Social protection in the 13 candidate countries

a comparative analysis

Employment & social affairs

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1. Introduction: The economic & demographic background

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This study analyses the social protection systems in the 13 applicant countries from an economic perspective, focusing on the functioning of the systems and the underlying structures. It looks at the socio-demographic and economic challenges the systems are faced with and the reforms undertaken and planned. The results are intended to enhance knowledge on social protection reform in Central and Eastern Europe, Malta, Turkey and Cyprus. The synthesis report is based on the 13 country studies. The country studies have been drawn up by national research institutes, the synthesis report by a team of social policy researchers from EU member states.

A substantial amount of information about the social protection systems of the candidate countries has been collected to date, especially on policy development, legislation and national statistics. However, comparative statistics are still relatively scarce. The second edition of the Eurostat yearbook on the candidate countries represents one attempt to make statistical indicators comparable and there has been increased monitoring of economic developments in the light of enlargement. With regard to social statistics, however, although efforts have been made to compile employment statistics and a pilot project has recently been launched to establish statistics on poverty and social exclusion, with the exception of periodic population censuses there is still a lack of substantial social data allowing for a comprehensive comparative assessment of the candidate countries. In this report we will outline the relevant data sources available at this time and the economic and socio-demographic conditions facing these countries.

1.1 Economic developments

The transition countries were faced with falling output and high inflation rates at the end of the 1980s and the beginning of the 90s and experienced a severe recession phase in the early 90s. This 'transitional recession' was mainly triggered by the changes in the economic system and necessary structural adjustments. Output fell across the region, reaching a low point in the years 1992-93. Since the mid-nineties most countries have experienced positive growth rates, and the weighted average growth rate of the 10 countries which will join the EU in 2004 has been higher than the average of the EU member states (see Table 1).

It is important to note, however, that there have been considerable differences across the Central and Eastern European candidate countries. Romania and Bulgaria again experienced negative growth rates in the mid-nineties, and growth rates in the Baltic States slowed in 1998/1999 due to their strong trade links with Russia and that country's 1998 economic crisis. Figures published for the last two years, however, show sustained growth particularly in the Baltic region.

Despite overall positive growth trends, some transition countries have not even regained their level of real GDP in 1989. According to estimates by the EBRD (EBRD 2002), in 2001 real GDP in Estonia was at 90% of the level of 1989, in Latvia at 75%, in Lithuania at 72%, in Bulgaria at 80% and in Romania at 84%.

The economic performance of all candidate countries over the past few years has been increasingly influenced by international economic developments and in particular by the situation in the European Union. Candidate countries are not economic islands - and although they are not members of the European Union, the increased economic exchange with EU member states and participation in a 'globalised' economy has tied them closely to international markets. Thus, the 2001/2002 recession has had a clear effect on economic development and economic growth slowed considerably at the end of 2001 in each of the 13 candidate countries to an extent depending on their degree of international involvement and peculiar national factors. However, strong domestic demand limited the slowdown and - despite the unfavourable international developments - the European Commission expects an average growth rate in the candidate countries of about 3.8 % in 2003.

Economic development in Turkey represents a clear exception to the overall picture. Turkey experienced a considerable economic crisis in 2001 due to severe monetary imbalances, which resulted in a decline of GDP by 7.4 per cent in 2001.

Table 1: Real GDP growth 1991-2002, forecasts 2003-2004

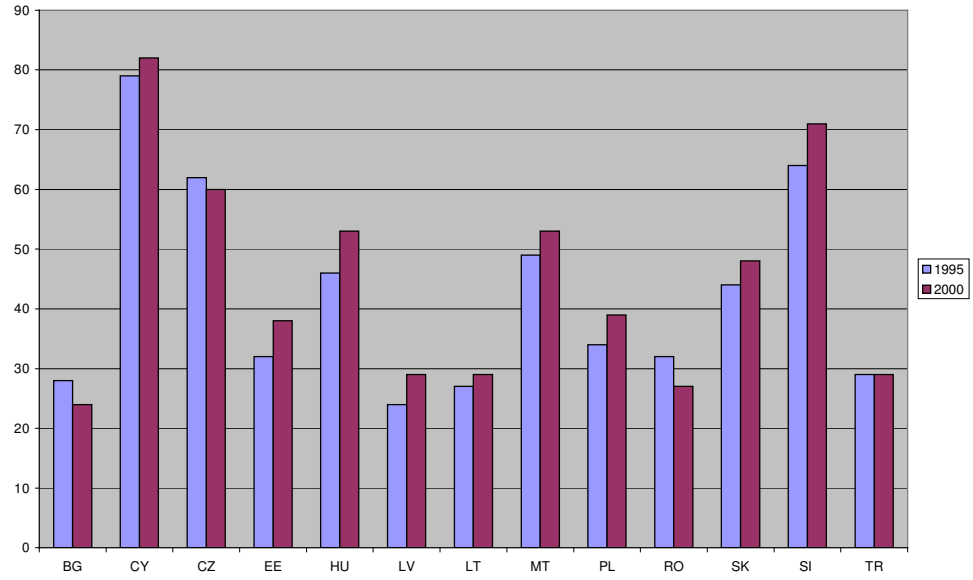
	1991-1999 (average)	**2000**	**2001**	**2002**	**2003 (forecast)**	**2004 (forecast)**
BG	-1.9 [1]	5.8	4.0	4.0	5.0	5.5
CY	4.1	5.1	4.0	2.2	3.5	4.1
CR	-0.1	3.3	3.3	2.2	3.2	3.8
EE	3.6 [2]	6.9	5.0	4.5	4.7	5.1
HU	0.4	5.2	3.8	3.4	4.5	4.9
LV	-4.8	6.8	7.7	5.0	5.5	6.0
LT	-4.1	3.8	5.9	5.0	3.5	4.5
MT	4.7	5.2	-0.8	2.8	3.4	3.6
PL	4.0	4.0	1.0	0.8	3.2	3.9
RO	-1.9	1.8	5.3	4.2	4.6	4.7
SK	4.6 [3]	2.2	3.3	3.9	3.9	4.8
SI	1.7	4.6	3.0	2.6	3.6	4.0
TR	3.3	7.2	-7.4	3.9	3.7	4.4
CAN-13 [4]	-	-	-0.1	2.9	3.8	4.4
AC-10 [5]	-	-	2.5	2.1	3.6	4.2
EU-15 [6]	1.9	3.4	1.6	1.0	2.0	2.6

1) Average 1992-99; 2) Average 1994-99; 3) average 1993-99, 4) weighted average, all candidate countries 5) weighted average, excluding Romania, Bulgaria and Turkey 6) weighted average.

Source: European Commission (2002b) for data 2001-2004; European Commission (2002f) for data 1991-2000.

Despite the higher growth rates across the candidate countries, by 2000 GDP per capita (in purchasing power standards) had increased only slightly or even decreased in relation to the EU average. This can be explained by the differences in absolute terms on which the growth rates are calculated. Figure 1 illustrates GDP per capita in relation to the EU average (=100) in 1995 and in 2000 for all candidate countries, showing that between these two years candidate countries were only able to close the gap to a limited extent.

Figure 1: GDP per capita in PPS (EU-15=100), 1995 and 2000



Source: European Commission 2002d, Annex IV.

Table 2: Inflation rates 1996-2001, forecasts for 2002/2003

	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
BG	-	1044.7	18.7	2.6	10.3	7.4	6.0	5.0
CY	-	3.3	2.3	1.1	4.9	2.0	3.0	4.2
CZ		9.1	8.0	9.7	1.8	4.7	2.0	1.9
EE	19.8	9.3	8.8	3.1	3.9	5.8	3.8	3.8
HU	23.5	18.5	14.2	10.0	10.0	9.2	5.2	4.3
LV	-	8.1	4.3	2.1	2.6	2.5	1.9	2.2
LT	24.7	8.8	5.0	0.7	0.9	1.3	0.2	1.0
MT	2.5	3.1	2.4	2.1	2.4	2.9	2.7	2.5
PL	-	15.0	11.8	7.2	10.1	5.3	2.1	2.5
RO	38.8	154.8	59.1	45.8	45.7	34.5	22.2	15.2
SK	5.8	6.1	6.7	10.6	12.1	7.3	3.7	8.2
SI	9.9	8.3	7.9	6.1	8.9	8.5	7.6	6.5
TR	81.2	87.3	81.4	61.9	54.3	54.4	45.4	27.5
CAN-13 [1]						24.2	18.4	11.6
AC-10 [2]						5.7	2.9	3.3
EU-15 [3]	2.4	1.7	1.3	1.2	2.1	2.3	2.1	1.9

1) All candidate countries, weighted average – source European Commission (2002b). 2) Excluding Bulgaria, Romania and Turkey, weighted average – source European Commission 2002b). 3) Weighted average, source: European Commission (2002f).

Source: European Commission (2002a) 1996-2000, HICP; European Commission (2002b) 2001 and 2002/2003.

Inflation is an important factor in the environment of social protection schemes. The real value of cash benefits declined dramatically in times of high inflation during the first years of transition and constant policy interventions were required in order to secure, for example, a minimum subsistence level for pensioners. On average inflation rates in the candidate countries have been falling in recent years. Turkey and Romania, however, are expected to retain high inflation rates into 2003. Inflation in EU member states ranged in 2001 from 4.4% in Portugal to 1.2% in the United Kingdom with an average of 2.3%.

Accession to the EU will bring a number of economic and fiscal challenges for future economic policy in the candidate countries.

Candidate countries will participate in Economic and Monetary Union (EMU) from the date of their accession, since EMU membership is part of the *acquis* and there will be no further possibility to "opt-out". The fulfilment of the Maastricht criteria will thus be a considerable determining factor for future monetary policy in the accession countries. After at least 2 years of participation in the Exchange Rate Mechanism a decision on the introduction of the Euro in the individual accession countries will be taken. As Table 3 illustrates, current levels of government debt in many of the candidate countries are rather low. Bulgaria, Hungary and Poland were among the few Central and Eastern European candidate countries to have higher external debts at the onset of transition. Nonetheless, fiscal deficits emerging during the last decade, in particular in Poland, the Czech Republic, Hungary and Slovakia, have contributed to rising government debt in these countries. The figures for Turkey indicate that public finances there still require major stabilisation.

In 2000 government debt as a percentage of GDP amounted to an average of 64.1 in EU member states, with national figures ranging from 5.3 per cent in Luxembourg to 110.3 per cent in Belgium.

Those accession countries which are characterised by a lower level of government debt, such as the Baltic states, Romania and Slovenia, will be able to include debt among their instruments for financing future social protection expenditures. For those countries which are now already at the 'limit' of the Maastricht criteria, however, this will not be an option.

Table 3: Government debt and annual balance

Government debt as % of GDP 2001		General Government Balance as % of GDP			
		1998	1999	2000	2001
BG	76.9 [1]	1.3	0.2	-0.7	-
CY	63 [1]	-3.7	-4.0	-2.7	-
CZ	23.7	-4.5	-3.2	-3.3	-5.5
EE	4.8	-0.4	-4.1	-0.7	0.2
HU	55.9	-7.8	5.4	3.4	4.1
LV	16.0	-0.7	-5.3	-2.7	-1.6
LT	23.6 [1]	-3.1	-5.6	-3.3	-
MT	60.6 [1]	-10.8	-7.8	-6.6	-
PL	40.9 [1]	-2.4	-2.1	-3.5	-
RO	22.8 [1]	-4.4	-2.1	-3.8	-
SK	32.4 [1]	-4.9	-5.7	-4.7	-
SI	25.8 [1]	-0.8	-1.3	-2.3	-
TR	102.5	-11.9	-18.7	-6.0	-28.7
EU-15 [2]	64.1	-1.6	-0.7	1.2	-

1) data for 2000 2) Data from European Commission (2002d)

Source: European Commission (2002c).

The development of the labour market

Social protection and the labour market are closely linked. Labour market developments in the candidate countries thus are of crucial importance for the assessment, the sustainability and the future development of social protection schemes. Participation in the labour market is, in particular, a key issue with regard to avoiding poverty and social exclusion. This is discussed in detail in Chapter 4. The following section outlines major trends and developments with regard to employment and unemployment.

The two major features of employment rates in the candidate countries are, firstly, that they are generally lower than in the EU-15 and, secondly, that they have even decreased in recent years. Structural economic change has led to large-scale job destruction, which has not been fully balanced by new job creation. This development has led to rising concern in the candidate countries that the Lisbon European Council target of reaching an employment rate of 70% in the European Union by 2010 might not be achievable.

In 2001 only two of the candidate countries had an employment rate higher than the European Union average (63.9%). These were the Czech

Republic (65%) and Cyprus (67.9%). Romania (63.3%), Estonia (61.1%) and Slovenia (63.6%) are above the 60% marker, whilst the rest of the candidate countries remain below this number.

The employment rate has decreased in most candidate countries in the last year (contrasting with the European Union, where the employment rate has risen), the exceptions being Cyprus and Hungary. In Latvia and Slovenia the rate has remained more or less stable.

The population aged between 15-24 is the cohort most affected by the fall in employment. In the last three years the proportion of this age group in employment has decreased very rapidly in most of the candidate countries. (The exceptions are Bulgaria and Cyprus, where employment rates have risen slightly.) This phenomenon contrasts with developments in the EU-15, where the rate has increased steadily. The employment rate for the other two age groups (25-54 and 55-64) has also fallen in most countries but more moderately, while there are exceptions, such as Cyprus and Hungary, where the employment rate for these two groups has risen, and Slovakia and Slovenia, where the situation has remained more or less stable.

Employment rates differentiated by gender show that, as in the EU member states, employment rates for women are in general lower than those for men. However, the gender gap, i.e. the differences between male and female employment rates, is generally lower than the EU average, and female employment rates in the candidate countries are higher than the average in the EU. Looking at the development over the past few years, we find that the employment rate for women fared better than that for men, either increasing more rapidly (in the case of Cyprus, Hungary and Slovenia) or decreasing more moderately (as in the Czech Republic, Poland, Rumania, Lithuania and Estonia). In certain cases (Bulgaria, Slovakia and Latvia) the rate decreased for men and increased for women.

The decline in employment has considerable consequences for the future financial sustainability of the social protection systems. Some of the candidate countries are even today faced with relatively high old age dependency ratios (see below) and the ratio of active employed persons paying social security contributions to those drawing benefits from the system is a crucial determinant of the financial situation in social protection. Increasing the employment rates of the elderly is seen as one of the key instruments for securing pension insurance finances in the future (Fortuny et. al. 2002).[1]

[1] This aspect will be discussed in more detail in chapter 2.

Table 4a: Employment rates 1996-2001, males

Employment rates for men (percentages)						
	1996	**1997**	**1998**	**1999**	**2000**	**2001**
BG						
15-24	-	-	-	-	23	20.9
25-54	-	-	-	-	72.1	69.3
55-64	-	-	-	-	34.9	34.2
CY						
15-24	-	-	-	40	38.3	39.6
25-54	-	-	-	91.7	92.5	93.6
55-64	-	-	-	66.3	67.1	67.9
CZ						
15-24	-	49.5	47.6	42.7	39.3	37.4
25-54	-	92.3	91.4	89.5	89.2	89.6
55-64	-	54.8	53.4	53.2	51.6	52.4
EE						
15-24	-	40.3	39.4	34.1	31.4	32.4
25-54	-	81.7	83.6	79.4	79.5	79.5
55-64	-	59.6	60.9	59.2	50.2	57.1
HU						
15-24	30.8	32.4	37.3	38.6	37	35.6
25-54	77.7	77.7	76.3	78.8	79	79.4
55-64	27.1	27.1	26.3	29.3	33	35
LV						
15-24	-	-	33.9	37.6	35.2	33.3
25-54	-	-	79.1	78.5	75.4	76.8
55-64	-	-	49.2	50.2	48.3	44.8
LT						
15-24	-	-	39.9	38.3	30.2	24.5
25-54	-	-	80.1	82.4	75.1	74.6
55-64	-	-	57	56.7	52.2	48.6
PL						
15-24	-	32	31.1	27.2	26.4	23.1
25-54	-	82	82.9	79.8	77.5	75.5
55-64	-	44.5	42.7	41.8	37.4	38.3
RO						
15-24	-	42.1	41.6	38.8	36.9	35.3
25-54	-	88.6	86.4	85.2	84.6	83.5
55-64	-	62.8	61.9	59.4	57.4	56
SK						
15-24	-	-	-	33.1	28.7	28.5
25-54	-	-	-	81.3	79.1	78.7
55-64	-	-	-	36.4	35.2	37.7
SI						
15-24	37.1	42.6	38.4	34.7	34.7	34.1
25-54	85.4	84.3	85.7	85.6	85.5	87.5
55-64	28.1	29.8	32.8	32.2	31	33
EU –15						
15-24	39.8	40.3	41.5	42.6	43.7	44.2
25-54	85.1	85.2	85.7	86.4	87.1	87.3
55-64	47.2	47.1	47.3	47.5	48	48.6

Source: European Commission (2002f).

Employment rates for women (percentages)						
	1996	**1997**	**1998**	**1999**	**2000**	**2001**
BG						
15-24	-	-	-	-	18	21.1
25-54	-	-	-	-	67.4	66.8
55-64	-	-	-	-	11.2	14.8
CY						
15-24	-	-	-	33.7	31	36.6
25-54	-	-	-	60.1	63.8	68.5
55-64	-	-	-	28.8	31.9	32.6
CZ						
15-24	-	35.9	35.1	33.9	33.6	31.5
25-54	-	78.1	76.4	74.3	73.7	74.3
55-64	-	24	23.2	23.6	22.1	23
EE						
15-24	-	30.5	31	24.4	23.2	21.3
25-54	-	76.2	76.4	75.2	74.2	72.2
55-64	-	40.5	42	39.3	37.5	41.9
HU						
15-24	24	24.7	29.9	31.2	29.2	27.1
25-54	62.9	62.1	63.5	65.8	66.7	67
55-64	10.2	10.7	9.3	11.1	13	14.6
LV						
15-24	-	-	25.9	28.7	24.9	24.5
25-54	-	-	73	71.1	71.8	75.1
55-64	-	-	28.1	26.4	25.9	30.1
LT						
15-24	-	-	28	29.2	23.2	21.3
25-54	-	-	77.8	80.7	76.8	76.4
55-64	-	-	27.4	31.8	34.5	31.8
PL						
15-24	-	23.6	24.5	21.5	21.9	19.8
25-54	-	66.7	67.8	67.6	64.5	63.5
55-64	-	27.7	25.2	24.5	21.8	23.8
RO						
15-24	-	34.2	33.3	31.9	31.1	30
25-54	-	75.8	74.3	74.1	72.7	71.7
55-64	-	48.2	48.4	47.3	47.3	45.8
SK						
15-24	-	-	-	29.1	27.9	26.9
25-54	-	-	-	70.5	69.4	70.5
55-64	-	-	-	10.6	10.2	10
SI						
15-24	34	34.3	34	31.2	27.4	26.4
25-54	78.5	78.1	78.5	78.6	79.6	80
55-64	12.9	16.4	19.4	14.9	14.3	14.4
EU –15						
15-24	33.2	33.4	34.5	35.7	36.7	37.1
25-54	61.8	62.4	63.2	64.6	65.9	66.8
55-64	25.8	26.1	26.3	27.1	27.9	28.8

Source: European Commission (2002f).

The labour markets in the candidate countries are characterised by high unemployment rates. Unemployment has been increasing in recent years and in 2001 unemployment rates in the 10 accession countries (AC-10) were nearly twice the EU average. The average unemployment rate for all candidate countries in 2001 was 11.7 per cent. Four of the candidate countries (Cyprus, Hungary, Slovenia and Romania) have a lower unemployment rate than the EU average. Bulgaria, Lithuania, Poland and Slovakia have considerably higher unemployment rates. These are also the countries where unemployment increased in 2001 – whereas it decreased in most of the others.

Table 5: Unemployment rates 1996-2001

Unemployment as a percentage of the labour force						
	1996	**1997**	**1998**	**1999**	**2000**	**2001**
BG	-	-	-	-	16.2	19.9
CY	-	-	-	5.9	4.9	4.0
CZ	-	4.3	5.9	8.5	8.8	8.0
EE	-	10.6	9.6	11.7	13.2	12.4
HU	10.0	9.0	8.9	6.9	6.6	5.7
LV	-	-	14.5	13.7	14.2	13.1
LT	-	-	12.5	10.2	15.6	16.5
MT	5.0	5.5	5.6	5.8	5.0	6.5 [3]
PL	-	11.0	9.9	12.3	16.3	18.4
RO	-	5.5	5.6	6.2	7.0	6.6
SK	-	-	-	15.9	19.1	19.4
SI	6.9	6.6	7.4	7.3	6.9	5.7
TR	6.7	6.5	6.8	7.6	6.6	8.5 [3]
CAN-13 [1]					10.7	11.7
AC-10 [2]						14.6
EU-15	10.3	10.1	9.5	8.7	7.9	7.4

Source: European Commission (2002a); European Commission (2002f) for 2001 and data on EU average.

1) all candidate countries, weighted average, source: European Commission 2002b.
2) excluding Bulgaria, Romania and Turkey, weighted average, source: European Commission 2002b.
3) Source: European Commission (2002b)

Unemployment rates differentiated by gender do not show a uniform picture. They are considerably higher for women than for men in Cyprus, the Czech Republic and Poland. Here the difference is comparable to the EU average, where female unemployment is 2.3 percentage points higher than male joblessness. In the other candidate countries female unemployment rates are slightly below the male ones with one exception – at 13.5 per cent the

female unemployment rate in Lithuania in 2001 was considerably lower than that for men (19.4 per cent).

Table 6: Youth unemployment rates and long-term unemployment 2000

	Youth unemployment (15-24 years) as % of the labour force (2000)	**Long term unemployment (> 12 months) as % of the labour force (2000)**	**Long term unemployment as % of all unemployed (2000)**
BG	33.3	9.5	58.7
CY	10.5	1.3	25.8
CZ	17.0	4.3	50.0
EE	23.7	6.3	47.4
HU	12.3	3.1	47.8
LV	21.4	8.1	57.1
LT	27.5	8.2	52.4
MT	-	-	62.3
PL	35.7	7.3	44.7
RO	17.8	3.4	49.2
SK	36.9	10.3	54.7
SI	16.4	4.3	62.7
TR	13.2	-	23.8
EU-15	15.5	3.7	44/46 [1]

Source: European Commission (2002a) for long term unemployment as percentage of total unemployment; European Commission (2002f) for youth unemployment and long-term unemployment as percentage of the labour force.
1) males/females. Source: European Commission (2002d)

Youth unemployment represents a serious problem in most of the candidate countries, being twice as high as the average unemployment rate.

Long-term unemployment (12 months or more) is widespread and applies to 50 per cent or more of all the unemployed in Slovenia, Malta, Bulgaria, Latvia, Slovakia, Lithuania and the Czech Republic. The correlation between long-term unemployment and social exclusion and poverty will be analysed in more detail in Chapter 4.

1.2 Demographic developments

Over the past decade a shrinking of the total population has been observed in all but five of the applicant countries. Slovakia and Slovenia show moderate average annual growth rates of 0.3% and 0.4%. Malta exhibits an average annual growth rate of 0.8%, which has been slowing in recent years, whereas Cyprus and Turkey show more significant growth rates of 1.4% and

1.7% respectively over the same period. Among those countries with the most significant average annual decreases in population are Bulgaria (-0.9%), Latvia (-1.0%) and Estonia (-1.2%). The projections for the year 2015 show a continuation of these trends with significant decreases in population figures for Bulgaria, Latvia, Estonia and Hungary, on the one hand, and an increase in population figures for Cyprus and Turkey, on the other. Turkey exhibits by far the most rapid increase in population at approximately 1m per year.

Comparing the overall population figures in the European Union and the applicant countries in 2001, the former had 378.1m inhabitants and the latter a total of 171.3m. Turkey accounts for more than a third of the population in the applicant countries.

Table 7: Total population on 1 January 1997, 1990, 1997-2001; projections for 2015

Total population on 1 January (millions)								
	1980	**1990**	**1997**	**1998**	**1999**	**2000**	**2001**	**2015** [1]
BG	8.846	8.767	8.341	8.283	8.230	8.191	8.149	6.8
CY [2]	0.608	-	0.741	0.746	0.752	0.755	0.759 [3]	0.9
CZ	10.316	10.362	10.309	10.299	10.289	10.278	10.267	10.0
EE	1.472	1.572	1.462	1.453	1.446	1.372	1.367 [3]	1.2
HU	10.709	10.374	10.174	10.135	10.091	10.043	10.005	9.3
LV	2.509	2.673	2.479	2.458	2.439	2.379	2.366 [3]	2.2
LT	3.404	3.708	3.707	3.704	3.701	3.699	3.693	3.5
MT	0.330	-	0.374	0.377	0.386	0.389	0.391	0.4
PL	35.413	38.038	38.639	38.660	38.667	38.653	38.644	38.0
RO	22.133	23.211	22.581	22.526	22.488	22.456	22.431	21.4
SK	4.963	5.288	5.379	5.388	5.393	5.399	5.403	5.4
SI	1.893	1.996	1.987	1.984	1.978	1.988	1.990	1.9
TR	44.016	-	61.992	62.923	63.864	64.815	65.784	79.0

Sources: European Commission (2002a); European Commission (2002d) for data on 1980; UNICEF (2001) for data of 1990; UNDP (2001) for projections for 2015.
1) Projected.
2) Total population including Turkish population.
3) Projected figures for 2001.

The main factors accounting for these above described largely negative demographic developments are changing reproductive behaviour, higher mortality and emigration. The first of these factors extended over the whole of the past decade, while the latter two were especially pronounced in the early 1990s. These trends go hand-in-hand with an ageing society and in most of the applicant countries have a significant impact on the social security systems, particularly the pension and the health care systems, as discussed in Chapters 2 and 3 below.

In the applicant countries there has been a sharp decline in the rates of natural population increase, and this has been especially pronounced in Bulgaria, Estonia, Hungary and Latvia. This decline was at its most rapid in the mid-90s in most of the Central and Eastern European countries and since then the rates have only slowly been recovering. A constant decline in the rates of natural population increase can also be observed for Malta and Cyprus. In these countries, however, live births have continued to exceed deaths by a considerable margin in recent years.

The downward trend in total fertility rates over the past decade reflects the fact that the population decrease in many of the applicant countries is to a significant extent attributable to a steady fall in the number of births. Increasing uncertainty about economic developments, a decrease in real wages and a change of priorities in governments' family policies can be seen as the main causes of these trends (Cf. Ellman 1997: 352 and Schmähl/Horstmann 2002: 32). The fertility rates in the Central and Eastern European applicant countries are considerably lower than the EU average of 1.47. Amongst EU member states fertility rates range from 1.24 in Italy to 1.74 in Denmark.

Table 8: Total fertility rate, 1980,1990, 1996-2001.

Total fertility rate								
	1980	**1990**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
BG	2.05	1.7	1.24	1.09	1.11	1.23	1.25	1.20 [1]
CY	2.46	2.4	2.08	2.00	1.92	1.84	1.83	1.79
CZ	2.10	1.8	1.18	1.19	1.16	1.13	1.14	1.14 [1]
EE	2.02	1.9	1.30	1.24	1.21	1.24	1.39 [1]	1.34
HU	1.91	1.8	1.46	1.38	1.33	1.29	1.33	1.32
LV	1.90	1.9	1.16	1.11	1.09	1.15 [1]	1.24 [1]	1.24
LT	2.00	1.9	1.42	1.39	1.36	1.35 [1]	1.33	1.25
MT	1.99	2.0	2.10	1.95	1.82	1.81	1.80	1.51
PL	2.28	2.0	1.58	1.51	1.43	1.37	1.34	1.29
RO	2.45	1.9	1.30	1.32	1.32	1.30	1.30	1.20
SK	2.32	2.0	1.47	1.43	1.38	1.33	1.30	1.21
SI	2.11	1.5	1.28	1.25	1.23	1.21	1.25 [1]	1.22 [1]
TR	4.36	3.4	2.59	2.57	2.55	2.53	2.50	2.50
EU-15	1.82	1.57	-	-	-	-	1.53	1.47 [1]

Sources: European Commission (2002a); World Health Organisation (2001) for data on 1990; European Commission (2002d) for data on 1980 and data on EU average; European Commission (2002e) for data on 2001.
(1) Projected figures.

However, fertility rates do not in themselves sufficiently explain the decline in populations. For a fuller picture we must turn to developments in life expectancy in the applicant countries.

Low fertility rates have been accompanied by high and/or significant increases in life expectancy over the past decade in some of the Central and Eastern European countries. This applies especially to Slovenia and the Czech Republic. Life expectancy in Slovenia (79.1 for women and 71.9 for men) ranks among the highest in the applicant countries (together with Malta and Cyprus). The Czech Republic has experienced a significant increase in life expectancy over recent years, resulting in figures of 78.3 years for women and 71.6 years for men. Likewise, a recovery in the life expectancy after an initial drop has counterbalanced a decrease in the fertility rate in Slovakia and Lithuania over the past decade. A significant rise in life expectancy can also be observed in Poland, Hungary and Turkey although the two latter countries still have a comparatively low figures. In Turkey this is especially pronounced for women. Increasing life expectancy is to a large extent attributable to an improvement in health conditions and public health (see Chapter 3 on health care). Although life expectancy in a number of the candidate countries is still lower than the EU average, the development in the candidate countries shows convergence with EU member states. At the same time, low fertility rates and an increasing life expectancy will challenge the financial sustainability of the pension and health care systems. In particular, the period for which pension benefits are drawn is expected to increase. It is still a matter of discussion whether changing morbidity patterns for the elderly will pose an additional financial burden on the health care system. However, it is obvious that health care systems will need to be adapted to an ageing society in terms of services, access and infrastructure. A growing number of households with elderly persons will challenge policies for social inclusion and the participation of the elderly in society. The demographic challenges for the social protection systems of the candidate countries and the policy responses in these countries are analysed in the following chapters.

Although Bulgaria, Latvia and Estonia show higher fertility rates than the other Central and Eastern European applicant countries, their rates of natural population increase are low. This can be explained by the fact that they have not experienced a considerable increase in life expectancy. All three countries are in the bottom half of the life expectancy tables (along with Turkey, Romania and Hungary). In the case of Bulgaria and Estonia this is aggravated by the fact that over the past decade there has been hardly any improvement in life expectancy. Mention should also be made of the fact that life expectancy in both Latvia and Estonia differs significantly for women (both: 76.0) and men (Latvia: 64.9, Estonia: 65.1). This is partly due to high rates of alcoholism and a significantly higher number of suicides among men in these two countries. The life expectancy for men at age 60 in these countries shows that mortality rates are considerable for men under 60 years of age.

Table 9a: Life expectancy for women at birth and at age 65 in 1980, 1990, 1996-2000

Life expectancy for women at birth and at age 65								
	1980	**1990**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
BG								
At birth	74.0	75.0	74.3	-	-	75.3	-	75.3
Age 65	-	-	15.1	-	-	15.6	-	-
CY								
At birth	77.0	78.3	-	80.0	-	80.4	-	80.4
Age 65	-	-	-	18.4	-	18.9	-	
CZ								
At birth	73.9	75.5	77.3	77.5	78.1	78.1	78.3	78.5
Age 65	-	-	16.4	16.6	16.9	16.9	17.1	
EE								
At birth	74.1	75.0	75.5	76.0	75.5	76.1	76.0	76.0
Age 65	-	-	16.2	16.8	16.4	16.9	16.9	
HU								
At birth	72.7	73.9	74.7	75.1	75.2	75.1	75.6	75.7
Age 65	-	-	15.6	15.9	16.0	15.8	16.2	
LV								
At birth	74.2	74.6	75.6	75.9	75.5	76.2	76.0	75.6
Age 65	-	-	17.6	17.6	17.3	17.8	17.6	
LT								
At birth	75.4	76.4	76.0	76.8	76.9	77.4	77.9	77.7
Age 65	-	-	17.2	17.3	17.4	17.8	18.2	
MT								
At birth	72.7	78.9	79.8	80.1	80.1	79.3	80.2	79.3
Age 65	-	-	18.5	18.4	17.9	17.6	18.4	
PL								
At birth	75.4	75.6	77.0	77.3	77.5	78.0	78.4	78.4
Age 65			16.5	16.8	17.0	17.1	17.5	
RO								
At birth	71.8	73.1	73.0	73.0	73.3	73.7	74.2	74.8
Age 65	-	-	15.0	15.3	15.3	15.3	15.5	
SK								
At birth	74.3	75.8	76.8	76.7	76.7	77.0	77.2	77.2
Age 65	-	-	16.4	16.4	16.3	16.5	16.4	
SI								
At birth	75.2	78.0	78.3	78.6	78.7	78.8	79.1	79.7
Age 65	-	-	17.3	17.6	17.5	17.6	17.9	
TR								
At birth	60.4	69.0	70.6	70.8	71.0	71.3	71.5	71.0
Age 65	-	-	14.3	14.3	14.3	14.3	14.4	
EU-15								
At birth	77.2	-	-	-	-	80.9	-	81.4 p
Age 65								

Sources: European Commission (2002a); European Commission (2002d) for life expectancy at birth, 1980 and EU average; World Health Organisation. Basic Indicators, for 1990; 1990: data of 1989-1990; European Commission (2002e) for data on 2001.

Table 9b: Life expectancy for men at birth and at age 65 in 1980, 1990, 1996-2000

Life expectancy at birth and at age 65 (men)								
	1980	**1990**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
BG								-
At birth	68.7	68.3	67.1	-	-	68.2	68.2	
Age 65	-	-	12.3	-	-	12.8	-	
CY								
At birth	72.3	73.9	-	75.0	-	75.3	-	-
Age 65	-	-	-	15.6	-	16.0	-	
CZ								
At birth	66.8	67.6	70.4	70.5	71.1	71.4	71.6	72.1
Age 65	-	-	13.1	13.2	13.4	13.6	13.7	
EE								-
At birth	64.1	64.8	64.5	64.7	64.4	65.4	65.1	
Age 65	-	-	12.2	12.6	12.3	12.6	12.6	
HU								-
At birth	65.5	65.2	66.1	66.4	66.1	66.3	67.1	
Age 65	-	-	12.1	12.2	12.2	12.1	12.5	
LV								
At birth	63.5	64.3	63.9	64.2	64.1	64.9	64.9	64.5
Age 65	-	-	11.9	11.4	11.3	11.3	11.9	
LT								-
At birth	65.5	66.6	65.0	65.9	66.5	67.1	67.6	
Age 65	-	-	13.0	13.3	13.4	13.7	14.1	
MT								-
At birth	68.5	73.8	74.9	74.9	74.4	75.1	74.3	
Age 65	-	-	14.7	14.6	14.5	15.1	15.0	
PL								
At birth	66.9	66.6	68.5	68.9	68.8	69.7	70.2	70.2
Age 65	-	-	12.9	13.1	13.4	13.3	13.6	
RO								
At birth	66.5	66.6	65.2	65.2	65.5	66.1	67.0	67.7
Age 65	-	-	12.5	12.8	12.7	12.8	13.0	
SK								-
At birth	66.8	66.8	68.9	68.9	68.6	69.0	69.1	
Age 65	-	-	12.9	12.9	12.8	12.9	12.9	
SI								-
At birth	67.4	70.0	70.8	71.0	71.1	71.4	71.9	
Age 65	-	-	13.6	13.8	13.8	13.8	14.1	
TR								
At birth	55.8	64.4	66.0	66.2	66.4	66.6	66.9	66.4
Age 65			12.7	12.7	12.7	12.7	12.7	
EU-15								-
At birth	70.5	-	-	-	-	74.6	75.3 p	
Age 65								

Source: European Commission (2002a); European Commission (2002d) for life expectancy at birth, 1980 and EU average; World Health Organisation. Basic Indicators, for 1990; 1990: data of 1989-1990; European Commission (2002e) for data on 2001.

In addition to a change in reproductive behaviour and different trends in the development of life expectancy, in some countries migration has had a noticeable impact on the demographic situation. Emigration has accounted

for a decline in population figures in all three Baltic countries, in Bulgaria and, in the early years of transition, also in Poland and Romania. Emigration involved up to 1.6% of the population in Lithuania and approx. 4% of the Bulgarian population. Migration was strongest in the first half of the 1990s with mainly ethnic motives. Examples of this are the return of the Russian, Polish, Ukrainian and Belarussian populations from the Baltic States, the emigration of the Turks from Bulgaria and migration between the Czech Republic and Slovakia. Since then emigration has slowed significantly, but still remains a factor. Whereas in the above cases net migration has been negative, except for the Czech Republic and Slovakia, where it has been neutral, in Slovenia and Hungary there has been net immigration.

Table 10: Net external migration, 1990, 1996-2001.

Net external migration in total (thousands)							
	1990	1996	1997	1998	1999	2000	2001
BG	-217.6	-64.5	-				-175.8 [1]
CY			-1.85	2.0	0.02	1.49	3.1
CZ	0.6	10.13	11.07	9.49	8.77	6.54	-8.6
EE	0.2	-5.6	-2.5	-1.1	-0.6		0.2
HU	22.60	10.09	10.46	14.04	16.43	12.55	14.0
LV	-0.5	-7.3	-4.8				-1.4
LT	-8.8	-0.9	0.1			- 0.31	-2.6
MT							2.3
PL	-15.80	-13.10	-11.80	-13.30	-14.00	-19.70	-16.70
RO	-96.9	-19.5	-13.3	- 6.25	- 2.12	- 1.69	-4.9
SK	0.1	2.3	1.7				1.0
SI	2.40	6.5	2.44	-2.11	2.34	2.62	4.7
TR		256.0	-287.0	40.98			1144.0
EU-15							1160.3

Sources: Country Studies. UNICEF (2001) for net migration 1990; European Commission (2002e) for data on 2001; UNICEF (1999) for data on 1990-1997 for BG, LV, LT, RO, SK.

1) Projected figures.

The demographic situation and development in the applicant countries show a common trend towards an ageing of the society. This can been seen from the declining shares of the population under 15 years of age and constant increase in the proportion of the population over 65 years old over the past decade, as well as from the development of the old age dependency ratio. Although there has been an increase in the old age dependency ratio in all applicant countries, this increase varies in level and degree.

Table 11: Age groups as a proportion of the population 1980,1990, 1996-2001

	1980	**1990**	**1996**	**2001**
BG				
< 15	22.2	20,5	17.7	15,5
> 60	15.5	19.2	21.4	21,8
>65	11.8	13.0	15.2	16,3
CY				
< 15			24.9	22.9
> 60			15.1	14.8
> 65			11.1	10.6
CZ				
< 15	23.3	21.7	18.3	16.2
> 60	16.9	17.6	18.0	18.5
> 65	13.6	12.5	13.3	13.9
EE				
< 15	21.6	22.3	20.3	17.7
> 60	16.1	17.0	18.8	21.2
> 65	12.5	11.6	13.4	15.5
HU				
< 15	21.9	20.5	18.0	17.1 [1]
> 60	17.1	18.9	19.4	19.7 [1]
> 65	13.5	13.2	14.2	14.6 [1]
LV				
< 15	20.4	21.5	20.4	17.3
> 60	16.5	17.6	19.1	21.5
> 65	13.0	11.9	13.7	15.2
LT				
< 15	23.6	22.6	21.6	19.1
> 60	14.3	16.0	17.3	18.8
> 65	11.3	10.8	12.1	13.6
MT				
< 15			22.0	19.8
> 60			15.9	16.9
> 65			11.4	12.3
PL				
< 15	24.1	25.3	22.5	18.8
> 60	13.2	14.7	15.9	16.7
> 65	10.2	10.0	11.2	12.3
RO				
< 15	26.6	23.7	20.2	19.6
> 60	13.2	15.5	17.6	17.9
> 65	10.3	10.3	12.2	12.4
SK				
< 15	26.1	25.54	22.3	19.221.7
> 60	13.3	14.87	15.2	15.5.2
> 65	10.5	10.3	10.9	11.51
SI				
< 15		20.9	18.1	15.77.5
> 60		15.6	17.8	19.38.1
> 65		10.6	12.5	14.12.8

Source: Eurostat New Cronos Database 1) Figures for 2000

Table 12: Old age dependency ratio, 1980, 1990, 1996, 2001.

Old age dependency ratio				
	1980	**1990**	**1996**	**2001**
BG	0.179	0.196	0.227	0.239
CY	-	-	0.173	0.159
CZ	0.216	0.190	0.194	0.199
EE	0.190	0.176	0.202	0.232
HU	0.209	0.199	0.209	0.214 [1]
LV	0.195	0.179	0.207	0.225
LT	0.174	0.162	0.182	0.202
MT			0.171	0.181
PL	0.155	0.155	0.169	0.179
RO	0.163	0.156	0.181	0.197
SK	0.166	0.160	0.163	0.166
SI		0.155	0.180	0.201
EU-15				0.24

Proportion of the population aged >65 to proportion of the population aged 15-65 years.
Source: Own calculation based on New Cronos Database, Table 11.
1) Figures for 2000.

Comparatively low old age dependency ratios and thus "young populations" can be observed in Cyprus (0.159) and Malta (0.181) as well as in Slovakia (0.166) and Poland (0.179). The highest values at the other end of the scale and thus comparatively the "oldest" populations are to be found in two of the Baltic states (LV: 0.225; EE: 0.232), Bulgaria (0.239) and Hungary (0.214). The relative proportion of the elderly in the population is, of course, a decisive factor for the shaping of pension policy in the candidate countries. Those countries with a larger share of the population over 60 and a corresponding increase in pension expenditures have experienced higher pressure to reform their pension systems.

Chapter 2 will discuss the options that have been chosen in the candidate countries to influence the financial developments in the old-age pension systems. It will further analyse the impact of the old-age dependency ratio and the so-called system dependency ratio (i.e. the number of beneficiaries in relation to the number of contributors).

Ethnicity is one of the main factors in social exclusion and poverty, as will be illustrated in more detail in Chapter 4. In a number of the applicant countries ethnic minority groups constitute a significant proportion of the population. The most important example is that of the Roma in Bulgaria, Romania, Slovakia and Hungary, who in some of these countries account for almost 10% of the total population. They therefore receive special consideration in the discussion of issues of poverty and social exclusion in the following analysis. Ethnically, Bulgaria is an especially heterogeneous

country with significant Roma and Turkish populations. There are risks of poverty among both groups. However, recent figures show that other minorities in these countries, including the Polish, Ukrainian, Belarussian and especially the Russian minorities, also suffer from discrimination, especially with regard to employment. Over the past decade the Baltic countries in particular have experienced a decrease in national minority populations due to emigration, as discussed above.

Table 13: Largest minorities as a percentage of national population

	Roma [1]	Russian	Polish	Ukrainian	Belarussian	Turkish
BG	8.9					8.5
CY						
CZ	2.7					
EE [2]		28.0		3.0	1.0	
HU	5.6					
LV [3]		29.1	2.5	2.6	4.0	
LT [4]		8.1	6.9			
PL	0.1			0.8	0.8	
RO	9.4					
SK	9.4					
SI	0.4					
TR	0.7					

Sources: Ringold (2000).

(1) Estimations for Roma population: 1991-1994.

(2) Estonian Statistical Offices. Figures for 2000.

