26	58.3
Latvia	0.46	18.3
OMS	***2.11***	***30.5***

Source: Eurostat, 2006.

Although labour market policies compatible with the market economy have been developed in the region, acute shortages of financial resources and available labour market services continue. Overall public expenditures on labour market policies remain very low compared with spending in OMS; with regards to active labour market policies we witness huge differences among the NMS.

The changes in the realm of pension policies have also been far reaching. The introduction of mandatory second tier old-age pension schemes run by for-profit private pension funds represents a clear trend towards recommodification. The move in this direction has been considerable: Hungary introduced a mandatory second tier in 1998, Poland in 1999, Latvia in 2001, Estonia in 2002, Slovakia in 2003, and Lithuania in 2004. At the same time, the purchasing power of the public old-age pension for current beneficiaries continues to be very low (see Table 5.3).

The changes in health care have largely been characterized by retrenchment, leading Ferge (2001) to argue: 'The public health funds operating now mostly as public insurance schemes severely limit the services they pay for.

Table 5.3 Average monthly old-age pension (in Euros)

Country	*2003*
Slovenia	420
Czech Republic	223
Slovakia	138
Hungary	176
Poland	222
Estonia	108
Lithuania	95
Latvia	94

Source: CANSTAT (2004).

Table 5.4 Comparison of the satisfaction with health-care system: Old versus New Member States (2003)

	Old Member States	*All New Member States plus Turkey, Romania and Bulgaria*
Very and fairly satisfied	56%	32%
Not at all and not very satisfied	42%	67%

Source: Alber, 2003, own calculations.

Many types of prevention, screening, and medical interventions, dentistry, and a long list of pharmaceuticals have been excluded from public funding.' Retrenchment within the realm of health care severely contributed to the high level of dissatisfaction with the performance of the (public) health-care system in the NMS.

The mediocre to poor quality of the formal, universally accessible health care has in some NMS contributed to an 'informal' or 'private' care system, financed through out-of-pocket co-payments to doctors (Leven, 2005; Bolanowski, 2007). Unfortunately, systematic data about the extent of these informal payments is not available. Nevertheless, despite these policy developments, the overall health status of the population in the NMS, measured by the life expectancy at birth, has improved since the beginning of the transformation.[2]

There is a considerable gap between the capacities and quality of institutionalized social care in OMS and NMS. Whereas only 4 per cent of adults in OMS report 'additional' family responsibilities, more than 28 per cent of respondents in NMS report such responsibilities (Alber, 2003, his own calculations). Partly this might be driven by the very low satisfaction rates with social services in NMS. This data reflects the extraordinary burden for

Table 5.5 Satisfaction with social services in Old and New Member States (2003)

	Old Member States	*All New Member States plus Turkey, Romania and Bulgaria*
Satisfied (values 6 to 10 on the 10 point scale)	52%	24%
Not satisfied (values 1 to 5 on the 10 point scale)	43%	74%

Source: Alber, 2003, own calculations.

Table 5.6 Family allowances as a percentage of total household income

Country	*1991*	*1999*
Slovenia	0.6	1.4
Czech Republic	4.7	1.6
Slovakia	6.4	4.3
Hungary	8.1	3.8
Poland	4.2	1.2

Source: UNICEF, 2001.

family caregivers. Insufficient institutional capacities create a form of dependency that burdens mostly women and in complex ways contributes to their normative preferences.

Traditional forms of public support for families with children significantly weakened during the transformation period: access to crèches and kindergartens was at least partially re-commodified as many of these previously public facilities were privatized and corresponding public subsidies were abolished. Family allowances declined in all countries with the exception of Slovenia, during the 1990s. This can be understood as privatization largely through the (re-)familialization of risk.

To sum up: compared with the former communist welfare systems, public responsibility for social risk coverage has obviously declined, and private financing has risen due to the recommodification of important welfare sectors. However, the transition to market economies has not made the public sector superfluous as it still dominates the financing of health and social care in the NMS. Compared with public social spending in OMS, public social expenditures – both in absolute and in relative terms – are more modest in the NMS (see Table 5.7).