(3) Data as of 21 July 2002.

(4) Country study Lithuania.

1.3 Social expenditures and social security financing

This section provides an introductory overview of social protection expenditures and the development of sources of financing for social protection in the candidate countries.

The level of social expenditures as a percentage of GDP indicates what proportion of the economic resources of a country is spent on social protection and health. The figures require careful interpretation, however, since public social expenditures are expressed in gross terms which do not reflect the effects of taxation on social benefits and usually do not include tax breaks for welfare purposes either (Adema 2001).

The average proportion of GDP absorbed by social welfare expenditures in the Central and Eastern European countries at the beginning of the 1990s was around 26 per cent for the Czech Republic, Slovakia, Poland, Hungary

and Slovenia and lower in the Baltic States, Romania and Bulgaria. In subsequent years, overall expenditures have increased in relation to GDP, but GDP itself has mainly been shrinking in the transition process (Hagemeijer 1999).

Table 14: Public social expenditures as a percentage of GDP

	1996	**1998**	**2000**
BG [1]	12.10	14.90	17.90
CY [2]	15.20	16.20	-
CZ [3]	17.40	18.10	19.50
EE [4]	15.90	14.74	15.20
HU [5]	24.80	24.20	23.20
LV [6]	17.50	17.60	17.80
LT [7]	14.20	15.80	15.80
MT [8]	19.30	19.60	19.80
PL [9]	31.00	29.50	29.90
SR [10]	23.28	21.88	21.70
SL [11]	25.50	26.10	
RO [12]	10.60	13.80	13.90
TR [13]		10.41	11.59
EU-15 [14]			27.60

Source: Country studies.
1) Health care, pensions, social benefits, other social expenditures
2) Education, public and private health care, pensions
3) Pensions including private social expenditure on pension funds, sickness cash benefits, social support and social care, health care, employment policy
4) State pensions, health insurance, family benefits, social assistance and social services, unemployment
5) Health care, pensions, education, other
6) Social insurance, social assistance, health care, employment
7) Consolidated social expenditures
8) Social security benefits, social welfare, health care.
9) Consolidated according to IMF approach, social insurance and health care, education
10) Health care, education, social security and welfare. World Bank estimates
11) Unemployment, family benefits, social assistance, pensions, health care, sickness benefits, educational grants.
12) Health care, social insurance, unemployment.
13) Source: OECD SOCX database, excluding education, administrative costs
14) Esspross, Figures for 1999

The average share of GDP for CEE countries in 1997-98 was calculated at 4.9 per cent for health and 13.3 per cent for social protection (Klugman et al. 2002). While different definitions of public social expenditures and the areas covered make cross-country and year-on-year comparisons difficult, the general trend was an increase in social expenditures as a percentage of GDP for the first 3 to 4 years of transition. The fact that public social expenditures

absorbed an increasing proportion of a declining GDP in the first years of transition indicates that social spending was more 'resistant' than other items in national budgets (Golinowska 1997).

ILO research suggests a strong inverse relationship between transition countries' expenditures on social protection benefits and the percentage of the population below the poverty line (Hagemejer 1999). Between 1998 and 2000 overall social expenditures as a proportion of GDP remained stable or increased only slightly.

The level of social expenditures as a percentage of GDP ranges from 22 to 26 per cent in Poland, Slovenia and Hungary and Slovakia. The Czech Republic spends around 20 per cent of its GDP on social protection and health, while the figure in the Baltic States, Romania and Bulgaria varies between 14 and 17 per cent. Of all candidate countries Turkey has the lowest level of social spending as a proportion of GDP. Only Slovenia, with a share of 26.1 per cent in 1998, approaches the EU average level. Social protection expenditures in EU member states in 1999 averaged 27.6% of GDP, while the figures for individual member countries ranged from 14.7 % in Ireland to around 30 per cent in Germany, France and Sweden. There was a decline in social welfare spending relative to GDP between 1994 to 1998 in many of the EU member states (European Commission 2002d:15). Such a trend was not apparent in the candidate countries nor, however, was there an overall increase in social expenditures either. In some countries with a relatively low share (such as Estonia, Bulgaria and Romania) the relative weight of social welfare spending increased, while countries such as Poland, Hungary and Slovenia, which already had a higher share, saw a decrease or at most only a very slight rise.

In a breakdown of social expenditures in relation to GDP, pensions and health are the most important items. Direct spending on social assistance and unemployment still represents a minor share of the social welfare budget, with average figures of around 1 per cent of GDP (unemployment) and 1-2 per cent of GDP (social assistance).

As with overall social welfare expenditure, pension expenditures in Turkey absorb the lowest share of GDP among candidate countries. Spending on pensions in Malta, where the state system based on the 'Beveridge' model provides only basic pension benefits, fluctuates around 5.5 per cent of GDP. Higher figures obtain for Romania, Bulgaria, the Czech Republic, Slovakia, Hungary, Lithuania and Estonia. In 2000 these countries' pension expenditures as a proportion of GDP ranged from 6.4% in Romania to 11.4% in Latvia. Slovenia (14.5 per cent) and Poland (13.5) spent the largest share of GDP on pensions. Both countries have implemented fundamental financial reforms in their old-age pension systems which are expected to decrease these proportions in the long run. Some countries with lower proportions (e.g. the Czech Republic and Bulgaria) have been faced with an increase in their figures in recent years.

Most EU member states spend between 8 and 14 per cent of GDP on pensions, while countries such as Ireland and the UK (3 and 5.3 per cent, respectively) have relatively low.

Total spending on health care (see Chapter 3, Table 9 for more details) in relation to GDP has been relatively stable over the last five years in most of the candidate countries. However, the level of spending varies considerably between candidate countries and the share of private expenditures in total health care spending has increased in recent years.

Turkey, Romania and Bulgaria represent the group with the lowest shares of health care spending, ranging from 2.9 to 5 per cent. The Baltic States, Poland and Slovakia spend around 6 per cent of their GDP on health care, while in Hungary, Slovenia, the Czech Republic, Cyprus and Malta the percentage varies between 6.8 (Hungary) and 8.8 (Malta). However, for the majority of the candidate countries the share is below the average for the EU member states, whose spending on health care in relation to GDP amounted in 1998 to 8.62 per cent.

The source of financing for social protection in the candidate countries has experienced a gradual but marked shift from payroll taxes and the general budget towards earmarked social security contributions paid by employers and employees. Indeed, for pensions social security contributions now serve as the main financing instrument. Although in a number of countries health care continues to be financed out of general taxation, this is also the sector where private financing (both formal and informal) has come to play an increasingly significant role over the last decade.

Table 15 below shows the mandatory social security contributions for the various branches of social protection in the candidate countries. Malta and Cyprus are the countries with by far the lowest social insurance contribution rates, reflecting the fact that social protection in these countries is largely financed out of taxes. The Baltic States are characterised by overall social security contribution rates of 30-35 per cent. Higher rates exist in Poland, the Czech Republic, the Slovak Republic and Romania with more than 45 per cent social security contributions on the individual wages. The burden of social security on labour costs thus is discussed in many of the countries and a further rise in social security contributions seems a political sensitive issue. In most of the countries the contribution rate is set by the government, but does not always generate sufficient resources for actual social protection expenditures. Possible deficits usually have to be covered by the state budget.

Table 15: Social insurance contribution rates 2002

	Pensions (old age, survivor and disability)	**Health**	**Unemploy-ment**	**Other (maternity, sickness, occupational diseases)**	**TOTAL**
Total (employer/employee)					
BG	29 (21.75+7.25) [1]	6 (4.5+1.5)	4 (3 +1)	3.7 (2,95+0,75)	42.7
CY	12.6 (6.3+6.3)	taxation	-		12.6
CZ	26 (19.5+6.5)	13.5 (9+4.5)	3.6 (3.2+0.4)	4.4 (3.3+1.1)	47.5
EE	20 (employer) [2]	13 (employer) [3]	1.5 (0.5+1)	/	34.5
HU	26 (18+8)	14 (11+3) [4]	4.5 (3+1.5)	/	44.5
LV	30.86	taxation	1.9	2.33	35.09 [5]
LT	25 (22.5+2.5)	3.0 (employer) [6]	1.5	4.5 (4+0,5)	34
MT	20 (10+10)				20
PL	32.52 (16.26+16.26)	7.75 (employee)	2.45 (employer)	4.07 (1.62+2.45)	46.79
SR	28 (21.6+6.4)	14 (10+4)	3.75 (2.75+1)	4.8 (3.4+1.4) [7]	50.55
SL	24.35 (8.85+15.5)	12.92 (6.56+6.36)	0.2 (0.06+0.14)	0.73 (0.63+0.1)	38.2
RO	35 (employer) [8]	14 (7+7)	6 (5+1)	/	55
TR	33.5 (employer) [9]	/	5 (3+2)	/	38.5

Source: Country studies, European Commission (2002g).

1) Rate applies to the 3rd working category. For the 1st and 2nd category (harmful working conditions) and additional contribution of 3 per cent has to be paid by the employer. There is an additional mandatory occupational pension insurance for the 1st and 2nd category.
2) Contributions to funded pension scheme as of 1 July 2002: plus 2 per cent of the wage.
3) Including sickness cash benefits.
4) The employer pays an additional lump sum of HUF 4500 (approx. 18 Euro) per month to the Health Insurance Fund.
5) 9 per cent of the overall contribution rate is paid by the employee.
6) No direct employees contribution, but 30% of the income tax of the employee are transferred to health insurance.
7) The employer pays for occupational risk insurance additionally between 0.2 and 1.2 per cent.
9) Rate applies to the 3rd category. For the 2nd group, an overall contribution rate of 40%, for the 1st group a contribution rate of 45% has to be paid by the employer.
10) Social insurance contribution rate (incl. health care) for SSK. Bag-Kur (for the self-employed) contribution rate is 35 per cent.

The share of the contribution payment between employer and employee differs across the countries. Only a few countries have split the rate equally between employer and employee. In many Central and Eastern European candidate countries the employees share is lower and a step by step approach of increasing the employees share over the next years is intended.

1.4 Summary

Most of the 13 candidate countries have experienced a period of economic recovery and stabilisation in recent years. There is, however, a large income gap between EU member states and many of the accession countries, which will only gradually be closed. Labour markets in the candidate countries are challenged by decreasing employment rates and by high and persistent unemployment. Moreover, accession countries will be affected to a greater or lesser extent by a future drop in fertility, becoming 'ageing societies' like the current EU member states.

These economic and demographic challenges put a considerable strain on the design and development of social protection schemes. The accession countries are expected to adopt strict fiscal policies with a view to future EMU membership. At the same time social protection is expected to provide security and support for those affected by the unfavourable developments in the labour market and the pensioners who will constitute a growing share of the population.

While candidate countries on average spend less of their GDP on social welfare expenditures, the burden placed on wages by social security contributions is already high and there is no scope for generating more funds by increasing contribution rates. The following chapters on pensions, health, and poverty and social exclusion analyse and evaluate the strategies chosen in the 13 candidate countries to respond to these challenges and to modernise their social protection systems.

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2. Pensions

Winfried Schmähl

2.1 The scope of this chapter

During the last decade pension reforms have been implemented all over the world. Pension policy design is a topical issue in many countries of the EU and beyond. In recent years the pension landscape in Europe has changed and one can identify some new elements and certain trends in restructuring arrangements for (income) protection in old age. This applies not only to EU member countries – such as Sweden, for example, which has carried out fundamental pension reform by introducing a so-called "notional defined contribution scheme" – but also to many formerly socialist countries.

This chapter focuses on the development of pension schemes in candidate countries, on reform measures already implemented or on those planned for the near future.[1] It is not a comparative report in the sense of comparing pension schemes, focusing, for example, on eligibility criteria for retirement or disability pensions.[2] Nor does it attempt to evaluate the national pension schemes. The focus here is on

- characterizing developments,
- identifying trends in policy development and its effects,
- problems of a more general nature confronting candidate countries
- aspects of pension schemes which may take on increased relevance in the future and particularly in the light of the EU enlargement process.

In view of the fact that many comprehensive reform packages in candidate countries have been implemented only recently (many of the reforms date back only to the second half of the nineties), and in view of the long-term transition periods for sometimes necessary system changes, it should be emphasised from the beginning that it is often much too early to gain a reliable picture of the effects of pension reform projects. Pension benefits from newly designed schemes which mainly cover younger employees will only be paid out in the distant future. Therefore the question of whether new

[1] Information on a draft version of this chapter by Agnieszka Chloń-Domińczak and Lauri Leppik is gratefully acknowledged.

[2] For more detailed information see Schmähl (1999).

or reformed schemes will prove an adequate instrument for social security in old age or in the case of disability can only be answered on the basis of assumptions and expectations regarding the future development of labour and capital markets, employment careers over the life cycle and many other factors.

In considering the 13 accession countries it seems useful to distinguish between the former socialist countries and the three Mediterranean countries of Malta, Cyprus and Turkey. Special attention will be paid to the fundamental pension reforms already implemented in some of the former socialist countries as they are often looked upon as paradigmatic for future developments in other countries too.

The chapter starts by characterizing pension schemes in general and those of the candidate countries in particular. This may contribute to the development of a typology of pension arrangements and illustrate some trends in pension policy.

2.2 Redesigning pension schemes towards a multi-tier structure: Emerging new concepts

It was obvious that during the process of transformation in former socialist countries changes in the state-dominated pension systems would become necessary.[3] As N. Barr put it: "The old system of pensions, although perhaps well-adapted to the old economic order, is ill-adapted in several ways to the needs of a market economy".[4]

- Pension benefits were in principle provided entirely by the state.
- There was easy access to benefits (e.g. low retirement ages, lax eligibility criteria for disability pensions, pension benefits for working pensioners).
- There was little differentiation in individual pension amounts although generous pensions were granted to privileged groups. This was often not well documented and the system in general lacked transparency.
- Pension amounts were on the whole relatively low.
- Despite this, pension costs – the macroeconomic fiscal burden of pension policy – were relatively high (measured, for example, by public pension expenditure in relation to GDP) because of the generous rules for taking up pensions.

The macroeconomic fiscal burden increased during the process of transformation because more people were claiming pensions while GDP

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[3] The legacy of former socialist times for pension systems will not be recapitulated here in detail. The main aspects have already been discussed in several publications, for example, Barr (1994), Chapter 9, Barr (2001), Schmähl and Horstmann (2002), Chapters 2 and 3.

[4] Barr (2001), p. 185.

decreased[5]. Because of an inadequate indexing of benefits, pension benefits deteriorated, making it necessary to take on reform measures within the public pensions systems.

The reform process that took place in all of the candidate countries widened the scope for designing pension systems. The developing market economies allowed in principle a greater diversity, at least as far as the design of pension schemes was concerned, and a rejection of exclusively state-managed pension schemes. A public-private mix in pensions provision is emerging in almost all of the countries under review but has developed to different extents. Besides the transformation of the political, social and economic order, there are many reasons why changes to a pension system appear on the political agenda. There are also many different options for designing (and reforming) a country's pension system. The design of existing pension schemes and of reform measures recently implemented, and the experience of foreign countries were all influential in the debate on pension reform in candidate countries.

2.2.1 Major options

A number of criteria can be used to analyse the type of changes which have taken place, to characterize and compare pension systems, and to determine whether there are trends already discernible or to be expected in the foreseeable future. This chapter will focus mainly on the following:

- 1st, 2nd and 3rd tier of a pension system, where the first tier is the basic old-age protection, the second is supplementary protection (often organized by employers as occupational pension schemes), and the third is additional private saving for old age[6];
- the distinction between public and private pension schemes in terms of provision of benefits and financing;
- the distinction between mandatory and voluntary schemes (with or without incentives);
- the method of financing pensions: pay-as-you-go financing or capital funding;
- the distinction between defined benefit and defined contribution schemes.

These various elements can result in a large number of different combinations even if restrictions or conditions limit the solutions which can

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5 By 2001 Poland, Slovenia and Hungary had a real GDP higher than in 1989, while the Czech Republic and the Slovakia had regained the level of that year. The three Baltic countries, Romania and Bulgaria had a real GDP that was still clearly lower than in 1989. See Svejnar (2001), Figure 1.

6 The difference between second and third tier arrangements, however, becomes blurred in some countries.

be practically realized in a country. In addition to the basic characteristics of pension schemes several additional elements (linked to those mentioned above) are relevant:

- the role of the state as provider and/or regulator of pension schemes;
- the organization of a pension scheme (as part of the state budget, as a separate social insurance budget, a separate pension insurance budget; with or without a self-governing administration),
- the coverage (total population, specific groups, with earnings above a certain floor or below a given ceiling),
- the financing (by earnings-related or flat-rate social insurance contributions and/or taxes; transfer payments from the state budget to a pension scheme; insurance premiums (calculated on the basis of risk);
- the design of benefits: lump-sum payments or regular pension benefits, and in the latter case (1) calculated on the basis of income; flat-rate; means-, income- or pension-tested; (2) indexation on the basis of prices and/or income (earnings),
- the main redistributive objectives of a pension scheme: avoiding poverty in old-age, income- or consumption-smoothing over the life cycle;
- the main type of income redistribution: intertemporal redistribution (over the life cycle) or interpersonal redistribution,
- a pure savings scheme or one combined with risk pooling (insurance).

Table 1: Design of a pension scheme

Some major choices in designing the different tiers of pension schemes	
1st tier	*Mandatory*, *PAYG* *Public* or *private* *Major goal*: • avoiding poverty in old age • income-related pension – defined benefit – defined contribution *type of redistribution*: • interpersonal • intertemporal (close contribution-benefit link)
2nd tier	Mandatory or voluntary Funded or PAYG Public or privately managed Linked to employment or company Defined benefit or defined contribution
3rd tier	Voluntary, privately managed, funded, defined contribution

Some of the major combination options of practical relevance for the developments of recent years are illustrated in Table 1 above.

2.2.2 Emerging new concepts in candidate countries

In the countries under review mandatory pension schemes as a first tier are all pay-as-you-go financed. There is no country that has a mandatory privately-managed first tier such as that in Chile.

There remain, however, important differences regarding the design of the first tier. In saying this, it is important to note that in those countries that are fundamentally reforming the first tier the "old" pension scheme is not being abolished but will fade away over time. In trying to characterize "the" pension scheme in a country, it is therefore important to distinguish between the present state, which may actually involve a hybrid, and a future state (after the necessary transition period) when the new scheme is the only form of first tier pension.

The mandatory first tier schemes differ in level as well as in the dominating type of redistribution as a result of the calculation and financing of pensions.[7] This will be discussed in the next section of this chapter.

Private pensions, if existing, always are elements of a second or third tier of the national pension system. While the third tier is in general voluntary (and fully funded), the second tier includes mandatory as well as voluntary funded schemes.

In the years before the collapse of the communist regimes and the transition towards a market economy there was – with only minor exceptions – a dominating picture regarding the combination of first (mandatory public) and second tier pension schemes:

In countries with public pension schemes with (a) flat-rate benefits, (b) a minimal differential between maximum and minimum pension levels or (c) a low level of benefits, there was generally a mandatory second tier pension scheme, either mandated by law or based on collective agreements (quasi-mandating), while in countries with more generous public first tier schemes supplementary second tier arrangements (mostly occupational pensions) were voluntary.

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[7] This refers to the type of redistribution designed ex ante. In fact, even in a pension insurance scheme aiming *ex ante* at pure intertemporal redistribution there will also be *ex post* interpersonal redistribution, for example, because of the different mortality of members even of one cohort.

Looking at the accession countries, we see that five of the former socialist countries have finally decided to implement mandatory second tier pensions.[8] Two other countries are in the process of doing this, while in two former socialist countries and in the three Mediterranean countries all pension schemes other than the first mandatory tier are in principle voluntary, although often subsidized.

Mandating second tier pension schemes is a recent development:

(1) Candidate countries with mandatory 2nd tier:

(1a) where the relevant legislation has already been passed:

Hungary	1998
Poland	1999
Latvia	2001
Estonia	2002
Bulgaria	2002

(1b) where implementation of a mandatory second tier is in preparation:

Lithuania (only draft law, not yet finalized)
Romania (only in the Action Plan of the Government, draft law announced)

(2) The following countries do not have a mandatory 2nd tier:
Slovenia[9]
Czech Republic
Slovakia
Malta
Turkey
Cyprus[10]

2.3 Mandatory public pension schemes – Development of dependency ratios as an important influencing factor

Mandatory pension schemes are the basic element of a national pension system. They are of the greatest importance both for individuals and for the economy. The mandatory public pay-as-you-go first tier schemes represent the most important source of income. The impact of funded schemes will increase over time and first be noticed in the financial markets, where there will be a surplus and an accumulation of capital for a number of years while relatively few benefits are paid out. It will take some time, however, before

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8 This development has been greatly influenced by the activities of the World Bank and the IMF. These proposals were also offered in countries without mandatory funded schemes.

9 It is only mandatory for insured persons in certain occupations where the employer is obliged to pay higher contributions in order to finance earlier retirement.

10 Mandatory, however, in the public sector.

funded schemes will affect the income of pensioners – depending on the rules under which the scheme is introduced (in particular the contribution rate compared to that of the mandatory pay-as-you-go scheme) and the rules governing the transition (see below).

Mandatory public pension schemes in Central and Eastern European countries have traditionally been *defined benefit* schemes. These schemes differed in terms of the

- degree of contribution-benefit link,
- the type of redistribution of income over the life cycle,
- the level of benefits.

The fiscal impact measured in terms of the ratio of public expenditure to GDP is additionally influenced by

- the coverage of the scheme,
- the "system dependency ratio" (pensioner ratio (PR) = number of pensioners (NP) to number of contributors (NC)),
- the (average gross) pension level (APL = ratio of average gross pensions (AP) to average gross contributory wages (AW) or taxable income).

In a scheme based mainly on contribution revenue the contribution rate (c) is of economic and political importance. In a pay-as-you-go scheme c (necessary to balance the budget) depends on the pensioner ratio and the (average gross) pension level:

Contribution rate = Pensioner Ratio * Average (Gross) Pension level

$$c = NP/NC * AP/AW.$$

All other things being equal, if there are transfer payments, for example, from the state budget to the budget of the pension scheme, c is lower.[11]

The pensioner ratio depends on many factors. One is the age structure of the population, which can be measured analogously to the pensioner ratio by an old-age dependency ratio (number of persons beyond the working age in proportion to the number of persons of working age[12]). This is often looked upon as a pure demographic indicator. However, this ratio is dependent on a definition of 'working age'. For the purposes of comparison a uniform working age is often used to determine the old-age dependency ratio. This can, however, be a misleading indicator for pension policy purposes if there is in fact a significant difference between countries in when people actually start and stop working.

Other factors influencing the pension ratio beside the old-age dependency ratio are of a political nature and include, for example, the coverage of the

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11 The contribution rate then only has to be fixed at such a percentage that all the expenditure not covered by the "federal grant" – or any other transfer payments from other institutions – can be financed.

12 This means persons – by definition – able to work.

system[13], the eligibility criteria for drawing benefits, such as retirement ages for men and women (fixed or flexible), early retirement options, the number of working years required, and the eligibility criteria for disability pensions. A further question is whether these criteria apply for all members of the pension scheme or whether there are specific criteria (privileges) for some groups of the population.

If the eligibility criteria are fulfilled, health conditions and labour market conditions will obviously influence the decision to claim a pension. These decisions will also be influenced by the benefit level and the replacement rate that can be realized[14]. Thus, evaluating pensioner ratios in different countries requires careful analysis. If, for example, decisions on instruments for influencing the pensioner ratio are to be based on empirical information, the factors influencing the level and development of pensioner ratios must be taken into account.

A careful analysis is even more important for the comparison of the macroeconomic expenditure ratios that often are used as an indicator of the fiscal sustainability of a pension scheme.

Below is some empirical information regarding the two types of Dependency Ratios: Figure 1 illustrates the fact that there is a large discrepancy between the old-age (demographic) dependency ratio (derived from the age structure of the population) and the pensioner ratio (system dependency ratio).

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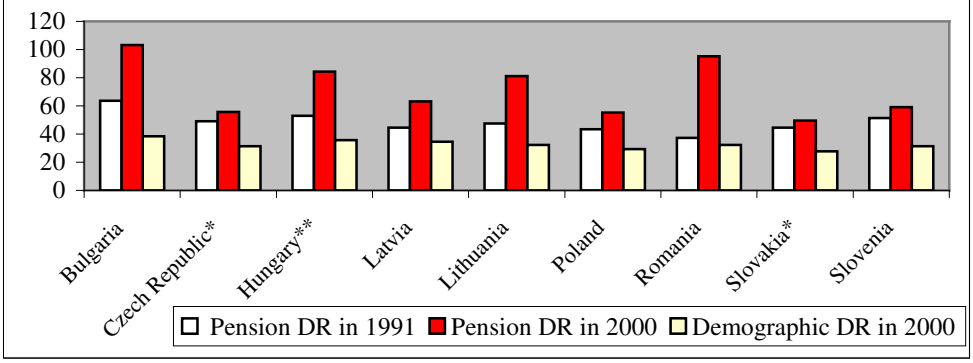
[13] For example, whether all persons in a country are covered by the same scheme or whether some groups, such as civil servants or farmers, are excluded from a general scheme and belong to a special scheme (e.g. the KRUS in Poland).

[14] Replacement rate as benefits compared to last individual wages (gross or net). Net replacement rates, however, depend not only on the conditions of the pension scheme but also on other factors, such as taxation and income-related transfer payments. What is called the “replacement rate” is often measured empirically not on the basis of last own earnings but as a general benefit level (for example, average pension to average gross or net earnings in general or for an average production worker).

Figure [1]. Demographic and Pension System Dependency Ratio[a]



[a)] The demographic dependency ratio (DR) is calculated as the population over 60 years of age divided by the population within the 20-60 age range, and the pension system dependency ratio is estimated as the ratio of contributors to pensioners.

*) For the Czech Republic and Slovakia the first column refers to 1995
**) For Hungary the middle column refers to 1998.

Source: Rutkowski (2002), Fig. 1

While the old-age dependency ratio does not differ so much between the countries covered, there are remarkable differences regarding the system dependency ratio (pensioner ratio).

For the pensioner ratio the decisive factor is the effective average retirement age and not the statutory retirement age (for claiming a full old-age pension). If there are also disability pensions, it is obvious that the average retirement age will be lower than the "statutory" retirement age. The same is true if there are different rules for specific groups of the population and/or if there is some flexibility in the age at which a pension can be claimed. Early retirement schemes and other pathways to retirement can be relevant, too. All other things being equal, a lower average retirement age increases the pensioner ratio.

Table 2 illustrates clearly that the effective retirement age is lower than the statutory retirement age (which is itself often different for men and women). It is difficult to obtain reliable comparative data on effective retirement ages because often it is not clear whether disability pensions have been included in the calculation. It is also important to note that the data for any one year are influenced by the size of the different age groups (birth cohorts).

Table 2: Effective retirement age in selected accession countries – 2000

Country	Men	Women
Bulgaria	53.8	53.2
Hungary	52.5[1)]	
Latvia	60.3	56.8
Poland	59.0	56.0
Romania[2)]	55.0	53.0
Slovakia	59.6	54.8
Slovenia	59.2	55.5

1) Average in 1999 for whole population

2) For early and old-age retirement. If disability is included, then 53.0 (men), 50.0 (women)

Source: Fortuny et al. (2002), p. 37 (based on national surveys for an ILO survey)

In nearly all countries there was an increase in the pensioner ratio during the nineties. One reason was the serious economic difficulties especially in the labour market. Pension schemes were, in fact, often used as an instrument of labour market policy and to cushion the effects of restructuring state enterprises. There was often pressure on the pensioner ratio from "both sides", so that it was pushed up by both an increasing number of pensioners and a decreasing number of contributors.

Bulgaria's pensioner ratio, for example, having increased dramatically particularly during the last few years, is exceptionally high. While the number of pensioners remained more or less constant, the number of "insured persons" fell by about 37% between 1996 and 2001. As a result, since 1996 there has been a continuous increase in the pensioner ratio until it now stands at about one pensioner to one insured person, as can be seen from Table 3.

Table 3: System dependency ratio in Bulgaria

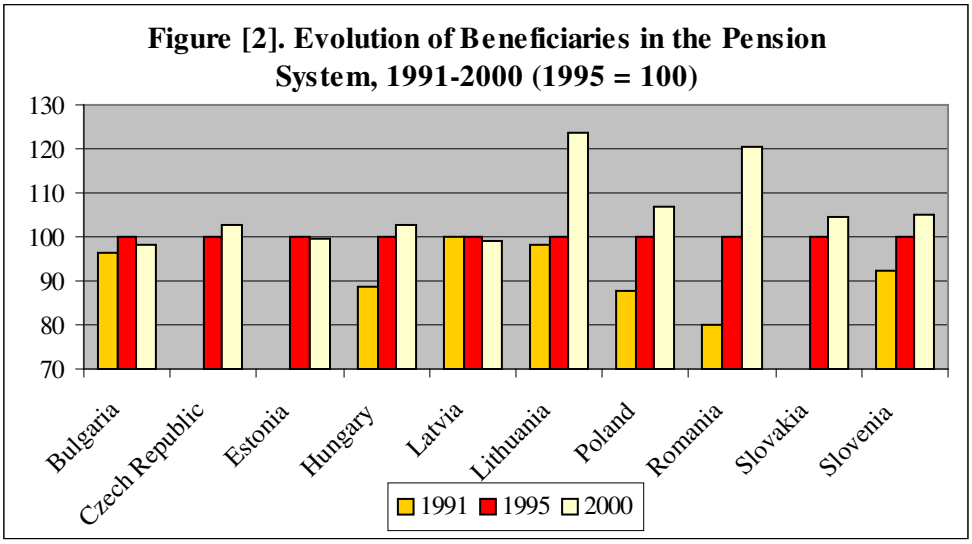
Pensioner Ratio (number of pensioners per 100 insured persons) in Bulgaria	
1996	68.6
1997	69.3
1998	71.8
1999	83.1
2000	103.0
2001	108.0

Source: Country Report Bulgaria

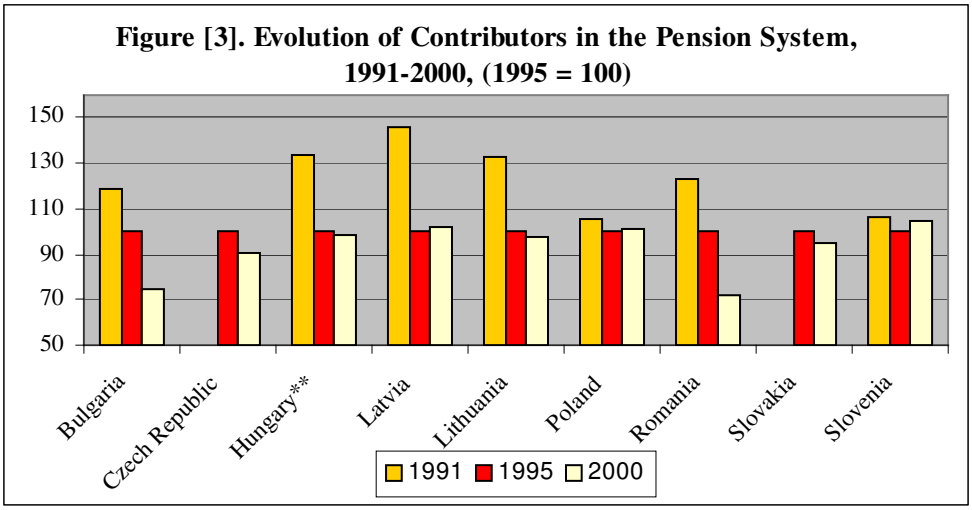
Hungary, Latvia, Lithuania and Romania also provide examples of a contributor base shrinking rapidly within a few years (Figure 3). Problems in revenue collection, though a major topic in many countries (see below),

were thus by no means the only reason for a sharply declining contribution base in many countries. There are also countries – such as Lithuania, Romania and Poland – where the number of pensioners increased remarkably within the five years from 1995 to 2000 (see Figure 2).

– Figures 2 and 3 –



Source: Rutkowski (2002), Annex Fig. 2



Source: Rutkowski (2002), Annex Fig. 3

There are also countries where both negative trends have combined to push up the pensioner ratio. In addition to Romania, which has an extremely high pensioner ratio, Hungary and Lithuania also suffer from this phenomenon.

These developments are the reason for the difference between the old-age dependency ratio and the pensioner ratio. It is not demography that is putting pension schemes under pressure today.

To avoid or to limit an increase in expenditure as a result of high system dependency often the benefit structure in pension schemes has been compressed.

The ratio of the expenditure of *public* pension schemes to GDP is influenced by both the development of pension expenditures and the growth rate of the economy. There is remarkable variation in this ratio between candidate countries. In the year 2000 Turkey and Malta had figures below 6% while Slovenia's figure exceeded 14%.[15]

A proper evaluation of such figures must take into account both differences in the definition of expenditure and whether, for example, pension benefits are taxable income and, if so, the degree to which they are taxed. Such tax revenue reduces the macroeconomic "burden" of pension expenditure or the "burden" on public budgets.

As was already mentioned in chapter 1, a similar variation in the ratios of pension expenditure to GDP is also to be found in present EU member states, the UK and Ireland being at the lower end (something over 5% and 3% respectively), while most of the member states have ratios between 8 and 14%.[16]

Of course, these different ratios reflect not only demographic and economic conditions but also strategic decisions in the design of pension schemes. Particularly influential here are political decisions on the public-private mix in pensions as well as the relative weight of pension policy compared with other areas of public activity. It is obvious that in pension policy there is no uniform model among present EU member states.

In view of the fact that many countries have only recently implemented changes in pension policy of an often fundamental nature, the present data provide only limited information regarding the fiscal sustainability of public pension schemes.

In addition, the ratio of public pension expenditure to GDP is often of low importance in the political process because GDP is not the contribution base for pension schemes. It is therefore important whether this contribution base develops in line with GDP. If, for example, wages and salaries are the main element of the contribution base (as in most countries), what matters is

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15 For more information see Chapter 1 of this report.

16 For comparisons regarding the macro-economic impact of pensions as well as their effect on the level and distribution of the income of private households, not only public pensions, but also private pensions need to be taken into account.

whether the labour income share is (more or less) constant and whether the part of the sum of wages and salaries from which contributions are effectively paid remains constant.[17] If one or both ratios are declining, the contribution rate necessary to balance the pay-as-you-go financed scheme will increase, even if the ratio of pension expenditure to GDP remains constant. It is the development of the contribution rate which is usually at the centre of public debate.

However, there have been attempts to change the rules aimed at influencing the dependency ratio (for example, an increase in retirement ages, which will show its effect, however, only slowly).

2.4 Trends in designing and developing mandatory pension schemes as the first and even second tier of the pension system

During the last few years several trends in former socialist countries have become apparent. Of pension reforms recently implemented some constitute a clear rejection of previous pension arrangements (and are thus often labelled "structural reforms"), whereas others are a further development of existing schemes (and thus labelled "parametric reforms"). However, this distinction can be misleading. Let us take as an example a 'parametric' reform which reduces the benefit level in a public scheme, thus making private saving much more necessary than before. This will result over time in a quite different structure of income in retirement and thus in a 'structural' change. Both types of reform can take place simultaneously in one and the same country, as in Bulgaria and Hungary, which introduced a mandatory funded tier and redesigned their existing pay-as-you-go defined benefit schemes. Other countries – such as Latvia and Poland – have changed their pay-as-you-go financed schemes more radically.

The compression of the benefit structure in the early years of transition stimulated proposals for restructuring the pension scheme, especially by trying to establish a link between what the insured contribute and what they can expect in future benefits. In many countries, therefore, public pension schemes have been redesigned either to implement a link between contribution payments and pension benefits for the first time or to strengthen this link if it already existed in principle. This can, however, only be achieved step by step. The instruments chosen differ, and one of the most important is a defined contribution scheme.

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[17] Even if all wages and salaries are declared to the revenue collecting agencies, there may be a floor and a ceiling so that wages/salaries are not burdened by contribution payments at all or only to some extent (in the case of contribution ceiling).

2.4.1 Defined contribution schemes

While all former socialist countries had defined benefit schemes aiming at interpersonal redistribution, two of the candidate countries have now changed their mandatory public pay-as-you-go scheme (first tier) into a defined contribution scheme. This has been done in Latvia and Poland and requires transition rules (see below). The concept has been developed in Sweden as well, whilst Italy is also in the process of changing its scheme in this way.[18] Latvia and Poland, together with three other countries, have now implemented a mandatory capital funded second tier of the defined contribution type. The design of defined contribution schemes achieves a strong contribution-benefit link, whether pay-as-you-go financed or capital funded.

The first country to introduce a mandatory *public* defined contribution scheme was Latvia. In doing so it copied the Swedish approach, although at that time it had not yet been implemented in Sweden itself. Defined contribution schemes already existed in many countries of the world as capital funded private life insurance schemes or as capital funded occupational schemes. The new approach – first implemented in Latvia and later also in Poland – was to operate the contribution defined schemes on a pay-as-you-go basis (this was labelled "notional defined contribution scheme", NDC, in contrast to financial (funded) defined contribution schemes, FDC). The scheme started in 1996 and in 1998 several amendments were introduced.

Three years later, in 1999, an NDC scheme was launched in Poland together with a second mandatory element, a capital-funded privately-managed defined-contribution scheme (FDC). This new scheme, however, did not cover farmers.[19] In Latvia, this second mandatory funded and (in principle) privately managed element was introduced with some delay in 2001. In both countries the new pension scheme, which will cover more and more insured persons over time, thus consists of two mandatory parts, both defined contribution schemes.

For those persons covered by the new schemes the retirement (but not disability) pension benefits in Poland and in Latvia will in future be calculated in an identical way for both mandatory pension schemes, the NDC and the FDC scheme.

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[18] The concept of defined contribution schemes based on pay-as-you-go financing has been discussed in several papers. See, for example, Cichon (1999), Disney (1999), for Sweden Palmer (2002).

[19] This means that in principle only those covered by ZUS are affected by the new rules and not those who are members of KRUS (farmers cultivating more than 1 hectare of land).

The three other countries that also introduced a mandatory capital-funded second tier of the defined contribution type – privately managed – have not shifted the first public tier from defined benefit to defined contribution. In Hungary, the mandatory funded defined-contribution scheme started in 1998, followed by Bulgaria, which introduced a funded defined contribution scheme in 2000.[20] Only recently – in 2002 – Estonia, too, introduced a mandatory funded tier. In Romania draft legislation introducing a mandatory privately-managed funded tier already exists. It is to be introduced when the financial situation of the public pension scheme improves.[21]

Defined contribution schemes have a clear and strong contribution-benefit link. In principle, pension benefits are calculated on the basis of the accumulated contribution assets (including some interest). In the NDC schemes – where no capital fund is built up – it is an interest rate defined by law (for example, the growth rate of average wages or the wage sum) and not by the development of capital markets. NDC schemes are like virtual saving schemes combined with an annuity calculated at the time of retirement. This is, in principle, a design like that of private life insurance. The monthly (yearly) pension benefit is based on the accumulated assets (sum of contribution revenue and interest – whether "real", as in an FDC scheme or virtual as in an NDC scheme) – and on remaining life expectancy at the time of retirement.[22]

To put it simply, the pension benefit is therefore calculated as *K* (sum of financial or virtual capital) divided by *G* (remaining life expectancy). *G* remains constant for the individual pensioner for as long as they receive benefits but changes over time for new retirees when their pension benefit is first calculated. This type of pension scheme thus reacts automatically to changes in life expectancy for new retirees without the rules having to be changed.

In contrast to voluntary private DC schemes, in a mandatory scheme remaining life expectancy can be calculated (as in Poland) as a unisex and not a gender-specific figure. This is to the advantage of women because of their higher average life expectancy.

How remaining life expectancy is calculated in DC plans can affect the financial conditions of the pension scheme (whether pay-as-you-go financed

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20 There is a professional pension fund covering employees working under "risky" conditions, who become eligible for an early retirement pension. All persons born since 1960 and covered by the public first tier pension scheme are covered by a universal pension fund.

21 In Slovenia the idea of a mandatory capital-funded element was rejected. Only part of the capital-funded insurance of the second tier is mandatory., like in Bulgaria. Here employees in certain occupations are mandatorily covered, i.e. in addition to the contribution paid into the public pension scheme the employer has to pay an additional contribution, which is the basis for an occupational early retirement pension.

22 The Swedish formula differs from this and has some specific features.

or capital funded): If the remaining life expectancy is calculated only according to the statistics at the time of retirement (as in Poland), then future expenditure development will be underestimated, should there be subsequent increases in life expectancy. If the calculation includes a projection of further changes in life expectancy (as is usual in private life insurance), these changes can be overestimated.

There are other effects that can be relevant for the fiscal sustainability of pay-as-you-go financed DC plans. One of these is the indexation of (1) the accumulated pension claims ("notional accounts"), (2) the pension benefits compared to (3) the development of contribution revenue. If the contribution rate remains constant, this last is in general the wage sum. In Poland, for example, indexation of pension claims (1) is linked to the Consumer Price Index (CPI) plus 75% of the growth rate of the real wage sum that is subject to pension contributions. The indexation of pension benefits (2) is based on the development of the CPI and 20% of average wage growth, while the development of contribution revenue is linked to the development of the wage sum that is the basis for contribution payments.

In the Polish case the "indexation" of (1), (2) and (3) is linked to different bases. The effect of the present rules is that the indexation of the pension claims (1) is lower than the growth rate of contribution revenue (3). And also the rate of indexation of pension benefits (2) is lower than that of contribution revenue or wages (3).

The development of the influencing factors can vary with time and thus threaten the aim behind the introduction of DC schemes, namely to stabilize the contribution rate.[23]

Whether an indexation of pension claims and of pension benefits with the growth rate of the wage sum is sufficient for the financial stability of the NDC scheme[24] based on a fixed contribution rate depends on some additional factors which will not be discussed here.

In the NDC scheme, contributors – whether male or female – with the same contribution record and belonging to the same birth cohort will receive the same pension benefit. In the FDC scheme the pension benefit depends on the investment decisions and the rate of return of the specific funds.

Another factor relevant to the Polish pension reform is that retirement ages remain gender-specific (men 65, women 60). In DC schemes this means that female pensions will be lower, even if contribution payments per year of insurance are the same for men and women. This is because the insurance record of women will be shorter, due to their lower retirement age.

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[23] Sweden implemented a buffer stock to enable it to respond to financial problems in the scheme. In Poland a buffer stock is also to be introduced if current revenues exceed expenditure. Meanwhile the state budget guarantees the pension payments.

[24] See Valdes-Prieto (2000).

Since they start to draw their pension earlier, their average life expectancy on retirement will be higher. This means a higher G-factor even in the case of unisex life expectancies. In privately managed FDC schemes this effect is even stronger because of the gender-specific higher life expectancies of women.

The fundamental shift in Poland towards NDC + FDC applies only to old-age, and not to disability pensions Disability pensions have not yet been reformed, although reforms can be expected in the not-too-distant future. There may emerge a widening gap between old age pension benefits in the NDC scheme and disability pension benefits in a defined benefit scheme. This may encourage the early claiming of a disability pension.