Social policy outcomes

The general consequences of the political and economic changes after 1989 for the people in all NMS have been an *improvement* in the standard of living

Table 5.7 Total public social and health expenditures as a percentage of GDP in the New Member States (2005)

	Slovenia	*Poland*	*Hungary*	*Czech Republic*	*Slovakia*	*Lithuania*	*Latvia*	*Estonia*	*EU-27*
Total public social and health expenditures	23.4	19.6	21.9	19.1	16.9	13.2	12.4	12.5	27.2

Source: Eurostat, 2008.

for some and *stagnation or deterioration for many*. The differences between the lower and upper strata have rapidly increased. The inequalities have risen more rapidly in the Baltic States with Poland following suit. Income inequality in the region at the end of the communist period was low compared to most OECD countries. By the late 1990s, however, the average value of the Gini coefficient in Central and Eastern European and Baltic States had risen to about the average OECD level (UNICEF, 2001, p. 26). The transition has been accompanied by a serious increase in poverty (Orenstein and Haas, 2003). Although the official EU statistics show rates of relative poverty similar to those in OMS (see Table 13.1), the level of absolute poverty in some NMS is quite high: 7.3 per cent of Hungarians, 8.3 per cent of Latvians, 7.8 per cent of Lithuanians, and 5.2 per cent of Estonians are reported to live on less than 2 USD per day at the beginning of the 2000s (GVG, 2002, p. 27).[3] As in most other countries, children are more vulnerable than the rest of the population. There are only two countries in the region that do not show signs of extreme forms of child poverty: Slovenia and the Czech Republic. In the NMS, about 440 thousand children lived on less than 2.15 USD a day by the end of the millennium. With the exception of the Czech Republic and Slovakia, there has been no attempt to define and provide an adequate subsistence minimum.[4] In Poland the rules of eligibility are so strict as to exclude the majority of the poor (cf. Ferge, 2001).

Table 5.8 provides three different variables of social exclusion and deprivation. The first column provides the mean number of items lacking from a list of seven durable consumer goods (TV set, video recorder, telephone, dish washer, microwave, car (or van) and personal computer). The second and the third columns present the proportion of the adult population admitting either having had solvency problems or been unable to save money.

Commonalities and differences of welfare state transformations

Owing to the variable speed of the reform processes and the lack of appropriate data, it is very difficult to offer any consistent conclusions concerning

Table 5.8 Mean deprivation of the population in the New Member States

Country	*Index*	*% with solvency problems*	*% not able to save*
OMS	*0.64*	–	–
Slovenia	0.54	5.2	67.7
Czech Republic	0.80	4.0	63.2
Slovakia	1.29	7.3	72.9
Hungary	1.37	14.3	87.5
Poland	1.52	11.3	86.1
Estonia	1.54	18.8	85.5
Lithuania	1.79	21.7	84.0
Latvia	2.07	24.2	88.2

Source: Russell and Whelan, 2003.

the ideal-typical welfare taxonomy emerging in the NMS or to identify a clear emerging public/private mix. Nevertheless, let us dare to offer some cautious characteristics of the general tendencies, similarities and differences, which should be submitted to further scholarly scrutiny. Slovenia is the country that most closely resembles the traditional Western European Continental model. The Czech Republic follows suit with universal access to core social and health services and universal access to a minimum of subsistence, but with less generous social welfare benefits and more targeting in less vital areas. Hungary and Poland grapple with major difficulties and combine universal access in some fields with a residual restrictive approach in others. Slovakia has made access to social welfare very tough and conditional at the beginning of the twenty-first century, thereby moving from a continental model towards a liberal welfare state approach, which is dominant in all three Baltic States. At the same time, the Baltic States have been – contrary to Poland, Hungary and Slovakia – able to preserve relatively high employment rates and a more flexible labour market (comparable to the OMS average). This summary underlines that we have not been witnesses of a one-dimensional transformation of welfare states in Central and Eastern Europe, but that welfare state transformations are indeed very complex. To get a better understanding of such welfare state transformations in one NMS, we will analyse the welfare state developments in the Czech Republic in greater detail.

Czech welfare state transformations

Historically elements of the current institutional design of the Czech welfare state can be traced back to Bismarck; first corporatist, compulsory health and social insurance schemes evolved at the end of the nineteenth century. In the interwar period, democratic Czechoslovakia possessed

a comparatively advanced social legislation that was emulated by other countries – namely Greece. Pre-1989 communist propaganda often showcased the well-organized Czechoslovakian health and social services. Hence, the reason for the final collapse of Communism was not so much related to the mediocre, technically outmoded quality and sometimes limited availability of social services as to the sorry state of the economy, and the loss of political legitimacy. A universal and uniform system of social security was to become the core of the state's social policy during the first turbulent years after the collapse of communism in 1989. Associated with the victory of neoliberal and conservative political parties in the 1992 elections, liberal and residual tendencies began to be asserted more forcefully in this field. This conception of social reform began to impose limitations on social security policy, which subsequently led to the conception of a three-tiered system: the first tier is based on compulsory public social insurance, reacting to foreseeable situations in a citizen's life, following the pay-as-you-go principle; the second tier consists of state social support, reacting to unforeseeable events, financed through general taxation; finally, the third tier relies on the social assistance principle of supporting citizens who find themselves in an emergency situation, co-financed by central and local authorities, nonprofit organizations and clients.

The subsequent development of social policies in the Czech Republic until present can be differentiated into three phases.

1st phase: Designing new institutions (December 1989–June 1992)

Social policy was developed and embodied in legislation on both the federal (Czechoslovak) level (Federal Ministry of Labour and Social Affairs) and national level (Ministry of Labour and Social Affairs of the Czech Republic). Although cooperation between the two ministries was not always ideal, from a political standpoint their position and those of the respective governments were always compatible. What they did is best described as an effort to systematically replace state paternalism by introducing more resilient and decentralized mechanisms that would be compatible with ongoing economic reform. These mechanisms were to be beholden to the regulative and executive powers of the state only where necessary. From the standpoint of the governments' prevailing political philosophy, this approach was a combination of socio-liberal and social-democratic philosophies.

The Czech social policy reform was based on three basic components: first, active employment policy; second, liberalization and pluralization of social welfare based on a Bismarck-inspired insurance system that has been deeply rooted in the country's modern history since the end of the nineteenth century; and third, the development of a social safety net for people in need. The 'Scenario of Social Reform', which was drafted and adopted by the federal government, became the core conceptual policy document guiding reform

in the social sector; it was significantly influenced by social-democratic as well as social-liberal ideologies. A plan for a universal and unified system of social welfare was adopted, which would offer universal compulsory health and social insurance (complemented by voluntary supplementary insurance for individuals or groups), and means-tested state social assistance. The latter would only be provided in the event of a citizen's inability to provide for him or herself *and* if all alternate possibilities of welfare and assistance had been exhausted.

2nd phase: Retrenchment (July 1992–June 1998)

Owing to a change in government a neoliberal policy, emphasizing the priority of economic reform, dominated in the coming years. The government not only declared it would limit the role and spending powers of the state in the sphere of social security, but also enacted some legislation along these lines, specifically the targeted and means-tested child allowances. Many social policy institutions, originally designed as pluralistic and corporatist, remained firmly in the hands of the state (e.g. the system of social insurance), due to the distrust by the government in the intermediary role of civil society institutions. The Czech neoliberal and conservative governments neglected conceptual work and a practical orientation towards long-term goals, especially preventive social policies (Potůček, 1999). Finally, the government was not enthusiastic in joining the EU and subsequently lagged in the implementation of EU requirements, as was reflected in the annual reports by the European Commission.

3rd phase: Social policy back on the political agenda (July 1998–June 2006)

The core of the consecutive governments' policies, dominated by the Czech Social Democratic Party, was the idea of a socially and environmentally orientated market economy. This was in sharp contrast with the more or less residual social policy accents implemented by the previous governments. However, the implementation of such programmes was seriously threatened by budgetary constraints caused by the acute fiscal problems of the country, the legislative delays caused by the weak position of the governments, the insufficient implementation capacity of the state, and the long-drawn-out reform of public administration.