It is important to note that the mandatory FDC schemes do not cover disability, and sometimes not even survivors, in cases such as Estonia.[25] This is important when comparing, for example, the "rates of return" of different schemes.

The collection of contribution revenue in DC schemes takes various forms as can be seen by comparing, for example, Poland, Hungary, Bulgaria and Estonia: In Poland the social insurance agency ZUS collects the contributions for both DC schemes[26], the NDC scheme that is run by ZUS itself and the FDC schemes, which are privately managed capital funds. In Poland, there have been severe administrative and implementation problems in transferring part of the contribution revenue to the different funds.

In Hungary the public pay-as-you-go scheme remains defined benefit. The revenue collection is separate for the first and the mandatory second tier: Employers have to collect the revenue for the mandatory FDC scheme (second tier).

In Bulgaria, the pay-as-you-go scheme remains defined benefit, too. But here the revenue collection for both mandatory schemes (pay-as-you-go DB and FDC) will be carried out by the National Social Security Institute and revenue will then be transferred to the private funds.[27]

In Estonia, the employer transfers individual contributions to the Tax Office together with the "social tax" (which is payable by the employer).

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25 It has to be noted, however, that in the case of the death of the participant assets already accumulated are inherited by the survivors, who can choose between withdrawing the accumulated sum in cash or transferring it to their own FDC account.

26 In plans for introducing pension funds in Romania a central collection of revenue for the public pay-as-you-go scheme and the capital funded element has also been incorporated in the design of the reform proposal.

27 The Country Study mentions here that these transfers are according to "the number of clients" of the funds. This would not take into account differences in earnings. The information in the report may be misleading on this point.

From the Tax Office the money for the FDC scheme (which is the individual contribution together with part of the social tax) is transferred to the Central Depository. From there the amount is transferred to the bank of the fund manager the contributor has chosen.[28]

With the introduction of these mandatory second tiers, which are privately managed, the role of the state in pension policy changed: Here the state is no longer the provider, but has an important role as regulator. Thus, taking the role of the state in the first and second tiers of pension schemes together, there is also a noticeable shift, with less providing and financing and more regulating. Regulation, together with an adequate infrastructure in the banking industry and the capital market, is of great importance for the functioning of funded schemes (see below).

2.4.2 Changes in defined benefit schemes

Switching from a defined benefit to a defined contribution scheme is a powerful strategy for reducing interpersonal redistribution within pension schemes. But it is not the only one. In several countries attempts are being made to implement or to strengthen the contribution-benefit link by various changes in the formula for calculating pensions and/or in eligibility criteria.

One observable trend is raising the number of years of previous earnings or contribution payments that are relevant for calculating pension benefits. For example, in Romania, the new pension formula for 2000 takes into account insured income over the entire contribution period.

However, many countries still have highly redistributive pension formulas for public pension benefits. For example, the Hungarian and Slovakian benefit formulas are non-linear. Other countries have flat-rate elements in addition to earnings-related elements or those based on length of service, as in Lithuania and Estonia. Even where, for example, in Lithuania, the number of contributing years required for entitlement to a full pension is being gradually raised, the formula for the public defined-benefit scheme remains considerably redistributive.

Attempts are also being made to reduce privileges for specific groups. Although there are changes in the eligibility criteria – particularly in gradually increasing retirement ages – those countries with a public defined-benefit scheme to a large extent achieve interpersonal income redistribution via this scheme.[29] Where minimum pensions exist or low pension benefits

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[28] See chapter 2.6 below for details on the Estonian case.

[29] This is particularly obvious in countries where the benefit calculation has a flat-rate component, such as the Czech Republic, Lithuania, Estonia, and the old scheme in Poland, or if earnings are taken into account at different percentages depending on the amount of earnings, as in Slovakia. There exists a great variety of benefit calculation

are topped up by means-, income- or pension-tested benefits, this is explicitly aimed at avoiding poverty in old age by measures of interpersonal redistribution.

As a means of increasing open government, as well as implementing a contribution-benefit link, changes in financing have been implemented in many candidate countries. Separation from the state budget and separate contribution rates for different "risks" (and branches of social security) have been achieved in most of the countries, but not everywhere. For example, social insurance in the Czech Republic remains part of the state budget though there are now plans to separate it off by 2004. In Malta there are no separate contribution rates. Employers, employees and self-employed all have to pay contributions to a universal scheme. The state itself contributes to social security an amount equal to 50% of the contribution revenue collected from these three groups.[30]

2.5 Fundamental regime change: Transition rules and financing of transition costs

Of particular interest are developments in those countries which have introduced a second mandatory capital-funded tier into their pension systems in addition to the mandatory public (basic) pay-as-you-go scheme. These countries are confronted with an "additional fiscal burden" (often called "double burden"). How high this fiscal burden actually will be depends very much on the concrete technical solution adopted for the transition from one system to another.

In view of the already high contribution rates financing the pension schemes in countries which decided on a regime switch, a principle objective in all but one country was that the total 'new' contribution rate for the first and second mandatory tiers should not be higher than the 'old' contribution rate in the public pension scheme.[31] The fact that part of the contribution revenue is usually channelled towards the new second (funded) tier, leads to a deficit in the first tier. This deficit has to be financed. All other things being equal, the amount of the deficit depends on:

- the contribution rate used for the second, funded tier,

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and financing instruments for achieving interpersonal redistribution in the pension scheme.

30 A "lack of clarity in financing sources" is mentioned in the Malta Country Report as a topic to be addressed in the future.

31 The exception is Estonia, where not only is 4 % of the already existing contribution rate of 20 % channelled into the funded tier, but employees joining the new scheme also have to pay an additional 2 percentage points. The total contribution rate has therefore increased from 20% to 22%.

- the number of contributors that are obliged to contribute to the second tier or have the possibility to do so.

Such a deficit could be covered by the state budget or by borrowing. If the deficit is to be financed from current public revenue it will be necessary to decide where the money is to come from. It can be found by increasing tax revenue or reducing other public expenditure. The deficit can also be reduced by reducing public pension expenditure. What is obvious is that all these alternatives in financing the transition costs affect personal income distribution.

The chances of debt-financing the deficit in the first tier are improved by the introduction of the mandatory capital-funded second tier. The new pension funds in the second tier will for a long time only collect contributions and accumulate funds without paying out pension benefits. These funds could be invested in state bonds. By doing this, part (but only part) of the implicit public debt of the pay-as-you-go scheme is converted into an explicit public debt (which, however, is not without its costs).

Apart from these alternatives, an instrument often discussed is that of financing the emerging deficit out of privatisation revenues. However, in principle this is just another way of financing the deficit of the pension scheme via the state budget.

What options have, in fact, been chosen by the candidate countries? There can as yet be no final answer to this question, because the transition period can be quite long. Even if, as in Bulgaria in 2002 or in Hungary and Estonia[32], the existing deficit is initially covered by a subsidy from the state budget, the sources of financing can change over time. It is an open question how sustainable these deficits made up by the state are, especially if the contribution rate to the funded scheme is increased over time, as in Hungary and Latvia. There is a political risk that the deficit in the pay-as-you-go scheme will be financed by reducing benefits in the public pension scheme. The greater the difficulties in financing the state budget, the higher the probability that this option will be chosen.[33]

For reducing pension expenditure a great number of alternative instruments are available. One option for many countries might be to increase retirement ages.[34] Bulgaria, for example, has already started to do

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[32] In Estonia the transition costs are estimated at about 0.6% of GDP or 8 to 9 % of the budget of the state pension insurance. While for a few years the deficit will be covered by some accumulated reserves, how the transition costs will be financed in future remains an open question.

[33] See also chapter 5

[34] Whether this also increases contribution revenue depends on labour market conditions.

this in combination with a comprehensive reform.[35] Another option which might result in lower benefits is changes in the indexation of pensions.

The emerging deficit in the pay-as-you-go system will also be determined to a considerable extent by the number of persons who are obliged to join the new scheme, and those who can do so voluntarily. Table 4 describes the coverage for those five countries which have up to now introduced a mandatory funded element into their pension system.

Table 4: Coverage by new mandatory funded pension schemes

Country	Covered		Not covered
	Mandatory	Voluntary	
Bulgaria	(a) Employees working under unhealthy job conditions (occupational scheme) (b) Employees born after beginning of 1960 (i.e. aged under 42)		
Estonia	New labour market entrants (born since 1983)	All persons born 1942-1982 (i.e. aged 19 to 60 in 2002)*	Persons born before 1942
Hungary	All new labour market entrants	Other employees – decision within a period of 20 months –**	
Latvia	(a) All new labour market entrants (b) Insured persons aged under 30 (in July 2001)	Those aged 30-49 (2001)	Those aged 50 and older
Poland	(a) All new labour market entrants (b) Employees aged up to 30 (1999)	Those aged 31-50 (1999)	Those aged 51 and older

* Persons born 1942-1956 could join until 1 November 2002, persons born 1957-1961 can join until 1 November 2003. For younger persons the option to join also remains open for future years.

** Until end of 2002 possibility to return to pure pay-as-you-go scheme.

Source: Country Studies.

35 However, one could not generalize that retirement age is increased quicker (or is higher) compared to a situation without an introduction of a funded second pillar and an emerging deficit.

In Hungary mandatory access was limited to those entering the labour market for the first time[36], while in Latvia and Poland all employees under age 30 became members of the new system. In Bulgaria this limit was even higher (under the age of 42). In Hungary, on the other hand, the proportion of employees given the option of joining the new scheme was larger than in Latvia and Poland. In Hungary an option even existed for some years to return from the mixed system to the pure pay-as-you-go scheme. In Poland and Latvia "older" workers remained in the old scheme. The widest option for joining the capital funded part exists in Estonia: After the introduction of the new scheme all workers[37] have the possibility to join the funded scheme, and this will also apply in the future, although only older workers have to choose within a few months of the introduction of the new scheme.

While calculating the number of persons joining the system mandatorily is relatively easy (depending in particular on the age structure of the labour force and age and gender specific labour force participation rates), there is some risk in estimating the number of those who will join the system voluntarily. In Hungary, for instance, the number of those who decided to join the new scheme voluntarily was about 100 per cent higher than expected. The deficit in the pay-as-you-go first tier was thus also correspondingly higher than originally estimated. The effect of a higher number of new participants in the mixed system – those who opted out with part of their pension claims – on the deficit in the first tier was reduced compared to original calculations and plans because the share of the contribution rate shifted towards the funded tier was not increased to 8% but remained constant at 6% (see Table 6 below).

Information regarding the development and the financing of transition costs is relatively vague. There is information on how much the pay-as-you-go contribution rate has been reduced. Contribution rates in at least four of these five countries are extremely high (see Table 5).[38] In Bulgaria and Latvia, which are at the beginning of the process of implementing a mandatory funded tier, 2 percentage points of the total contribution rate is channelled to the funded tier. Here as in other countries it is planned to increase this contribution rate, without increasing the total contribution rate, and perhaps even reducing it (as is planned in Latvia[39]). In Latvia there are plans to increase the contribution rate to the funded tier from 2% to 10 % by 2010, while reducing the "social tax" which finances the pay-as-you-go part

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[36] This was abolished in 2001. However, after the change in government in May 2002 the mandatory coverage was once more introduced with effect from January 2003.

[37] Self-employed persons are excluded if they do not have wage income in addition to their earnings from self-employment.

[38] The contribution rate in Table 5 for Poland covers old-age pensions. There is an additional contribution rate of 7.07 % for disability, survivors and short term benefits.

[39] There are plans to reduce the total contribution rate to 33% and to increase the rate for the funded tier to 10%.

accordingly. The contribution rates in the three other countries (Estonia, Hungary and Poland) are already higher than 2 percentage points.[40] Estonia is the only country where the introduction of the mandatory funded scheme has been accompanied by an increase in total contribution rates (2 percentage points). The development of the contribution rate reserved for the funded tier and deducted from the revenue for the pay-as-you-go scheme is a highly important factor influencing the deficit in the first tier.

Table 5: Contribution rates in mandatory pension schemes

Country	Total			Pay-as-you-go (1st tier)			Funded (2nd tier)
	Sum	Employer	Employee	Sum	Employer	Employee	
Bulgaria	29.00			27.00			2.00
Estonia	22.00	20.00	2.00	16.00 20.00[2)]	16.00[1)] 20.00	–	4.00 + 2.00[1)]
Hungary	28.00[3)]	20.00	8.00	22.00	20.00	2.00	6.00
Latvia	35.09[3)]	26.09	9.00[4)]	33.09	26.09	7.00	2.00
Poland	19.52	9.76	9.76	12.22	6.11	6.11	7.30

[1)]Reduction of social tax paid by the employer (4%) and channelled to the funded scheme. Additional contribution (2%) by employee.
[2)]If not joining the funded scheme.
[3)]2001
[4)]There are plans to increase rate for employees and to reduce employer's rate.

Table 6: Contribution rates in Hungary 1998 – 2002[1)]

	Total	Employers	Employees total	Employees to		Total to pay-as-you-go
				Funded scheme	Pay-as-you-go scheme	
1998	31 (31)	24 (24)	7 (7)	6 (6)	1 (1)	25 (25)
1999	30 (31)	22 (23)	8 (8)	6 (7)	2 (1)	24 (24)
2000	30 (31)	22 (22)	8 (9)	6 (8)	2 (1)	24 (23)
2001	28 (31)	20 (22)	8 (9)	6 (8)	2 (1)	22 (23)
2002	26 (31)	18 (22)	8 (9)	6 (8)	2 (1)	20 (23)

[1)] Figures in brackets are rates legislated for in 1997.

In Hungary the original plan when introducing a funded element and the mixed scheme was to keep the contribution rate constant (at 31%). In fact, within 4 years the total contribution rate was reduced by 5 percentage points,

[40] The contribution rate to the pay-as-you-go scheme in Estonia has been reduced from 20 to 16% – paid by the employer alone. These 4 percentage points are transferred to the funded scheme if the employee pays an additional 2 percent contribution. The contribution rate to the pay-as-you-go scheme remains unchanged (20%) if the worker does not himself contribute to the funded scheme.

[41] In Latvia there are also plans to reduce the total contribution rate.

the effect of which was felt solely by the pay-as-you-go scheme (and even more than according to the original reform legislation) (see Table 6). It can be assumed that this will put additional pressure on the pay-as-you-go scheme, especially its benefit level.[42]The development of the deficit also depends on the number of employees in general, the development of contributory wages and on the number of persons who opt for the new scheme.

For Poland the transition costs (as a percentage of GDP) are estimated as follows[43]: 0.8% (1999), 1.4% (2000), 1.8% (2001), 2.2% (2002)[44], 1.8% (2003), 1.8% (2004).

The authors of the Polish reform proposal assume that between 2010 and 2012 the pay-as-you-go scheme will no longer be in deficit.[45] In Latvia official estimates predict that the deficit in the pay-as-you-go scheme will end by 2007-2010. Among other factors the volume of the transition costs depends – as mentioned above – on the contribution rate channelled from the pay-as-you-go to the funded tier. As planned, this is in Latvia, for example, much higher than in Estonia. Therefore, the transition costs as a percentage of GDP vary remarkably from country to country, as can be seen from Table 7.

Table 7: Transition costs in Estonia and Latvia as a percentage of GDP

	Estonia		Latvia	
	Per year	Accumulated	Per year	Accumulated
2005	0.6	2	1/2	1
2010	0.75	5	2	7
2015	0.83	7	2	15
2020	0.83	10	2	22

Source: Casey (2002)

Such estimates of transition costs are always based on a number of assumptions regarding the development of pension schemes as well as the

42 In Latvia there are also plans to reduce the total contribution rate.

43 Krajewski (2001), quoted in Country Study Poland (3.1.3). The transition costs are caused not only by the transfer of some part of contribution revenue to funded schemes but also by a new contribution ceiling of 250% of the average gross wage.

44 The increase calculated for 2002 is based on the fact that in 1999-2002 not only contribution payments for capital funded accounts were transferred to the pension funds, but also the contribution base has been limited to 250% of the average wage. The government is preparing a proposal to finance the entire debt (including interest) by the state budget issuing government bonds.

45 Chloń, Gora, Rutkowski (1999), p. 49, quoted in CountryStudy Poland (3.2.2). A more recent discussion of transition costs can be found in Chloń-Domińczak (2002), pp. 169-178.

economic activity in the country concerned(GDP). Such assumptions can always be disputed. However, it sounds rather optimistic to assert that in about 10 years there will be no transition costs. The question whether, for example, revenues from privatization will be able to cover at least part of the transition costs, as in Poland, depends on many factors influencing the type, development and outcome of the privatization process. In general (fiscal) transition costs can be expected to continue for decades.

In Lithuania, the transition costs are seen as the main problem in establishing a mandatory capital-funded second tier because of the already high contribution rate. Hence, no further increase in the contribution rate is intended. This in turn means that part of the contribution revenue must be shifted to the funded scheme, resulting in a deficit in the pay-as-you-go scheme as experienced in other countries. Due to these financing problems, it is not expected that such a reform will be implemented in the near future. Estimates of the transitions cost during the first 15 years after such a reform in Lithuania come to approximately 0.9 percent of GDP.[46]

Looking at the fiscal burden when implementing a second, mandatory, funded pillar, it is an interesting question for the future how these transition costs will be distributed among different groups of the population and between different cohorts. The present experience shows that the transition is easier to manage from a purely fiscal point of view if only the new entrants on the labour market are covered mandatorily. Such a successive inclusion in the new scheme distributes the costs more evenly over time. Whether this is politically acceptable is another question, for then the transition process from the old to the new scheme would be extended over a period of about 40-50 years.

2.6 Improving the collection of contributions

The shift towards defined-contribution as well as funded schemes is also linked to the issue of revenue collection. This is a severe problem in many countries. It is not only a matter of a 'shadow economy' where wages are paid in cash and taxes and social contributions are evaded, the problem also involves the reluctance to pay of both employers and employees in the formal economy. Often there was – and in some countries still is– only a symbolic contribution paid directly by the employee, while the majority of contribution revenue came from the employers. In the past there was only a weak link between contribution payments and benefit calculation. There was little or no awareness about the contributions paid by the employer on behalf of the employee, nor did this clearly affect the amount of the pension benefit. Needless to say, there was little willingness to pay a higher contribution. By contrast, in a contribution-defined pension scheme it becomes obvious that the amount of the contribution payment matters. Thus

[46] Country Report Lithuania ; see also Medaiskis (2001).

the introduction of a defined-contribution scheme – either as a first or as a second tier – is intended to stimulate the willingness on the part of the employee to pay his contribution and to check whether his employer actually pays the employer's share of the contribution.

One instrument for establishing or to increasing the contribution-benefit link was to shift part of the contribution payment from employer to employee. This was the case, for example, in Poland, Hungary and Latvia, although in the majority of countries the employer's contribution remains (often considerably) higher than the employee's share. In Poland, the contribution payment is already shared equally between employer and employee, and in Latvia a nearly equal distribution of employer's and employee's shares was envisaged as well, but not realized.

To give employees incentives to pay contributions a redesign of the benefit formula in defined-benefit schemes was also planned, and even implemented in several countries aiming at enhancing the contribution-benefit link. This is done in various ways: by reducing elements of interpersonal redistribution (for example, by changing from a non-linear to a linear pension formula, as Hungary has decided on starting in 2013) or by financing redistributive parts of the expenditure (for example, special conditions for specific groups) from general tax revenue instead of contribution revenue. These are developments that are also taking place in EU member countries.

2.7 Income and poverty in old age

2.7.1 Pension policy and poverty in old age

Poverty and social exclusion is discussed in detail in chapter 4 of this report. The focus in this chapter is on pensioners and the main instruments of pension policy. The impact of future developments specifically on these issues – in particular the consequences of radical reform strategies implemented in some countries – will be taken up below.

It is well documented that in Central and Eastern European candidate countries poverty was a severe problem during transition. In the absence (at least periodically) of indexation, periods of high inflation resulted in an erosion of the real value of pension benefits, hitting particularly hard those financing their living costs from social security transfers. For example, in Romania the average real pension in April 2000 was only worth about half its value in 1990.[47] Only in 2001 did Romania start a system of full price

[47] However, other factors beside inflation can influence the development of the real value.

indexation of pensions to stop a further deterioration in the purchasing power of pensions. Providing the initial pension benefit is above the poverty rate, mechanisms of indexation (based on prices or wages or a mixed index of both factors) are an important instrument for avoiding poverty after retirement.

While working pensioners were a common phenomenon in socialist times, employment possibilities for pensioners subsequently decreased dramatically. For example, in Slovakia before 1990 approximately one third of all old-age pensioners were still working, but by 2000 this figure had fallen to only about 8%.[48]

Poverty in old age still is a great problem in many countries. However, in some countries age-specific poverty rates show that poverty is lower for this group compared to other groups of the population or to the average of the whole population.[49] For example, the poverty rate for Romania has increased with time, the average reported[50] for the year 1998 being 27.3% and in 2000 30.6%. Yet those aged over 65 have a poverty rate below average (11.4%). Moreover, there are remarkable differences between regions as well as between urban and rural areas.

For Poland poverty in old age is at present not seen as a major problem[51], but may become so in the future as one result of pension reform measures (see below).

The incidence of poverty in old age is also linked to the role of the family. Social protection by integration in an extended family will reduce the probability of living in poverty in old age. Data presented for Cyprus illustrates the fact that poverty is to be found particularly where people are not included in such family networks. For Cyprus a high incidence of poverty is reported for elderly, divorced and single persons.[52] For 1996/97 it is reported for Cyprus most pensioners (about 62% of retired males and 67% of retired females) live below the poverty line. The average poverty rate is reported to be 25.5%. Among those aged over 65 and living alone the

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48 Country Report, p. 53. The low real value of pensions is mentioned as one important incentive for staying in the labour force.

49 This is not the place to deal with the problems of measuring poverty and the real meaning of published figures on poverty rates when, for example, shadow activities, home production etc are taken into account. The same applies to comparing poverty rates based on different methodologies. In the following only information from country reports is cited.

50 Country Report Romania, p. 28.

51 The poverty rate of old-age pensioners is 5.1% and below the average for the total population (8.1%); poverty is measured as subsistence level. A similar picture exists for other definitions of the poverty line.

52 These “reasons” may overlap.

incidence of poverty exceeds 90%.[53] Pension benefits here are obviously not sufficient to avoid poverty in old age.

Some data for Slovenia – see Table 8 – illustrates the fact that the number of elderly people and/or pensioners considered poor depends on the number of persons per household as well as on the household structure pensioners are living in. According to these data, elderly persons (60 years and older) have a poverty rate above average of the total population[54], while poverty amongst pensioners in a pensioner household[55] was only slightly above the average.[56]

Table 8: Poverty incidence[1)] in Slovenia 1993 – in per cent –

All persons	7.1
Persons aged 60+	12.6
– men	11.9
– women[2)]	13.1
Pensioners	6.7
– in pensioner[3)] households	7.3
– single female	7.8
– pensioners in pensioner couple households	4.7
– in other pensioner households[4)]	11.2

[1)] Equivalent household income of the person.
[2)] 31% of elderly women without pension entitlements.
[3)] Households with at least one pensioner, no household member is employed.
[4)] The other household member is not the spouse.

Source: Stanovnik and Stropnik (2000)

It is also obvious that the number of old-age pensioners considered poor depends on the definition of poverty. The variability of the findings is illustrated in Table 9 by some figures for Poland giving poverty rates in 1999 and 2000 based on 5 different *types* of definition (and not only different parameter values for one type of definition, such as 50% or 60% of average household income based on a specific equivalence scale).

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53 Country Report Cyprus , pp. 40, 52-54.
54 Here defined as 50% of median equivalent household income.
55 No household member is employed.
56 The data are always *equivalent* household income, not personal income.

Table 9: Poverty rates of old-age pensioners based on different definitions – Poland 1999-2000 –

Definition	Poverty rate in %	
	1999	2000
Subsistence minimum (absolute poverty)	3.6	5.1
Relative poverty	9.6	10.8
Subjective poverty	34.9	38.2
Social minimum	35.2	39.0
Income threshold in social assistance	8.6	8.4

Source: GUS (2000), quoted by Golinowska (2002), p. 34

Definition applied:

absolute poverty	≈ US $ 2-4 per day
relative poverty	50% of average household expenditure per consumption unit (OECD equivalent scale)
subjective poverty	Leyden poverty line
social minimum	based on a basket of goods and services essential for participation in social life (assuring integration)
social assistance	447 PLN with application of OECD equivalent scale

Source: Golinowska (2000), pp. 23-26

Although figures differ widely in absolute terms, all indicators – except social assistance threshold – show an increase in the poverty rate.

Some countries have special schemes for those with low pensions or those who have not fulfilled such eligibility criteria for the public pension scheme as a minimum number of years of insurance. Estonia, for example, has a flat-rate "National Pension" for persons lacking the required pension insurance years for old age, work incapacity or survivors' pensions. The national pension itself is well above the subsistence level. The amount of this benefit is also the pension guarantee level for old-age pensioners. Disabled pensioners with a low degree of incapacity to work (40-50%) receive a pension that is below the subsistence level.[57] It is well known from other countries that even a flat-rate or basic pension may not be sufficient to avoid poverty in old age. In Latvia more than half of all newly granted pensions in the years 2000 and 2001 were minimum pensions.

Another instrument focused on pensioners with low income, incomplete insurance careers etc. is a means-tested income supplement for old-age and disability pensioners or survivors. This exists in Slovenia, for example, where almost 10% of all pensioners receive it, as well as in Hungary. Here

[57] See Country Report Estonia, p. 46.

the income supplement is intended to ensure an income equivalent to 80% of the minimum old-age pension per person in the case of couples and 95% for singles.[58] In Poland there is a special transfer payment for disabled people without entitlement to an old-age pension (e.g. those disabled since birth, or early in life) as well as a tax-financed benefit topping up low pensions from the first and second tiers for female and male workers with 20 years or 25 years of employment respectively. In other countries, such as the Czech Republic, there is only a general means-tested social assistance that is not focused specifically on pensioners and no special scheme for the elderly or disabled or persons with low pensions.

To sum up, there is no uniform picture on poverty amongst pensioners in the candidate countries. This applies equally for the question of whether pensioners are (on average) more or less vulnerable than the total population. The answer will depend not only on the quality of empirical data but also on the definition of the poverty line used and equivalence scales for different size and structure of households. Poverty data are already highly sensitive to small changes in definition, etc.

Equally, the instruments used in the attempt to avoid poverty amongst pensioners vary considerably, as the examples given above illustrate. Finally, information on poverty in recent years can be of very limited relevance when considering how things may change when pension reform measures are implemented. These changes will often only affect the income of pensioners over time.

2.7.2 Future income in old age after fundamental pension reform

The "systemic" pension reforms in some of the candidate countries – supported in particular by the World Bank – have attracted special attention. From the point of view of social policy the important question is how much these new schemes will be able to provide adequate retirement income in the future. It is obvious that the defined contribution schemes – whether NDC or FDC – will limit the degree of interpersonal redistribution. It will be important to see whether, for example, in the case of unemployment or illness contributions will continue to be paid towards the pension schemes.

From a gender-specific point of view, in mandatory DC schemes unisex life expectancy tables can be used, while in voluntary schemes gender specific tables will be necessary. Because of higher female life expectancy women have to pay more than men during their working life or have lower benefits per month (per year) in voluntary schemes. In mandatory schemes with fixed contribution rates and unisex life expectancy tables the periodic pension benefit depends (a) on the earnings the contributions are based upon, (b) the retirement age and (c) the return on investment, which can

[58] Financing is from tax revenue, 15% from state budget, 25% from local government.

differ in FDC-schemes according to how the contribution revenue is invested. Where, as in Poland, there is still a lower female retirement age, pension benefits are lower for women (even in the case of earnings identical to those of men) as was pointed out in 2.4.1. Together with other arguments this may stimulate a discussion on whether the retirement ages for men and women should not be equalised.

DC schemes taking into account actual or projected figures for remaining life expectancy will automatically lower the pension benefit in the case of increasing life expectancy – unless the contribution rate is increased in advance. The introduction of DC schemes is in most cases linked to a wish to stabilise the contribution rate over time. Unless retirement is postponed this can result in an unexpected reduction in pension benefit in old age. The nature of DC schemes means that contributors have no advance information about the level of the benefits they will receive in old age.

If mandatory funded elements are introduced at the expense of the pay-as-you-go scheme[59], and particularly if the total contribution rate is reduced, a reduction in benefits can be expected. Combined with the dominant demographic trend, the ageing of populations, an additional political pressure to reduce benefit levels must be reckoned with. Whether the objective of avoiding poverty will suffer remains an open question. The Country Report for Poland mentions this as a potential danger for the future. If, because of changes in pension schemes, a growing percentage of pensioners become eligible for means-tested social assistance this may result in political pressure for additional changes in pension policy, especially for increasing the benefit level.

2.8 Some trends, experiences and future problems[60]

2.8.1 Administration

The implementation of reform measures, especially where more fundamental changes were introduced, revealed the presence of administrative problems which needed to be solved. Administrative aspects are involved, for example, if a closer contribution-benefit link is to be introduced into a pension scheme. For this requires (not only in private but also in public schemes) the development of individual accounts. This development will gradually be implemented in many countries in the process of extending the period of the working life that is taken into account for calculating an earnings-related pension. The transfer and distribution of

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59 Only in Estonia is the carving out combined to some extent with topping up.

60 Schmähl (1999) includes a great many country-based experiences and developments which cannot be repeated here. The reader is therefore referred to Schmähl (1999) as a supplement to this chapter.

centrally collected contribution revenue to different privately managed pension funds has continued to be a problem in Poland. It will be interesting to see the experience provided by different models of contribution collection (centralized or decentralized) (see 2.6 above).

2.8.2 Restructuring financing

As already mentioned, there is not only a trend towards the privately managed schemes and capital funding which (at least in former socialist countries) did not exist before, but also a trend in most of the candidate countries in recent years to improve the financial situation of the public pension schemes by reducing pension expenditure development (increasing retirement ages, cutting privileges, changing the indexation of pension benefits) and increasing revenue. Changes are often intended to provide incentives for contributing to the scheme. There are also attempts to obtain revenue from the state for credited pension claims that are not based on contributions, or for special supplements.

There is a trend in some countries to change the proportion of contribution rates paid by employers and employees. One aspect of this is the incentive for employees to pay for their pension benefit if it is clearly increased by their contribution payments. Another aspect is labour costs and their effect on both international competitiveness and informal economic activity in the shadow economy. This is an important argument in political debates in many countries. However, it can be misleading only to compare contribution rates can when discussing the relative weight of the employer's social insurance contributions in total labour costs. Total labour costs and productivity (i.e. unit labour costs) are the critical factors in international competitiveness.[61] If, for example, a contribution rate of 20% paid by the employer alone is compared to the same rate shared equally by employer and employee (10% each), this overstates the relative weight of the employer's contribution in total labour costs as well as the effect of reducing this "burden" by halving it into two equal shares[62]: If the employer's contribution is 20%, this is 16.66% of total labour costs (which is the sum of gross wages (100) and contribution rate (20)). If the employer's share is reduced to 10%, the employer's contribution is reduced only by 0.91 percentage points to 9.09% of total labour costs.[63]

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61 Labour costs divided by productivity (either per worker or per time period, for example, working hour).

62 Another aspect, one not discussed here, is the shifting of the burden, especially of the employer's contributions, forward into prices or backwards onto wages.

63 Obviously the reduction of total labour costs is not 10 percentage points – as might be expected from the lower contribution rate – but around 7½.

2.8.3 Functioning capital markets

The functioning of capital funded schemes requires an efficient national capital market and banking sector. In recent years there has been some loss of confidence in the stability of this sector (see, for example, the banking crisis in Latvia in 1995). Some countries, such as Latvia, first introduced facilities for voluntary funded schemes such as life insurance and pension funds, which were in general tax privileged, to gain experience and to prepare the ground for more ambitious projects.

Many of the candidate countries have a small population. This affects risk-pooling, particularly if there are competing suppliers of pension products. In countries which introduced mandatory funded schemes a process of concentration took place within a very few years. The number of pension funds in Poland in 1999 (the year the new pension system was launched) was 21, in 2001 17. In 1998 Hungary saw the launch of 36 mandatory funds but by 2001 this number had fallen to only 21.

Capital markets in accession countries are in general (very) small and "...in an international context only the capital markets of Poland and, to a lesser extent, of the Czech Republic and Hungary play some role" (Caviglia et al. 2002, p.21). It is not astonishing that large proportions of the accumulated contribution revenue in funded schemes are invested in state bonds. The ratio of investment in public bonds does, however, vary. While in Poland they account for around 60-70% of assets, in Hungary their share exceeds 90%. Investment of pension fund assets in government bonds also occurs quite often in OECD countries, but the percentage of all these assets varies remarkably. This explicit public debt will burden public budgets in the future.[64] For the future development of funded elements in the pension system a well-functioning legal and regulatory framework is essential.

There is a strong dominance of capital markets by the commercial banking sector. Banks from EU member states are strongly involved in the banking system of candidate countries. This is one indication of the integration of these countries with EU member states even before accession. However, this also means that the economies of these countries are highly dependent on the economic development of EU member countries.[65]

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64 On the other hand, reform plans are aiming at a reduction of the implicit public debt in pay-as-you-go-financed schemes.

65 There is as yet little experience of the functioning of capital funded schemes covering a larger proportion of the population in candidate countries. What is needed is careful monitoring, especially with regard to the effect of regulations. Countries in transition are copying the rules of other countries with a longer tradition in this field, but even there problems exist.

2.8.4 Demography, labour force participation of older workers and retirement ages

Although demography is in general not a crucial problem for the pension schemes today, the ageing of the population will be a challenge for nearly all candidate countries in the future, Turkey being the major exception (see chapter 1 of this report for details). It is not "natural" demographic development alone that matters, but also migration.

The effect of international mobility of labour on old-age security depends on whether those involved are working legally or illegally and whether they are covered by a pension scheme. For example, it is reported that about 200,000 Lithuanians are working abroad (often illegally). If there had been jobs in Lithuania that were now vacant, these migrant workers could be said to reduce the revenue of the pay-as-you-go scheme in their home country. However, one can equally argue that in fact without them the number of unemployed would have been higher, although this would depend on the type and duration of their work abroad.

The effects of labour migration on pension schemes in transition countries seem not to have received much attention yet, but may become an important topic when it comes to integrating these countries into the EU. The estimates available so far for future migration flows and the type of migration vary. Today, migration is looked upon primarily as a challenge for some of the present EU-member countries, although the scale of additional migration flows often seems to be overestimated.[66] However, there may be regional concentration. As far as cross-border activity is concerned it is important which pension scheme the worker belongs to.

An increase in the retirement age is on the political agenda in many of the candidate countries and in recent years there have already been decisions to implement this increase. Table 10 gives some information on the changes already decided upon in several countries. Turkey had an exceptionally low statutory retirement age. According to this information only three countries (Cyprus, Hungary and Latvia) will have the same statutory retirement age for men and women.

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[66] For example, in Germany in 2001 there were nearly 600,000 nationals of the ten candidate countries of Central and Eastern Europe registered as inhabitants. The majority, more than 310,000, were from Poland, and Poles now constitute the 5th largest group of foreign nationals in Germany. (There are nearly 1.9 million persons from EU-member countries and from Turkey around 2 million.) There are also emigration and immigration flows of remarkable size.

Table 10: Changes in statutory retirement age

Country	Pre-reform retirement age		Changes as element of pension reform		
			Year of change	Final retirement age (year when this will be realised)	
	Men	Women		men	women
Bulgaria	60	55	2000	63 (2005)	60 (2009)
Cyprus	65 (60 public sector)	65 (60 public sector)	no change		
Czech Republic	60	53-57[1)]	1996	62 (2006)	57-61 (2006)
Estonia	60	55	1994	63 (2007)	60 (2016)
Hungary	60	55	1998	62 (2001)	62 (2009)
Latvia	60	55	1995	62 (2003)	62 (2008)
Lithuania	60	55	1999	62.5 (2003)	60 (2006)
Malta	61	60	no change		
Poland	65	60	1999[3)]		
Romania	62	57	2001	65 (2015)	60 (2015)
Slovakia	60	53-57[1)]	no change		
Slovenia	60 (58[2)])	55 (53[2)])	1999	63 (58[2)]) (2000)	61 (58[2)]) (2000)
Turkey	55	50	1999	60 (2000)	58 (2000)

1) Retirement age depends on number of children (57: childless; 56: 1 child; 55: 2 children; 54: 3 children

2) Earliest possible age with 40 years of service (for men) or 35 years (for women; after the reform in 1999 38 years)

3) Statutory retirement age in principle unchanged, but before 1999 there were many exceptions (lower retirement ages for specific groups)

Even after the phasing-in of new statutory retirement ages hardly any country will have 65 as the statutory retirement age, the exception being Cyprus. In Romania this age is scheduled for 2015, but only for men.

The effect of raising retirement ages on the financing of the pension schemes depends on labour market conditions, health conditions and on the development of age-specific morbidity and mortality. As long as high unemployment characterises the labour markets, the increase in retirement

ages may simply increase unemployment.[67] For those who can stay longer in employment there will be higher pension entitlements. For those who have no chance of longer employment a rising retirement age may reduce the pension benefit. This will apply if there are deductions from the full pension benefit in the case of retirement before the statutory retirement age.

The important factor for pension financing is not the legal retirement ages but the effective (average) retirement age, together with the age from which the full pension is paid without deductions and the formula for calculating the pension in the case of early retirement. For example, in Estonia the pension is reduced by 4.8% for every year of early retirement and increased by 10.8% for every year retirement (or pension take-up) is postponed. Deductions from the full pensions and supplements can be designed to influence retirement decisions. It is, however, necessary that the rules for disability pensions are co-ordinated with those for old-age pensions.

According to an ILO survey in some candidate countries only a small percentage of employees continue working until the statutory retirement age.[68] This reduces the effective (average) retirement age. In Lithuania, Malta and Turkey no early retirement scheme existed at the time of the survey (2000), but other countries had one or more schemes.

In Slovenia the concept of a partial pension has been introduced. This offers those who are eligible for an old-age pension the option of combining employment with half of the (full) pension. Whether this can provide incentives to stay longer in the labour force will also depend on labour market conditions, on the institutional design of this instrument and on the individual preferences of employees and employers. The experience with partial pensions in Germany, for example, has in practice so far been highly disappointing – although many arguments speak for this approach.

2.8.5 Shadow economy

A factor of remarkable size in many countries is the informal sector *or* shadow economy. There are obviously many problems in measuring factors that are "in the shadows". On average – according to a recent calculation – the shadow economy in 22 transition countries was twice as high (measured either in GDP or in terms of the labour force) as the average in 21 OECD countries.[69] Amongst the transition countries – according to these calculations – the size of the shadow economy varied. Bulgaria's shadow

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[67] This depends among other factors on whether the demand for labour remains more or less constant.

[68] In the year 2000 the share of early retirement and disability in total retirement in the Czech Republic was 41.7% and 29.2% respectively, in Cyprus 77% and 21%, in Latvia 45% and 32%; Fortuny et al. (2002), p. 41.

[69] Schneider (2002).

economy, for example, was twice as large as that of the Czech Republic or Slovakia (see Table 11). Those people only engaged in the shadow economy will not accumulate pension claims during their period of informal economic activity. This can worsen living conditions in old age.

Table 11: Size of the shadow economy in transition countries

Country	In % of GDP (average 2000/2001)	Labour force in % of working age population (1998/99)
Bulgaria	36.4	30.4
Romania	33.4	24.3
Poland	27.4	20.9
Slovenia	26.7	21.6
Hungary	24.4	20.9
Czech Republic	18.4	12.6
Slovakia	18.3	16.3

Source: Data from Schneider (2002), Figures 2.2 and 2.4

2.8.6 Political sustainability

Pension systems must be not only fiscally but also politically sustainable. The latter will depend on the stability of governments as well as on the presence or otherwise of a relatively broad political consensus between major political parties, trade unions and employers' organisations on the fundamental questions concerning the design and development of the national pension system. The sometimes frequent changes in government (as in Latvia, for example) have hampered the reform process or changed the direction of the planned reform. Table 12 shows that in some countries governments were in power for an average of less than 2 years, while in others the percentage of re-elected governments was zero. However, there are also examples which show that even after a change in government the direction of the reform has not always changed.

Table 12: "Stability" of governments

Country	Month of first free elections and period considered	Average time between elections (months)	Average government duration (months)	Percentage of re-elected governments
Bulgaria	6/1990-6/2001	31.6	21.0	20
Czech Republic	6/1990-6/1998	32.0	18.2	50
Estonia	3/1990-3/1999	36.0	12.9	0
Hungary	3/1990-5/1998	48.0	48.0	0
Poland	8/1989-9/2001	36.5	17.9	0
Romania	5/1990-11/2000	42.0	15.9	75
Slovakia	1/1993-9/1998	32.7	17.5	0
Slovenia	12/1992-10/2000	47.0	23.3	100

Source: Data from Roland (2001), Table 1

For the political sustainability of a pension system the effects of reform measures will be of the utmost importance. The introduction of the capital funded pension schemes as mandatory schemes was accompanied by high expectations regarding the effects on financial markets as well as on the economic development in the country (economic growth).[70] In the public discussion, the effects of fundamental reform proposals on the living conditions of workers and pensioners often seem not to attract the same attention. These effects will, however, be an important criterion for the evaluation of a pension system. Especially in countries with more fundamental reforms, however, these effects will only become apparent in the future.

The importance attached to the social problems of minorities varies from country to countries.[71] This issue can be of relevance in the social security context if certain rules apply only to a country's citizens (and not to all

[70] This is illustrated, for example, in the Polish Country Report.

[71] The relative importance as a social problem is dependent not only on the number of people but on many other aspects. One indicator of the subjective evaluation of persons in different countries of whether ethnic differences are important can be seen from survey findings. In Romania, Latvia, Slovakia and Estonia more than one third of the population responded that ethnic relations posed some threat to peace and security in their society. This may also indirectly affect social policy measures. Survey question: Do you think ethnic relations pose a threat to peace and security in this society? (Number of respondents: 12,718). Percentage of respondents answering: "some threat" (including a small percentage of respondents who see the issue as a big threat); (others: little or none) Slovenia 10; Poland 18; Hungary 19; Lithuania 22; Czech Rep. 24; Bulgaria 29; Romania 32; Latvia 37; Slovakia 43; Estonia 43; Russia 44; Taken from Table 2 (p. 20) in Richard Rose, How Free from Fear Are Citizens in Transition Societies, in: Transition Newsletter, May-June 2002, Vol. 13, No. 3 (pp 18-20).

residents) or distinguish between citizens and other persons living in the country. Country reports provide no evidence of such direct discrimination. There may, however, be indirect effects, for example, regarding participation in labour markets, etc. which can influence the ability to accumulate pension entitlements.

2.8.7 Outlook

During the last few years a clear trend has appeared towards a multi-tier structure in the national pension systems of the candidate countries. Some countries have established, in addition to the first tier (mandatory public scheme), a third tier of voluntary private (tax privileged or subsidised) pension arrangements. Later – as already discussed – mandatory second tier arrangements were implemented in some countries. It is not surprising that in former socialist countries the previously state-dominated pension system has been diversified. What is surprising, however, is how quickly the mandatory second tier has been implemented in some countries and in others found its way onto the political agenda. This development will change the pension landscape in Europe and also, after EU enlargement, in the EU.