An important aspect of social policy regulation was represented by the EU-accession preparatory process, speeded up by a clearly pro-European governmental policy. The EU's Open Method of Coordination began to be applied with the annual elaboration and implementation of the National Employment Action Plans, guided by the European Employment Strategy at the end of the 1990s (Ministry of Labour and Social Affairs, 2004a). In 2002 the European Commission asked all candidate countries' governments to elaborate Joint Inclusion Memoranda in order to identify key problems and policy measures to fight poverty and social exclusion. A social inclusion

Table 5.9 Public social and health system expenditures as a percentage of GDP (1992–2006)

Year	*1992*	*1997*	*1998*	*2006*
Pension security benefits	7.6	8.0	8.1	8.3
Sickness and maternity benefits	1.2	1.1	0.9	1.0
Unemployment and employment policy expenditures	0.4	0.2	0.3	0.4
Family allowances (state social support system)	1.8	1.6	1.6	1.1
Social care benefits and social services system	0.8	0.7	0.8	0.9
Others	1.8	0.1	0.1	0.2
Administrative expenditures	0.2	0.3	0.3	0.3
Social security system expenditures – total	13.7	12.1	12.1	12.2
Health care system expenditures	5.4	6.7	6.6	6.8
Total Expenditure[5]	19.2	18.8	18.7	19.0

Source: Research Institute for Labour and Social Affairs, 2007.

agenda was formally set with the preparation and approval of this document by the representatives of the European Commission and the Czech government in 2004 (Ministry of Labour and Social Affairs, 2004b). The preparation and approval of a National Action Plan on Social Inclusion 2004–2006 followed suit (Ministry of Labour and Social Affairs, 2005a). Despite the progress achieved, the weak spot of the document is the lack of explicit goals, poorly defined responsibilities for implementation, and missing links to the budgetary process (Potůček, 2007).

Despite the shift from liberal-conservative governments (in power from 1992 until 1997) towards coalition governments led by Social Democrats (in power from 1998 until 2006) and their respective approaches to social policy, the overall trend in public social expenditure has been surprisingly stable (see Table 5.9).

The majority of these expenditures are financed through obligatory employees' and employers' contributions to the social and health insurance funds. The state pays contributions into these funds for children, pensioners, parents on maternity or paternity leave, the unemployed, the disabled, soldiers and prisoners (see Table 5.9).

Although the share of private funding for social and health care is still comparatively low, some fields have seen a slow and steady increase of the private share (e.g. through co-payments for prescription drugs).

Employment and unemployment policies

The attention paid to active and passive employment policy fluctuated significantly over the years according to the political orientation of the

Table 5.10 Compulsory social insurance contributions as a percentage of gross earnings

Czech Republic, 2007	*Employee*	*Employer*	*Employed person, total*	*Self employed person – see note*
Pension insurance	6.5	21.5	28	28
Health insurance	4.5	9.0	13.5	13.5
Sickness insurance	1.1	3.3	4.4	4.4 (or 0)
State employment policy contribution	0.4	1.2	1.6	1.6
Total	12.5	35	47.5	47.5 (or 43.1)

Note: Self-employed persons decide the basis for the contribution calculation by themselves, with minimum level of 50 per cent of income after deduction of expenses, but at least 25 per cent of average monthly salary, and with a maximum ceiling of 40 500 CZK, representing approximately 2 times the average monthly salary. The basis for their health insurance is calculated according to the formula of 50 per cent of average monthly salary. They may decide to opt out from sickness insurance and arrange it for themselves privately.

Table 5.11 Expenditure for ALMP as a percentage of all LMP expenditures (Czech Republic, 1991–2004)

Year	*1991*	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*
%	31	55	35	28	26	21	14	18	25	37	43	44	N/A	34

Sources: Ministry of Labour and Social Affairs, 2006; Eurostat, 2006.

various governments, with the right-wing orientation being more in favour of passive policies, and the left-wing orientation supporting active employment policies, which is also reflected in spending levels (see Table 5.11).

The share of expenses for active employment policy stabilized at the level of about one-third of total LMP expenditure. In 2006 European structural funds added approximately one-third to the amount allocated by the Czech state budget. Nevertheless, the share of ALMP expenditure as a percentage of GDP comprises only about one-third of the resources allocated to these policies in the OMS. Not surprisingly only 8 per cent of the unemployed participated in individual measures; the ratio of clients/case-workers fluctuates between 250–400/1 (Sirovátka, 2007a). The government launched (and Parliament accepted) the first National Programme of Employment in early 1999. The National Employment Action Plan 2004–2006 (Ministry of Labour and Social Affairs, 2004a) has been elaborated under the auspices of the European Commission and the Czech Ministry of Labour and Social Affairs.

Despite these improvements, the unemployment insurance system only provides very modest benefits. On average unemployment benefits provide a net replacement rate of 28.5 per cent of the estimated net average earnings in 2005. Unemployed workers under the age of 50 are entitled to receive

benefits for a period of 6 months; unemployed workers between 50 and 55 for 9 months; and those above 55 for one year. About 4–6 per cent of households claim social assistance benefits, and most social assistance claimants (62–3 per cent) are unemployed (Sirovátka, 2007b).

Czech employment policy is executed overwhelmingly via assigned public institutions, i.e. labour offices. Through the implementation of the Employment Act in 1991 a network of public regional Labour Offices was created to administer state employment policy in the regions. In addition to offices in regional capitals, branch offices were established in the bigger regional towns. Their services are relatively easy to access for job-seekers throughout the country. Private firms focus their services nearly exclusively on finding good candidates for high executive positions in multinational companies. As there are scarce resources allocated for the active employment policy, the space for the engagement of private enterprises and civic associations in the provision of labour market services is very limited. Nonetheless, there is clearly a window of opportunity in the utilization of the European Social Fund.

Old-age pensions

Pension insurance covers old-age pensions, disability pensions, widow and orphan pensions, contributions for the treatment of a family member, and administration costs. 1995 saw a significant legislative change in the structure of compulsory social insurance with the passing of a new law on old-age pensions. According to this new law, the statutory retirement age for women was raised from a minimum of 53 to 57 years (the actual limit depends on the number of children), while for men the retirement age rose from 60 to 62. These reforms were to be implemented over a 12-year period. In 2003 the retirement age was further raised to 63 for men and for women without children. Again the age increase will be phased in over a longer period of time; the new pension age will be fully effective for men in 2016 and for women in 2019. The basic pension insurance law conceives the old-age pension as consisting of two components made up of a fixed amount paid to all senior citizens and one that is dependent on the number of years worked and the income earned; the law is based on the principle of substantial redistribution of accumulated finances towards persons with a lower level of earnings. Old-age pensions for persons with higher working incomes are affected by a regressive calculation formula. The average net replacement ratio of old-age pension benefits declined from 66 per cent (1990) to 52.7 per cent in 2006. The gross replacement rate dropped over the same time period from 52.7 per cent to 40.8 per cent and will further decline to 38 per cent by the year 2010 and to 35 per cent in 2015. The average, actual monthly public old-age pension benefit was 8173 CZK (approx. 290 €) in 2006. This decline is the result of various reforms enacted by the conservative-liberal governments. The low replacement rates reflect a very residual conception of old-age insurance that differs considerably from the Continental practice; furthermore, the future

prospects do not rule out the possibility of average public pension benefits falling below the subsistence level. The collection of the contributions as well as the management of the pension fund is fully in the hands of the state, instead of the originally envisaged independent public corporation – a Social Insurance Fund.

Although the public compulsory social insurance still dominates the Czech system of old-age pension insurance, voluntary private pension insurance contracts, introduced in 1994, are attracting ever more customers. The employer may pay part or the whole contribution on behalf of the insured, providing the employee has agreed. The state supports participation in private pension schemes through the provision of state subsidies and income tax allowances. This scheme represents a popular and quite successful example of public–private mix of welfare provision. The attraction of these schemes among the middle and upper classes will further increase with the projected decline of the public pension. At the end of 2004 there were almost 3 million contracts of voluntary private pension insurance in the Czech Republic, covering about 37 per cent of the Czech population above the age of 18. It presents an increase in participation of 8.2 per cent since 2003 (Úřad státního dozoru v pojišťovnictví a penzijním připojištění, 2005, p. 25). Employers contribute to about 27 per cent of all voluntary private pension insurance contracts (ibid., 2005, p. 36). Many contractors, however, use this scheme as a profitable opportunity for short-term savings only.