A regular monitoring of developments, including the effect on the income situation of the elderly, will be necessary. There are great differences in the income structure of the various accession countries. There are countries where the family is still highly important for life in old age. Efforts are being made in many countries to reduce the number of working pensioners – especially where it is often necessary to work because of the low pension benefits – or at least to abolish the possibility of drawing a full pension in addition to income from work.[72] On the other hand, in the long-term it will be necessary to increase the labour force participation rates of older workers in order to cope with the challenges of an ageing population. As experience in many countries shows, it is difficult to put this topic on the political agenda as long as unemployment levels remain high. However, this topic is now on the agenda in the EU and it can be expected that this will also influence the policy approach in candidate countries (see also 2.9).

Pensions in most of the candidate countries remain low, even if the pension level seems to be high compared to wages, for wages themselves are often low. Information on pension levels or replacement rates can therefore be misleading in judging living conditions after retirement. A great number of other factors besides pensions – other types of public transfer payments, subsidies, etc. – must be taken into account if adequate information is to be

[72] The evaluation of this measure depends on the structure of the pension scheme – whether highly interpersonally redistributive or in principle more a type of insurance. If the latter, after reaching a "normal" retirement age taking up employment should not affect the pension benefit negatively.

collected on the living conditions of pensioners, particularly in comparison to those of employees.

The issue of poverty avoidance in old age is, and will remain, important for the foreseeable future. The effects both of future developments in health care and the newly designed pension schemes on income in old age are far from obvious. These topics – to be discussed in Chapters 3 and 4 – are closely linked to the area of social security in old age and to pension policy. Decisions on an adequate level of pensions in a country must take into account the need for spending income in the case of illness or long-term care. This will depend on the provision and financing of these goods for the elderly and whether the elderly, generally in need of more medical treatment than younger people, have to pay for it, and how high those payments will be.

2.9 Pension policy and EU enlargement

Most of the country studies see in general no need for further changes to pension schemes after the period of preparing for negotiations with the EU. However, certain issues do arise. One is the gender issue and the different retirement ages for men and women. This may stimulate a raising of the retirement ages for women. In the Malta Report mention is made of different gender-specific rules for crediting pension claims without contribution payments.

The implementation of the co-ordination rules (1408/71; 574/72) may require improvements in administrative capacity. This finds special mention in the reports on the smaller countries (Lithuania, Estonia). Administering the work related to the Regulations of Co-ordination (such as 1408/71) requires specific skills and competences on the part of the administrative staff. Even today, within the EU-15, there is a lack of information as a general problem in the application of the rules for co-ordination. Enlargement will only increase the complexity.

Specific problems are expected to arise with co-ordination in cases where persons are covered by both defined-benefit and defined-contribution schemes. For example, when calculating the pension of a foreign pensioner who worked for some time under Latvian pension rules, will the life expectancy of Latvia be used for calculating the annuity? This still seems to be an administrative problem in Latvia. Decisions will be necessary on whether, for example, mandatory funded schemes are to be included in the co-ordination rules and, if so, how. This is also linked to the free movement of capital. For example, in Latvia the funded pension schemes are only allowed to invest 15% of their capital abroad. Such limitations are expected to be incompatible with the free movement of capital within the EU. Will they therefore have to be abolished?

Beside these aspects mentioned in country reports, the enlargement of the EU may have several additional effects on the national pension schemes. One is the effect of EU enlargement on overall economic developments, whether there will be, for example, an "integration dividend" and how it is to be distributed. Another is migration. This can burden national pension schemes or help them to ease financial problems.

A remarkable degree of economic integration has already taken place.[73] However, large differences in living conditions, if measured, for example, in GDP per head in purchasing power parity, continue to exist. While, for example, in 1999 the Baltic states were at about 30% of the average of the EU-15, Slovenia's GDP per head (which was around 70% of the EU average) was higher than that of Greece. This is one, but only one, of many factors relevant for migration decisions.

Nor is enlargement a matter of starting from scratch in the field of pension policy because a great number of bilateral agreements between candidate countries and member states already exist.

The effect of EU enlargement on specific sectors of the economy is also relevant in the context of pension policy. Specific challenges are coming from agriculture. Today certain agricultural trade barriers between candidate and member countries are the highest of all sectors of the economy. The integration process may remove these barriers, but it will also extend protection rules and subsidies available under the Common Agricultural Policy. This will affect farmers and agricultural employees in both candidate and member countries and have implications for pension policy, whether there are specific schemes for farmers (such as KRUS in Poland) or workers in this sector are integrated into general schemes.

EU enlargement may also have indirect effects for pension policy over and above its effect on economic development. For example, there are political decisions on economic stability criteria that have to be taken by all EU member states and not only those joining the EMU. Every member state, for instance, has to deliver a programme for convergence aimed at achieving such convergence criteria as balancing the public budget in the medium term. The Stability and Growth Pact (SGP) and the Broad Economic Policy Guidelines (BEPG) can have important influence on strategy and choice of measures in pension policy. These are among the different channels for influencing the national old-age security systems of EU-member states (see Figure 4).

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[73] For example the percentage of goods from candidate countries exported into the EU is on average 50% or even more of all their exports.

Figure 4: Channels of possible influences on national old-age security systems at EU level

Implementation of the 4 basic freedoms Competition & antitrust rules		Maastricht convergence criteria	Convergence of problems & objectives
Regulations Directives Recommendations	ECJ ruling	SGP (incl. BEPG)	Open method of co-ordination (OMC)
↓	↓	↓	↓
National old-age security system			
Structure:	Pay-as-you-go vs. capital funded Contributions vs. taxes Compulsory vs. optional Public vs. private 1st, 2nd, 3rd pillars (quantitative importance)		

Source: Revised version of Schmähl (2002: 102).

One new channel is linked to the process of "open co-ordination" and the decisions taken in establishing indicators and "benchmarks". This can affect political decisions at the national level.[74] The definition of objectives – at least where stated in general terms – seems not to be the problem. Subsumed within three broad principles 11 objectives have now been formulated:[75]

- Adequacy of pensions (3 objectives)[76]
- Financial sustainability of pension systems (5 objectives)[77]
- Modernisation of pension systems in response to the changing needs of the economy, society and individuals (3 objectives)[78]

There will be little disagreement about this in general. However, as soon as this is divided into sub-dimensions, and particularly when attempts are made to define concrete indicators, opinions can be expected to diverge. The same will apply to the fixing of benchmarks. Decisions on both indicators and benchmarks are extremely important. [79]

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74 See for further aspects Schmähl (2002).

75 European Commission (2002).

76 Objective 1: to prevent social exclusion, Objective 2: to enable people to maintain living standards, Objective 3: to promote solidarity.

77 Objective 4: to raise employment levels, Objective 5: to extend working lives, Objective 6: to make pension systems sustainable in a context of sound public finances, Objective 7: to adjust benefits and contributions in a balanced way, Objective 8: to ensure that private pension provision is adequate and financially sound

78 Objective 9: to adapt to more flexible employment and career patterns, Objective 10: to meet the aspirations of women and men for greater equality, Objective 11: to demonstrate the ability of pension systems to meet the challenges.

79 There are now the national strategic reports on pension policy that had to be delivered to the Commission in September 2002, but there is no agreement on common indicators.

It will be decisive what the results of this decision process on indicators etc. are. There are conflicting views and interests. The Ministers of Finance are primarily interested in the effects of pensions and pension policy on public budgets. It has already been mentioned that the design of pension schemes and the public-private mix in both EU member states and candidate countries vary widely. Public expenditure on pensions as a percentage of GDP thus also differs considerably. This is an input indicator. Pension policy should, however, focus on the output of all activities, in particular the economic situation of the elderly. Yet the output – the benefit side of pension policy – is often difficult to calculate and may become apparent only later, as has been the case in the process of introducing capital-funded pension schemes. The outcome of pension schemes depends on the development of labour and capital markets as well as on political decisions.

As already mentioned above, this process and the set of indicators agreed upon will have an influence on all member states. While the present member states can take part in the ongoing decision process, the candidate countries have so far been excluded even though they will be affected as soon as they have joined. In view of the political will to integrate these countries into the European Union in the near future it is surely worth considering including them at least in the discussions, if not in the decision process. The European Commission announced in December 2002 that candidate countries will be integrated into the system of national reports even before accession.[80]

There is no uniform model of social security in the EU even today and one will certainly not exist in an extended EU. On the contrary, the inclusion of new member states will render the pension landscape in the European Union more diversified even than it is today. Especially the new notional defined contribution schemes introduced in Latvia and Poland as a first tier of the pension scheme and mandatory capital-funded defined-contribution schemes already established in five candidate countries will shift the balance between different approaches to pension policy in the European Union.

A special focus within EU member states is on increasing the employment rates of older workers as one of the strategies to cope with the challenges facing pension schemes. In present member states employment rates vary considerably, but in most the employment rate drops dramatically after the age of 60.

There is a target value of 50% for the employment rate for persons aged 55-64 in the EU. Most of the present member states are far from this target. Table 4 in chapter 1 shows that among the candidate countries, too, only Cyprus, Estonia and Romania have employment rates of about 50%.[81]

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80 EU Commission, Memo/02/298, Dec. 17, 2002.

81 In Romania there is a high employment rate in the agricultural sector. This sector will undergo deep restructuring if Romania becomes a member country

The objective of increasing the employment rates of older workers is expected to influence discussion on policy instruments in present candidate countries, too.[82]

Postponing retirement, increasing the effective age of retirement and gradual retirement may become important tools, especially in the light of demographic ageing and future labour market conditions. Work after retirement may even become interesting for firms as well as for employees. Changes to, or affecting, the retirement age, however, need to be announced well in advance to give both employers and employees the opportunity to adapt their plans. Increasing the effective retirement age also requires a comprehensive approach going well beyond pension policy. This would include *inter alia* health conditions and further training to improve the skills of older workers. This is only one example of the fact that, to be successful, both pension policy and the design of sustainable pension schemes demand an integrated policy approach.

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[82] Among other new developments that will become relevant for candidate countries is a forthcoming Directive on occupational pensions. This will influence the rules on the supervision and investment behaviour of pension funds.

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3. Health Care[1]

Elias Mossialos, Martin McKee and Laura MacLehose

Introduction

However varied geographically, economically, politically, or socially, the EU candidate countries may appear, they are united by the endeavour to achieve the status of European Union membership.

The pre-accession countries consist of ten Central and Eastern European (CEE) countries (Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, and Slovenia) plus the three Mediterranean countries of Cyprus, Malta, and Turkey. This division is apparent in many ways. For example, in terms of health care, the countries of Central and Eastern Europe all possess a social health insurance system, while Cyprus, Malta and Turkey do not (although Cyprus is due to implement a social health insurance system by 2005). This division is also reflected in the countries' historical, economic, political and social backgrounds, as the central and eastern European group of countries[2] have a shared experience of post-socialist governance and recent transition involving democratic and economic liberalisation.

To understand the challenges that face these countries in relation to health systems and health status requires exploration of several interconnected issues. This paper will examine health trends, the financing of health care (including the collection and pooling of funds and trends in health care expenditure), the provision of services (including contracting mechanisms, provider payment systems and pharmaceuticals), health care reforms aimed at improving the delivery of services (taking into account the integration of primary and secondary care, hospital performance and public health infrastructure), as well as issues relating to mental health and the health of minorities. Due to the variety of topics discussed and multitude of data sources used, it is important to emphasise at the outset the implications of using routine data sources. Differences in national accounting practices, varying definitions, and the lack of a standard data collection method across

[1] The authors are grateful to Anna Maresso, Anant Murthy and Esther Cho for their valuable assistance in providing background information.

[2] The exception to the central and eastern European grouping is Slovenia, which was previously part of the former Yugoslavia and not part of the former Soviet bloc.

countries mean that the following information should be approached with caution. All data may not be directly comparable[3].

An examination of health trends will reveal the commonalities among countries, which have implications for the arrangement of the health systems. Health care expenditure trends will examine the escalating costs experienced by all countries including public and private resource trends. Informal payments, often distorting the effects of instituted reforms, will also be discussed, with a summary of evidence from different countries. The financing of health systems was the subject of early and radical reforms in CEE. In most countries the intention of the reforms was to shift away from the centralised integrated state model known as the Semashko system to the decentralised and contracted model of social health insurance. This was modelled in part on the basic features of the Bismarck model found in western Europe but significant differences also emerged as the model was adapted to the particular context of CEE. The shift resulted in changes both to the way money was collected and pooled and created a new relationship between purchasers of care and providers. Finally, certain issues that create particular challenges for health care systems are reviewed.

The decade since the break-up of the Soviet bloc has brought enormous political and socioeconomic change. The health sector has not been spared the effects of transition, and the countries emerging from the process have each engaged to varying degrees in health system reform. It is at least possible to examine how this process has unfolded, to identify successes and failures, and to better understand the scale and nature of the remaining challenges. Empowered citizens and improved health and living standards for many people in CEE countries are just two manifestations of reform success. Despite these successes, negative trends such as rising poverty and real income decline are apparent in some countries. The EU candidate countries face a new and challenging environment, not only in terms of (i) total funding for health care, but also in terms of (ii) the efficiency of their health care services with the funding available and (iii) the development of sufficient government and technical capacity. Responding and adapting to a market society may be a key obstacle, but one that will only develop with time.

The purpose of this paper is to describe and analyse several trends in the EU candidate countries, evaluate experiences, and draw some conclusions. The intent of the authors is not to explain the development of the outcomes thus far, but to consider the outcomes themselves. Importantly, the lack of information and significant data limitations relating to aspects of social exclusion should be taken into account when considering the implications of health care in CEE.

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[3] Information presented in this paper as well as in many of the tables is drawn in part from 13 studies on the social protection systems of EU candidate countries.

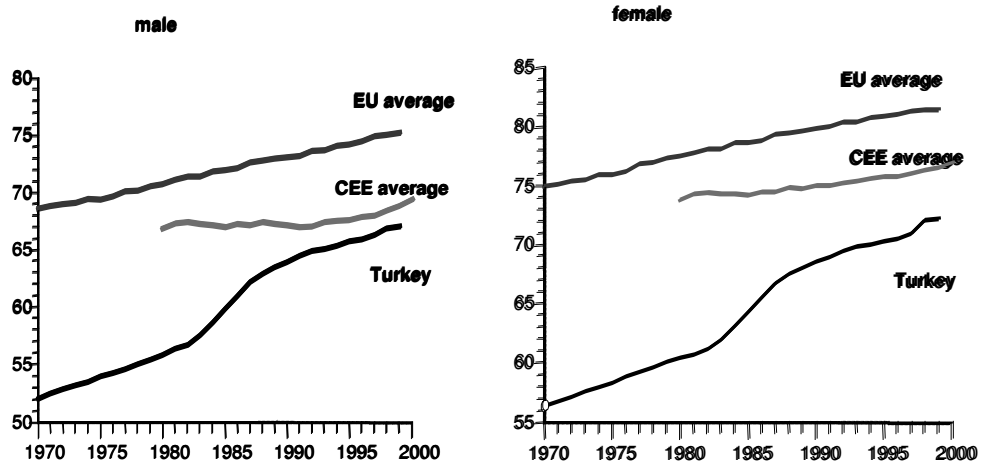
3.1. Health Trends

For the present purposes the candidate countries fall in to three broad categories: the countries of central and eastern Europe (CCEE); Malta and Cyprus; and Turkey. They are differentiated on two grounds. The first is availability of data. Thus, mortality data, and to varying degrees data on morbidity and the determinants of health are available from the countries of central and eastern Europe, Malta and Cyprus (southern part only) but there is very incomplete coverage of Turkey.

Turkey

The absence of comprehensive data on adult mortality means that it is not possible to provide any detailed analysis of the health of the Turkish population. On the basis of mortality estimates, figures for life expectancy have been produced, but they should be interpreted with caution. They indicate that life expectancy at birth has been increasing relatively rapidly in the 1980s byut still lags behind the central and eastern European average and, especially, the European Union (EU) average.

Figure 1 Life expectancy in the EU, CEE and Turkey



Source: WHO, Health For All Database, 2002

A recent review suggested that Turkey is experiencing high levels of cardiovascular disease (Onat 2001). This is supported by a detailed analysis of available mortality data and studies on Turkish migrants in Germany that suggests that the available data substantially under-estimate the true burden of cardiovascular disease in the Turkish population(Razum *et al.* 2000). Other research on Turkish migrants to Germany suggest that rates of cancer, where the lag period between exposure to risk factors and disease is often several decades, remain lower than in the German population (Zeeb H *et al.* 2002). Turkey does, however, differ from many countries at a similar state

of economic development in having implemented effective and wide-ranging tobacco control policies. Faced with evidence that the transnational tobacco industry was targeting Turkey, with rates of smoking related cancers rising in the early 1990s (Firat 1996), Turkey has withstood concerted efforts by the transnational tobacco industry to subvert its policies, including attempts to stage Formula 1 events in the country that would have undermined the ban on sponsorship, and grants to academic departments to run the industry's now notorious campaigns that are allegedly aimed at stopping children smoking while actually having the opposite effect. In the area of tobacco control, therefore, Turkey has taken a more principled position than some existing EU member states (Gilmore *et al.* 2002).

There is rather better information on the health of mothers and children, with one of the few nationally representative sources of health data in Turkey being the 1998 Demographic and Health Survey (DHS) (http://www.hips.hacettepe.edu.tr/english/1998turkishsurvey1.htm#Tables). The DHS, which is one of a series of surveys dating from the 1970s, documents a declining, but still relatively high rate of infant and childhood mortality, with marked regional variations. At present, therefore, in the absence of an effective system of vital registration in Turkey, including comprehensive collection of causes of death, it is only possible to say that it appears to be experiencing the double burden seen in many middle income countries outside Europe of a level of childhood mortality that, while falling, is still relatively high while traditionally low levels of non-communicable disease in adulthood are rising.

Malta & Cyprus

The second division is between the two Mediterranean candidate countries, where life expectancy at birth is almost the same as the European Union average (Table 1) and the countries of central and eastern Europe, where life expectancy is still considerably below the EU average.

Table 1 Life expectancy at birth in Malta and Cyprus compared with EU and CCEE

Life expectancy at birth (years) in 1999	**EU average**	**CCEE**	**Cyprus**	**Malta**
Male	75.11	68.74	75	75.12
Female	81.37	76.5	80	79.38

Data for latest available year. Sources: WHO European and Eastern Mediterranean Regional Offices

Put another way, if Malta and Cyprus were already in the EU they would rank 2nd and 11th, respectively, (of 17) in terms of male life expectancy at birth and 13th and 14th, respectively, in terms of female life expectancy. Yet while Malta has relatively low death rates from many common causes of death, deaths from some diseases, such as ischaemic heart disease, are relatively high. Interestingly, given its geographical position, in the Mediterranean, and its cultural inheritance, bringing together different

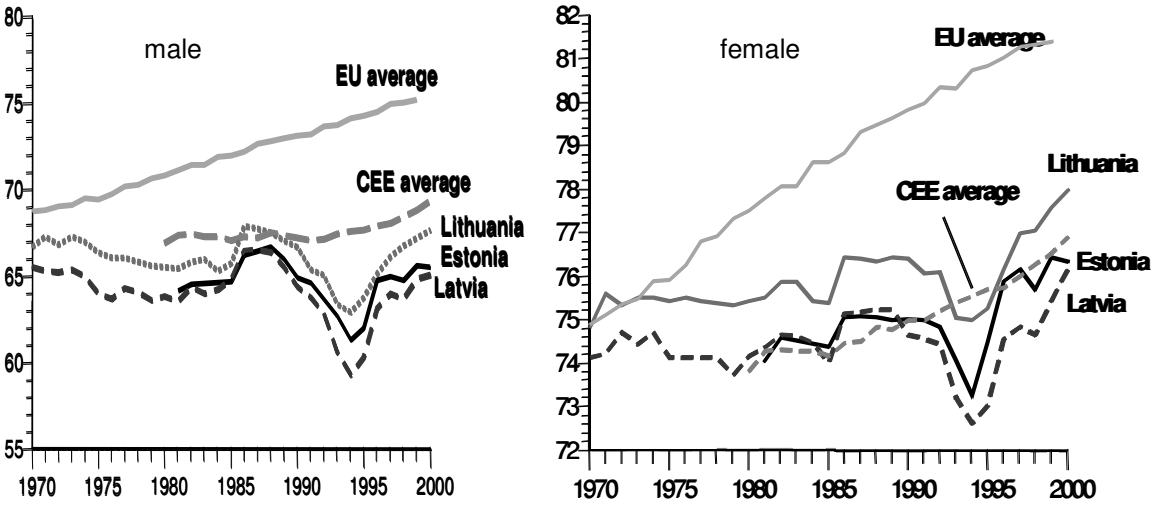
influences including many elements of a British diet, it has a pattern of mortality that resembles more closely that in the United Kingdom than that in its Mediterranean neighbours such as Italy.

Nonetheless, the candidate countries facing the greatest health challenges are those in central and eastern Europe, which will be the focus of the remainder of this section.

Central & Eastern Europe

The first thing to note is that, in health terms, the CCEE are far from homogenous. There are again divisions, between the Baltic States[4] that were part of the Soviet Union, those that were part of the Soviet bloc in the post-war period, and Slovenia, which was part of Yugoslavia. Even though over a decade has passed since the political transition in this region, these divisions continue to be mirrored, to a considerable extent, in patterns of health (Figure 2).

Figure 2 Life expectancy at birth (in years) in the Baltic States, other countries of central and eastern Europe, and the European Union



Source: WHO, Health For All Database, 2002

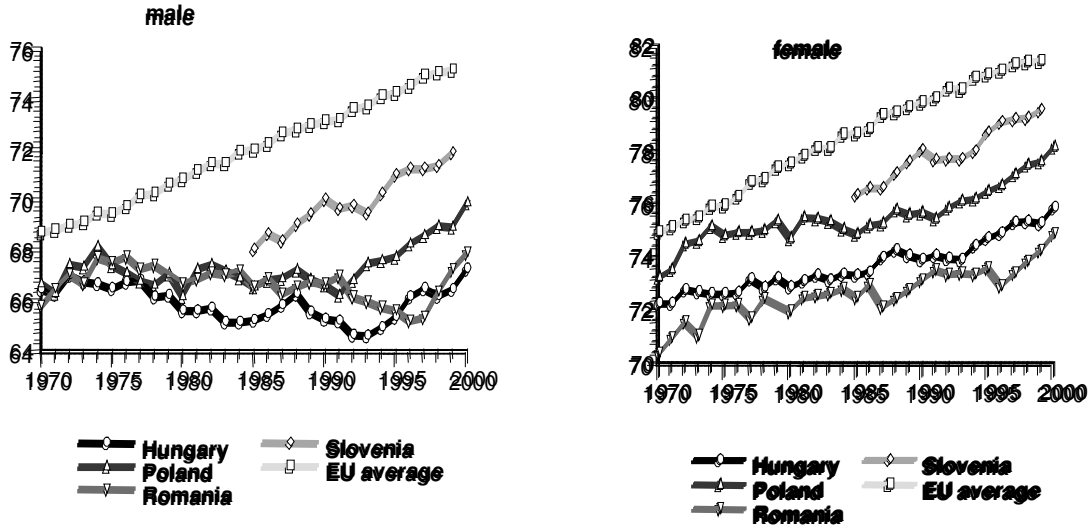
Thus, the three Baltic States experienced a series of large fluctuations in life expectancy from the mid 1980s, which were almost identical to those experienced in other ex-Soviet countries and, in particular, Russia and Ukraine until 1998 since when the three Baltic States have continued to improve while the other ex-Soviet states have once again deteriorated.

The situation in the other CCEE was quite different. Since 1990, the more "western" of the CCEE, such as Poland (Zatonski *et al.* 1998), Hungary, the Czech Republic (Bobak *et al.* 1997) and Slovakia have experienced rapid

[4] The Baltic States are composed of Estonia, Latvia, and Lithuania.

improvements in life expectancy while the more "eastern" ones, such as Romania and Bulgaria, only began to show improvement in the late 1990s. Slovenia occupies a position mid way between the European Union and the other CCEE (Figure 3).

Figure 3 Life expectancy at birth (in years) in selected central and eastern European countries and in the EU



Source: WHO, Health For All Database, 2002

The poor health in CEE countries not only represents the sum of numerous individual tragedies but also has important, negative, macro-economic consequences. This is manifest in several ways: the additional costs incurred from health care expenditure on individuals who spend many years in poor health; the opportunity cost of lost lives; and the lost productivity from the loss of a potential worker who would contribute to the economy. The consequences, both human and economic, are even more stark when the consequences of ill health are added to those of premature death. Thus, while life expectancy (representing the impact of mortality) within CEE countries ranges from 71.3 years in Romania to 75.2 years in the Czech Republic, health-adjusted life expectancy (HALE) (a measure that takes account of both premature death and years spent in ill-health) in CEE countries is significantly lower, varying from 57.7 years in Latvia to 66.9 years in Slovenia. The situation is improving but the gap remains wide between the CEE candidate countries and the existing EU-15 (Table 2).

Table 2 Population & Health-Adjusted Life Expectancy (HALE) for EU Candidate Countries.

	Total Population in 2000	**Total Population in 2001**	**Health-adjusted Life Expectancy (HALE) in 2000**
Country	(in thousands)	(in thousands)	(years)
CEE countries			
Bulgaria	8,170	7,866	63.40
Czech Republic	10,273	10,260	65.60
Estonia	1,370	1,377	60.80
Hungary	10,024	9,917	59.90
Latvia	2,373	2,406	57.70
Lithuania	3,696	3,689	58.40
Poland	38,646	38,577	61.80
Romania	22,435	22,408	61.70
Slovakia	5,401	5,404	62.40
Slovenia	1,977	1,986	66.90
Other EU candidate countries			
Cyprus	755	759	66.30
Malta	386	392	70.40
Turkey	65,293	67,632	58.70
Regional averages			
EU average	376,948	376,977	70.12
CEE average	120,859	120,867	62.51
Pre-accession countries' average	13,138	13,283	62.62

Sources: WHO, Health For All Database, WHO Regional Office for Europe, Copenhagen, Denmark, 2002.; World Health Report 2001, WHO, Geneva, Switzerland, 2001; EUROSTAT, 2002.

Note: Health-adjusted life expectancy is a summary measure of the equivalent number of years in full health that a newborn can expect to live based on current rates of ill-health and mortality.

3.1.1 The mortality gap

Measures of mortality offer a valuable place to begin to understand the health gap in Europe but it is necessary to look beyond the aggregate figures to ask who is dying of what? Mortality can be disaggregated in many ways. One way is by gender. Thus, it is apparent that men have been especially vulnerable, in all of the CCEE, but in particular in the Baltic States (McKee and Shkolnikov 2001). Another way of looking at the data is by age. Deaths among infants and young children have fallen steadily throughout the 1970s and 1980s, a decline that has accelerated in the 1990s. There are a few exceptions, for example Romania, as a consequence of the policy adopted in the late 1980s of giving inadvertently HIV contaminated blood transfusions

to many undernourished children who had been abandoned in "orphanages" (Kozintez *et al.* 2000). Death rates among older people are slightly higher in the "eastern" CCEE, Romania and Bulgaria, but have fallen in the "western" countries, such as Poland and the Czech Republic. However the greatest impact has been on deaths in early middle age. Among the CCEE, deaths in this age group increased steadily throughout the 1980s. Subsequently, each country has experienced an improvement, but beginning at different times. In Poland and the Czech Republic it began almost at once while in Hungary and Bulgaria it only started in the mid 1990s. In Romania it was delayed until 1997. This age group was also affected most in the FSU, with their deaths driving the large fluctuations in overall mortality (Leon *et al.* 1997).

These changes have led to overall death rates among middle-aged men being about 2.5 times higher in the CCEE than in western Europe. Among women the differences are somewhat smaller and do not exhibit the peak at middle age seen among men. Death rates at older ages among both men and women and in the CCEE are about twice those in western Europe.

A third approach is to look at causes of death. The causes underlying these changes are extremely complex and the following description is, of necessity, a simplification. In the countries of central Europe, such as Poland, the Czech Republic and Hungary, there were short-lived increases in deaths at the time of transition, largely due to deaths from external causes, especially traffic accidents, which then declined steadily during the remaining years of the 1990s (Winston *et al.* 1999). Later sustained improvements in life expectancy, beginning at different times in the 1990s, have largely been due to falls in cardiovascular disease, in some cases such as Poland falling quite steeply, although in some parts of southern Europe, where rates were previously extremely high, a decline in deaths from cirrhosis has also contributed to this overall improvement.

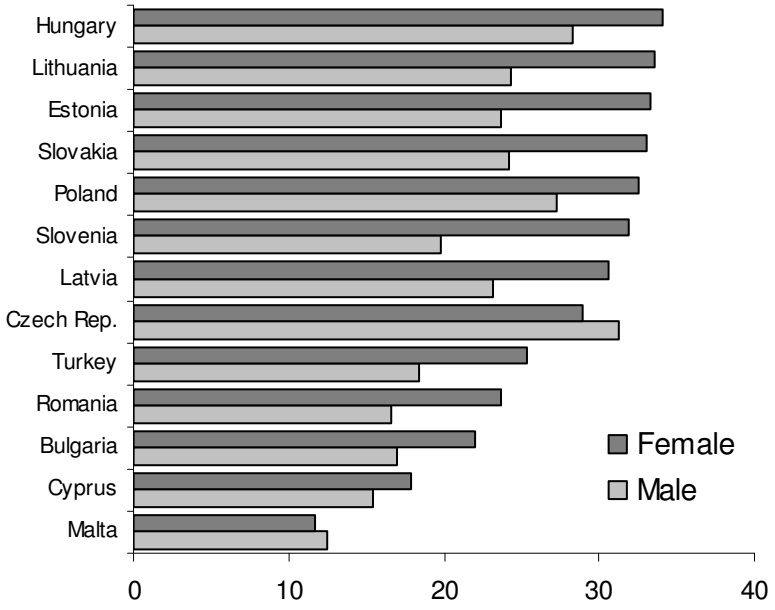
The situation in the Baltic States has been quite different. To understand what happened there it is necessary to go back to events in 1985, when Mikhail Gorbachev, implemented an initially highly effective and wide ranging anti-alcohol campaign (White 1996). This led to an immediate improvement in life expectancy. This was due largely to a decline in cardiovascular diseases and injuries with smaller contributions by other causes associated with alcohol, including acute alcohol poisoning and pneumonia. It is these same causes that have been the driving force in the sequence of fluctuations in overall mortality that have occurred, remarkably consistently, in all three Baltic States and in Russia (and to some extent in Ukraine and Belarus) during the 1990s (McKee *et al.* 2001). These similarities have led to a now extensive body of research that has indicated the central role played by high levels of alcohol consumption in these fluctuations in mortality, as well as shedding light on the reasons why people drink the way they do.

3.1.2 Beyond mortality

Measures of mortality have many advantages as indicators of the health status of a population. They are available over many years and death is unambiguous, even if ascertainment of the precise cause may sometimes be difficult. Measures of morbidity are more problematic and traditionally focus on notifications of infectious diseases. There are few examples of the diseases registries established in some western countries that would allow tracking of change, although as will be described later, some examples are now emerging.

There is, however, some evidence on self-rated health and long standing disabilities, derived from a variety of household surveys. Thus, the percentage of the population reporting a long-standing illness is relatively high in the CCEE, with rates in Cyprus and Malta similar to those seen in the EU (Figure 4).

Figure 4 Percentage of the population reporting a long-standing illness in EU candidate countries



Source: Eurobarometer 2002

One of the most striking features of mortality in the CCEE is the way that men have been affected much more than women. Much of this can be explained in differences in lifestyle, in particular use of alcohol and tobacco. This is consistent with research on those rare populations where the gender gap in mortality is small (Jedrychowski *et al.* 1985; Leviatan and Cohen 1985). However, as Figure 4 shows, when measures such as self-reported

health or long-standing illness are considered, surviving women fare rather worse than men.

3.1.3 The health gap: The immediate causes

The preceding section has described the gap in mortality between the two parts of Europe and begun to offer some tentative explanations. In the subsequent section the reasons for this gap will be examined in more detail. Differences in the health of populations can be examined at different levels. At one level, taking a biomedical approach, it is possible to describe the differences in rates of specific diseases. On a second level it is possible to look at the biological risk factors, such as smoking or alcohol consumption, that underlie these differences in diseases. On a third level it is possible to enquire about the underlying reasons why people are exposed to risk factors, asking questions about choice and empowerment. Finally, even if people acquire diseases, in many cases modern health care can prevent untimely death so a final level of analysis looks at the effectiveness of the health care response.

The first part of this analysis looks at the specific diseases that contribute to the east west gap and their major risk factors: as already noted, a few specific conditions emerge as major contributors to this gap, cardiovascular disease, injuries and violence, cancer, and some alcohol-related diseases such as cirrhosis. Each will be considered in turn.

Cardiovascular disease

Deaths from cardiovascular disease are much more common in eastern Europe than in the west. In central and eastern Europe this clearly reflects high levels of many traditional risk factors, such as a diet rich in saturated fats and high rates of smoking. Differences in access to and quality of healthcare for cardiovascular disease may also explain some part of the differences in mortality for this condition. In Poland there has been a marked decline in deaths from cardiovascular disease since the transition that is believed to reflect a change in the composition of fat in the diet (Zatonski and Willet (In press)) following removal of subsidies and the opening of the retail sector to international trade.

Trends in cardiovascular disease in the Baltic States, as in other parts of the former Soviet Union have, however, presented epidemiologists with more of a puzzle. On several occasions death rates have changed substantially from one year to the next and death rates are especially high among the young. Deaths are also more likely to be sudden (Laks *et al.* 1999), with many victims showing little evidence of coronary atheroma at post mortem (Vikhert *et al.* 1986). The conventional risk factors, such as lipid levels, and physical activity, identified in western epidemiological research, have little predictive value (Perova *et al.* 1995). There is also evidence of differences in biochemical mechanisms (Shakhov *et al.* 1993).

The emphasis, in western epidemiology, on the role of lipids has distracted attention from the other elements of thrombosis, first described by Virchow over a century ago (Virchow 1856). These include changes in vascular endothelium, permitting lipid to accumulate, and changes in platelet and fibrinolytic activity, influencing the propensity of blood to clot (West 2001). Eastern European diets are characterised by large quantities of fat and very low levels of fruit and vegetables (Pomerleau *et al.* 2001). Correspondingly, antioxidant activity in blood, which is determined primarily by intake of micronutrients, is extremely low (Bobak *et al.* 1998). While changes in lipids are important, these other mechanisms may provide an explanation for rapidity of the reduction in cardiovascular deaths seen in some countries such as Poland and the Czech Republic.

However these mechanisms cannot explain all of the observed effects, and in particular the much higher rate of sudden cardiac death among young men. Here it is likely that alcohol is playing an important role. In all of northern Europe, but especially in the Baltic States, alcohol is typically drunk as vodka and in bouts (Bobak *et al.* 1999), unlike the more steady consumption in southern and western Europe. Reanalysis of studies looking at the cardiovascular effects of alcohol consumption found clear evidence that episodic heavy drinking, identified in various ways including frequent hangovers or getting into trouble with the police or frequent absence from work for alcohol related disorders, was consistently associated with a substantially increased risk of, especially, sudden cardiac death (Britton and McKee 2000). Other work has disentangled the physiological basis for these findings, showing very different responses of lipids, blood clotting and myocardial function to binge drinking and regular moderate consumption (McKee and Britton 1998).

Injuries and violence ('external causes')

All of the CCEE experienced a transient, but substantial increase in deaths from injuries, especially road traffic accidents (Figure 5). This was especially marked in the Baltic States. Although death rates have fallen back considerably they remain much higher than in the EU. While all causes of injury are more common, the gap is particularly great for homicide and suicide (Figure 6). Other external causes of death that are very much more common than in the EU are drowning and deaths in fires.

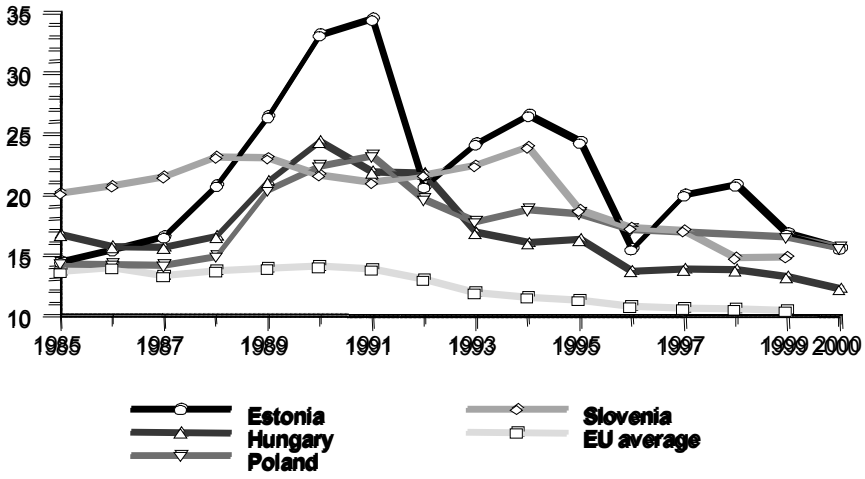
Clearly many factors contribute to these deaths. In the case of road traffic injuries they include poor quality of roads and lax enforcement of speed limits. However it is also clear that alcohol plays an important role.

Death rates from unintentional injuries reflect many factors related to risk and its perception, and to the environment. Throughout the CCEE there have been few of the design features that enhance safety in the west,

although this is now changing. In some cases effective health care could save lives but it is either unavailable or of poor quality, especially in rural areas suffering from poor communications and transport infrastructure.

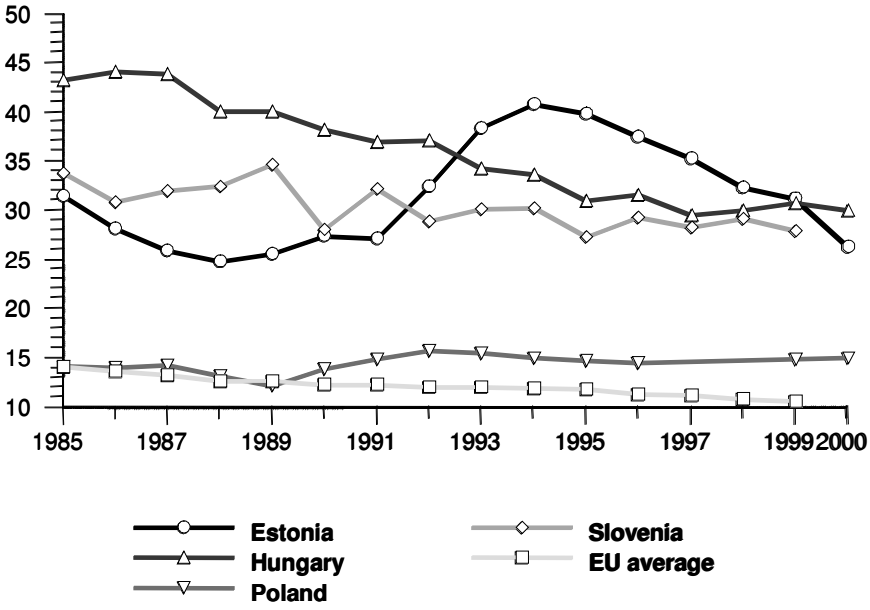
Childhood injuries are an important contribution to the overall injury burden in both EU and candidate countries. From 1991 to 1995, had childhood injury death rates been at the EU average level (UNICEF 2001), there would have been over 2000 fewer deaths per year among children aged 1 to 14. This does not include Malta, Cyprus and Turkey.

Figure 5 Death rates (per 100,000) from road traffic accidents in selected countries



Source: WHO, Health For All Database, 2002

Figure 6 Death rates (per 100,000) from suicide in selected countries



Source: WHO Health For All Database, 2002

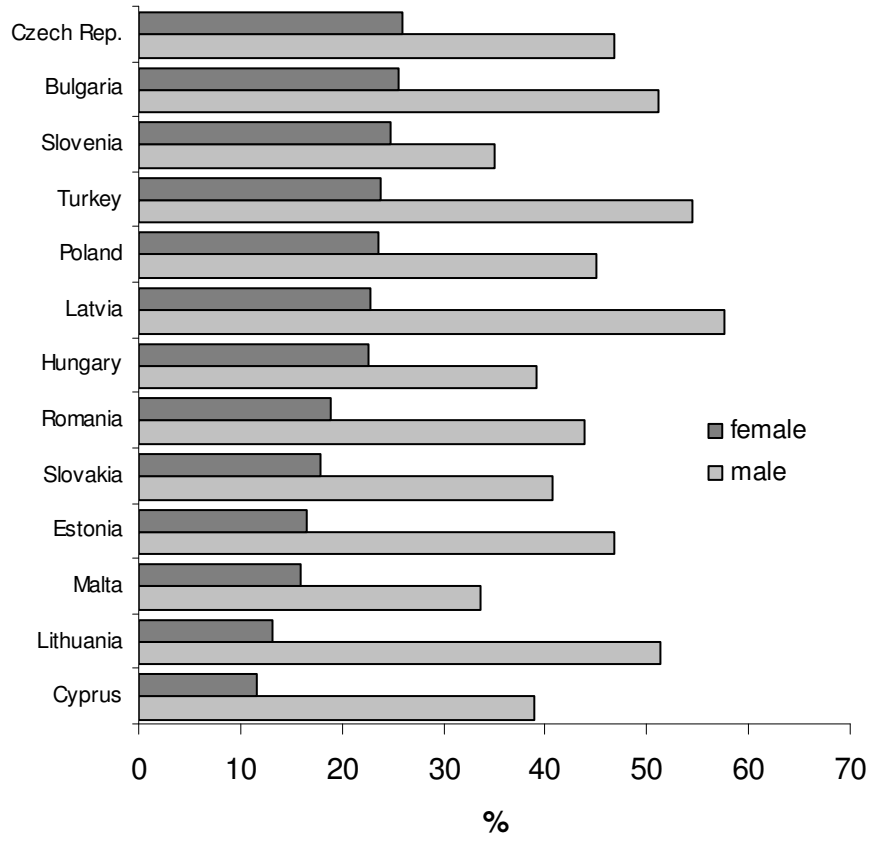
Within this high burden of disease there is a large East-West gap in injury mortality rates. A study of figures of childhood injury mortality for 1991-1995 showed that all candidate countries (data not including Turkey, Malta and Cyprus) had much higher injury mortality rates than all EU current member states with the exception of Portugal. Portugal ranked about midway in the ten candidate countries reviewed. At the lowest end of the spectrum, 5.2 children per 100,000 children aged 1-14 died of injuries in Sweden. At the opposite end, in Latvia the figure was 38.4 (a rate of one child in every 200 between his or her first and fifteenth birthdays).