Since 1995 there has been a public discussion under way on reforming the whole concept of the old-age pension system. It was initiated by experts from international financial institutions, especially the International Monetary Fund and the World Bank, who strongly recommended that the country opt for compulsory private co-insurance. This new type of old-age insurance would complement the pay-as-you-go public scheme that would gradually lose its importance. It was argued that this change would be inevitable owing to demographic trends (aging of the population) and the demand for investment in the national economy that would be satisfied by the newly established and privately run for-profit pension funds. In contrast to most of their neighbours among the CEE, the Czech Republic resisted this pressure. There were two main factors that explain this significant difference:

(1) The country was not in as deep a fiscal crisis as the other CEE countries and was less dependent on loans provided by international organizations.
(2) There was strong political opposition among the Social Democrats, who were the main party in government between 1998 and 2006, and trade unions. They emphasized the risks of such a reform referring to the fragility and volatility of financial markets. In addition they were sceptical about the huge demand for additional financial resources during first decades after the introduction of such a private pension system.

Although a comprehensive pension reform has not yet been introduced, the discussions are ongoing. Neoliberal theorists, right-wing politicians and representatives from financial institutions continue to support the idea of compulsory private co-insurance, whereas institutionalists, left-wing politicians and trade unions favour voluntary nonprofit co-insurance schemes (with financial contributions from both employees and employers). In 2005–06, a task force, with members from political parties, experts and civil servants, was established by the government to draft a policy document stating the principles for future pension reform. The task force suggested reforms of the statutory pension system, including the further increase of the retirement age, the creation of a reserve fund and support for the further development of voluntary private pensions. Although the document did not include the element of compulsory private insurance that had been discussed previously and despite its modest reform proposals, Parliament did not approve the document as the Communist Party of Bohemia and Moravia's deputies refused to support it, even though the party's representatives in the task force endorsed it.

Health services

The Bismarckian legacy shaped the reform of the Czech health services after 1989. Even though there were good reasons for the transformation of the over-institutionalized state-owned communist health care system into a more flexible National Health Service model financed through general taxation, older professionals and the general public overwhelmingly preferred the system of compulsory health insurance financed by employees, employers and the state. Subsequently, major changes were achieved: the decentralization of health care, the establishment of public Health Insurance Funds, the privatization of most primary health-care providers and some (smaller) hospitals, and the modernization as well as the improvement of care delivery. Consequently, the overwhelmingly public funding of health care is associated with an increasing share of private provision.

Paid work and family responsibilities

Until 1995 child allowances were paid to all families with dependent children, but through the introduction of the State Social Support Act this universal benefit was changed into a means-tested benefit. Although the Social Democrats proposed a return to the previous universal benefit, they were unsuccessful in re-introducing the scheme, because of political resistance among the coalition parties, the opposition parties, as well as fiscal constraints. The real purchasing value of child allowances and tax credits have declined between 1989 and 2002 by 27 to 45 per cent (the actual decline depends on family type) (Hiršl, 2003). This has contributed to a worsening of the situation for many families. In 2002 37.7 per cent of children lived in households with incomes in the lowest income quintile and 25.7 per cent

Table 5.12 Trend of public and private expenditure on health services in the Czech Republic

Year	*Public (CZK, per inhabitant)*	*Private (CZK, per inhabitant)*	*Total (CZK, per inhabitant)*	*Public (%)*	*Private (%)*
1995	9032	905	9938	91	9
2000	12748	1336	14085	91	9
2001	14298	1612	15909	90	10
2002	15208	1749	16957	90	10
2003	16499	2057	18556	89	11
2004	17212	2179	19391	89	11
2005	18149	2668	20818	87	13

Source: Institute of Health Information and Statistics of the Czech Republic, 2006, pp. 196–7.

in households with incomes in the second income quintile. 13 per cent of children are at risk of being poor, based on the EU threshold of less than 60 per cent of median income (Večerník, 2005).

The subsequent decline in the fertility rate to the lowest level (at about 1.2) in Europe was one of the decisive reasons – apart from ideological factors among the governing Christian and Social Democrats and the EU's programmatic and political influence – contributing to the articulation and approval of an explicit Czech family policy in 2005 (Ministry of Labour and Social Affairs 2005b). As a consequence, a maternity leave benefit at 69 per cent of the previous salary (with the upper ceiling of 694 CZK per day) is now paid for 28 weeks. Furthermore, the monthly parental leave benefit, which is paid for a maximum of four years, was increased from CZK 3696 (ca. 130 €) in 2006 to CZK 7582 (ca. 270 €) in 2007. In addition a dense network of (mostly public) kindergartens, with newly introduced free access for pre-school children (5–6 years old) is available to parents.

The status of the Czech welfare state

The situation of full employment, income levelling and relatively generous aid to families with children contributed to low levels of poverty during Communist rule. Although poverty has increased, various public social policies have effectively mediated the effects. The Czech Republic does exhibit typical features of strong adherence to the continental, or even more specifically, Central European, Bismarckian, corporatist, achievement-type welfare state. It stems from its modern history and has been revitalized even after more than four decades of etatist bureaucratic collectivism (Deacon, 1997). It is ideologically rooted in the social thinking of Albín Bráf, Tomáš Garrigue Masaryk, Karel Engliš, Josef Macek and others, in the long tradition of the Social Democratic movement,[6] and the strong support among the Czech public for policies based on the principles of achievement-remuneration and

Table 5.13 The status of the Czech welfare state as of 2006

Dimensions	Policies				
	Employment and unemployment	*Old-age pensions*	*Health services*	*Paid work and family responsibilities*	*Summary*
Financing	national public, with the contribution of ESF	mostly public; increasing share of private co-investment	mostly public (below 90%)	mixed; disproportionally low share of public resources	public resources prevail; modest
Regulation	national public, with EU intervention; collaboration with firms in an effort to increase employability and employment	public; collaboration with private funds in delivering voluntary co-insurance	public, weak	public and non-profit private	centralized at the national level; involvement of EU and civil society weak; corporatist institutions matter
Provision	prevailingly public	prevailingly public	mixture of public and private	mixture of private and public	prevailingly public; share of private (non-profit and for-profit) providers increasing
Outcomes	mediocre	modest, universal	good, universal	families with children and caring women in a disadvantaged position	in general satisfactory; important deficiencies and inefficiencies identified
Summary	centralized, underdeveloped	reform necessary to sustain the system in the long run	underfinanced, better regulation needed	unsatisfactory, new public initiatives and provisions needed	coping with challenges – with difficulties and shortcomings

social justice.[7] It has much in common with the neighbouring German and Austrian welfare states (including the institutional and attitudinal resistance to change) – despite the increasing incidence of residual elements. The policies with regard to their specific public/private mix are summarized in Table 5.13.

As can be derived from Table 5.13, the various reforms until now have not comprehensively changed the post-communist welfare state established in the early 1990s. The public still plays a crucial role. Partially this is the result of the limited influence of external actors and the domestic political system. Because of the proportional electoral system, Czech governments are relatively weak in designing and enacting any 'radical' reform. The requirements as well as the institutional and financial support provided by the EU have been important, especially with regards to institution building.

Conclusion

The end of Communism was characterized by an underdeveloped and skewed market, ill-functioning and misused state, and a very weak civic sector. The years to come brought about the maturation of the market, still fragile, badly performing and politically fragile states, and a recovering, but not very influential civic sector. What ramifications did these developments have for welfare state transformations in NMS? Is there a newly emerging post-communist welfare state in Europe?[8] Our analysis shows that, a broad variety of approaches and institutional frameworks have evolved in the various NMS. Despite some similarities, each country has developed its own approach towards social welfare restructuring. With regard to the public/private mix it has to be emphasized that the Baltic countries seem to rely much more on private and market elements compared with the other five countries studied. Although the provision of welfare has been partially privatized in all these countries as an inevitable consequence of the introduction of a market economy, the Czech example shows that the public sector still dominates many policy areas. The transformations do not only differ between the various countries, but also between the various policy domains. For instance, although the provision of health care was largely privatized in the Czech Republic, it relies for about 90 per cent of its finances on public funding. Hence, overall it would be wrong to speak of a one-dimensional trend towards outright privatization and the surrender of public responsibility. Furthermore, political parties and power resources still seem to have a great influence on the design and the transformations of the welfare states in NMS. After nearly 20 years since the collapse of Communism and subsequent economic, political and social transformations it is not clear whether these have led to new social policy equilibria.