Cancer

Cancer covers a multitude of disease each with their own risk factors; here we consider two examples, lung and cervical cancer. Smoking has been extremely common among men in all of eastern Europe (McKee et al. 1998; Pudule et al. 1999), possibly encouraged by a shared experience of military service as teenagers. Consequently, death rates from lung cancer among men are extremely high, in some cases reaching levels never previously observed anywhere in the world (Zatonski et al. 1996) Interestingly, death rates from lung cancer are presently falling in the Baltic States but cohort analysis in Russia, which exhibits the same pattern, shows that this will be short lived, reflecting transiently lower levels of commencing smoking in the austere period of the late 1940s and early 1950s (Shkolnikov et al. 1999). In contrast, smoking has always been relatively uncommon among women. This is now changing, and female smoking rates, especially among young women in major cities, are increasing rapidly, encouraged by

aggressive advertising by western tobacco companies (Figure 7) (Hurt 1995). Consequently, lung cancer rates among women can soon be expected to start rising (Bray et al. 2000).

Figure 7 Smoking rates in EU candidate countries, 2002



Source: Eurobarometer (2002)

The policy response to tobacco was initially weak but more recently several countries, in particular Poland (Fagerstrom *et al.* 2001), Hungary and the three Baltic States, have enacted anti-tobacco programmes that are stronger than those in many EU countries.

Cervical cancer is also somewhat more common than in the west, a finding that is unsurprising given the high rates of sexually transmitted diseases and, until recently, the difficulty in obtaining barrier contraceptives (Levi *et al.* 2000). Unfortunately, the few effective cervical screening programmes are rare exceptions and screening is often opportunistic, with little quality control, and generally ineffective.

In brief, the pattern of cancer mortality in the eastern European candidate countries is complex and changing. In the future, it is likely that deaths from

some types, such as stomach cancer, will continue to decline while others, such as breast and prostate, will come closer to those in the west.

Infectious diseases

As in the west, acute infectious disease is no longer one of the leading causes of death. This reflected the high level political commitment to disease control during the twentieth century, following Lenin's famous statement in response to outbreaks of typhus that "If communism does not destroy the louse, the louse will destroy communism" (Field 1957). The Soviet model was especially successful in reducing vaccine preventable diseases, in part because of its pervasive system of monitoring and use of compulsion, although a breakdown of control systems in some countries following independence has allowed them to re-emerge (Markina *et al.* 2000). In contrast, the lack of investment in infrastructure, with many rural hospitals lacking hot water even in the early 1990s, meant that other aspects of infection control were poor. This was exacerbated by adherence to outdated concepts of disease transmission and surveillance.

The other infectious diseases causing concern are sexually transmitted diseases (STDs), HIV and tuberculosis. Rates of STDs rose rapidly in many countries in the 1990s. They have since fallen although there are concerns as to whether this reflects a true reduction in incidence or a decline in notification, as treatment is increasingly being provided privately (Platt and McKee 2000). Rates of HIV infection are still low, in global terms, but are rising extremely quickly in many parts of the CCEE (Dobson 2001). At present, spread is primarily due to needle sharing among addicts but the epidemic is beginning to move into the wider population by means of sexual spread.

Rates of tuberculosis have also increased markedly in the 1990s in some countries, in particular the Baltic States. Rates are especially high among the large prison population, where conditions are highly conducive to rapid spread and where treatment is often inadequate (Stern 1999). A matter of particular concern is the high rate of drug resistant disease (Farmer *et al.* 1999). The co-existence of HIV and resistant tuberculosis poses enormous challenges for the future, and which have yet to elicit an effective response.

Finally, changes in land use, related to the adoption of new agricultural practices and a relaxation of earlier restraints on planning is contributing to a shift in patterns of zoonotic infections, such as an increase in leptospirosis in Bulgaria (Stoilova and Popivanova 1999) and in tick-borne encephalitis in the Baltic States (Randolph 2001).

3.1.4 The underlying factors

Lifestyle choices are heavily influenced by social circumstances and they can only be understood fully by considering the context in which they are made. The social forces driving trends in mortality in these countries are still inadequately understood, although some parts of the picture are clear.

In general the transition has had a beneficial effect on health, with considerable gains in some areas. Thus, the opening of markets has ensured access to fresh fruit and vegetables all year round and to healthier (by virtue of lower sugar or fat content) forms of common foods. Similarly, the emergence of an active consumer market has encouraged greater attention to safety and to routine maintenance, with a concomitant reduction in injuries. However open borders cannot be selective, only admitting 'goods' while excluding 'bads'. Thus, those promoting dangerous substances, such as tobacco and narcotics, have been able to create new markets for their products, whether among young women, in the case of the tobacco industry, or those on the margins of society, in the case of those trading in narcotics. Both have taken advantage of the turmoil in parts of the former Yugoslavia to increase the flow of smuggled goods into the rest of Europe, with the tobacco industry using this route as a means of circumventing sales taxes in many countries.

So not everyone has fared so well. In addition to the grater exposure to substances hazardous to health, income inequalities have widened and some groups have been left behind in the quest for modern market economies. It is now clear that the most vulnerable are those who have experienced the most rapid pace of transition (Walberg *et al.* 1998), and who are least able to draw support from social networks (Kennedy *et al.* 1998). The individuals most affected have been men, with low levels of education (Shkolnikov *et al.* 1998), low levels of social support (such as the unmarried (Hajdu *et al.* 1995)) and low levels of control over their lives (Bobak *et al.* 1998).

These findings paint a picture of societies in which young and middle-aged men in particular have faced a world of social and economic disruption that they were poorly prepared for (Cockerham 2000). For many, the opportunities are constrained by low levels of education and a lack of social support. The situation is often exacerbated by easy access to harmful substances such as alcohol or, increasingly, heroin. This situation is not unique to the former countries of central and eastern Europe. It can be seen in societies throughout history and in many parts of the world where an established order has been overturned and the old certainties have disappeared (McKee 2002).

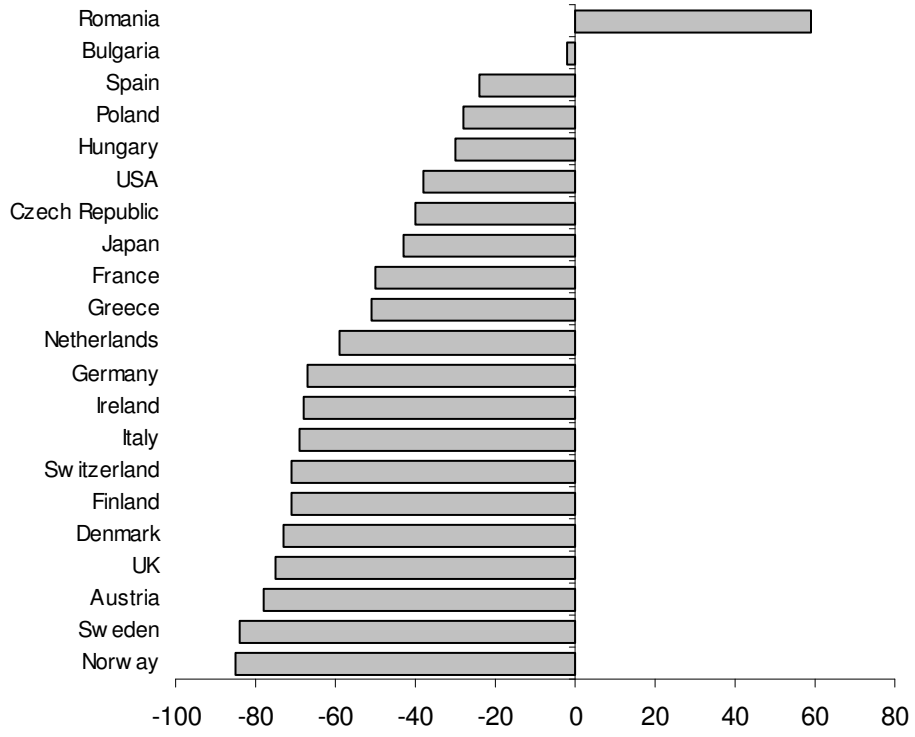
3.1.5 The contribution of health care

There is now considerable evidence that timely and effective health care interventions have played an important role in reductions in mortality in western countries (Mackenbach *et al.* 1998). Research using the concept of avoidable mortality, has suggested that about 25% of the mortality gap between east and west Europe between birth and age 75 could be attributed to inadequacies in medical care in 1988 (Velkova *et al.* 1997), with deaths from avoidable causes declining at a slower rate in the east than in the west. A more recent analysis, comparing the Baltic States with the United Kingdom (selected as an example of a western European country) shows that the east-west gap in deaths from avoidable causes began to emerge about 1970, at the time when many modern pharmaceuticals and innovative surgical techniques were being adopted in the west, but not to anything like the same extent in the east (Andreev *et al.* In Press).

While the specific impact of health care on measures of population health is often difficult to detect, there are several well-documented examples of where this has been identified (Becker and Boyle 1997; Nolte *et al.* 2002). Research on neonatal mortality has sought to separate the impact of health care from broader social determinants, with the former assessed by birth-weight specific survival and the latter by the overall birth weight distribution. In the Czech Republic (Koupilová *et al.* 1998) there were considerable improvements in birth-weight specific mortality, and by implication, the quality of care. As a consequence, closing the remaining gap with the EU will require policies that address the social determinants of low birth-weight.

Another area where the impact of health care can be identified is cancer survival. Research from the 1980s and early 1990s showed that cancer survival was somewhat lower in CCEE than in the west, almost certainly reflecting the lack of access, at that time, to the then emerging expensive new chemotherapeutic drugs. However, in the 1990s, there have been considerable improvements, as can be seen from the case of testicular cancer (Levi et al. 2001), which now has a high cure rate in western countries. Figure shows the change in death rates between the mid 1970s and mid 1990s. The apparent deterioration in Romania is likely to be an artefact due to improved case recognition. However the decline in mortality began much later in the CEE countries and, at least up to the mid 1990s, had been rather slower than in the west.

Figure 8 Change in deaths from testicular cancer age 20-44: 1975-9 to 1995-9



Source: Levi et al, 2001.

3.1.6 Summary

The candidate countries are as diverse in their health status as they are in other parameters. They can be divided, in broad terms, into three groups: Turkey, the two Mediterranean island countries, and the ex-communist countries of central and eastern Europe, however, especially within the last grouping, differences in health status, already substantial in 1990, have in many cases increased further.

Although the lack of data makes it difficult to assess the health of the Turkish population, it seems probable that their health needs are considerable, with a double burden of high mortality from traditional causes in childhood and growing rates of non-communicable diseases as seen in more developed countries. The strong stance taken by Turkey on tobacco control is, however, a very positive measure that will reduce levels of premature death in the future.

In contrast, Malta and Cyprus have patterns of health that are similar to those in existing EU member states.

Much more is known about patterns of health, and their causes, in the countries of central and eastern Europe. While transition has brought about overall improvements in premature mortality, the picture remains uneven, with some groups doing better than others. Death rates from many non-communicable diseases remain much higher than in western Europe. This seems to reflect, to a considerable extent, traditionally high levels of smoking (among men) and poor dietary intake, with especially low levels of fresh fruit and vegetables. Death rates are also high from injuries and violence and, taken with the high rates of cirrhosis in some countries, this indicates the important role played by alcohol. However it is important to look beyond the immediate risk factors to understand the role that social and economic transition has played, both positive and negative, in a process that has brought both winners and losers. Finally, it is clear that while great improvements in health care have been achieved, there is still much to be done.

3.2 Financing health care[5]

A number of tools have been developed to facilitate the analysis of health care financing. One of these identifies distinct functions within the health care system: revenue collection, pooling, purchasing and provision (Kutzin 2001) (Figure 9). Revenue collection refers to the process of mobilising resources, usually from households or corporate entities but also external donors. Pooling refers to the spreading of financial risk across the population or a sub-group of the population through the accumulation of prepaid health care revenues. This facilitates solidarity, primarily between the healthy and sick and, depending on the method of funding, between the rich and the poor. Purchasing is the process of obtaining services from providers on behalf of the covered population. Provision of services and how these are delivered, and by whom, are discussed later in this paper.

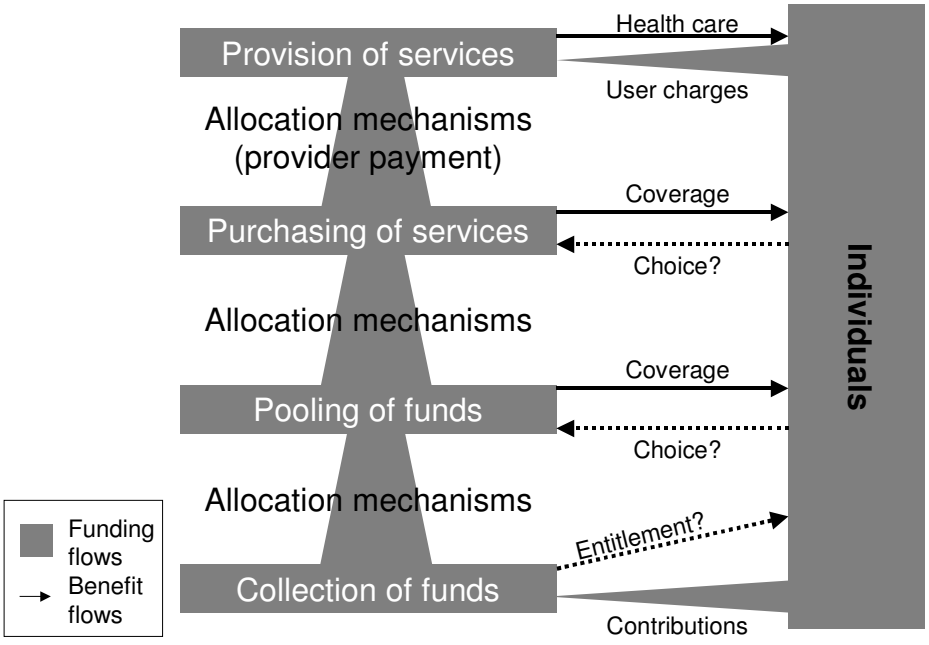
For each of these functions it is possible to identify certain policy issues. These are outlined in Table 3 (Preker *et al.* 2000). Decisions on each of these policy issues will shape the overall structure of the health care financing system. For example the equity of the financing system will depend both on the level and distribution of the contributions. Equity of access will depend on who has access and to what services as well as on the extent and nature of user charges and informal payments. Efficiency will be influenced largely by the extent of pooling and the methods of provider payment. Depending on the extent of decentralisation and fragmentation in the system these functions and the associated decisions may be carried out by different bodies. For example, central government might decide the contribution rate and the proportion to be paid by the employer and the

[5] This section draws from Dixon A. Langerbrunner J. and Mossialos E. Facing the challenges of health care financing. USAID conference, Washington D.C. 29-31 July 2002.

employee. However, collection of the contributions may be the responsibility of regional branches of the health insurance fund.

The financing of health systems was the subject of early and radical reforms in central and eastern Europe (CEE) and continues to be so in all pre-accession countries. In most CEE countries the intention of the reforms was to shift away from the centralised integrated state model of Semashko to the decentralised and contracted model of social health insurance. This was modelled in part on the basic features of the Bismarck model found in Western Europe but significant differences also emerged as the model was adapted to the particular context of CEE (Table 4). In seven out of 10 CEE countries SHI was administered by an agency other than the government itself. This could be through a National Health Insurance Fund which would be in charge of setting and collecting and distributing funds. However, in Estonia, Hungary, Lithuania and Slovenia fees and benefits are set by the government or the government intervenes at some point through the process of administration.

Figure 9 Functions of health system financing and population links



Source: Kutzin, 2001

Table 3 Policy issues related to different financing functions

Financing function	**Related policy issue**
Collection of funds	How much money to collect and from whom?
	Who and what to cover?
Pooling of funds	How to pool resources?
	How to allocate resources to purchasers?
Purchasing of services	From whom to buy and how to buy?
	At what price to buy and how to pay?

Source: Adapted from Preker et al, 2000

Table 4 Shift Toward the Bismarck Model of Social Insurance

Country	Year SHI Law Passed	Year Contribution Collection Began	Autonomy Of health insurance fund(s)	Contributions and benefits set by the Government
Bulgaria	1998	1999	Yes	No
Czech Republic	1990	1993	Yes	No
Estonia	1991	1992	Yes	Yes
Hungary	1991	1991	No	Yes
Latvia	1993	1993	Yes	No
Lithuania	1991	1991	No	Yes
Poland	1997	1999	Yes	No
Romania	1997	1999	Yes	N/A
Slovakia	1994	1994	Yes	N/A
Slovenia	1992	1992	Yes	Yes

Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Czech Republic (Copenhagen: WHO Regional Office for Europe 2000); WHO, Health Care Systems in Transition. Malta (Copenhagen: WHO Regional Office for Europe 1999); WHO, Health Care Systems in Transition. Slovenia (Copenhagen: WHO Regional Office for Europe 2002); ILO athttp://www.ilo.org/public/english/regioneurpro/geneva/reports/001/cyprus.htm and http://www.ilo.org/public/english/region/eurpro/mdtbudapest/newsletr/93-4/nl4_51.htm; Social Security Administration, 1999; Ministry of Development and Prognosis at http://www.andr.ro/engleza/investment/business/content/5_3_social_insurance_system.htm.

The recent shift to more decentralised systems of health care financing may also have been influenced by the historical context of CEE health systems. The integrated state models of care took their root from early 20th century developments in medicine and public health. Shortly after the Bolsheveik revolution, Dr. N.A. Semashko chaired a health conference in Moscow that established citizenship as the basis for free medical care. This early resolution lead to the development of a Russian health ministry that pre-dated the Ministry of Health in the UK. The language of Semashko propaganda that emerged from this early period clearly designated health as a public affair to be run under the auspices of the State. These early developments in the organization of care led the way for the provision of

health care to become an essential component of the central planning system, just as education or housing had become (Mihalyi 2000).

Systems of funding may also have been influenced by the dispersion of political ideology between countries. For example the system of universal free health care established in post-revolutionary Russia provided a prototype for other socialist countries. The Union of Soviet Socialist Republics established in 1922 faced severe health problems; much of the existing infrastructure was destroyed during the civil war and the subsequent famine made a large proportion of the population vulnerable to ill-health. Activities focused primarily on the control of infectious disease and the delivery of health services through the work place. Bed capacity was built up to accommodate the need to isolate infectious disease patients and the Semashko model had some success in infectious disease control. In the countries of central and eastern Europe the adoption of Soviet-style health care was less a matter of choice rather ideological necessity. For instance, in Czechoslovakia, the post-war government initially continued with an insurance-based system. Even with the seizure of power by the communists in 1948 the system was rolled out under the National Insurance Act (1948) to cover all citizens under a single national insurance fund (Kaser 1976). It was not until 1951 that a "System of Unified State Health Care" was introduced modeled on the system of health care in the Soviet Union (Jaros and Kalina 1998). The only significant deviation from a Soviet-style health service in the communist bloc was in Yugoslavia where health centres and hospitals were "self-managed", or unconstrained by the centrally planned norms which dominated health services in other countries (Kunitz 1979).

The strict bureaucratic hierarchy and command economy under the Semashko model had severe effects on the delivery and quality of medical care. Decision-making and resource allocation decisions occurred at the highest-levels and left little room for patient input. Consequently, shortages were common and crowding in clinics and hospitals accompanies extensive waiting lists. Providers had few resources and were often required to work without necessary equipment or medicines. Poorly-aligned incentives and a low prioritisation of health generally resulted in poor quality service.

Despite these challenges however, basic public health services were relatively effective and there existed a general expectation among citizens that the government would be responsible for the provision of health services. Citizens generally expected a level of security and solidarity. While the organization and delivery of health services did not go unchanged, expectations regarding the government's role in health care have largely survived, although few countries have kept the unlimited, universal entitlement to care that defined the early regimes (Kornai and Eggleston 2001).

The historical expectations of the citizens may have also had an impact on recent health care financing reforms. Despite the shift away from more centralised systems, health coverage, in theory, has remained nearly

universal in many CEE countries. For example, the exemptions in the contributions schemes of Estonia and Hungary have helped keep coverage of the population at 94% (Leppik 2003) and 99% (Gal 2003), respectively.

In Slovakia, despite a move toward insurance financing, the historical expectations of free care at the point of service remain and have lead to the preservation of broad benefit schemes. While cost pressure has been increasing, the Ministry of Health has little political will to redefine the scope of covered services (Vagac and Haulikova 2003).

Moreover, the development of more autonomous health care structures has not lessened the high levels of government intervention and regulation. In Poland, despite the national health reforms of 1999 that created independent sickness funds to contract directly with providers, the Ministry of Health is now considering many reform proposals as a result of the perceived failure of the funds to adequately take account of patients' health needs. Financial limitations within the sickness fund system are believed to have limited the fulfilment of universal and equitable health coverage, and some reform proposals now call for the complete centralisation of all funds into one National Health Fund accountable to the Ministry of Health (Golinowska 2003).

An emphasis on the promotion and financing of primary care in Latvia may reflect the historic emphasis on equity in basic health services that existed under the Soviet style delivery systems. However, this may be more in response to the exclusion of many populations from the Latvian system. Polling in that country reveals that costs and accessibility problems have caused large percentages of the population to visit medical providers irregularly or incorrectly follow the prescribing orders of doctors. The heavy involvement of local governments in primary care may be a result of the significant geographic inequities in access rather than historical or path dependent influences (Bite and Zagorskis 2003).

There are numerous factors which influence the development of models of funding, some will promote continuity, others discontinuity with the past. In either case, the past should not be ignored as it may mediate or limit the possibilities for change. Finally we should not always be confined into looking at contemporary models as we may find that history can teach us more. Indeed the emergence of health maintenance organisations (HMOs) in the USA was heralded as a major innovation in health insurance. Yet integration of insurer and providers can be found in 19th and early 20th century Europe. Known as friendly societies, voluntary societies or mutual funds these early forms of insurance relied on capitated payments from their members and employed doctors to provide services and reimbursed the costs of drugs (Abel-Smith 1998). Thus ideas from the past reappear albeit in a modified form.

In CEE candidate countries, the shift toward more decentralised systems of health care financing resulted in changes both to the way money was

collected and pooled and created a new relationship between purchasers of care and providers. It was intended to earmark or protect health funds, prompt greater efficiency and responsiveness, and signal a move away from the perceived shortcomings of the past. It often took place, however, against a backdrop of socioeconomic and institutional upheaval. In addition, legislative reform was not always matched by concrete change on the ground and the objectives set out in policy were not fully or even partially attained in some cases. Cyprus, Malta and Turkey, although not undergoing the drastic economic and political upheaval the CEE candidate countries are experiencing, have assumed significant health system changes as well.

The candidate countries face a new and challenging environment, not only in terms of (i) total funding for health care, but also in terms of (ii) the efficiency of their health care services with the funding available and (iii) the development of sufficient government and technical capacity.

3.2.1 Collection of Funds

Prior to the transition to market economies, revenue for health care was generated mainly from state-owned enterprises. Private sources were negligible except for informal payments to providers. Like in tax-financed systems, health competed with other areas of public spending and expenditure on health was the outcome of political negotiations and reflected priorities (these tended not to favour health which was seen as an unproductive sector). During transition two new sources of funding emerged: social health insurance contributions and out of pocket payments (both official user charges and informal payments) (Preker 2002) There were a number of reasons why many of the countries in CEE shifted to social health insurance (Dixon *et al.* 2002):

- Break the monopoly of government over the ownership and financing of health services;
- Increase the responsibility of individuals for their own health and the financing of health care making funding of health care apparent to its users and contributors;
- Improve efficiency by making health care providers more accountable for the use of resources (Chinitz 1997)
- Give responsibility for health care to organisations independent from government (mainly driven by ideological concerns about the role of the state).

Despite the switch to social insurance contributions, general tax revenues continued to play a significant role in health care funding in many countries. Voluntary health insurance was intended to develop as a supplementary source of revenue. However, the market in private health insurance remains small in most countries and does not contribute significantly to health care expenditure. Private funding, in the form of informal payments for health

services within the public health care sector, is much more significant. However, the level and scope of these payments varies significantly between countries (Lewis 2002).

3.2.2 Sources of funding

The source of funding provides a gauge of the level of control that the state can exercise in the allocation of health care resources (Dixon 2001). The greater the proportion of public expenditure as total expenditure, the more likely the state can intervene in the distribution of resources. This is an important factor in the reforms of central and eastern European countries as the devolution of responsibilities may require state intervention at a later stage should a level of devolution be inadequate to handle some responsibilities. This also allows the state to institute cost-containment measures or to overcome financial barriers to treatment.

The main sources of revenue for health care are taxes, social insurance contributions, voluntary insurance premia and user charges (formal and informal). Most countries rely on a mix of these sources. Taxes are compulsory for the whole population and are levied by government. Social insurance contributions are compulsory for all or some of the population; they are kept separate from other government revenues and are usually managed by a fund or funds independent of government. In CEE countries the term social insurance is often used to describe payroll taxes which are in fact levied by government and managed by a fund which government largely controls. However for the purposes of this paper we will use the term social insurance to include payroll taxes.

In terms of equity, direct taxes (e.g. levied on individuals, households or firms) are usually set progressively, that is the higher the income the higher the proportion paid. In contrast indirect taxes (e.g. levied on goods and services) are regressive because those on lower incomes spend a greater proportion of their income on consumption. Social insurance contributions are usually levied proportionately to income. Where an income ceiling is applied, above which income is exempt from contributions, social health insurance becomes mildly regressive. Furthermore, because contributions are levied only on earned income (not on profits or income from investments and savings) they place a heavier burden on those with lower incomes. In contrast private health insurance and user charges are higher for those in greatest need, thus relating how much you pay to how ill you are (or are likely to be). In terms of efficiency, taxation is associated with strong expenditure control, it draws on a broad revenue base and is administratively efficient. Depending on the organisation of social insurance, expenditure control might be strong if there is a single fund or government caps the overall budget or sets contribution rates. Social insurance draws only on earned income and therefore adds to the cost of labour with a potentially negative effect on economic growth. If separate

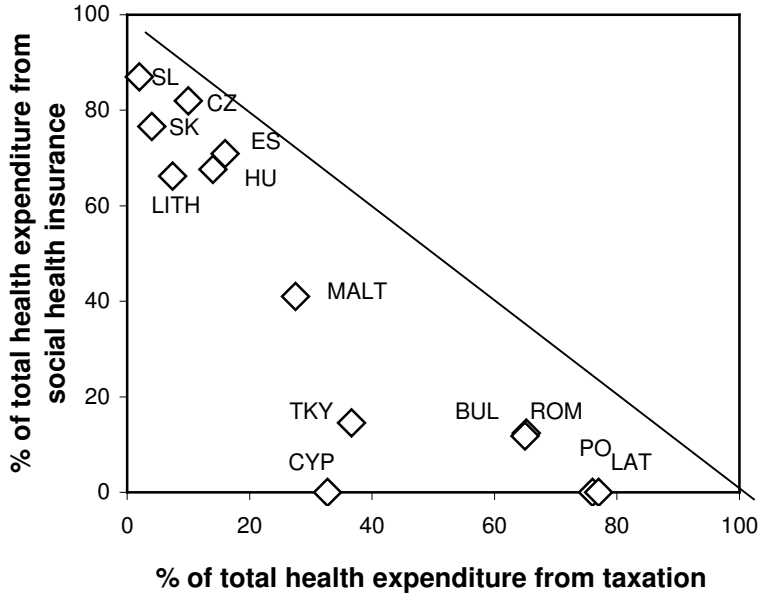
systems of collection are implemented this will add to administrative costs. Both social insurance and taxation in theory are associated with access free at the point of use and near universal coverage. User charges and voluntary health insurance relate access to ability to pay (Mossialos *et al.* 2002). Nevertheless, user charges have some appeal for low and middle-income countries as a way of mobilizing additional revenue: first, because establishing prepayment health funding is difficult in a dire economic environment; and second, because of the pre-existing informal payments. In these countries, the revenue base for employment-related contributions or taxation is extremely limited because unemployment is high, a high proportion of labour is in agriculture, self-employed or informal and the informal economy is large. Charging is therefore one of the few ways of mobilizing any revenue at all. However, substantial evidence indicates that user charges disproportionately affect the rural poor (Mossialos *et al.* 2002).

Figure 10 shows the relative importance of taxation and social health insurance in the countries of CEE towards the end of the 1990s[6]. The distance from the diagonal represents the share of private funding ((out-of-pocket expenditure and voluntary health insurance)[7]. There were four countries which funded health care predominantly from taxation: Bulgaria, Latvia, Poland, and Romania. Six countries relied predominantly on social insurance contributions: The Czech Republic, Estonia, Hungary, Lithuania, Slovakia, and Slovenia.

[6] These data is likely to have changed. For example since 1998 Poland has implemented a social health insurance scheme.

[7] However, informal payments which are significant in most accession countries are not included.

Figure 10 Percentage of total expenditure on health from taxation, social health insurance and other sources (includes voluntary health insurance and out-of-pocket payments) in the EU accession countries in 2000 or latest available year.



Key: BU: Bulgaria, CYP: Cyprus, CZ: the Czech Republic; ES: Estonia; HU: Hungary; , MALT: Malta, LAT: Latvia; LITH: Lithuania, PO: Poland; ROM: Romania; SK: Slovakia; SL: Slovenia, TKY: Turkey.

3.2.3 Informal payments

In the early 1990s, during the transition period in CEE countries, staff salaries were very low and often delayed. Instead, money was sought from payment requests and were shifted to patients by staff. In a positive sense, informal payments to health staff during the economic difficulties allowed healthcare staff to remain in health facilities and provide healthcare during this time of economic difficulty. However, demands for the payment requests also resulted in the excluded and some of those were unable to pay. The most severely affected were typically the poorest or those chronically ill.

Out-of-pocket payments are made in the public sector in some countries despite not being officially endorsed, and informal payments made by patients and families to supplement formal coverage are common. Informal payments take a number of forms and may exist for a number of reasons. They range from the *ex ante* cash payment to the *ex post* gift in-kind. These payments or gifts may be part of the culture, may be due to the lack of a cash economy, a lack of finances to pay health care workers and a lack of drugs and basic equipment to treat patients or due to weak governance. At their worst they may be a form of corruption, undermine official payment

systems, and reduce access to health services (Ensor and Duran-Moreno 2001).

In CEE, they have come to represent a large proportion of total health expenditure as other sources of revenue have collapsed (Ensor and Duran-Moreno 2001). These payments exist for several reasons (Lewis *et al.* 2000):

- *Lack of financial resources in the public system*. Without payment, patients cannot obtain basic supplies such as drugs or bandages needed for treatment. Staff rely on payments to supplement their small or nonexistent public salaries.
- *Lack of private services*. The private sector is not fully developed, so patients with money have fewer options to obtain services elsewhere. In western Europe physicians may legally work across the public-private divide, shifting patients to their private practice. Treating patients for a 'private' payment in the public sector may arise where private practice does not exist.
- *Desire to exercise consumer leverage over providers*. No third party is involved in the transaction, which makes the provider accountable to the patient. This seems to be an important factor in the level of informal payments in CEE countries as well as in Cyprus and Turkey and may explain the low demand for voluntary health insurance.
- *Cultural tradition*. Southern European, CEE countries have a long tradition of informal payment that has persisted despite attempts in some countries to curb it.
- *Lack of transparency in health facility operations* (Shahriari and Belli 2001).

The opportunistic environment created by the deficiency of resources offers informal payments as a perverse incentive for providers. The cultural acceptance and inability of the government to regulate such actions perpetuates the practice. Hence, estimated frequency of informal payments in the region are typically high. However, data on the extent and size of informal payments is scarce because they are covert and, in some countries, illegal.

According to a 2000 World Bank report which reviewed informal payments across the European region, 21% of all healthcare in Bulgaria incurred informal charges in 1997. This figure ranged up to 78% in other candidate countries (Lewis 2000). The percentage of patients reporting that they had been required to make some payment for a service was 78% in Poland.

A 1999 World Bank/USAID survey observed that 71% of GP visits in Slovakia involved payments while 59% of specialist visits involved payments. The percentage of patients reporting that they had been required to make some payment for a services was 60%, and it is estimated that almost three in ten hospital patients made some kind of informal payments

to providers. Between 1993 and 1998, the number of patients who paid for hospital admissions grew by approximately 10%. The World Bank report also observed that 71% of GP visits involved payments while 59% of specialist visits involved payments. The average payment to specialists was more than 3.5 times the average payment to GPs (Vagac and Haulikova 2003).

While little empirical evidence exists in Hungary as to the extent of informal payments, some research by Kornai and colleagues in 2000 has provided numerical guides of their prevalence. An attempt to calculate the portion of Hungarian doctors' salary comprised of unofficial payments estimated that only 38% is made of official income with the remaining 62% stemming from informal payments. When asked if some informal payment should be made for customary medical interventions, 31% of a sample of 1400 Hungarians answered in the affirmative for a routine injection, 48% answered in the affirmative for a routine gynecological examination, and 86% answered in the affirmative for a house call made at night. Moreover, estimates on the overall extent of informal payments made by doctors are lower than those made by public (Kornai 2000). Notably, greater discussions on the topic occurred in the late 1990s. The Hungarian government established the Informal Payment Committee to assess the situation and propose possible solutions. A concluding report from the committee found that cultural reasons were much to blame. The fast introduction of the social insurance scheme following the war replaced a system of direct payments. Also, many doctors come from working classes, and the emergence of informal payments was strongly related to the low level of respect granted to members of the medical profession. Despite its findings however, the committee could not come up with a specific agenda of solutions and did not have any political power. It was dismissed in 1999 and has not been replaced (Gal 2003).

According to a 1999 survey conducted by the TARKI Social Research Centre, the size of all informal payments in Hungary is roughly 4.6% of total health expenditures (Gal 2003). Informal payments are more widespread in gynaecological and surgical hospital services compared to internal medicine and mental health services. Payments are less frequent in outpatient settings services, and the amount varies by specialty. GP home visits may get 3-3.5 Euros, while a gynaecological service after delivery may receive 40-78 Euros and a cardiac surgeon after operating may receive 117-197 Euros (Gal 2003). The number of physicians in Hungary has exacerbated the problem, as excess capacity has been significant. Despite considerable health care sector downsizing, the number of first-year medical students increased by 40% since 1990 (Gal 2003). Older doctors have incentives to work after retirement because of low pension amounts. Salaries in the last decade remained low, and were falling in real terms. However, in October 2002, the government took steps to raise physicians' salaries, although this alone may not prove effective as salary increases may

not by themselves lead to any significant reduction in the extent of informal payments.

In Latvia, the Transparency International 2000 Annual Report estimated that approximately 25% of patients make informal payments sometimes, while 5.7% made payments on almost every visit. A regional breakdown reveals that Riga has the highest proportion of under-the-table payments, with 46.1% of Riga respondents making such payments.

In Romania, a recent survey of public perceptions conducted by the Centre for Policies and Health Services revealed that 39% of people with high incomes paid unofficial fees or gifts for medical services in 2001 while 33% of people with below average income paid unofficial fees or gifts (Mihai 2003).

However, informal payments are not high in the Czech Republic where doctors' salaries have risen above the rate of inflation of average wages. The level of payments is highest for inpatient care with drugs and outpatient care subject to lower fee levels. A 2000 survey of health care staff and public officials in three CEE countries and the Ukraine revealed that 5% of Czech doctors confessed to accepting "something more" than a small gift (Miller *et al.* 2000). However, poor pay alone may not completely explain the willingness of physicians to accept informal payments. Doctors in the Ukraine, Bulgaria, Slovakia and the Czech Republic were 18% more likely than the average government office to have reported a second income, and were also well above average in their reporting of having a "family income" that was enough for a "fair" or "good" standard of living. More significantly, while poor pay increased the willingness to accept gifts, it was those with the highest salaries and the best family incomes who more frequently received such payments, a likely result of the positions of power held by these individuals (Miller *et al.* 2000). A feeling of moral self justification as well as being in a position of bargaining power may also contribute to the practice of accepting informal payments. Further survey data is needed to establish more accurately the level and extent of informal payments in the Czech Republic.

Furthermore, lack of transparency means that tapping this revenue is difficult for publicly funded systems. Converting informal payments into formalized cost-sharing arrangements requires compliance from the providers, who may lose substantial income (especially if income has to be declared for tax purposes) and public support. Securing these is not an easy task. Experience from other non-European low-income countries suggests that whether such initiatives can be implemented in practice depends on the ability of government to regulate providers and their willingness to set priorities among or limit the services on offer. The ability to achieve the objectives of improving efficiency and quality without jeopardizing equity critically depends on a number of policy measures. These encompass skills and capacity of staff, the development of appropriate incentives and

exemption systems and suitable information systems to support the accounting and auditing of such payments (Mills *et al.* 2001). Informal payments can abate government efforts to improve accountability and management as well as reduce the revenue base upon which the health system may rely upon (Shahriari and Belli 2001). Informal payments do represent an important source of revenue in countries in which prepayment systems have collapsed, and phasing them out without developing suitable alternatives would, most likely, be damaging.

The nature of physicians' services may also impact the pervasiveness of unofficial payments. While the number and role of private insurance providers in Lithuania is quite limited, the effect of private providers of medical care can may be substantial. Private health care organizations have developed significantly in Lithuania, and the number of physicians working in the private sector has increased in recent years. Surveys conducted before and after the implementation of a national insurance scheme and the growth of private providers reveal a decline in the extent of informal payments (Dobravolskas and Huivydas 2003). This trend seems to follow the Czech experience regarding the role and compensation of providers.

In Romania however, the implementation of a national health insurance system has not stopped patients from offering informal payments to providers. This is despite the fact that all insured persons under the system must make monthly contributions for the benefit package regardless of whether they actually receive any medical services (Mihai 2003).

In addition, there is little evidence on how informal payments affect utilization because obtaining information is difficult. However, where these are required ex ante (in some countries in both western and eastern Europe), patients who cannot afford the payments either cannot obtain treatment or access the same level of services or have to wait longer for it. In addition to the financial barrier imposed by fees, patients in some countries are further deterred by the uncertainty about prices caused by informal payments (Mills and Bennett 2002). There is no evidence as to whether official fees affect equity more strongly than informal payments.

3.2.4 Private medical insurance

Voluntary insurance was conceived in many countries as a complement to social health insurance, covering those services excluded from the benefits of the social health insurance scheme. In practice the boundaries between public and private insurance were not defined in part due to the failure in many countries to define a basic benefits package (as described in the next session). In practice there was some demand for private insurance to duplicate or supplement social health insurance cover due to the inadequacy of access.

The proportion of private medical insurance (PMI) in the candidate countries is generally minimal. Only in Slovenia is the proportion of PMI substantial accounting for approximately 12% of the total health expenditure. In Malta around 25% of population have some type of private medical insurance but most have rather basic coverage.

Although faster access to specialists and better hospital amenities are the primary motives for seeking PMI, travel health insurance is also a main factor and, in some accession countries, the only reason for seeking PMI (Table 5).

There are likely several system-specific reasons why private medical insurance remains relatively small in CEE. Generally, the comprehensive nature of benefits may not create strong incentives for the development of private insurance markets, except for minor services and amenities. Without restrictions on the package of benefits, it becomes difficult to measure the potential for private payments. The generous level of public benefits in Slovakia, for example, is considered to be one of the main challenges to reform, particularly with respect to the introduction of supplementary health insurance (Vagac and Haulikova 2003).

Moreover, informal payments and cultural tendencies regarding the financing of medical care may restrict the growth of private insurance. Historical reliance on out-of-pocket payments as well as informal payments may lead to hesitation on the part of individuals to pay third-parties. While this would be true as well for national social insurance systems, the effect is likely to be more pronounced when private, for-profit entities are collecting and pooling contributions. Patients may be more comfortable paying physicians and other providers directly, compared to payments made to private health insurance firms that have hitherto not attracted a large percentage of the population and have gone relatively unregulated. Paying third-party entities may be viewed as needlessly meddling with the doctor-patient relationship and reducing assurances of quality care (Mossialos and Thomson 2002)

In Slovakia, where informal payments are significant and the market for private medical insurance is not substantial, public trust in insurance firms and the Ministry of Health itself is relatively low. A 2001 Agency Markant survey observed more than one-third of respondents as being distrusting of the General Health Insurance Company while almost two-thirds did not trust the Ministry of Health (Vagac and Haulikova 2003).

Table 5 Private Medical Insurance in EU Candidate Countries

Country	Provided By	For What	Expenditure for Private Health Insurance
CEE candidate countries			
Bulgaria	Commercial insurers	Amenities	Minimal
Czech Republic	Nonprofit insurers Commercial insurers	Amenities excluded from basic package, care in private hospitals; Travel insurance	Minimal
Estonia	Commercial insurers	Mainly travel insurance	Minimal
Hungary	Commercial insurers Voluntary health funds Foreign managed-care Companies	Amenities, care in private hospitals, loss of salary during sickness, gratuities	Minimal
Latvia	Commercial insurers Employer-Sponsored Schemes	Patient payments dentistry, sanatoria treatment, rehabilitation, drug expenditures	Low but growing
Lithuania	State Insurance Agency Commercial insurers Insurance societies Mutual insurance societies	Mainly travel insurance	Minimal
Poland	Commercial insurers Foreign managed-care Companies	Amenities excluded from basic package, care in private hospitals	Minimal
Romania	Commercial insurers	Travel insurance; Employees of a few foreign companies	Minimal
Slovakia	Commercial insurers Foreign managed-care companies	N/A	1% of THE (1995)
Slovenia	Commercial insurers, Adriatic Mutual insurer, Vzajemna	Co-payments, drugs, emergency care abroad	11.6% of THE (1998)
Other EU candidate countries			
Cyprus	Commercial insurers Employer-Sponsored Schemes	Private (primary & secondary) health care services	3% of THE (2002)
Malta	Commercial insurers Domestic insurance companies Foreign insurance companies	Amenities excluded from basic package, care in private/overseas hospitals	N/A
Turkey	Commercial insurers	Amenities excluded from basic package, faster access	Low

Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Lithuania (Copenhagen: WHO Regional Office for Europe 2000); WHO, Health Care Systems in Transition. Malta (Copenhagen: WHO Regional Office for Europe 1999); WHO, Health Care Systems in Transition. Slovenia (Copenhagen: WHO Regional Office for Europe 2002)

In Latvia, where informal payments remain common, the private insurance market is visibly growing, however it exists mostly in the form of group insurance schemes purchased by large employers, and the lack of

clear boundaries and regulation has led to some exploitation by private insurers (Bite and Zagorskis 2003).

Therefore, while a historical or cultural reliance on unofficial payments can impede the growth of private insurance markets, there is mixed evidence that the successful implementation of some national insurance scheme can assist in the reduction of informal payments to providers. However, the interaction between historical path dependence, cultural attitudes, public acceptance and trust of health care institutions, and the ability of governments to implement reform plans should not be oversimplified.

In most countries the limited experience with private insurance has yielded little evidence of its performance. The lack of regulation or oversight of solvency among the insurance industry is a persisting hazard. However, non-profit insurers, voluntary health funds, foreign managed care companies, and other insurance agencies and societies have joined the list in offering such services. Other countries have taken a more cautious approach limiting, until recently, the sale of voluntary insurance to the insurance funds (responsible for social insurance) as in Slovenia. These are often supplementary policies including cover for co-payments under public insurance, thus nullifying their effect, at least for those who can afford supplementary cover. Following accession to the European Union, the market for voluntary insurance in these countries will have to open up to competition from private insurance companies and will be subject to limited regulation. If private health insurance markets are to operate effectively there need to be clear boundaries set between the public and private sector in terms of benefits and beneficiaries, and proper regulation of their activities to protect consumers.

3.2.5 Defining contributions

With the shift to social health insurance in many CEE countries the burden of contributions has largely fallen on labour costs. The size of the contributions and the respective shares between employers and employees in different countries are shown in Table 6.

Contributions are generally shared between the employer and employee. Often the employer pays at least half, if not all (as in the case of Estonia), of the social health insurance contribution. Only in Poland is the employee responsible for the entire contribution. Latvia, Cyprus, Malta, and Turkey do not mandate contributions. Latvia's financing of the health care system is through an earmarked portion of the general taxation. The Mediterranean countries are also financed through general taxation, although Cyprus is due to implement a social health insurance system by 2005. Policy makers need to bear in mind that if the employer share of the contribution is too high,

there is a disincentive for employers to hire additional workers. Thus, the labour market may be inadvertently affected (Pavlova and Groot 2000).

Table 6 Size and nominal distribution of the social health insurance contribution between employers and employees in EU Candidate Countries

Country	**Size of Contribution (% of Earnings)**	**Nominal Distribution of the Contributions Between Employers and Employees (Percent)**
CEE candidate countries		
Bulgaria	6	75:25
Czech Republic	13.5	66:33
Estonia	13	100:0
Hungary	14	79:21
Latvia	N/A	N/A (resources drawn from state budget subsidies and personal income taxes)
Lithuania	N/A	Employer: 3% of payroll (+ 30% natural person income tax) Employee: 1% of monthly wage
Poland	7.75	0:100
Romania	14	50:50
Slovakia	13.25	50:50 (+employer pays 0.53% additional for professional diseases & injuries at work)
Slovenia	13.45	53:47(employer pays 0.53% additional for professional diseases & injuries at work)
Other EU candidate countries		
Cyprus	4.55 (Planned)	66:44 (planned)
Malta	N/A (resources drawn from progressive general taxation)	N/A (employer and employee payroll contributions are made for non-health related welfare programs)
Turkey	N/A	N/A

Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Slovenia (Copenhagen: WHO Regional Office for Europe 2002)

3.2.6 Defining Beneficiaries and Benefits

Universal coverage of the population with access to health care is the stated aim of all European health systems. However, inadequate financing and parallel resultant 'informal charging' in some mainly CCEE candidate

countries has led to the exclusion of parts of the population in some candidate countries. Concerns have also been raised about the exclusion of some minority groups, such as the Roma (discussed below), from complete access to full healthcare in some candidate countries. Informal payments were common in the early 1990s in a number of candidate and other countries in the European region when the economies faced were in great difficulty.

In theory entitlements to health care benefits have remained universal (100% of the population) in theory in most countries. However, anecdotal reports from Poland indicate that those who do not pay insurance contributions directly (and there are significant numbers in the region, such as the self-employed, those in small informal businesses, farmers, the unemployed, students, and pensioners) are treated as "uninsured." Contributions must either be subsidized by other public revenues or they may be asked for out-of-pocket payments at the point of service (Chawla 2000).

Table 7 Entitlement and coverage in EU candidate countries

Country	Basis of Entitlement	Basic Benefits Coverage	Co-Payments for Basic Benefits
Bulgaria	Contributions	Universal	No
Czech Republic	Permanent Residence	Universal	No
Estonia	Taxation (13% of payroll tax earmarked)	Universal	Yes
Hungary	Contributions	Universal	No
Latvia	Permanent Residence	Universal	Yes
Lithuania	Contributions	Universal	Yes
Poland	Contributions	Almost universal	No
Romania	Contributions	Universal	No
Slovakia	Permanent Residence	Universal	Yes
Slovenia	Contributions	Universal	Yes
Cyprus	Taxation, but a National Health Insurance scheme is scheduled for 2005	Only 65% of the population is fully covered	Yes
Malta	Citizenship	Universal	No
Turkey	Taxation	Universal	Yes

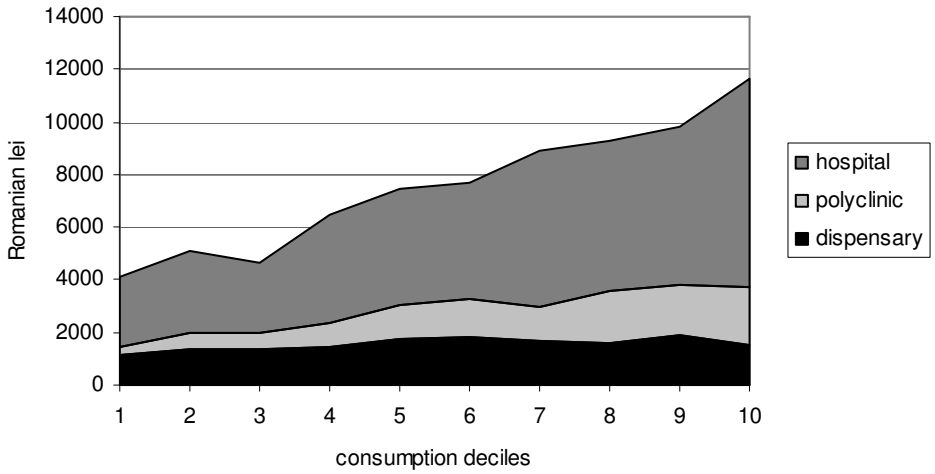
Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Czech Republic (Copenhagen: WHO Regional Office for Europe 2000); WHO, Health Care Systems in Transition. Malta (Copenhagen: WHO Regional Office for Europe 1999); WHO, Health Care Systems in Transition. Slovakia(Copenhagen: WHO Regional Office for Europe 2000).

As it may be determined from the table above (Table 7), entitlement is often based on contributions to the social health insurance plan. This has great implications on the equity within the system, as those who are not able to contribute to the plan will not be covered. Likewise, the inaccessibility of services for a portion of the population introduces the problem of unmet health needs within the population.

While there is limited information regarding the equity of health care utilisation, some emerging evidence exists in Romania and Bulgaria. Even where entitlement is universal there may be substantial differences between population groups in their ability to access services. Several studies in CEE (Chakraborty 2002) show incidence of public expenditure on health care and social assistance programs are not always well-targeted. The non-poor often benefit disproportionately. In addition, there are marked differences in resource allocation between capital cities and other cities, and urban and rural areas. Despite the ideology of equity, these disparities were prevalent during the pre-transition phase, and in many countries have not been corrected. Indeed, some longitudinal analyses show disparities growing over the last decade (World Bank 2002).

Figure 11 illustrates estimates from 1994 data from Romania, showing per capita spending by income deciles. It shows that higher income groups benefit more than low income groups particularly from hospital services.

Figure 11 Spending per Capita on Health Care, by Facility Type and Income deciles, Romania, 1994



Source: World Bank, 1997

Note: 1= lowest, 10= highest income decile

In Bulgaria, despite the large-scale economic restructuring of the late 1990s, the health care system was perceived as having not suffered from a substantial loss of equity. Estimates of demand and the factors associated with utilisation of health services remained egalitarian, with age and self-

reported health status as the most likely predictors of utilization (Balabanova and McKee 2002). However, utilisation data masks important complexity in the type and extent of medical care sought and received. The poor often obtain services at poor quality state facilities for which there are limited, if any, user charges. Moreover, assessments of utilisation may be limited to primary care, yet the poor are more likely to face limitations in access at high levels of care as a result of bureaucratic procedures or unresponsiveness. At these levels of care, higher income patients are more likely to opt directly for private treatment, while the poor have fewer choices and are limited to official channels of care (Balabanova and McKee 2002).

There is also some evidence in Estonia that patients in lower income groups have reduced access to care compared to their high income counterparts, as measured by health care utilisation data (Kunst 2002). In Poland, the burden of informal payments adversely affects lower income patients' access to care, as higher income patients are more likely to avoid making such payments by accessing private sector outpatient services (Lewis 2000).

Historically most CEE countries provided comprehensive coverage in theory. In practice services were rationed. Countries in both western Europe and CEE are attempting to cope with funding many and expensive medical and health services. Defining a package of benefits (e.g. limiting what is covered) has been seen as one option to cope with the discrepancy between available (public) resources and existing (perceived) demands. Some countries in the region have attempted to define a more concise or "basic" benefits package to be financed from the National Budget and/or via National Health Insurance.

But, in most cases, changes in benefits packages were done in a very incremental way or not at all and in most instances, attempts to develop a systematic "basic package" failed.

Many factors/issues made it very difficult to determine a package and implement it. Some of the challenges have been technical, others more political. For example, exhaustive information about the cost-effectiveness of interventions in a particular setting is not available and would be extremely costly to obtain. Where entitlements are defined they tend to focus on individualised curative interventions rather on the wider population interventions and public health initiatives. On the other hand, citizenry and politicians see comprehensive and free health care as a right, and are not ready to accept cuts in benefits. Providers, who depend upon the income, similarly oppose it (Bultman 2002; Dixon *et al* 2002).

The beneficiaries who are entitled to benefits because they contribute may be identical to who and what is covered by the pooled funds. However, the

pool may cover a larger population than just those who directly contribute. For example, the social health insurance funds are expected to cover the whole population including the non-working and therefore non-contributing population through transfers from tax revenues and transfers from other social insurance funds (e.g. employment and pension funds). Where there is no explicit entitlement to certain benefits, but the system is in theory comprehensive, purchasers, such as regional authorities or insurance funds tend to make decisions about what to buy thus undermining equity of access. Where a basic package of benefits is defined, purchasers may have the freedom to offer supplementary benefits. However, this is rare in the CEE countries (Dixon *et al* 2002).

3.2.7 Pooling of Funds

Another important function of health care financing is to pool the resources collected from various sources and to allocate these to purchasers. The extent of pooling will depend on how much of the revenues collected are pooled through a single fund and whether different sources of funding are pooled or remain separate. For example tax revenues may be pooled together with social insurance contributions to enable funds to purchase health care services on behalf of all citizens. Alternatively pooling may be limited if tax revenues are kept separate to provide public services directly for those who do not make insurance contributions. Where there is decentralisation or multiple collection agents pooling may occur at the national level if mechanisms exist to redistribute through a central pool. For example, if regional taxes are levied and retained by local government pooling only operates at the local level. However, if central taxes are used to compensate regions for the different income levels and/ or different health needs of the populations covered then pooling is extended to a national level. Similarly systems of resource allocation may be used to pool funds between competing insurance funds.

Pooling enhances efficiency because it reduces the incentives for risk selection and may break historical patterns of allocation. It also increases equity and solidarity principles by sharing risks across a larger population. Voluntary health insurance may, if it is group rated, pool risks amongst the employees of a company or if it is community rated amongst the residents of a particular area. However, usually voluntary health insurance is initially individually risk rated (and may be experience rated subsequently) therefore pooling amongst subscribers is extremely limited. If user charges are retained by the providers who collect them, there is little pooling of funds. However, where revenues from user charges are pooled with other revenues to provide services for a specific population pooling of revenues may occur.

Pooling mechanisms

A well designed pooling function can be judged on the extent to which multiple revenue streams are integrated or fragmented and the size of the

population across which pooling occurs. In smaller countries which are predominantly funded by social insurance such as Hungary, Slovenia and others, revenue streams are less fragmented (Preker 2002). Problems still persist due to the lack of pooling of resources for operational expenditures (from social insurance contributions) with capital investment (usually from other sources such as central and local taxation). Some additional funding is also allocated directly from general government revenues to teaching hospitals, thus distorting the pooling.

Decentralisation in many countries has included the devolution of revenue collection to regional government or to regional funds (e.g. Poland and Romania). In order to ensure adequate pooling between regions resource allocation methods were designed which aimed to ensure some redistribution according to the health needs of the population covered. However, regional governments have been reluctant to surrender revenues that they have collected to central government for redistribution to other regions. Similar political tensions exist in Italy where a similar redistribution mechanism has been introduced. Centralised collection of funds still occurs in Bulgaria, Estonia, Latvia, Lithuania, Cyprus, Malta, and Turkey. In Bulgaria, Estonia, Latvia, and Lithuania, a centralised agency will collect the hypothecated social health insurance contribution (Table 9).

In Bulgaria, the National Social Security Institute collects the social tax and transfers funds to the National Health Insurance Fund which further distributes the funds from the Head Office in Sofia to the 28 regional and 120 municipal offices. Estonia's Taxation Agency, as well as Lithuania's State Social Insurance Council (SODRA) follows suit by collecting a 'social tax' which includes the SHI contribution among other social benefits contributions (such as maternity, pension or sick leave). Latvia, like Estonia, collects an earmarked portion of income tax. In this case, the hypothecated tax is 28.4% of each individual's income tax (Table 8).

With the transition to social health insurance and the creation of multiple insurance funds, pooling of funds has become more fragmented. Similar methods of resource allocation (or reallocation) can be employed to ensure pooling across multiple insurance funds even where these are not regionally defined. However, these risk adjustment mechanisms as implemented in Germany, Netherlands, Israel and Switzerland require significant information about individual members of funds. Where allocations have been crudely weighted according to age and sex there has been increased scope for opportunistic behaviour by funds, namely to select good risks. More sophisticated formula will generate significant costs and require technical capacity to implement.

Table 8 Collection and redistribution of funds in health care systems in EU candidate countries

Country	Fund Collector	Fund Redistributor
CEE candidate countries		
Bulgaria	National Social Security Institute	National Health Insurance Fund
Czech Republic	General Health Insurance Fund + 7 other sector/enterprise insurance agencies	Each Fund distributes
Estonia	Taxation Agency	Central Sickness Fund (7 Regional Departments) (+1 Seaman's Sickness Fund)
Hungary	National Health Insurance Fund (HIFA) + network of 19 county HIF offices	Each Fund distributes
Latvia*	State	SCHIA** distributes funds to 8 regional funds
Lithuania	State Social Insurance Council (SODRA)	State Sickness Fund
Poland	16 Regional Sickness Fund + 1 Trade Sickness Fund	Each Fund distributes
Romania	42 District Health Insurance Funds	Each Fund distributes
Slovakia	5 Health Insurance Companies***	Each Fund distributes
Slovenia	National Health Insurance Institute (NHII)	Each Fund distributes
Other candidate countries		
Cyprus	Ministry of Finance	Ministry of Health
Malta	Ministry of Finance	Ministry of Health
Turkey	Ministry of Finance Social Insurance Organization (SSK) Bag-Kur (Self-Employed Fund) Government Employees Retirement Fund (GERF)	Ministry of Health SSK Bag-Kur GERF

Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Estonia (Copenhagen: WHO Regional Office for Europe 2000); WHO, Health Care Systems in Transition. Lithuania (Copenhagen: WHO Regional Office for Europe 2000); WHO, Health Care Systems in Transition. Malta (Copenhagen: WHO Regional Office for Europe 1999); WHO, Health Care Systems in Transition. Turkey (Copenhagen: WHO Regional Office for Europe 1996); Lember 2002; Orosz and Burns 2000; Bara et al. 2002.

NOTES: Latvia: * 1993: 32 territorial sickness funds; 1997: 32 merged into 8 regional (6 are local government; 2 are branches of the SCHIA); ** State Compulsory Health Insurance Agency (SCHIA); Slovakia: ***2 are established by law and solvency guaranteed by state (General Health Insurance Company [VsZP] and the Common Health Insurance Company [SZP] covering army, police and railway employees)

3.2.8 Resource allocation

In many CEE countries the main purchasers of services are insurance funds. However, in some countries regional authorities are also responsible for

purchasing. In some cases, funds are collected and retained by the purchaser in which case there is no allocation mechanism. Where there is pooling either through a central fund or central government, resource allocation mechanisms are used to allocate resources to purchasers.

Several countries – such as Poland and Lithuania– have developed new geographic allocation formulas based on per capita or "demand side" principles relative to older "supply-side" Semashko-driven normatives. One premise of this approach is that it results in reallocation of resources according to population needs, as well as consumer preferences and priorities. In process terms, this involves access to certain technical skills (e.g. public health skills to assess health needs and evaluate outcomes; and access to evidence on the cost and effectiveness of interventions). Often the information and technical expertise required is scarce or non-existent. Estonia is relatively unusual in having public health involvement in the purchasing and supervision of health services. Mechanisms for needs assessment are conspicuously absent from most countries in the region.

The use of risk adjustment in allocating funds can occur on several different basis or combinations thereof. For example, Latvia and Poland allocate funds based on regional divides. In addition to the allocation to regional funds, funds are distributed via capitation based on size and age structure of the population in Latvia (Karaskevica and Tragakes 2001) but via an Equalisation Fund in Poland (McMenamin 2002). The Equalisation Fund in Poland redistributes funds based on age and average income of the population. Romania divides the funds into districts; however, the National Health Insurance Fund can reallocate up to 25% of collected funds to underfunded districts (Bara and van den Heuvel 2002). It seems that the countries other than those listed, do not divide funds geographically. However, demographic characteristics, such as age and sex, are typically the basis on which reallocation occurs. In the Czech Republic, the elderly aged more than 60 years old are allocated funds at three times the standard capitation rate. In Slovakia, the standard characteristics of age and sex structure of the population are used for reallocation of funds. This has resulted in redistribution towards VsZP, the General Health Insurance Company, which covers the majority of the Slovak population (68% of total population), due to the greater proportions of children and elderly covered by this particular fund.

3.2.9 Health Care Expenditure Trends

Whatever role the health system plays in health status, two aspects of health systems with likely implications for health in the candidate countries are clear: resources for healthcare are much lower than those found in the existing EU member states and secondly, that many of the Central and Eastern European candidates faced fairly dramatic resource falls for health in the early 1990s. In terms of the level of resources allocated to health care as part of overall GDP, there is considerable variation amongst the candidate

countries. At the lowest, Romania spends around 2.9% of GDP on health, while at the other end, Malta spends 8.8%[8] (Table 9) (World Health Organisation 2002). With the exception of Malta, which allocates a greater proportion of GDP to health than do the EU countries on average, candidate countries, with the exception of the Baltic states and Romania, Bulgaria and Turkey which allocate very low levels to health, give slightly less of their GDP to health but the gap is very narrow. Although there is a small difference in allocation of GDP to health between candidate countries and EU member states, some candidate countries have made great strides in increasing the health GDP expenditure over the last fifteen years (Cyprus, Lithuania, Malta, Turkey). In other countries, however, the percentage of GDP spent on health diminished between 1995 and 2000 (Bulgaria, Estonia, Hungary, Latvia, Slovakia and Slovenia). However, Kornai and McHale found that there is evidence that of above normal spending in most CEE countries when there is control for income and demographics (Kornai and McHale 2000).

Real per capita health expenditure (from taxation or insurance and direct public expenditure for services) in the candidate countries in 2000 ranged from US$190[9] in Romania to US$1462 in Slovenia. The levels of expenditure in 2000 showed an increase from 1995 (Table 10).

Almost all EU candidate countries exhibit a decreasing trend of public health expenditure. This is due to the increasing expansion of the private sector in most countries. Most countries have public expenditures greater than 75% indicating that roughly 25% of the remaining expenditure is contributed to private expenditure, although informal payments are not accounted for in these figures due to the covert nature of informal payments.

[8] These figures do not include informal payments, thus possibly underestimating the effect of health expenditure.

[9] At international dollar rate ($)

Table 9 Measured National Expenditure on Health selected variables , 1995-2000

Member State	Total expenditure on Health Share in GDP (%)						General Government expenditure on Health Share in Total expenditure on Health (%)						Private expenditure on Health Share in Total expenditure on Health (%)					
	1995	1996	1997	1998	1999	2000	1995	1996	1997	1998	1999	2000	1995	1996	1997	1998	1999	2000
TRANSITION COUNTRIES																		
Bulgaria	4.4	3.8	4.3	4	4.1	3.9	81.9	80.8	81.1	79.4	78.9	77.6	18.1	19.2	18.9	20.6	21.1	22.4
Czech Republic	7.3	7.1	7.1	7.1	7.2	7.2	92.7	92.5	91.7	91.9	91.5	91.4	7.3	7.5	8.3	8.1	8.5	8.6
Estonia	8.6	7.2	6.3	6	6.6	6.1	91.4	89.8	88.5	86.3	80.4	76.7	8.6	10.2	11.5	13.7	19.6	23.3
Hungary	7.5	7.2	7	6.9	6.8	6.8	84	81.6	81.3	79.6	78.2	75.7	16	18.4	18.7	20.4	21.8	24.3
Latvia	6.5	6.3	6.2	6.6	6.4	5.9	65.4	63.1	61.8	61.1	62.9	60	34.6	36.9	38.2	38.9	37.1	40
Lithuania	5.2	5.5	5.9	6.3	6.1	6	86.3	76.9	77.7	76.7	75.1	72.4	13.7	23.1	22.3	23.3	24.9	27.6
Poland	6	6.4	6.1	6.4	6.2	6	72.9	73.4	72	65.4	71.1	69.7	27.1	26.6	28	34.6	28.9	30.3
Romania	2.8	4.5	4	3.5	3.3	2.9	66	72.2	62.9	56.9	59.3	63.8	34	27.8	37.1	43.1	40.7	36.2
Slovakia	7	7.5	6.1	5.9	5.8	5.9	82.1	81.2	91.7	91.6	89.4	89.6	17.9	18.8	8.3	8.4	10.6	10.4
Slovenia	9.1	8.8	8.9	8.7	8.7	8.6	78.1	79.4	79.3	78.7	78.6	78.9	21.9	20.6	20.7	21.3	21.4	21.1
OTHER PRE-ACCESSION COUNTRIES																		
Cyprus	7	7.7	8.2	7.9	7.8	7.9	55.4	52	51.3	53.1	53.3	53.8	44.6	48	48.7	46.9	46.7	46.2
Malta	8.3	8.4	8.6	8.4	8.4	8.8	71.4	70	67.9	69.3	67.5	68.5	28.6	30	32.1	30.7	32.5	31.5
Turkey	3.4	3.9	4.2	4.8	4.9	5	70.3	69.2	71.6	71.9	71.1	71.1	29.7	30.8	28.4	28.1	28.9	28.9

SOURCE: WHO, World Health Report, 2002.

Table 10 Measured National Expenditure on Health selected variables, 1995 – 2000

Member State	Per capita Government expenditure on Health at average exchange rate (US$)						Per capita Government expenditure on Health at International Dollar rate ($)					
	1995	1996	1997	1998	1999	2000	1995	1996	1997	1998	1999	2000
TRANSITION COUNTRIES												
Bulgaria	56	37	43	48	49	46	197	154	165	153	155	154
Czech Republic	340	366	334	360	347	327	836	848	853	867	889	942
Estonia	188	193	179	188	192	167	485	432	427	420	435	426
Hungary	274	261	255	257	256	238	569	548	565	600	618	640
Latvia	75	82	88	100	111	104	203	200	218	241	249	239
Lithuania	72	89	120	140	133	134	239	241	291	324	301	304
Poland	144	175	164	173	177	171	306	344	332	355	397	403
Romania	29	51	40	37	31	31	116	216	162	122	121	121
Slovakia	196	225	211	215	191	188	489	564	558	587	580	618
Slovenia	667	662	643	671	687	621	887	923	991	1010	1076	1154
OTHER PRE-ACCESSION COUNTRIES												
Cyprus	465	474	468	495	493	478	547	575	624	659	689	762
Malta	510	517	507	527	528	553	514	518	502	525	527	550
Turkey	65	78	90	108	98	107	134	162	196	218	208	230

SOURCE: WHO, World Health Report, 2002.

3.2.10 Implementing social health insurance

Contributions for health care in practice are a mix of taxation, social insurance, voluntary insurance and out of pocket payments in most countries, in part because of the failure of social insurance to generate a significant proportion of health care expenditure. There are a number of reasons why this was so (Dixon *et al*. 2002):

Weak macroeconomic context: During the period of transition, all CEE countries underwent some disruption in economic activity, with the GDP of many countries declining in real terms between 1990 and 1997. This decline translated into decreases in real wages, increases in poverty and wider income distributions. The decline of the formal economic eroded the tax base of many countries, while limited tax enforcement capacity further limiting government's ability to collect revenues and finance health care needs. The countries that have been more successful in making the transition to social health insurance contributions (accounting for more than 60% of total expenditure on health) are also those with the highest levels of per capita GDP (Slovenia, Czech Republic, Hungary and Slovakia) (Preker 2002).

Labour market features: High levels of unemployment mean that the proportion of the population in formal employment is low, thus creating a very narrow revenue base from which to draw contributions. The numbers of people in formal employment are low and therefore few employers are required to contribute. Many of those in formal employment are public employees, thus the employer share has to be made by government out of tax revenues. In addition, there are large numbers of self-employed and a large agricultural labour force for whom contribution rates are lower and only levied when a profit is declared (which is not usual), considering 1989 as the baseline, it is apparent that total employment has fallen in all candidate countries. Those countries which exhibited rather high levels of total employment before the transition, Bulgaria, Slovenia, Hungary, Latvia and Poland appear to have lost the greatest proportion of employed. In 2001, Slovakia (18.6%), Poland (17.4%) and Bulgaria (17.3%) have approximately one-fifth of their labour force officially registered as unemployed. Furthermore, as Table 11 shows the size of the shadow economy is significant in all CEE candidate countries ranging from 18.3% of GDP in Slovakia to 39.1% in Estonia in 2000/01. This is also the case with the shadow economy labour force which in 1998/99 ranged between 16.3% of the working age population in Slovakia to 33.4% in Estonia (Schneider 2002).

Low compliance: Compliance has been extremely difficult in part due to some of the features of the labour market mentioned above. The large

informal economy that developed following transition has meant widespread evasion of contributions (and taxes). Corruption in the economy as a whole, and the health care system in particular, may affect the population's ability to pay and undermine public acceptance of social insurance if they are having to back additional informal payments. Low levels of compliance are further exacerbated because there is often no link between contribution and benefit. The historical legacy of the socialist era was that many countries had an enshrined constitutional right to health care for all, which was retained. Consequently, from the outset entitlement to health care benefits under social insurance has been universal and unrelated to contribution status. This contrasts with the gradual expansion of social health insurance in Western Europe during the twentieth century to different population groups as economic development progressed. It is only very recently that France and Belgium have extended the right to health care benefits to all legal residents. Thus, in Eastern Europe there are reduced incentives to contribute whilst at the same time large expenditures for the funds.

Lack of transfers to health insurance: Contributions to the health insurance funds on behalf of the non-working population should in most countries have been made through transfers from other social insurance funds, such as unemployment and pension funds, or from government revenues. However, due to chronic deficits across the social security system, these transfers were in many cases not made and substantial arrears built up. Health insurance funds were often obliged to provide health services to the whole population despite the lack of contributory income. The result was large financial deficits in the health insurance funds.

The sustainability of health care systems in the region depends largely on the ability to generate sufficient revenue. This is a key challenge given the number of contextual and structural problems in the region. However, in order to match funding to benefits and beneficiaries, policymakers must also take decisions about who and what to cover.

Table 11 The Size of the Shadow Economy in CEE Countries

Countries	Size of the Shadow Economy (in % of GDP)				Shadow Economy Labour Force in % of (Working Age) 1) Population, 1998/99
	Physical Input (Electricity) Method		DYMIMIC Method		
	Average 1990-93	Average 1994-95	Average 1990-93	Average 2000/01	
Bulgaria	26.3	32.7	27.1	36.4	30.4
Czech Republic	13.4	14.5	13.1	18.4	12.6
Estonia	33.9	38.5	34.3	39.1	33.4
Hungary	20.7	28.4	22.3	24.4	20.9
Latvia	24.3	34.8	25.7	39.6	29.6
Lithuania	26.0	25.2	26.0	29.4	20.3
Poland	20.3	13.9	22.3	27.4	20.9
Romania	26.0	28.3	27.3	33.4	24.3
Slovakia	14.2	15.2	15.1	18.3	16.3
Slovenia	22.4	23.9	22.9	26.7	21.6
1) Working age population means population between the age of 16 and 65.					

Source: Schneider 2002[10]

3.3 Contracting and purchasing of services

3.3.1 Introduction

This section concentrates on the challenges facing the candidate countries in central and eastern Europe. The systems that they inherited from the communist era had many weaknesses, reflecting a model of care that has long become obsolete. Large hospital facilities were designed for patients with diseases that either resolved spontaneously, were quickly cured by basic treatments or were equally rapidly fatal. Staff with few resources to deploy required only basic training. Nevertheless, under-investment in staff development and appropriate technology meant that many were needed. Primary care was especially weak, serving largely as a funnel for directing the sick to secondary care or as a means of controlling absence from work

[10] Author's calculations using the DYMIMIC method and values using the physical input method.

due to sickness. Patients, used to shortages in every area of their lives, grudgingly accepted unresponsive and poor-quality services as inevitable.

The inherited model in most CEE countries was characterized by an emphasis on supply-side input norms and planning. This was perceived as overly rigid, with structural incentives that encouraged overly expensive specialized care relative to more cost-effective primary and outpatient care. Countries in transition found themselves with too many staff, beds, and facilities(Table 12).

There was a related perception of underpayment to individual physicians and nurses, regardless of specialty (Ensor 1993). As early as 1987, the CEE and FSU countries began testing new organizational and financing models to improve efficiency and assure better funds flows. The "New Economic Mechanism" (NEM), for example, picked a number of geographic demonstration areas and re-organized the polyclinics into family practice groups. The objective was to shift the locus of care to less expensive outpatient and primary services.

Table 12 Measures of Health Care Resources in EU Candidate Countries

	No. doctors/ 100,000 pop	**No. nurses/ 100,000**	**No hosp beds/ 100,000 (2000)**	**Average Length of stay**
Malta	263	-	542	4.63
Slovenia	*215	*693	*555	*7.6
Czech Republic	337	920	855	8.8
Cyprus	***260	***451	***476	-
Slovakia	323	748	797	9.4
Poland	*226	-	*581	-
Bulgaria	337	462	741	-
Hungary	*361	286	841	6.7
Lithuania	380	758	924	8.3
Estonia	322	633	718	7.3
Latvia	320	518	873	-
Romania	189	402	744	-
Turkey	*127	*240	264	*5.4
EU average	387	-	596	**8.2

* 1999 ** 1998 ***1997

Source: All data apart from Cyprus Health For All Database 2002. Cyprus data from WHO EMRO

However, attempts to reduce health care capacity in the CEE region have generally met considerable barriers. While shrinking health care budgets have by necessity reduced hospital capacity to some extent, modern systems that are responsive to health needs have yet to be developed successfully. One characteristic in this regard that is common to many countries of the region is an over-reliance on market mechanisms, especially when it follows or is in conjunction with substantial reductions in funding. The quality of services and infrastructure tends to deteriorate, and hospitals managers turn to deficit financing, focusing solely on survival rather than the implementation of alternative interventions designed to reduce admissions or increase rates of discharge (Healy and McKee 2002). Moreover, the prevalence of multiple funding sources has led to poorly-aligned incentive structures that create behavioural distortions that are very often difficult to correct. When the sources of funding differ, significant coordination is required to ensure that incentives are consistent with reform goals. The lack of an evidence base has also made the process of provider reform difficult, leaving policymakers and health professionals with little guidance from which to draw (Healy and McKee 2002).

Consequently, there has been rather less reduction in hospital capacity or investment in alternative facilities than might have been expected. Many governments, however, have decentralized ownership. As Table 13 shows privatisation has largely been restricted to pharmacies, dental and some primary care pharmacies and dental clinics, with few examples of hospital privatisation despite much political rhetoric. More frequently, hospitals have been transferred from central to local government. This has proceeded in tandem with the introduction of new management structures within hospitals, supported by new information systems and training programmes. Decentralization has made hospital reform more difficult. In any municipality the hospital is a major employer, and doctors and hospital mangers wield more influence over local politicians, making restructuring extremely difficult politically.

Regarding staff, another common characteristic of the region is a substantial imbalance in the number the doctors and nurses, adversely affecting the efficient delivery of care. Moreover, while the exclusion of women from the medical workforce has not been a significant problem, there may still remain a gender gap with regard to the specific roles and status within the professions (Healy and McKee 1997). Not surprisingly, there is a severe need for additional educational opportunities for medical staff, and incentives must be created to ensure that trained staff are not inclined to exit service as a result of the poor working conditions and pay.

At the outset, it is important to recognize that health care delivery takes place within a wider context. In particular, the health needs of the population being served are changing. This has important implications for health care delivery.

Superficially, it may seem easy to describe what has happened to health care delivery systems in this region by looking at the available data on hospitals and other routinely collected statistics. But what is meant by the word "hospital"? Is it somewhere that can provide a wide range of complex and invasive treatments, or is it simply a place where people can rest while they either recover or die. In the Soviet model, hospitals were traditionally required to deal with many social ailments, compensating for the lack of long-term care and an absence of social workers for community outreach, as well as to provide housing of last resort for "social cases" such as the elderly and orphans.

Another commonly used measure is the number of hospital beds. Again, this has very little meaning. A bed is simply an item of furniture. It contributes almost nothing to health care unless it is supported by trained staff and functional equipment and is contained within a coordinated organizational structure. Too many of the hospital beds that are recorded as existing in this region are simply beds. As hospital reimbursement during the communist period was based on the number of beds and the number of staff, it is not surprising that many hospitals established a system of "virtual" beds in order to attract higher allocations from the health budget.

Table 13 Share of Private Health Care Providers in the EU Candidate Countries

Country	**Inpatient Beds (%)**	**Primary-Care Physicians (%)**	**Dentists (%)**	**Pharmacies (%)**
CEE candidate countries				
Bulgaria	~0	Minor	82	70
Czech Republic	9	95	~100	~100
Estonia	10.3	98.3	98.7	99.9
Hungary	~0	76	70	98
Latvia	1.7	N/A	67.3	~100
Lithuania	N/A	7	50	~100
Poland	~0	Minor	~100	93
Romania	~0	Minor	~100	90
Slovakia	~0	98	~100	100
Slovenia	~0	14	37	68
Other candidate countries				
Cyprus	39	58	N/A	N/A
Malta	7.95	N/A	N/A	N/A
Turkey	N/A	N/A	N/A	N/A

Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Czech Republic (Copenhagen: WHO Regional Office for Europe 2000); WHO, Health Care Systems in Transition. Malta (Copenhagen: WHO Regional Office for Europe 1999).

Many countries have sought to develop primary care, with innovative training programmes in medical schools, investment in facilities and new methods of payment. Nevertheless, experience shows that this will require a major shift in medical education, not just the retraining of general practitioners.

Most obviously (although surprisingly frequently overlooked by those who undertake international comparisons of health care expenditures) sicker populations require more health care (Wanless 2002). This highlights the importance of having a health policy that seeks to reduce future demand for care through promotion of health, as well as ensuring that the need for care today is met to the extent possible with the resources available to the health system. However, the main consequence of differing disease patterns is that the types of care provided will also differ. Older populations suffer from chronic conditions and may have more complex disorders, often with multiple disease processes, requiring care from coordinated teams of health professionals with a central role for the primary care physician. Populations that have experienced high rates of smoking have not only high rates of lung cancer and heart disease but are also much less likely to have an uncomplicated recovery from anaesthesia, thus requiring additional post-operative facilities. Populations with low birth rates require fewer obstetric facilities, but those with high rates of teenage pregnancy will have more low-birth-weight babies and so require additional neonatal intensive care facilities. Societies with high rates of violence will require additional trauma facilities.

In theory there are two main models of purchasing: integrated models (under which the providers are owned and managed by the insurer) and contract models (under which the providers are separate from the insurer). Many countries have been moving from integrated command and control models of publicly operated provision toward one or another new form of "purchasing" in which public, or quasi-public, third-party payers are kept more organizationally separate from health service providers. The CEE candidate countries have all implemented contract models whereas the Mediterranean candidate countries still maintain the integrated model. Malta has announced, as of July 2001, of the transformation towards a contract model and will begin the gradual implementation in public hospitals.

The rationale for this "purchaser-provider split" model has been to (Figueras *et al.* 2001):

- improve services by linking plans and priorities to resource allocation, for instance, to shift resources to more cost-effective interventions and across care boundaries (e.g. from inpatient to outpatient care). Purchasing, in this sense can be regarded as an alternative way to do some of the things that have been traditionally pursued via planning;
- better meet population health needs and consumer expectations by building them into purchasing decisions;

- improve providers' performance by giving purchasers policy levers, such as contracting or financial incentives or monitoring tools, that can be used to increase provider responsiveness and efficiency;
- facilitate decentralization of management and the devolution of decision-making by allowing providers to focus on the efficient production of services as determined by the purchaser;
- introduce competition or contestability among providers and thereby use market mechanisms to increase efficiency.

In several European countries alongside the shift to contracting has been a shift away from historical or norm based budgeting to activity- or performance-related pay. The new forms of provider payment are intended to increase productivity and efficiency and ensure the high quality of services provided. However, they rely on good information systems and may be costlier to administer.

In the following sections we review the experience of financing health care in CEE over the past ten years, describing what has happened and offering some analysis of the implementation process.

3.3.2 Contracting mechanisms

Concurrent with the shift to social health insurance in CEE, contracts are increasingly used as a new model of relationships between purchasers and providers. Currently, there is no comprehensive account of contracting and existing evidence on its impact in Europe (Duran *et al.* 2003). CEE countries have tended to use "soft" agreements, rather than selective provider contracts that contain full accountability. Nevertheless, many countries continue to push for contracting that is more performance-based, as in Romania with primary care physicians (Vladescu and Radulescu 2001).

One disappointment to date has been the lack of selective contracting from among both public and private sector providers. Furthermore, the low payment rates discourage providers from seeking contracts, as in Poland. Whether purchaser or provider-driven, this has prevented competition or contestability among providers and thereby not fully utilized possible market mechanisms to increase efficiency.

Contracting for services in CEE countries has been challenging for a number of reasons (Dixon *et al.* 2002).

- *Inadequacy and low predictability of funding:* Since contracts express a clear-cut commitment of a purchaser to reimburse the cost of provided services (contracts in many CEE countries are regulated by the Civil Code and therefore legally binding), attempts to start contracting require a realistic evaluation of available funding. Insurers simply cannot pay all

providers' bills. Debt increases, payment rates must be adjusted downward, and providers lose interest in volume and quality contractual provisions.

- *Low operational autonomy of providers:* To act as contracting parties, providers must have flexibility to respond to purchasers' demands and, in particular, be able to increase or decrease capacity, acquire and dispose of excessive capacity, borrow money within limits, take financial responsibility for the performance, etc. The trend has been to provide facilities with greater rights and responsibilities (Preker and Harding 2001). The Baltic States have restructured state owned polyclinics into freestanding practices and independent contractors. State-owned hospitals have gained the status of public non-profit organizations with new contracting rights and responsibilities - in Bulgaria, Czech Republic, Estonia, Latvia, and Lithuania.
- *Lack of timely information and routine information systems:* In both Eastern and Western Europe, contracting is limited by insufficient information. The minimum information requirements for effective contracting cover patient flow data, cost and utilization information across specialties or diagnostic groups, and demographic and risk groups. Large investments are often required for information systems, including the capacity to process contracts and monitor outcomes.
- *Technical capacity and management skills:* Contracting requires particular skills (e.g. identifying cost-effective medical interventions, negotiating and monitoring providers' performance and communication strategy) that are not needed under direct public service provision. The corresponding capacity building exercise has been patchy and discontinuous. Other than some examples in Eastern Europe such as Budapest and Krakow, there are few health system management schools in CEE.

3.3.3. Provider payment systems

With the former Semashko model, the line item budgeting system was used in all countries. Line item budgeting meant that allocation primarily reflected historical budgets plus some inflation factor; there was limited or no reallocation across categories, or from year to year; and, under difficult economic constraints, salaries, food and medicines took priority. Many countries have adopted new provider payment mechanisms.

Health Insurance Funds and even Ministries of Health now more typically use "performance-based" systems to pay for services. For primary care services, some variant of capitation is used is all CEE countries. In Estonia, Latvia, Lithuania and Poland capitation payments are age-weighted. In Poland, the age adjusters place more weight on younger and older patients. The rates differ not only between sickness funds, but between physicians contracting within the same fund as well. To help damper incentives for specialists referrals, some sickness funds require primary health care to

subsidize specialist care services. In these cases, GPs are extremely reluctant to make referrals to specialists. Conversely, GPs who cover only their own costs do have a tendency to make relatively large numbers of specialist and hospital referrals (Golinowksa 2003).

In Slovakia, while general practitioners are paid under a capitation system, specialists are paid under a fee system, although insurers have restricted the number of patients per specialist, effectively creating waiting lists. Capitation rates are established by the Ministry of Health, and rates differ between children/adolescents and adults/gynaecological care. Currently, there are no differences based upon age or region, and insurers do not differ in their payment rates. Physicians have a tendency to over-refer patients (Vagac and Haulikova 2003).

Payment can go to the physician directly. Some of these models extend the traditional mix or services (e.g. minor surgeries) or "carve out" priority services such as immunizations and pay fee-for-service (FFS) for these services (Romania, Estonia), or pay a bonus for rural placement (Estonia and Lithuania).

For different age groups are used to adjust capitation payments in Lithuania. There is some evidence in that country that the capitation model has led to an increase in the number of referrals to specialists and hospitals. Outpatient specialist care in Lithuania is paid according to the consultation, however the insurance system restricts the number of services provided to prevent induced demand for additional consultations (Dobravolskas and Huivydas 2003). In the Czech Republic, primary care physicians were entitled to a cost-containment bonus. In Bulgaria, additional payments were made for unattractive working conditions and for the primary care physicians role in the management of health priorities. This fee-for-service and bonus add-on to the capitation model is important as some capitation models have been shown to decrease utilization of preventive services. In Bulgaria, the additional payment made to physicians' capitation rate was deemed to be responsible for approximately 600,000 residents of distant geographic regions receiving direct access to medical care for the first time (Noncheva and Satcheva 2003).

In Cyprus and Malta primary care doctors are paid on a fee-for-service basis whereas I Turkey they are salaried. Specialists working at ambulatory settings are paid on fee-for-service in most countries (Table 14)

In general, pharmacists' mark-ups are a percentage of wholesale prices. Margins are regressive in Hungary (16% mark-up for the highest wholesale price and 30% for the cheapest), Poland (12%-40%), Lithuania (12%-32% for non-reimbursed drugs), Latvia (20%-38%) and Bulgaria (20%-33% with a maximum of 30BGL for most expensive drugs). Malta (20%) and Cyprus (30%) apply fixed margins, while in Czech Republic the average

pharmacists' mark-up is 22% of ex-manufacturer prices. In Slovenia pharmacy margin is between 8-9%, but pharmacists are also paid for pharmaceutical services on a fee-for-service basis. Generic substitution is allowed in the Czech Republic (when an original product is not available), Hungary (unless doctor explicitly asks for a patented product) and Poland. In Lithuania, the use of generics is encouraged through the reference price system. Pharmacists must dispense the cheapest drug in Romania (when doctors specify generic name on prescriptions) and in Poland.

For policies to encourage the use of generics to be successful, it is important that pharmacists are reimbursed in such a way as to not discourage them from dispensing the least expensive product. Fixed margins do no provide an incentive for pharmacists to dispense generic medicines. This is due to the pharmacist receiving the same reimbursement for dispensing a original drug as for dispensing a generic drug.

In countries where pharmacists are reimbursed based on a percentage of the dispensing price, there is also a disincentive to dispense generics. Because generic prices are lower than those of originator drugs, the percentage which the pharmacist receives when a generic is dispensed is also lower.

Hospital payment mechanisms are also important target for reform. Inpatient services in Slovakia, for example, are considered oversupplied and poorly structured, and reimbursement is currently under a prospective budget system based upon historical costs. However, the system has changed frequently in the past. Within hospitals, management tends to be poor and a dearth of information on inputs, costs and outcomes has prevented the efficient allocation of resources. On a system-level, there are few initiatives for management improvements, and no hospitals have been closed nor have directors been removed for mismanagement. Staff levels have not been substantially reduced and the private sector has yet to play a significant role in the provision of inpatient care. While budgets are set prospectively, the reliance upon historical costs have eliminated incentives for management or efficiency improvements (Vagac and Haulikova 2003).

However, many countries are developing new hospital payment systems which pay for a defined unit of hospital output. The most popular approaches in the early years of transition were the per diem and per case-based payment systems. Per diem and simple per case were most often developed both because they required little data or capacity to design and implement, but also these were seen as methods to promote greater productivity by providers and also generate increased revenues to providers. Individual countries started at different levels of expertise and interest, and have progressed differently. However most combined different levels of per diem and simple case-mix (e.g. department of facility) measures, and typically included only recurrent costs not capital costs or depreciation.

Nevertheless, these steps serve as a developmental framework for examining these countries in terms of alternative hospital payment models.

In Lithuania, the per case hospital payment system has led to incentives to increase productivity as measured by length of stay, however the number of admissions has increased significantly. In 1990, the average length of stay was approximately 20 and this decreased to approximately 11.2 by year 2000. The number of admissions per 100 of the population was observed to be approximately 17 in 1990, however this figure jumped to approximately 24 by year 2000. The per case payment in Lithuania is determined by the Ministry of Health, and adjusted upward for university hospitals (Dobravolskas and Huivydas 2003) .

There has also been considerable enthusiasm for systems based on diagnosis related groups (DRGs). Two issues arise, the first being the law of unintended consequences. In Hungary, for example, the introduction of a DRG-based system led (as expected) to a reduction in length of stay, but also to a rise in the number of admissions as hospitals compensated for the lower payments they were receiving for each admission (Orosz and Hollo 1999). In several countries, reductions in payments for ambulatory care have led to higher rates of hospital admission.

In Romania, hospitals payments have been a topic of substantial reform. In 2001, a new financing scheme was implemented and 23 hospitals begun establishing codes and administrative processes to receive reimbursement under a DRG system. While difficulties regarding the application and administration of the new system are significant, initial results of the system indicate that extending the DRG scheme to other acute hospitals would be favorable (Mihai 2003). Moreover, the Romanian government has approved a plan to assess possibilities for full and partial privatisation of some hospitals. This plan has prompted additional assessments of hospital efficiency and operations.

Providers have responded to these incentives. These per diem and case-mix systems have driven up volume of cases admitted and put fiscal pressures on the purchasing organization (e.g. Hungary and Czech Republic). Decreasing numbers of beds and lowered average lengths of stay were offset by increasing admissions in the 1990s – a trend that started in the mid 1990s in Eastern Europe, and the late 1990s in former Soviet countries when these began utilizing new payment methods. Most purchasers have had little capacity or experience of quality assurance or administrative mechanisms to stem the rapid increases in volume driven by the underlying incentives.

In Poland, payment incentives have led hospitals to engage in strategic behaviour. Payments are made on a per-admission basis, with adjustments for time and ward type, but interestingly, not diagnosis. Sickness funds have not followed through on restrictions relating to the number of admissions, allowing hospitals to increase admission rates while also strategically admitting patients to more profitable wards. This has also led to an under-utilisation of outpatient services, despite being more appropriate in many cases. Polish hospitals are also likely to have substantial intensive care and long-term care wards, as these are reimbursed on a per person, per day basis. Bed occupancy rates are higher in these wards, and there is a clear incentive for extending lengths of stay (Golinowksa 2003).

Table 14 Provider Payment Systems in EU Candidate Countries

Country	**Primary Care (General Practitioners)**	**Outpatient (Specialist) Care**
Bulgaria	Capitation + additional payment for unattractive conditions and management of health priorities	Visit Fee for primary and secondary examinations Service Fee for diagnosis services
Czech Republic	Capitation + cost-containment bonus	Fee for Service (FFS) with overall time limit applied to volume of invoiced services
Estonia	Age-weighted Capitation & FFS	
Hungary	Capitation	FFS with national cap
Latvia	Age-weighted Capitation	
Lithuania	Age-weighted Capitation + rural/urban adjustment	Age-weighted Capitation + rural/urban adjustment
Poland	Age-weighted Capitation	FFS with national cap
Romania	Weighted Capitation + FFS	FFS
Slovakia	Capitation	FFS with national cap
Slovenia	Capitation and FFS with a national cap	FFS
Cyprus	FFS	FFS
Malta	Public: Salary Private: FFS	Public: Salary Private: FFS
Turkey	Salary	N/A

Sources: Authors' estimates, 2003; WHO, Health Care Systems in Transition. Malta (Copenhagen: WHO Regional Office for Europe 1999); WHO, Health Care Systems in Transition. Slovakia (Copenhagen: WHO Regional Office for Europe 2000)

A number of countries in Eastern Europe are now shifting policy objectives, from revenue enhancement and increasing provider income, to

goals more related to cost containment and efficiency. With this shift, hospital global budgets and capitation are emerging as the "next generation" of payment incentives beyond per diem and per case systems. Global budgets are being developed in seven of the countries for which information is available and already exists in five others**,** with capitation pilots in a number of countries such as Hungary and Poland (Langenbrunner and Wiley 2002). Some countries (e.g. Hungary) face fiscal pressures such that they cannot wait for sophisticated risk-adjusted payment cap systems, and instead sub-sectors (e.g. primary care, outpatient care, hospital care) are being capped at a national level as a first step to stopping the current haemorrhaging of expenditures. A summary of countries and hospital payment systems is provided in Table 15.

Table 15 CEE Countries: hospital payment systems

Country	**Line Item**	**Per Diem**	**Per Case**	**Global Budget**
Bulgaria			X	Developing
Czech Rep			X	X
Estonia		X	Developing	
Hungary			X	
Latvia		X	Developing	
Lithuania			X	
Poland			X	
Romania			X	X
Slovakia		X		
Slovenia		X		
Turkey	X			

Source: Dixon A., et al., 2002

While the number and types of new payment systems in the region is a clear change over the last decade, results have been mixed to date, due to a number of issues in the region discussed above as well as other specific issues that await future policy leadership, including (Dixon *et al.* 2002):

- *Fragmented public sector pooling and purchasing:* The scope for payment incentives changing behaviour is limited by disintegration of health finance pooling. Newly emerging insurance systems have often co-existed with the old financing mechanisms through direct (non-contractual) allocation of Government resources to providers. In many CEE countries, there have become too many actors allocating funds (insurance, central and local treasuries and health authorities, sometimes commercial insurers), each trying to control its portion of the money.
- There are successes. In the Baltic States, Czech Republic, Hungary, Slovakia, and Slovenia, insurers control most (>70%) of public funds. Purchasing is increasingly integrated, which facilitates financial

planning and planning of medical services delivery (both strategic and operational) with the focus on efficiency gain and predictability of flows of funds.

- Related, increasing out-of-pocket payments in many CEE countries, discussed above, further disintegrate the pooling through public channels. Out-of-pocket payments can further influence patient episode and treatment choice as patients tend to make larger payments for riskier interventions such as surgery (Lewis 2000; Orosz and Hollo 1999).
- *Poor complementarity of design:* Payment reforms across settings often do not complement one another, hurting allocative efficiency. Similarly, closed sub-budgets (of the primary care, outpatient specialized care and in-patient care) now being applied are important tools for cost-containment, but will these generate adverse incentives for purchasers? Are patients being "dumped" form other sub-sectors? Are there adequate risk sharing mechanisms? And if not, will this cap only result in a complete shift of all risk onto the providers, which is both inequitable and inefficient?
- *Institutional impediments:* New pilots and payment programs are often blocked by legal or administrative impediments, such as civil service reform. And, there are significant vested interests concerned with preserving the current system, particularly in those areas that could lose from change, to be overcome.
- *Deficits:* In the early 1990s in Eastern Europe, public providers became indebted to their suppliers, and often appealed to the Government for subsidies or bailouts. In many of the former Soviet republics, debt has been almost constant, such that much spending occurs not on a cash basis but through a process of mutual debt settlement. A facility wishing to use part of its budget for, say, building maintenance, must first find a contractor with an outstanding debt with the local administration or insurance fund (depending on the source of funding). This debt is then cancelled or reduced in return for repairs to the building to an agreed value. If a debtor cannot be found for the service or commodity required, a facility may be tempted to obtain some other commodity just to ensure that the budget gets spent. The mutual debt settlement system helps to ensure that services can be provided even in cash-less circumstances, but does lead to sub-optimal allocation decisions and is administratively costly to operate (Ensor and Langenbrunner 2002).
- *Monitoring and quality:* Each payment system design brings with it unintended consequences and opportunities for changing levels of quality of care, both better and worse. The monitoring capabilities by the purchaser are, however, too often underdeveloped. Future directions for purchasers in the region should include providing supports to ensure that quality is safeguarded and optimised.

3.4. Pharmaceutical policies

Pharmaceutical policies in the thirteen EU candidate countries are an amalgam of different approaches, institutional structures and levels of development, as countries have organised their pharmaceutical sector in different ways. Even so, as the countries of the former Soviet block have to share some characteristics for historical reasons and face similar problems, it might be useful to look at these ten candidates as one large group. On the other hand, the three Mediterranean candidates – Turkey, Cyprus and Malta – are different in all aspects and therefore cannot be grouped together.

The Baltic states and the countries of Central and Eastern Europe have had to rethink and reform their health care policies as part of the general restructuring of their states after the fall of communist regimes. For the pharmaceutical sectors this meant radical changes as the centralised systems, state monopolies (of production, distribution and retail) and imports from the former Soviet Union have been replaced by market economies, privatisation and Western products.

3.4.1 Privatisation and market liberalisation

Following the privatisation of the pharmaceutical industry, drug companies and wholesale networks are in the hands of entrepreneurs and operate according to commercial strategies and methods. In Hungary, 6 out of 7 Hungarian drug companies were owned by multinationals in 1997 and more than 90% of wholesale trade is held by 5 private companies and one public company. Privatisation also has led to a growth in importers, distributors and pharmacies: in 1993 there were 500 public pharmacies in Slovakia, in 1999 there were 1045 - while in Bulgaria around 300 private importers and distributors were registered in 1997. The transition to market economies brought with it the liberalisation of markets and imports. The Baltic and Central and Eastern European countries can no longer rely on cheap Soviet imports, partly because these do not meet European pharmaceutical standards. On the other hand, markets have been opened up to pharmaceuticals imported from Western Europe. This has improved supplies of drugs and shortages are generally no longer a problem. However, it has also led to significant price increases.

3.4.2 Rising drug prices and costs

Most, if not all, of the countries have witnessed an escalation of drug prices and the consequent increase in pharmaceutical spending as a proportion of total health care expenditure.[11] In Slovakia, 16.8% of total health care

[11] This is also due to the fact that other components of total health care expenditure such as salaries remain relatively low whereas pharmaceutical expenditure represents a larger portion of low health budgets.

expenditure was spend on drugs in 1990, while this amount fluctuated between 28% - 30.1% from 1993 to 1998 (Hlavacka *et al.* 2000). Romania is an interesting example as the absolute level of drug use is low, yet the proportion spent on pharmaceuticals accounted for 20% of total health care expenditure in 1998 (Vladescu et al. 2000). Hungary might have experienced the most dramatic escalation with pharmaceuticals representing 28.5% of total health care expenditure in 1996 (Gaal *et al.* 1999). In Estonia, the actual expenditure on drugs in 2001 was approximately 33% higher than expected. Such large expenditure increases in that country have corresponded with increases in pharmacy sales, which grew by 24% in 2000 totalling 3.4 million prescriptions (Leppik 2003). Between 1999-2001, spending by sickness funds on drugs in Poland increased by approximately 57%, although changes made in 2002 to the list of refundable medicines is expected to help control this rapid rise in costs (Golinowksa 2003). Lithuania might have been the largest 'spender' on drugs: as much as 37% of total health care expenditure went to pharmaceuticals in 1996.

As a result, cost-containment has become a major challenge and priority for governments as they wish to bring pharmaceutical expenses under control. Various measures have been introduced, with limited success, such as 'selective' reimbursement with reference prices and co-payments; practice guidelines, prescribing monitoring and budgets (which are less common) to encourage cost-conscious prescribing and the promotion of generics products. These will be looked at in detail in the sections on reimbursement and prescribing controls which follow.

3.4.3 Pricing decisions

In most countries, pricing is the responsibility of the Ministry of Health (MoH), but the pricing methods which are applied in the 13 countries differ and it is difficult to group the various approaches. Yet some pattern can be found among the methods.

Some countries determine prices by fixing maximum wholesale and retail margins which are added on to the ex-manufacturer prices. This is the method used in Hungary, Lithuania and Estonia. In Malta pricing is 'free' as profit margins are regulated. The Czech Republic applies stricter controls as the Ministry of Finance (MoF) sets the maximum market prices, reference prices and the combined maximum margins for wholesalers and retailers (Busse 2000). Romania and Slovenia take into account the drug prices in 3 foreign countries with Romania selecting the lowest of these and Slovenia calculating the average price, while the Czech Republic and Latvia also make comparisons with drug prices abroad. In Poland (for imports) and Latvia (for drugs on the positive list), prices are negotiated between state

agencies and manufacturers. In Bulgaria, pricing decisions are taken either by the National Health Insurance Fund or by the MoH.

Some countries make a distinction when pricing between imports and locally produced drugs (such as Poland and Cyprus) or between reimbursed and non-reimbursed drugs (e.g. Latvia and Poland). The Agency for Medicinal Products (a department of MoH) is responsible for the pricing of all pharmaceuticals in Slovenia, but rapid price increases meant that the government intervened in 1995 by controlling prices.

3.4.4 Reimbursement decisions

The three Baltic states and seven Central and Eastern European countries as well as Cyprus, all have public reimbursement systems in place, even though the manner in which the systems are organised varies from country to country. In Malta, on the other hand, drugs are either provided free of charge or are paid for entirely by the patients.

While many countries divide their reimbursement system into 3 categories or reimbursement levels, there are different ways of defining these groups or levels. The Czech Republic and Slovakia divide pharmaceuticals into 3 reimbursement groups (fully, partly, or not reimbursed), Latvia groups diseases into 3 categories (100% compensation for the most serious, 70% and 50% for the less serious), while Cyprus classifies people according to 3 reimbursement levels: those entitled to free health care, those entitled to 50% reimbursement, and those not entitled to reimbursement. Bulgaria has 3 more unusual categories: pharmaceuticals which are fully covered by the national budget, drugs which are partially covered by the health insurance, and medicines covered by the MoH for veterans. Hungary applies a 'combined' system with 50% or 70% reimbursement for most diseases, but 90% or 100% reimbursement for people on public assistance and those with serious diseases. In Poland the type of drug and the type of patient are considered. While reimbursement in Slovenia normally is at 75% or 25% of the retail price, specific groups of people (e.g. children, students or seriously ill) are by law fully covered by compulsory health insurance. In October 2002, the reimbursement structure in Estonia was amended to create four categories based on type of disease and type of patients. In general, co-payment is expected for all purchased pharmaceuticals, but the share which is reimbursed varies from 50% to 100%, with disabled persons and those over the age of 63 receiving 90% reimbursement for all drugs. Since January 1 2003, the reimbursement scheme also includes a capped 'stop loss' measure, paying up to three-quarters of all drug costs for patients who have exceptionally high out-of-pocket drug costs over the course of one year.

In some countries additional conditions apply if pharmaceuticals are to be reimbursed. In Hungary if a new drug is considered to be too expensive, the

expert committee which determines reimbursement levels can require that a particular specialist prescribes the drug if it is to be reimbursed. Furthermore, people who suffer from severe chronic diseases, must have their drugs prescribed by specialists in order to benefit from 90% or 100% refund, while the 'socially deprived' must get their prescriptions from their family doctor and drugs must be dispensed from specially registered pharmacies if they are to benefit from the 100% reimbursement. In Czech Republic specific conditions for reimbursement are defined by law, and include the diagnosis of the patient, the specialisation of the prescribing doctor or the need for approval by a review doctor.

All EU candidate countries are concerned with ensuring that the more vulnerable members of society have their pharmaceutical expenses covered, as levels of reimbursement are higher:

- for those suffering from serious/ chronic/ 'high cost' diseases[12] and
- for vulnerable social groups[13] (such as the disabled, those with mental disorders, pensioners, the unemployed, low income persons and families, children, students, pregnant women, war veterans and prisoners).

Somewhat oddly, the President of the Republic, ministers and MPs receive drugs free of charge in Cyprus. In Malta, while there is no reimbursement systey in place, drugs are provided free-of-charge to people under a certain income level and certain population groups (Pink Card holders) and to people suffering from serious diseases.

The categories which consist of drugs which are fully or partially reimbursed are often considered as positive lists. In some countries partially or less refunded drugs are on the 'supplementary' list (e.g. in Poland) and on the 'intermediate' list (e.g. in Slovenia). Lithuania has two positive lists, one with the reimbursed drugs for specific diseases, and one with drugs for specified social groups. Romania has a positive list divided into two: one list with 100% reimbursed generic substances for 26 diseases, and one with generic substances for which 70% of reference price is refunded. Negative lists, including products which are not reimbursed, exist in Slovenia. Poland has a notional list for non-reimbursed drugs, and all social insurance organisations in Turkey have negative lists.

The criteria which influence the decision on whether or not to include a drug in the national reimbursement system are comparable, as all countries seem to take quality/ efficacy and costs into consideration. While drugs in Estonia have to be "medically effective and economically reasonable", drugs in Latvia have to go through therapeutic and economic evaluation,

[12] This is the case in Hungary, Poland, Lithuania, Estonia, Latvia, Slovenia, Romania, Bulgaria.

[13] This is the case in Hungary, Poland, Lithuania, Estonia, Slovenia, Bulgaria, Cyprus.

which are similar to Lithuanian criteria which in addition become stricter for the more expensive drugs. In autumn 2002, the Baltic states agreed on common guidelines to evaluate the cost-effectiveness of pharmaceuticals. All three countries have decided to use such analyses as the basis for drug reimbursement decisions. The common principles will enable cooperation between state institutions in the evaluation of applications, and harmonised requirements will facilitate and simplify the application process for applicants. In Hungary, drugs must meet criteria of quality and efficacy as well as cost-containment if it is to be placed on the positive list. Efficacy, safety and cost are considered in Cyprus. In Poland drugs must be inexpensive, known by doctors, essential for treatment, and go through a test-year, but there are problems with the transparency of criteria and discrimination against foreign drugs. In many countries, however, the criteria are not clearly stated (e.g. in Romania, the health insurance law does not specify any details on how the positive list is to be compiled).

All the Central and Eastern European candidate countries and Lithuania, have introduced reference-pricing systems, often as part of an effort to reduce reimbursement costs. However, it is not known whether the reference price system had an impact on pharmaceutical expenditure. The three Mediterranean countries do not apply reference prices.

3.4.5 Co-payments

Co-payments appear to be growing in many countries. In Slovenia, co-payments have increased since 1997 when a number of drugs were removed from the positive list, while drugs were added to the intermediate list. Out-of-pocket payments on drugs also remain significant in Bulgaria and Lithuania. However, as discussed in the section on informal payments above, in many EU candidate countries informal and direct payments constitute a significant part of pharmaceutical expenditure.

3.4.6 Prescribing controls

Prescribing controls can be considered a direct consequence of the high pharmaceutical costs which most, if not all, the countries have experienced. Considering how problematic escalating pharmaceutical expenditure, economic constraints, over-spending and over-prescribing (which might be a ‘leftover’ from the socialist past of CEE and Baltic health care systems) are for many countries, it appears that not enough is done to contain costs. Some form of prescribing controls and cost-containment measures are in place in nearly all the countries, and in Malta where they are not, authorities seem acutely aware of the need to influence prescribing practices. In addition, among the countries where measures are in place, there is an awareness that more could and should be done to control costs.

In Hungary, despite serious overspending and over-prescribing, there are few control mechanisms, no financial incentives for doctors to limit costs, but there is a computerised system which monitors prescriptions. In Lithuania, although pharmaceutical expenditure is high, there are no measures to monitor, inform, or rationalise drug consumption. In Estonia economic constraints make it necessary to promote cost-conscious prescribing, yet until now only some practice guidelines have been put in place, with no financial incentives. In Romania rational prescribing is not yet legally required, cost-containment measures have been introduced on an ad hoc basis and there is no formal national medicines policy. In Turkey unsuccessful attempts have been made to encourage the prescribing of generics. Finally, in Malta there are no measures to monitor, control or analyse prescribing, or to encourage cost-effective treatments (only a strict procedure for authorisation of non-formulary drugs).

In Cyprus a drug formulary and practice guidelines exist and doctors must prescribe according to both. However, there are no monitoring systems to evaluate prescribing patterns. In the Czech Republic prescribing guidelines are in place (but only few on cost-effective prescribing), yet the General Health Insurance Fund has introduced guidelines for prescribing expensive drugs and plans to introduce negative practices (recommending what should not be prescribed). In Slovakia the Ministry of Health has issued recommended procedures which doctors must follow but these are rarely respected. In Bulgaria prescribing guidelines for GPs and formularies for clinical diagnosis are in place but are not respected by doctors. This is also the case in Estonia. In Poland there are plans to introduce a computerised database on prescribing behaviour and costs. Data will be fed back to doctors, and it would make prescription budgets for doctors possible. Information for patients and professionals about medicines is also planned.

Four of the thirteen candidate countries seem to apply more effective and better organised measures of cost-containment and control. In Latvia, for example, primary care doctors have to remain within their budgets and therefore, have a strong incentive to limit costs by prescribing generics. In the Czech Republic, the health insurance funds set spending limits for pharmaceuticals for each health care provider and penalise in case of over-spending, defined as 20% above the average or an annual increase in drug costs. In Poland several demand and supply side measures have been applied, as only the cost of the cheapest drugs are reimbursed by the state, pharmacists being required to dispense the cheapest pharmaceuticals, and guidelines on cost-effective prescribing being published regularly in bulletins together with reimbursement regulations.

Finally, Slovenia appears to have the most advanced system of monitoring and controlling prescribing patterns, and there are plans to introduce new measures, including an electronic database of medicinal products.

3.5 Mental health policies and the health of minorities

3.5.1 Mental Health Policies in EU Candidate Countries

Mental health illnesses are some of the most significant components of the global disease burden. In addition to being leading causes of disability, mental health disorders adversely impact economies and social structures, particularly amongst nations in the midst of major political and socio-economic transitions. Countries in central and eastern Europe face considerable challenges, particularly since the incidence of mental illness in this region has not been matched with many of the reforms in treatment and rehabilitation that have been observed in the west.

The overall burden of disease in the former socialist countries due to neuropsychiatric disorders is estimated at 17.2% (DALYs), the second highest ranking after established market economies (25.1%) (Jenkins *et al.* 2001) and notably higher than the world average (12.3%) (World Health Organization 2001). Whilst these rankings suggest that the prevalence of mental health illness is comparable to that found in western Europe and other developed countries, there is a general consensus that developments in both the treatment of mentally ill patients and the organisation of mental health services in eastern Europe has not kept up with reform measures that had been adopted in the west to improve conditions in mental health care (Roberts 2002; Van Voren and Whiteford 2000).

This is largely due to the historical legacy of eastern European countries where mental health care was not considered to be a high resource priority in health system funding and was characterised by large institutions in the form of psychiatric hospitals or asylums, a custodial rather than therapeutic attitude to patient care, and a reliance on pharmacological interventions. The hierarchical systems of central planning made critiques of established practices and procedures difficult, and limited the ability of mental health institutions to react to both developments in the field as well as environmental challenges (Tomov 2001). Moreover, for several decades psychiatry in the states of the former Soviet Union and Eastern Europe was isolated from western developments and from its evidence base in journals, conferences, and other modes of information exchange.

To a large extent, many of these features still characterise the mental health care systems in the region. The WHO report on mental health has identified several system and policy-level barriers to the implementation of effective interventions for mental disorders (Table 16).

Table 16 Barriers to implementation of effective interventions for mental disorders

Policy Level	Health System Level
Limited mental health budgets – not meeting the extent of mental health prevalence	Large Tertiary Institutions
Mental health policy inadequate or absent	Stigmatisation, poor hospital conditions, human rights violations and high costs
Mental health legislation inadequate or absent	Inadequate treatment and care
Health insurance that discriminates against persons with mental behavioural problems (e.g. Co-payments)	Primary health care
	Lack of awareness, skills, training and supervision for mental health
	Poorly developed infrastructure
	Community mental health services
	Lack of services, insufficient resources
	Human Resources
	Lack of specialists and general health workers with knowledge and skills to manage disorders across all levels of care
	Psychotropic drugs
	Inadequate supply and distribution of psychotropic drugs across all levels of care
	Coordination of services
	Poor coordination between services including non-health sectors

Source: Adapted from WHO (2001) (World Health Organization 2001)

Whilst it is difficult to generalise about all eastern European countries, the persistence of some commonly shared characteristics demonstrates that there are several challenges still facing mental health reform.

As with many countries in the world, mental health services in the region are poorly resourced making the successful implementation of reform even more difficult. EU candidate countries have a per capita health expenditure that is only one-fifth that of EU countries (Jenkins *et al.* 2001). Moreover, there are few mental health economic studies in psychiatry for the region (Shah 2000). The subsequent lack of adequate economic evaluations of resource allocation formulas may hamper the cost-effective use of the few mental health resources that are available.

Funding is likely to move away from a current reliance on external donors (e.g. Open Society Institute) and become increasingly dependent on local sources, either government-based through state budgets or health insurance

sources or from the private sector, through growing numbers of local foundations and charities (Van Voren and Whiteford 2000). However, the high level of co-payments paid directly by patients for medical services, including mental health care, seems likely to continue. Moreover, the downward pressure on state funding for mental health care and the decentralization of mental health financing (e.g. insurance funds on the municipal government level) may threaten both the availability of resources in the long-term and the delivery of care (Balicki *et al.* 2000).

Few countries in the region have produced detailed mental health strategies as opposed to broad policies. In one case, after years of pressure from the psychiatric association, the Bulgarian government has approved a mental health policy document that includes priorities and time frames but it specifies no mechanisms for moving from institutional to community care. In Malta, a mental health policy document detailing the importance of both a multidisciplinary treatment approach and shift to community based care has been approved by the Cabinet, however improvements have proceeded quite slowly (Muscat 1999). Although a mental health policy and national program have existed in Turkey for several years, there is no national legislation on mental illness (World Health Organization 2000a). One consequence of the heavily institutionalised environment is that patients continue to be recipients of care that is custodial rather than therapeutic in nature. This is accompanied by attitudes of dependence in both staff and patients, fostering behavioural patterns that maintain a large gap between the two, and also has hindered the development of user-groups able to advocate improvements (Jenkins *et al.* 2001).

The development of mental health reform strategies has also been hampered by the lack of adequate epidemiological studies that assess true service "needs" based on actual levels of disease, severity, disability, and risk. Consequently, governments may rely on service use or "supply" data as a proxy for actual health care needs, thereby making the need for reform less apparent (Jenkins *et al.* 2001). Of course, public interest and attitudes can have a significant impact on the progress of reforms. Research in Poland completed in 1996 found that over 70% of survey respondents observed individuals with mental health disorders being disparaged by the use of terms such as crazy, idiot or abnormal. The same study performed three years later, found statistically negligible changes in results (Czabala *et al.* 2000).

Moreover, the generally poor conditions within mental hospitals and care homes have given rise to concerns about protecting the human rights of institutional residents. For example, the violation of rights documented from 52 care homes in Hungary in 2001 included the restriction of patients' movements (despite no legal authority to detain persons against their will); invasion of privacy, inadequate communication facilities, ineffective complaint and monitoring mechanisms, poor access to medical treatment,

and the use of outdated medication. In addition, some of the care homes surveyed continued the use of severely restricting "cage beds," despite international condemnation of the practice by disability rights groups as well as The Council of Europe's Committee for the Prevention of Torture and Cruel and Inhumane or Degrading Treatment or Punishment. Hungary's 'guardianship' arrangements have also come under scrutiny where people considered to be mentally incompetent, including social care home residents, are placed under the authority of a third party who can control their place of residence, financial affairs, legal actions and medical treatments. The inadequate legal services and protection extended to medically ill people may place states at risk of litigation before the European Court of Human rights if they fail to adequately monitor and address problems in mental disability care (Roberts 2002).

Developing alternative means of treating people with mental disorders requires reform of traditional organisational structures as well as clinical practices. The polyclinic system inherited from the former soviet system does not yet provide a primary care system that is able to detect and treat people with common mental disorders. This is exacerbated by the fact that there is almost no community based care and it is often equated with outpatient or dispensary care. The transition to more community based care is hampered by a lack of funding and often ministries of health see deinstitutionalisation as a cost containment opportunity rather than as a policy of transferring funds to community care. In addition, the presence of health insurance schemes (either social insurance or private/voluntary insurance) may have little positive impact, as benefits are generally linked solely to biomedical health services. Community-based psychosocial services in Lithuania, for example, while not funded through the social services sector, are also excluded from health insurance cover (Jenkins *et al.* 2001). Furthermore, community social structures, including the role of the family, were weakened first under the former soviet-style systems and later with the strain of economic transition. Labour market difficulties, for example, have limited attempts to develop employment opportunities for those with mental illnesses (Czabala *et al.* 2000). This has led to a lack of support for people with severe mental illness outside the framework of institutionalised care and a more limited capacity to develop NGOs in the mental health area.

Meanwhile, macroeconomic crises have also hindered efforts to develop alternative treatments. Many hospitals face severe budget constraints, and system-wide resources are insufficient to meet existing demands, let alone those of any community based services. With respect to economics on the service level, poorly aligned financial incentives have led to a desire among some hospitals directors to increase admissions, and not surprisingly, the lack of funding has led to poor quality care, low staff morale, and inadequate resources for even the most basic of necessities. Until recently in Poland, the allocation of funds amongst health care organizations was based on prior year budgets and involved no detailed analyses of costs. Under such

schemes, there was little incentive to expand services, and efforts to develop community psychiatric services were limited (Langiewicz and Slupczynska-Kossobudzka 2000). Overall, the share of public funds in total health expenditures has declined in Poland from roughly 90% in the 1980s to approximately 60% more recently (Balicki *et al.* 2000). The continued push to reduce state financing of health care services, the growth of out-of-pocket costs, and the development of the private sector may erode access to services for the economically vulnerable, particularly as eastern countries face greater social and economic differentiation.

In addition, most CEE candidate countries as well as Turkey, Malta, and Cyprus, lack clinical protocols for patient management. This should include individual care planning that assesses psychological, physical and social needs, the management of these needs, continuity of care in the community and a routine audit of outcomes. The training of psychiatric personnel in Eastern Europe needs to be updated and expanded to reflect new developments and to counter the low therapeutic expectations that professionals tend to have when diagnosing and treating their patients. The availability of health information amongst professionals should be improved, as access to the Internet and commonly used medical databases is limited (Jenkins *et al.* 2001). Greater co-ordination of mental health services – and services for substance abuse (known as narcology services) - with the health and social sectors, as well as with non-statutory services and NGOs is also seen as crucial to addressing each patient's need and for successfully identifying and dealing with co-morbidity. Psychiatrists in Hungarian hospitals, for example, must often deal with alcohol and drug dependence, since the lack of adequate care networks or outpatient treatment options shifts the burden of this type of patient care onto hospitals where long-term beds are already in short supply (Tringer 1999). In Poland, social workers (welfare officers) have not been trained in the evaluation and diagnosing of mental health disorders, although some progress has been made amongst occupational medicine practitioners (Czabala *et al.* 2000). In Malta, although psychiatric care is provided through multidisciplinary teams, a shortage of physicians and a lack of incentives for doctors to enter psychiatry may limit access to quality service (Muscat 1999). Reliable and affordable access to appropriate psychotropic drugs also impacts on the effectiveness and quality of patient care. Currently, the supply of medicines is variable and often reliant on limited NGO supplies, dispensed through outpatient clinics.

In spite of the considerable obstacles facing mental health care reform, positive measures in many countries have been progressing incrementally since 1989. In Malta, a central Mental Health Review Tribunal exists to review instances of compulsory detention and ensure that human rights are protected and the largest psychiatric facility with over 600 mostly long-stay beds has been targeted for management reforms (Muscat 1999). Although the Estonian government does not yet have a formal mental health policy, it

has passed legislation outlining both the rights of patients and criteria for involuntary treatment (World Health Organization 2000b).

Most CEE candidate countries now have one or more psychiatric associations, and non-governmental health sector groups, such as relatives groups, psychiatric nurses groups, and at least 100 mental health NGOs have emerged in the region. Although many of these groups may face disinterested bureaucracies, university departments, and psychiatric hospitals, their influence can indeed be substantial, as demonstrated by the Bulgarian Psychiatric Association's lobbying of its Ministry of Health (Tomov 1996). In 1993, the Network of Reformers in Psychiatry, a multi-disciplinary network that unites approximately 500 mental health reformers in 29 countries, was established. More than 100 non-governmental mental health organisations in the CEE are linked to this network which has become the impetus for reforms in mental health care across the region. Amongst its activities has been the development of pilot programmes, some of which have become examples of best practice for collaborative efforts in training and information exchange between professionals committed to implementing reform (Geneva Initiative on Psychiatry (1998) Network of Reformers 2002).

The Network has also adopted a model ethical code in 1998 and is actively working to disseminate the code amongst professionals in the region. Legislative reform of mental heath acts is underway in several countries and service delivery systems are slowly developing away from custodial care institutions to alternatives such as community based services (the transition to community care has been implemented in the Czech and Slovak Republics and is at the development stages in Bulgaria). Community psychiatric nursing is available in parts of Cyprus, and NGOs there have worked jointly with some outpatient departments and counselling centres to serve drug addicts. The parliament in Cyprus has also approved legislation covering the rights of the mentally ill and the government has appointed a multidisciplinary team of professionals to monitor the quality of services (World Health Organization 2001). In Lithuania, having passed mental health legislation in 1995 concerning the rights and protections granted to individuals with mental illnesses, the government is now in a the first stage of a ten year program on mental disease prevention (Republic of Lithuania 1999). In Poland, associations of user groups have called for community based treatment, and there has been a reduction in the number of beds at large psychiatric hospitals along with an encouraging increase in the number of small psychiatric wards, day treatment hospitals, and mobile community teams. In addition, the Polish Mental Health Act and its subsequent amendments in the late 1990s embodied international pacts and conventions on human rights and helped provide legal protection for the rights of people with mental illnesses (Czabala *et al.* 2000; Langiewicz and Slupczynska-Kossobudzka 2000). Indeed, there is some evidence that the use of physical restraints in Poland became less arbitrary as a result of new national protocols and regulations following the passage of the Mental Health Act

(Kostecka and Zardecka 1999). Training courses in multi-disciplinary teamwork have been adopted in many countries and these developments have been augmented by the translation of academic and clinical evidence from western languages. Other initiatives aimed at closing the information gap are directed at establishing national publication programmes (Bulgaria, Lithuania and Romania) and the translation of the International Classification of (Mental) Diseases into CEE languages (Lithuanian and Romanian editions have been released) (Van Voren and Whiteford 2000).

Given the prevalence of mental illnesses as well as their social and economic impact, the need for significant reform in Eastern Europe is substantial. Fortunately, governments have begun to recognize the detrimental effects of mental disorders and have started to attack barriers to successful diagnosis, prevention, treatment and rehabilitation. However, despite some recent progress, additional resources and continued momentum are necessary to ensure that improvement initiatives do not suffer a disappointing fate.

3.5.2 Health of Minorities

Ethnic minorities make up an important part of the population, including the Roma people, or Gypsies in some southern and eastern European countries, or other ethnic minorities in Balkan countries. Concerns about disparities in equity of access, while always present, have come to the fore in the decade since the collapse of communist regimes (Paci 2002).

Any examination of the health of those living in candidate countries would be incomplete without a discussion of the health of the largest minority population in the region, and one with considerable and often poorly understood health needs (McKee 1997). Over 5 million Roma people live in the CCEE. Estimates suggest that they account for over 5% of the population in Bulgaria, Hungary, Romania, and Slovakia so they are a far from insignificant minority (Brearley 1996). Originally from north eastern India, they began a slow westward migration about 1000 years ago. By the fifteenth century they were well established in the Balkans, with smaller groups throughout western Europe. At first they were welcomed, but the intolerance that accompanied the reformation and the rise of the nation state in the sixteenth century soon led to persecution. In the eighteenth century Austria-Hungary required Roma children over 5 to be taken from their parents and brought up in non-Roma families. In Romania, Roma people were kept as slaves until the 1860s. Up to 500 000 were exterminated in Nazi camps.

In CCEE Roma people continue to exist on the margins of society, subject to widespread and often institutionalised racism. Although subject to attempts at forced assimilation by the post-war communist regimes, they were also afforded some protection, but this has largely disappeared in the

1990s, with an increase in racist attacks, often with semi-official approval. As a consequence, implementation of policies to protect the human rights of the Roma population has become an issue in accession negotiations in some countries. In Bulgaria, the Framework Convention of the Council of Europe on the Protection of National Minorities helped spur efforts to fight discrimination and increase levels of health care among Gypsies. In 1999, a National Program for the Equal Protection of Gypsies was adopted to help coordinate the efforts of many groups in the fight against discrimination and human rights abuses (Noncheva and Satcheva 2003).

Against this background, it is unsurprising that health policymakers and researchers have paid little attention to the health needs of Roma people, even though their distinctive way of life suggests these needs may be different from those of the majority population. Understanding these needs is inevitably complicated by the problem of defining the Roma population because of their reluctance to identify themselves and enforced assimilation. However what evidence exists suggests that life expectancy is considerably lower (up to 10 years) than that of the majority population infant mortality is up to four times higher (Braham 1993). Information on the causes of their high levels of premature death is subject to the uneven pattern of research, which has focused on genetic or infectious disorders (symbolising the risk of contagion of the majority population) rather than non-communicable diseases (Hajioff and McKee 2000), the rates of which reflect they poverty, lack of education, overcrowding, and unemployment from which they suffer (Koupilova *et al.* 2001).

There is a particular lack of knowledge about access to health services and how to provide them appropriately. Ethnographic research among Roma people has described a strongly held set of health related beliefs in which some diseases are seen as Roma, and thus treated by traditional healers, and others as due to contact with the outside world, requiring the services of the formal healthcare system (Fonseca 1995). Relations with the majority population are governed by a series of rules about what is pure or impure. There are also a range of specific rituals dealing with birth, death, and caring for the ill. These can lead Roma people to accept some aspects of care and reject others, behaviour that is often seen as irresponsible for not fitting in with the norms of the majority.

The challenge facing the public health community in the CCEE is how to involve the Roma population in both the research that is needed to understand their health needs better and the responses to them. Too often the Roma population have been subjects, rather than participants in these processes.

More broadly, elements of discrimination have also played a role in the history of mental heath services of the CEE region. There is a legacy of political abuse of psychiatry and incarceration in mental institutions as a

means of repression in the former Soviet Union and some countries in Eastern Europe. The Geneva Initiative on Psychiatry, originally set up in 1980 as the International Association on the Political Use of Psychiatry (IAPUP), was established to lead efforts within many national and international psychiatric organisations to eliminate the systematic abuse of psychiatry. The IAPUP along with other psychiatric organisations worked to expose the abuse of psychiatry and initiate a movement within the psychiatric field to protect the human rights of victims. As a result of these efforts, the union of Soviet psychiatrists and neuropathologists were forced to withdraw from the World Psychiatric Association (WPA) in 1983. Years later, the Soviets openly acknowledged the system of abuse and began work on preventing future human rights abuses. By the time of the political and social upheaval in the region in 1989, the institutions of repression were breaking down and many prisoners of psychiatric hospitals were released (Geneva Initiative on Psychiatry (1998) Network of Reformers 2002).

3.6 Health care reform – the unfinished agenda

Health care systems in many candidate countries have undergone wide ranging reforms over the past decade. Those in central and eastern Europe have discarded Soviet model systems and replaced them with social insurance systems. They have broken up monolithic structures and sought to empower local management. Yet the process has not been straightforward and there is still much to do. The following sections look at some of the outstanding issues.

3.6.1 Health Care Financing

Three important issues in respect of financing demand consideration. First, the implementation of effective health insurance systems, which has been central to financing reform in many central and eastern European countries, has proved problematic. General government revenues often continue to play a significant funding role, despite the switch to social health insurance contributions. There is now a substantial body of evidence that helps to explain this and other experiences of implementing insurance. Where social insurance has been seen to fail, failure can be attributed to: the weak macroeconomic context; reliance of some countries on out-of-pocket payments and general taxation; low levels of employment and formal activity within labour markets; poor compliance and high levels of corruption; and lack of transfers from tax or social security funds to health insurance. Tackling these issues will not be simple. Wider economic recovery and institutional capacity-building may go some way towards increasing the revenue collected through payroll taxes but further efforts to ensure compliance will also be necessary, including dealing with corruption. In higher income countries with higher levels of formal employment (namely the Czech Republic, Estonia, Hungary, Slovakia and Slovenia) social insurance appears to have been an effective way of mobilizing

resources for the health sector. Lower income countries in the region such as Romania, with little formal employment, found that insurance contributions were not viable. Further efforts to ensure compliance are necessary. However, the delegation of responsibility for revenue collection to quasi-state agencies or independent insurance funds has created significant challenges for the state in this respect. Lack of compliance in the health sector is likely only to be solved if corruption in the wider economy is reduced.

Second, addressing informal payments must be a major priority in many countries. Data on their extent in a range of eastern European countries suggest they are widespread in both ambulatory and hospital care. Informal payments are a response of the health care system, particularly providers, to the lack of financial resources and a system that is unable to provide adequate access to basic services (Balabanova and McKee 2002).

Finally, defining a more realistic benefits package will be a key strategy in ensuring financial sustainability. Despite political and technical difficulties and concerns about equity, countries may need to consider explicitly defining more limited entitlements to ensure that public revenues are targeted at the most cost-effective interventions and the poorest segments of society and protect public health. As revenues increase, so too will the benefits and the levels of coverage, thus providing a motivation to the population and employers to comply.

On the purchasing side, two areas of reform have been particularly important. First are efforts to enhance the cost- effective purchasing of services through the separation of purchaser and provider functions; ascribing purchasing functions to insurance funds; and employing contracts as the main tool for resource allocation. The introduction of these new models in some countries has been challenging for a number of reasons, including: the inadequacy of funding and the unpredictability of funding flows; low provider autonomy; the absence of routine information systems; a lack of timely information; and sparse technical capacity and information management skills. Second, the introduction of performance-related payment systems for providers is a widespread strategy for enhancing efficiency. Capitation has been introduced for primary care services in many countries, and it is common for new hospital payment systems to be developed that link payment to a defined unit of hospital output. The results to date have been mixed. This is due to a number of issues including the fragmentation of public sector pooling and purchasing; poor design of payment systems that do not dovetail or complement each other; institutional impediments and vested interests; the financial deficits of public providers; and limited capability to monitor inputs or outcomes.

To move towards fulfilling the aims underpinning the reforms of health financing, both funding and resource allocation need further attention.

Mechanisms for pooling resources need to be strengthened with other sources of public expenditure included with social health insurance contributions to ensure the most cost-effective use of funding. Where multiple funds or regional governments currently collect revenues and are expected to reallocate resources to poorer/ high risk funds or regions, revenue collection could be centralised and resources allocated based on a simple risk adjusted capitation. This would overcome some of the inefficiencies in having multiple collection agents and the difficulties of establishing national pooling through reallocation.

The technical and administrative capacity of purchasers also needs to be strengthened to exert maximum pressure for provider efficiency. This requires the development of information and monitoring systems that can deliver timely and accurate data on provision and the training of personnel to use this information effectively. Similarly, government regulation and stewardship will be vital in ensuring that purchasers act in the best interests of the population.

Strategies for reforming health care financing and delivery are highly dependent on the context within which they must be implemented. One factor is the nature of the system that has been inherited, with its domination by hospitals and underdevelopment of primary care (Field 2002). Another contextual factor is the legal and financial framework that is in place. Work by development economists has highlighted the importance of issues such as property rights, banking systems and access to funds for investment. For example, an early attempt to privatise some Czech hospitals was unsuccessful because of the lack of legislation governing not-for-profit organizations (Busse *et al.* 2001). The political context is also important. Major reform requiring primary legislation relies on a combination of skills to design the law and to steer it successfully through the legislative process. It also benefits from a degree of political stability, something that has been rare in health ministries in this region in the past decade (Busse and Dolea 2001; Delcheva and Balabanova 2001).

3.6.2 Improving Hospital Performance

Strategies to improve hospital performance must act at many levels. Ultimately, governments retain responsibility for overall health system performance. They, or agencies acting on their behalf, are responsible for ensuring that there is an overall strategy for promoting health that includes the health care sector, and that identifies the resources that the health care sector needs to work effectively. These resources are not simply financial. The health care sector can function effectively only if it has access to trained staff, means of ensuring their optimal distribution, systems for procuring and distributing appropriate technology and pharmaceuticals (while limiting acquisition of inappropriate items), and methods for raising capital for

investment in facilities. In addition, the system requires a facilitating environment with functioning financial, regulatory and legal systems.

Similar issues confront those working in hospitals. High-quality care involves attention to inputs (people, facilities and equipment), to processes (linking management of resources to quality assurance) and to the environment, in particular a supportive culture (McKee and Healy 2002).

The most important and the most expensive resource available to a hospital is the staff that work in it. Yet this resource is often extremely poorly trained and managed. This section focuses on two key issues – skill mix and good employment practices.

In many candidate countries, the roles adopted by different professional groups, such as doctors and nurses, have changed little despite the enormous changes in medical practice. Responsibilities remain rigidly demarcated. Yet many western European countries have seen major changes in how different health professionals work. One change has been substitution, with nurses in particular taking on many roles previously regarded as requiring a physician (Shum *et al.* 2000). This includes both a greatly extended technical role (for example in intensive care units or performance of endoscopies) but also responsibility for the routine management of common diseases such as asthma and hypertension, including prescribing within guidelines. Another change has been the creation of new occupational groups, such as phlebotomists to take blood samples.

As the attractions of employment in the private sector increase, it will become more difficult to retain skilled staff in the health sector. One issue is, inevitably, money. Unless salaries are competitive, recruitment and retention are bound to be difficult. But people also have other expectations (Grindle and Hildebrand 1995). One is to provide a system of educational development, recognizing the importance of life-long learning. Another is to recognize the changing composition of the workforce in many countries by adopting family-friendly policies, such as workplace crèches and opportunities for part-time work. A third is to create a sense of ownership by involving staff at all levels in decision-making.

There is also increasing recognition in wealthy countries of the ethical dilemma in accepting migrant health professionals who are in search of better living conditions, more opportunities and a better life for their families. This is not only an important "brain drain" from countries in this region but is also an economic hardship for countries that fund the education of health professionals who are then not available to the local health care market.

Management also involves ensuring that those who are employed are actually contributing to the work of the organization. This means tackling

abuses, such as unauthorized private work undertaken from public facilities. It also means tackling sickness absence. High levels of sickness absence are more likely to indicate a problem with the organization than the individual and, where they exist, should provoke questions as to why people do not seem to want to come to work.

One reason might be the state of the premises. Some health care facilities were obsolete 20 years ago and have since deteriorated further. They may be totally inappropriate for current models of care. Too many health care facilities do not take account of the fact that many people who use them will be disabled or partially sighted. Their configuration often physically separates departments that should be working together. Conversely, emphasis on the hospital as an institution often acts as a barrier to alternative ways of providing care, such as freestanding facilities for non-urgent surgery or minor injury units. Financing mechanisms often provide a strong disincentive to investment in renewing facilities.

The third input is appropriate technology. Some of the first people to take advantage of the opening of borders in the early 1990s were selling medical technology that was either unaffordable or unnecessary. Partly in response to these excesses, some countries have developed health technology assessment programmes or are drawing on assessments undertaken elsewhere, but there is still much to be done to ensure that the distribution of medical technology supports the development of integrated care. Moreover, some elements of the multinational pharmaceutical industry have taken advantage of the breakdown of continuing medical education and medical ethics, as well as low salaries and the receptiveness to free-market practices. In many countries, these companies provide the only continuing medical education available, resulting in product bias and sales incentives that ultimately hurt the consumer.

The final issue in relation to hospital performance has emerged from research on the relationship between organizational culture and quality of care. This research has found that hospitals that are seen as good places in which to work, with ease of communication between different professional groups and an open process of decision-making, achieve better outcomes. Conversely, major organizational change can have profound implications for the hospital workforce; while hospitals must adapt to their changing environment, radical restructuring may damage staff morale and so adversely affect the quality of patient care (Aiken and Sochalski 1997).

3.6.3 The Interface between Primary, Secondary and Tertiary Care

Interfaces have two qualities. One is that they provide an opportunity to insert filters so as to limit who crosses them, for example to ensure that referrals are appropriate. Second, they should facilitate movement for those

who meet the criteria to cross them, ensuring that not only the patient moves freely but also the information that is required to optimise his or her treatment (Hensher and Edwards 2002).

There are two important interfaces between primary care and hospitals. The first is the inward interface, through which patients are referred to hospital. The second is the outward interface, across which they are discharged. Each raises different issues. In addition, many patients (especially those with chronic diseases) will move repeatedly across both interfaces, raising important problems of coordination.

Turning first to the inward interface, there is evidence from many countries that many patients admitted to hospital would be more appropriately managed in a different setting. These studies also show that, in most cases, a more appropriate setting does not exist (Coast *et al.* 1996). Yet some things can be done. One way is to look at how common diseases are managed and whether more could be undertaken within primary care. Another is to recognize that many patients are admitted to a hospital ward for a period of observation and investigation to decide whether they require further treatment. This has led to the creation of medical assessment units, which enable a coordinated series of investigations to be undertaken without admitting the patient to an acute ward. A third approach relates to non-urgent surgery, where the advent of short-acting anaesthetic agents and new surgical techniques has made it possible to perform many operations without admitting people to hospital.

The outward interface, through which patients are returned to the community, can also be made to work more effectively. Once again, one challenge is to create the appropriate settings for care. These may include a variety of types of residential facility for the most frail, various types of rehabilitation facility, or the strengthening of community support to enable people to remain in their own homes. A second challenge is to place sufficient emphasis on discharge planning. Ideally, this should begin as soon as the patient is admitted to hospital, thus ensuring that all necessary arrangements are put in place for their discharge. Good communication between the hospital and the referring doctor is a crucial aspect of high-quality, cost-effective follow-up after discharge, but in several candidate countries this is still poorly developed.

3.6.4 Developing Primary Care

The final issue facing policy-makers as they reform health care delivery is the strengthening of primary care. In the Soviet model, primary care was the "poor relation" of the hospital sector. Staff were poorly paid and of low status, and the inadequacy of their facilities and equipment meant that their

role was limited to referring for specialist care or regulating sickness absence.

All countries have accepted that this must change (Rico and Saltman 2002). In some cases progress has been considerable; in others it has only just begun. Reform should focus on two broad areas. The first is organizational reform that will give primary care more power and control over other levels of care. This typically involves giving primary care professionals or institutions new ways of steering patients to the most appropriate care setting, whether in hospital, nursing home or their own home. Where these reforms have been successful they have enhanced the position of primary care at the centre of the different health care delivery sectors, facilitating a process of "virtual integration".

The second area is organizational reform to expand the range of services and functions of primary care. This includes the provision of new or enhanced services as well as the adoption of services previously delivered at other levels of care. New services fall into several categories. Some were either not previously provided (such as rehabilitation) or were often underprovided (some health promotion measures). Others were provided at other levels (hospital or community care), thus reflecting "substitution" by primary care as the new provider. Substitution, in turn, encompasses both total substitution, in which primary care provides the entire service (as in minor surgery or specialized diagnostic services) and partial substitution, in which primary care collaborates with other levels to produce the service (as in shared care programmes). The reform of primary care, with the strengthening of family medicine, will play a key role in achieving these goals.

3.6.5 Public Health Infrastructure

The public health challenges facing policy makers in this region are clearly substantial but, in many cases, the public health response has been weak. An earlier analysis of the policy inaction on childhood injuries provides some clues as to why this has been so (McKee *et al.* 2000). One problem was that worsening health in the 1980s was invisible. Data on health trends presented to politicians is often limited to easily understood aggregate measures, such as life expectancy at birth. While this has the benefit of simplicity it obscures the complex nature of mortality. In the CCEE in the 1980s it was recognised that life expectancy was stagnating but this concealed a substantial increase in mortality among young and middle aged men, which was counteracted by a steady fall in infant mortality (Chenet *et al.* 1996)

A second problem was a lack of public health capacity. Organisations responsible for public health were typically weak (McKee *et al.* 1993). The Soviet model sanitary-epidemiological system had been very effective in tackling communicable disease in the post-war period but was unable to

adapt to the challenge of non-communicable diseases (Bojan *et al.* 1994; McKee and Bojan 1998). As in many countries, a career in public health was less enticing than many of the alternatives, thus attracting many of the weakest graduates, a situation exacerbated by the Soviet system of undergraduate specialisation in the Baltic States.

Public health functions can, of course, reside in many other settings, within government, academia, and non-governmental organisations. In many countries these functions were also weak or, in the case of non-governmental bodies, virtually non-existent. Many, although not all, national statistical offices confined their activities to the minimum necessary to satisfy the reporting requirements of WHO. In some places the academic public health community was somewhat stronger, but these were isolated examples.

A third issue was a lack of clear ownership. No-one was responsible for broadly defined population health. Finally, effective public health interventions often require working across sectors. However the widespread use of highly centralised vertical programmes conspired against collaboration at local level and central government ministries guarded their responsibilities jealously (Gorbachev 1996; Varvasovszky and McKee 1998). The situation has changed substantially since 1990 but there are still many problems. Analytic capacity remains weak. Some ministries of health have become even weaker than in the communist period. In many countries the public health system has remained relatively untouched by the process of reform, partly reflecting the low priority given to it by government but also their reluctance to adopt new ideas, in some countries due to corruption among a group that is invested with much discretionary power but low wages and little accountability.

New schools of public health, with staff who have received training abroad teaching modern public health concepts, have, however, emerged in several countries (McKee *et al.* 1995). Some, such as the Hungarian School of Public Health in Debrecen, Hungary are now well established and use innovative learning methods, combining Masters and Doctoral level training with short courses. There are many examples of innovation, such as the establishment by the Hungarian School of Public Health of a network of sentinel health monitoring stations that provide data for research and teaching, as well as facilitating close links with public health practitioners. Elsewhere, several networks of academic centres have developed, such as BRIMHEALTH, established by the Nordic School of Public Health and bringing together centres in the Baltic Republics and North-Western Russia. Several of these centres, such as the Hungarian School are now participating in major international research programmes.

The Open Society Institute (OSI) (http://www.soros.org/), which has provided major support to all of these ventures, has recently established a

major development programme, involving twinning with western Schools of Public Health and in partnership with the Association of Schools of Public Health in the European Region (ASPHER) (http://www.ensp.fr/aspher/). This aims to help established schools to develop further and to support the development of other nascent projects. The new institutions that are emerging will only become effective if they can draw on appropriate, locally relevant evidence on the causes of disease and the appropriate responses.

The challenges facing population health in the candidate countries of central and eastern Europe are considerable. Although life expectancy has improved considerably since the 1990s, when it was stagnating, the gap with the EU is only slowly closing. In some places old threats, such as tuberculosis, are reappearing and new ones, such as smoking among women and HIV, are emerging for the first time. But there are also many examples of success. Death rates from cardiovascular disease are falling rapidly in all countries. Transition-related increases in injury deaths are being brought under control. However, many of these successes owe more to wider societal changes, such as growing prosperity and opening of markets, than to specific public health policies. Unfortunately, the public health infrastructure remains weak in many countries.

Several needs are apparent. One is a greater number of people from a wide range of disciplines trained in modern public health. In some countries newly established schools of public health are already making a substantial contribution to this goal. These individuals need a secure career structure that rewards them sufficiently to ensure their retention and gives them the opportunity to use their newly developed skills to develop and implement the healthy public policies that are noticeable by their absence. These changes will only come about if politicians recognise the need to improve the health of their population, recognising that progress is possible and necessary.

3.6.6 Implementing Change

Successful change requires that certain conditions be in place. These often involve a mix of new mechanisms or related institutional changes. They include changes in technological resources (e.g. telematics) and human resources (e.g. new training and skill-mix arrangements) employed in primary care settings. Change also requires policies that increase the autonomy of primary care, promote teamwork, create incentives for coordination with other levels of care, and increase the quality and responsiveness of service provision. This may require a generational change, since in most countries the current medical education system is poorly suited to the new situation confronting primary care.

Ultimately, the success or failure of reform will depend on the impact of reforms on the societal objectives of health improvement, equity and efficiency, and on the extent to which health systems respond to consumers. There are no simple solutions to the challenges faced. Rather, complexity must be an inherent factor in any realistic approach to balancing affordability and effectiveness in what is an immensely complex environment surrounded by powerful interest groups. Policy-makers need therefore to address stewardship and to take a whole-system perspective, adopting a clear health strategy and sponsoring effective regulatory systems so as to provide the framework that health care purchasers, providers and public health professionals need. This paper gives some indication of the degree of complexity and the elements they will need to combine. The extent to which these different elements will combine in any given country to have an impact on health outcomes remains open to debate, and is an area where national policy-makers must bring their expertise to bear.

3.6.7 The consequences of accession for health and health care

While several candidate country populations have a health status similar to the EU average, some have a way to progress before matching indicators such as life expectancy. There remains a wide disparity in available resources for health between the Member States and all candidate countries. As healthcare remains the preserve of national governments rather than the EU, accession will not directly address the health care aspect of the health gap. However, a wide range of EU legislation will affect health and healthcare indirectly in the candidate countries.

Membership of the EU brings with it the right to the free movement of people, goods and services anywhere within the EU borders. This right has implications for the movement of both health professionals and patients across borders. Examination of patterns of movement of health professionals within the current EU member states shows very low levels of migration. However, the candidate countries now preparing for accession have, in general, a much lower level of funding available for health care resources and staff salaries compared with other recent new EU members such as Austria and Finland. Consequently, fears have been raised that there maybe widespread professional movement from some candidate countries to more well off current EU member states with staff shortages (Nicholas 2002). On the more positive side, evidence from Poland and other candidate countries shows that preparations for accession are resulting in improved nurse education and general broad reviews of the education of health professionals (Zajac 2002). The situation regarding any implications for health systems as a result of patient movement across borders remains somewhat unclear. The European Court of Justice has made a number of rulings on the issue which appear to allow some limited cross-border movement additional to the basic EU schemes already in place (such as provisions for students or tourists away from their home country). If free

movement of all patients becomes legally simple, health systems in candidate countries may benefit through offering competitively priced health services to patients from other countries. There might also be concerns for national health budgets in less well off candidate countries should large numbers of their citizens seek more costly health care in other EU member states (Busse 2002). The issue of widespread 'informal' payments requested of patients in a number of candidate countries (Lewis 2000) may however complicate true free movement of patients across borders into the candidate countries.

Aside from the legal implications for health systems that EU accession will bring for candidate countries, the accession process has already started bringing in additional funding from the EU and other donors for accession related activities. Although the PHARE programme has been criticised for giving inadequate attention to health, some health system reforms and strengthening of health and safety systems have received additional funding through this programme (Rosenmuller 2002). However, the overall very limited support for health in candidate countries as part of the accession process may hinder adequate preparation for integration into common EU health programmes, such as the communicable disease surveillance networks (MacLehose and McKee 2002).

Most EU candidate countries have introduced legislation incorporating elements of the *acquis communautaire* on pharmaceuticals. Yet much work remains to be done in the areas of intellectual property and regulation. The proprietary industry seeks the highest possible protection while candidate countries' own pharmaceutical industries may profit from greater access to the enlarged EU market. Patients may benefit from safe and efficacious products that meet EU-wide standards. However, the cost of new medicines may outweigh the resources available in many candidate countries, and reimbursement differences across insurance systems may create access problems for certain population groups (Rosenmuller 2002).

Unfortunately, the provision of mental health services and the status of mental health sufferers in CEE countries has not received significant attention during the accession process. As the prevalence of mental illnesses and their social and economic effects are becoming more widely understood, the need for substantial mental health reform in EU candidate countries is more clear. However, the exclusion of mental health considerations from accession countries may allow an opportunity for reform to go to waste. In addition to the harmonisation of some legal systems and the introduction of new legislation protecting against human rights abuses or inhumane treatment, attempts should be made to link financial resources to measurable improvements in mental health services. Strong incentives will be necessary to ensure that governments heighten their attention to mental health policies and upgraded them in priority. Although some progress has been made, particularly amongst medical

professionals and within the NGO community, substantial nationwide efforts remain necessary. Perhaps special attention within the EU, either in the form of monitoring boards or professional councils, may assist CEE countries in their reform efforts, particularly with respect to the difficult transition from institutional to community-based care. Effective mental health care reform in the CEE region will require a greater focus.

Drawing on the experience of the transition in central and eastern Europe since 1990, it seems likely that accession will have a broadly beneficial impact on health, although there will be losers as well as winners. For example, increasingly open markets will bring more diverse diets. Where this diversity increases access to nutritious foods such as fruit and vegetables this will be beneficial; where it increases access to junk food it will be harmful. As part of the preparation process, candidate countries are adopting the health and safety legislation of the EU. Although not comprehensive and sometimes criticized for a lack of monitoring and applicability to small enterprises (Wright-Reid 2002), standards may be improved somewhat through accession for countries with weak worker health protection. Similarly, for countries with historically weak health promotion track records, the need to adopt EU legislation on tobacco control is likely to bring about some health improvements in relation to the current high burden of tobacco associated illness in most applicants (Delcheva 2002). However, on the other hand, there are concerns that some countries, such as Poland, with stronger tobacco control legislation than the EU may be forced to weaken their high standards (Gilmore and Zatonski 2002). Whether this concern is justified remains to be seen. However, experience of past accessions, such as that of Finland in 1995, which had to weaken strong alcohol control measures, shows that trade is often given the upper hand over public health in EU matters (Osterberg 2002). The participation of the candidate countries in the EU disease surveillance networks will bring benefits for health for the whole enlarged EU region although further support for this participation is needed (McKee and MacLehose 2000/2001).

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4. Social exclusion & poverty

Martin Evans

Introduction

The 13 candidate countries form two groups in the existing poverty literature. The ten ex-communist countries of Central and Eastern Europe represent one group that share a common policy legacy and a shared experience of major economic, political and social upheaval during their transition to market democracies. The remaining three countries, Malta, Cyprus and Turkey have previously been grouped as "Mediterranean" countries characterised as having more recent and lower profile development of poverty measurement and policy than Northern European countries[1].

For the first group, one major legacy of the Communist era was an ideological avoidance and denial of poverty as structural concern for social policy. Near universal employment at low pay was accompanied by work-based welfare systems, which, together with subsidised prices and services, largely prevented income poverty under communism. Policy makers saw poverty as social pathology – experienced by individuals who for some reason could not work. Highly stigmatised services were developed to cater for them. The transition shock and economic collapse experienced by all these countries in the early 1990s fundamentally changed such social policy's assumptions about poverty. Many people lost work and had no income, and the majority of those employed continued with low wages but their employers could no longer provide high levels of non-wage benefits and the state could ill afford to continue general subsidies. Living standards fell for the majority and the incidence of poverty became widespread. The policy response required a combination of contributory, categorical and safety net income maintenance programmes to be introduced and sequenced appropriately. Differences within the first group largely reflect the design and sequencing of this response alongside their underlying demographic and macro-economic profiles. However, we also see underlying differences in their acceptance and appreciation of income poverty as direct and pressing concern in the latter parts of this chapter.

[1] See for instance Korayen K, and Petmedidou M (1998*)*

By contrast, Cyprus, Malta and Turkey have fundamentally different policy histories and varying appreciation and experience of poverty. Poverty research in Turkey and in other North African and Arab countries in the region is particularly poorly developed and poverty and social exclusion have low priority despite its widespread incidence.[2] Poverty in Malta has been championed by voluntary organisations and, in particular, Caritas[3]. Poverty in Cyprus has a low overall relative profile and incidence.

The thirteen different policy histories of these widely varying countries are now converging as they apply to join the European Union and future inclusion in EU level policy developments on poverty and social exclusion. This chapter considers four main questions that help provide a profile of the current evidence base at an early point in that convergence.

First, *How are poverty and social exclusion viewed by the candidate countries and with what resulting poverty national poverty measures and indicators?*

Second, *What evidence is there of poverty and social exclusion in the candidate countries and how does this compare to EU experience?*

Third, *What are the drivers of poverty and social exclusion – and how far do they reflect the EU's core challenges identified for Member States* (European Commission 2002).

Fourth, *What are the issues for poverty and social exclusion for the candidate countries in an enlarged EU?*

4.1 Poverty, Social Exclusion and the Policy Agenda

4.1.1 National Perceptions of Poverty and Social Exclusion

Transition – the process of changing from a communist regime - brings a number of crucial common structural policy problems for poverty and social exclusion. The transition shock created unprecedented levels of post-war poverty, while the change to democratic politics and policymaking made responding to poverty an essential but contentious area of debate and action. Early recognition of poverty as a policy problem was rare, and the Czech Republic and Slovenia stand out as examples of early interveners. Poverty

[2] See Korayen K, and Petmedidou M (op cit)
[3] See Caritas (1994) *Poverty in Malta, A First Report*. Malta: Poverty Watch; and subsequent reports.

elsewhere emerged as a major issue in the mid to late 1990s. The reasons for this delay are several. First, early policy design tended to focus on reforming existing contributory pensions and other benefits and of introducing unemployment insurance. Second, large-scale poverty lasted longer than expected but short-term poverty had been seen as a "natural" temporary outcome of transition. Third, policy responses were difficult to design and there was severe fiscal pressure that constrained spending on social assistance programmes. Fourth, evidence of continuing widespread poverty and of poor effectiveness of transfers for some groups took time to gather and to make and impact on policy makers. Often such evidence came from external sources, particularly the UNDP and World Bank. Lastly, the national level experience of transition differed widely, with some countries delaying underlying macro-economic and structural reforms for longer than others, leading to differences in the underlying macro-economic drivers of the economy and in resulting growth.

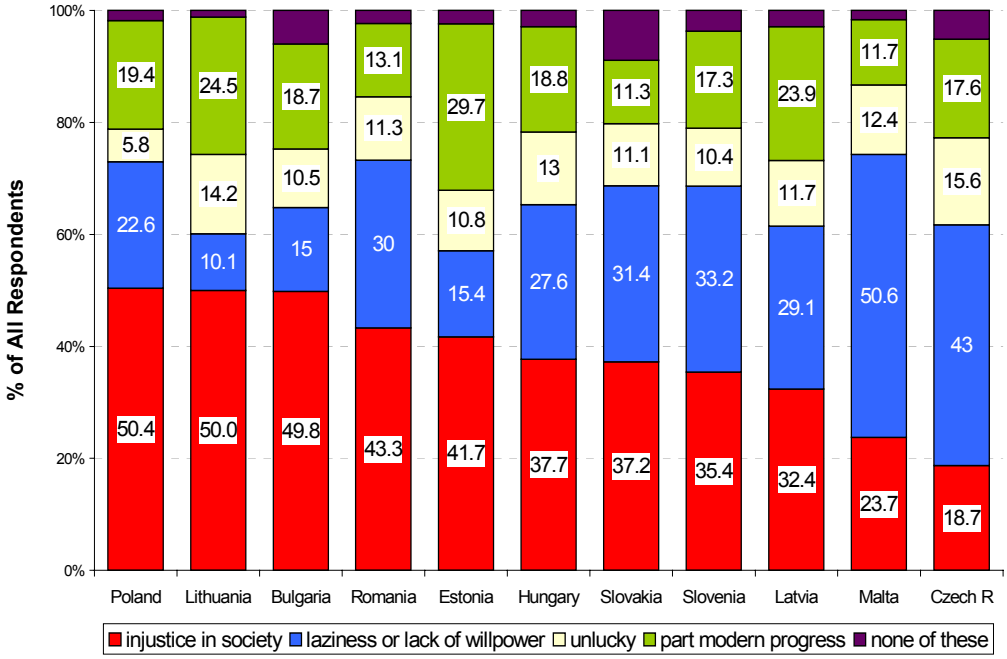
Looking across the transition countries, the point at which poverty reached the policy agenda during the 1990s indicates the ways in which these factors came together. Major reform in Bulgaria and Romania was linked to underlying structural economic reforms in response to economic crisis in the mid 1990s and to underlying essential changes in economic institutions. At a similar time Poland reacted to a World Bank report that pointed out the structural poverty in rural areas and other wider concerns. Estonia in late 1999 and Latvia in 1998 reacted even more recently to detailed reports of incidence and composition of their poor. There are two transition countries where poverty could improve its priority in policy making. Hungary introduced a radical social protection reform in 1995 and moved towards means testing and provoked a wide debate about poverty and social protection but does not have poverty as a strategic component of policy formulation. While in Slovakia the term "material distress" is still preferred to poverty and no unambiguous acceptance of poverty as an important concern for policy makers and. More recently, across all these countries poverty and social exclusion has also entered the policy domain as an outcome of discussions with the EU about accession and one outcome of the accession process so far is a heightened awareness of poverty and social exclusion.

Cyprus' low unemployment and strong familial solidarity has meant that while income poverty is on the policy agenda it is perceived as relative disadvantage and has low overall policy priority. Incidence of deep poverty tends to be among migrants and especially among the small numbers of illegal migrants. Malta similarly sees the incidence of absolute poverty as very low and tends to measure poverty in relative terms but has more problems with unemployment as a driver of economic exclusion. Reducing poverty is an understated concern of Turkish Government economic and social plans as Turkey has large structural income inequalities and a significant proportion of its population living below an absolute poverty line

together with high levels of illiteracy (compared to the other twelve candidate countries) and high unemployment rates.

When we turn attention from policy makers to public opinion and public perception of poverty across the thirteen countries there are further important factors that influence policy. Cross-national evidence from the European Values Study provides some insight into how different populations view poverty. Figure 1 shows the national responses to the question, "Why are there people in this country who live in need?"[4]

Figure 1 Attitudes to the Poor in 1999/2000



Source: European Values Study (Halman L 2001) Table 11

The question asked in the study allows respondents to choose between four reasons for poverty: injustice in society, laziness or lack of willpower, bad luck or a part of modern progress. Figure 1 ranks the participating candidate countries left to right by the percentage of survey respondents who considered "injustice in society" as the most important reason for people being poor. This reason can be seen as contrasting most with the view that the reason for poverty was "laziness or lack of willpower" and can thus be considered to be a proxy for implicit support for social rather than individual responsibility in tackling poverty. Figure 1 shows great variation across the ex-communist candidate countries – with around 50 per cent in Poland, Lithuania and Bulgaria seeing social injustice as paramount. All the other ex-communist countries have over 30 percent whose attitudes are similar and the one country that stands out has having very low prevalence of such

[4] Turkey and Cyprus did not participate in the EVS study

attitudes (under 19 per cent) is the Czech Republic, where 43 per cent see poverty as mainly caused by individual failing - laziness or lack of will power. Malta, too, has similar profile of attitudes towards the poor with over 50 percent thinking poverty is due to individual laziness and only 24 per cent due to injustice in society. The conclusions from the EVS concerning Central and Eastern European Countries having greater solidaristic views on social policy are supported by evidence from the 1999 International Social Survey Programme (ISSP). (Redmond, Viola and Suhrcke 2002).

There is less comprehensive evidence of attitudes of the poor themselves, although participatory studies of poverty have included some of the candidate countries[5]. In an overview of poverty and transition by the World Bank the poor were found to have a number of common grievances. First, the poor often felt cheated out of assets after the privatisation and divestment of previously state-owned assets that often lacked transparency and was often seen as unfair or corrupt. Second, the poor often felt cheated out of entitlements, both social protection and services, which became more rationed and had often levels that were inadequate and poor and/or corrupt delivery. Third, the poor were more likely encounter difficulties in probity in the provision of health and education services[6]. The poor also saw themselves, usually quite accurately, as suffering disproportionately from increased levels of crime. Many of the poor felt helpless and viewed the transition process as an event beyond their control that has caused their downward income mobility and loss of status. (World Bank (2000) pp. 44-50). The evidence of widespread disillusionment with corruption and blocked opportunities for success in Central and Eastern European Countries is confirmed elsewhere. Over half (52 per cent) of CEEC respondents agreed that corruption was necessary to get to the top, as against 29 per cent in the Western Europe. Only 12 per cent agreed that people were rewarded for their effort, as against 42 per cent in the West, while only 19 per cent agreed that people were rewarded for their intelligence and skills – compared to 52 per cent in the West. (Redmond, Viola Schnepf and Suhrcke 2002. p.10).

Additionally, national studies also point to the vulnerability of the poorest in their experience of transition and their lack of voice. Bulgarian attitudinal survey evidence from 1996 shows that almost three quarters of respondents said that "the failure of the economic system" was the most important reason for poverty, but almost 45 per cent also cited "the lack of equal opportunities"[7].

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[5] For instance Bulgaria was included in the Voices of the Poor study by the World Bank (Narayan et al 2000a and 200b).

[6] See also the previous discussion of "informal payments" in Chapter 3.2.9

[7] See Bulgarian national report that quotes the Centre for the Study of Democracy study of 1996.

Such attitudinal evidence points to exclusionary forces such as corruption and discrimination that act to cause and reinforce income deprivation but the concept of Social Exclusion is a very recent arrival in the policy makers' vocabulary. However, it is recently more apparent in those countries that are developing pre-accession programmes that reflect the European Council's commitments in Lisbon, Nice and Stockholm to promoting sustainable growth that reduces social exclusion and promotes inclusion. Slovenia's adoption of a National Programme to Fight Against Poverty and Social Exclusion that was based on academic and government research findings. Other countries have developed "Action Plans", "Poverty Reduction Strategies" or similar documents that identify risks of exclusion and poverty – often focusing on economic exclusion from the labour market. Policy documents sometimes frame a definition of poverty and deprivation in a way that acknowledges elements of a social exclusionary approach directly or indirectly and thus it is important not to overstate the change in policy terminology that has seen social exclusion more recently addressed as a particular focus. For instance, Latvia's definition of poverty remains focussed on income deprivation but also acknowledges participation and social resources by seeing poverty as the "*Situation where an individual or a certain part of the population find themselves when, because of insufficient material and social resources, they have limited opportunities to obtain the essentials (food, shelter, clothing and in some instances also care) and to participate in society to the extent considered acceptable in that society*". However, most of the transition economies find it difficult to encompass a view of social exclusion that demonstrates a wider view of poverty and deprivation while they still have to prioritise reductions in absolute income deprivation.

4.1.2 National Policy Definitions

Income poverty depends on an identified threshold, the poverty line, which can be adopted for a number of different policy reasons. Indeed, a number of lines can thus be adopted in each country. One helpful distinction is to separate three types of governmental approach to poverty measurement.

1. A specific measure of poverty incidence (usually a head count) is often used to assess the overall incidence poverty in order to answer questions about the overall income distribution and the aggregate effects of economic and social policy. This can be called an *aggregate poverty measure*.
2. Poverty lines can also be used to design safety net or programmes in order to identify groups for assistance. This can be called a p*rogramme poverty measure*
3. However, policy lines can also be implied from programme-specific income thresholds that have no direct justification from or link to absolute or relative poverty measures – such as

minimum pension or minimum wage levels. This can be called a *poverty proxy*

While definition of a poverty measure/line by government carries with it an assumption about policy performance and poverty reduction against such lines, policy makers are not always willing to adopt any of these three measures as a poverty commitment.[8] A separate question is thus whether there is official recognition of any of the three measures as an indicator of poverty. Few countries report an official poverty line. Cyprus has a relative poverty line. Lithuania's is a relative consumption based line and Turkey has an absolute poverty line based on food requirements.

Aggregate poverty measures are more common and in Cyprus, Lithuania Slovenia and Turkey match the official poverty line. Other countries' aggregate poverty measures tend to be based on minimum consumption models. For instance Hungary has a subsistence minimum basket of goods, while Latvia on the other hand has developed three poverty thresholds based on percentages of average consumption.

Programme poverty lines are problematic because so many of the transition economies have severe budget constraints that make a safety net set on minimum subsistence baskets of goods unaffordable. Thus Estonia and others set a "subsistence minimum" in the laws relating to social assistance but Parliament in fact determines what level this should be. Early attempts to set benefits at a subsistence level or to set a notional subsistence level basket of goods became unsustainable and were allowed to fall in real value when they were not indexed to prices. Latvia produced a lower version of a calculated subsistence minimum – a "crisis subsistence minimum" when the original levels were unaffordable as a basis for safety net benefits. Slovakia similarly has a subsistence minimum set by legislation but has differentiated two sub-levels of the minimum for safety net purposes – a "social minimum" and an "existence minimum".

In the absence of single or sustainable poverty lines many of the countries rely –officially or unofficially – on the level of social assistance or other benefits to define poverty. This means that there are overt and covert Poverty Proxy measures in many countries, so that, for instance, the Guaranteed Minimum Income in Latvia ends up as one of the main poverty line measures while minimum pension does so in Hungary. However Poland and the Czech Republic only appear to use social assistance levels as a poverty measure, but with an associated minimum income standard present in the latter. Outside the transition countries there are fewer multiple lines and proxies but in Malta the minimum wage– set according to consumption

[8] Indeed, World Bank suggests *"Policy makers should be aware that the role of safety net policy is not to raise all families to a standard of living equal to or above the poverty line through the use of income transfers. Rather, poverty lines represet goals set for society and means to identify groups who are eligible for extra assistance*" Andrews & Ringold (1999*)*

patterns - is used as the basis for an administrative poverty line, but as previously said this is not the official poverty line.

Some countries have abandoned official adoption of poverty lines at some point in time and non-government organisations – for example, Trade Unions in Bulgaria, have continued to produce data using that measure.

This overview shows several important themes in the conception and definition of poverty at the national level:

1. Poverty for many of the transition countries is only a recently held official policy concept
2. External influences on poverty identification and recognition have been strong – particularly from World Bank and UNDP in the transition countries and more recently from European Commission
3. Social Exclusion is little used but is growing in official use – but partly because of EU accession driven response.
4. There are real problems of consistency of poverty lines within many countries –both consistency over time and between different measures

The different approaches to conceptualising and measuring poverty across the thirteen countries should not obscure the fact that there is a large level of overall consistency in the identification of groups that are most at risk. Most of the evidence is informed by empirical research within each country, often undertaken in conjunction with international organisations. These groups mostly reflect the groups identified by Member States and the EU in the "core challenges" to social inclusion. Discussion is thus left to Part 3 of the chapter below.

4.2 Incidence and Indicators of Poverty & Social Exclusion

The current evidence on poverty and social exclusion reflects a wide range of national and international policy interventions and studies. The ten transition countries have had over ten years of assessment and assistance from the World Bank, UNDP and other international organisations such as UNICEF[9] and the EU, and there is as a result a considerable body of evidence on poverty and deprivation. Consistent and comparable time series of such data are less comprehensively available, especially in poverty measurement. However, World Bank poverty assessment studies and UNDP Human Development Reports provide sources of consistent data. The unique additional contribution of UNDP Human Development Indices (HDIs) is that they provide consistent time series of data for both candidate countries and Member States on aggregate multi-dimensional poverty. However, using such data is unusual for EU discussions of poverty because such data – and other data on basic subsistence needs – has been more often

[9] The UNICEF Innocenti Centre in Florence in particular and their data in the TransMONEE database.

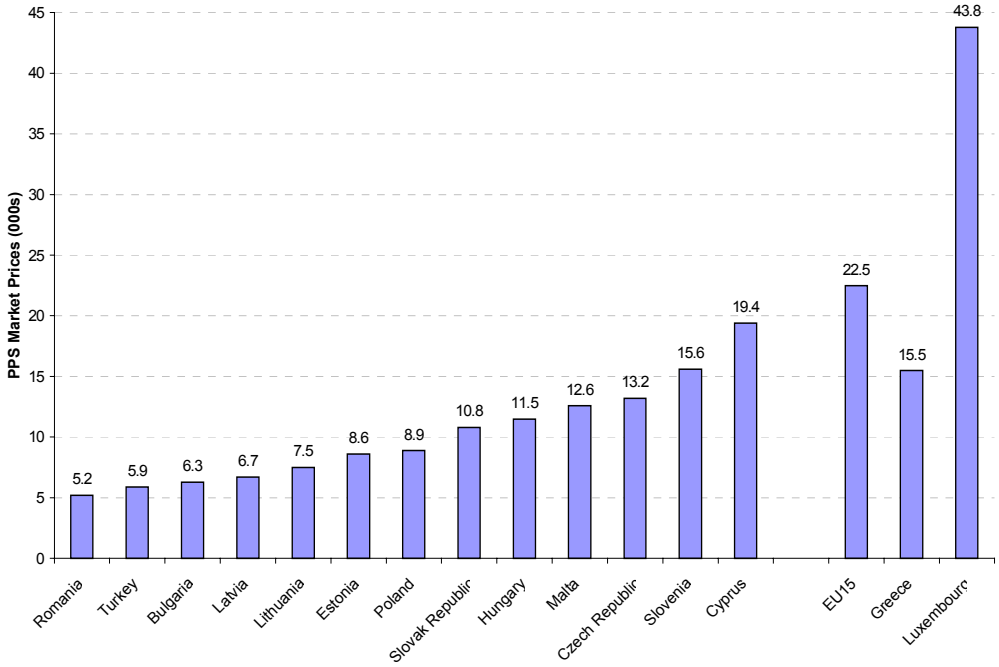
associated with discussion of developing countries. We show below that within the candidate countries there are those where such data is highly relevant and appropriate and this Chapter uses evidence to bridge the approaches to measuring poverty and social exclusion that exist in developing and industrial countries. To date, the debates on social exclusion and poverty in the EU have developed from a point of view that will require broadening to fully appreciate the profiles of poverty across the thirteen applicants.

4.2.1 National Level Poverty & Inequalities

Figure 2 shows the per-capita Gross Domestic Product in purchasing power parity for all the candidate countries in 2000 and also shows the EU15 equivalent together with the same data for Greece and Luxembourg - the lowest and highest country figures in the EU respectively. Per-capita GDP of national income and it is clear from Figure 2 that there is a very wide range across the candidate countries - both some relatively poor countries by EU levels and others close to level of the poorer Member States.

Table 1 shows the candidate countries' per capita GDP in purchasing power parity expressed as a percentage of the EU15's average over the period between 1996 and 2000. The countries have been ranked by their 1996 values with Cyprus (83 per cent) at the top and Latvia (26 per cent) at the bottom. Some of the poorest candidate countries have fallen further behind the EU average, Turkey, Bulgaria and Romania, especially. Latvia on the other hand has shown strong growth and has narrowed the gap by over 4 percentage points – rising from 25.9 per cent to 30 per cent of EU15 average. Convergence towards the EU15 average has also occurred in most of the other candidate countries, the main exception being the Czech Republic, which in 1996 had per-capita GDP of over 64 per cent but which fell by over five percentage points to under 59 per cent by 2000.

Figure 2 Per-Capita GDP 2000 in Purchasing Power Parity



Sources: Eurostat Yearbook 2002 p 158 and Eurostat Statistical yearbook on Candidate and South-East European Countries 2002

Table 1 GDP Per-capita 1996-2000. Current Prices in PPS as a percentage of EU15.

% of EU 15	1996	1997	1998	1999	2000	Trend 1996-2000
Cyprus	83.4	82.7	84.0	85.2	86.2	2.8
Czech Republic	64.3	62.5	60.0	58.7	58.8	-5.5
Slovenia	64.2	65.8	66.7	68.5	69.4	5.2
Malta	53.6	54.6	54.7	55.3	56.3	2.7
Hungary	46.2	47.5	48.6	49.8	51.1	4.9
Slovak Republic	46.2	47.9	48.5	48.3	47.9	1.7
Poland	35.9	37.5	38.3	39.0	39.4	3.5
Estonia	33.8	36.8	37.8	36.9	38.5	4.7
Lithuania	32.5	34.1	35.0	32.9	33.3	0.8
Bulgaria	29.0	26.5	27.0	27.1	28.0	-1.0
Romania	28.7	26.5	24.6	23.6	23.3	-5.4
Turkey	27.6	29.1	28.8	26.4	26.3	-1.3
Latvia	25.9	27.7	28.3	28.7	30.0	4.1

Source: Eurostat Statistical yearbook on Candidate and South-East European Countries 2002 Table 6.8.

Note: Trend measured as percentage point difference.

These trends mean that inequality in underlying GDP per capita between candidate countries grew between 1996 and 2000. International level

inequality using this measure between the candidate countries is far greater than within EU15 countries. This means that, as Table 2 shows, if the inequality in per-capita GDP is compared between the 13 candidate countries, the 15 Member States and the 28 countries in total, the potential for international inequality more than doubles with the inclusion of the 13. Such large increases in inequality between countries' per-capita GDP will increase further when sub-national areas and regions are taken into account – a point that is discussed further in Part 3.

Table 2 International Inequality in Per-Capital GDP

	1996	**2000**
Inequality between 13 Candidate countries	0.406	0.414
Inequality between 15 Member States	0.232	0.266
Inequality between 28	0.483	0.506

Source: Author's calculations from Eurostat Yearbook 2002 and Eurostat Statistical yearbook on Candidate and South-East European Countries 2002

Note: Inequality measured using the Coefficient of Variation.

This comparison of national level profiles is essential context with which to approach an overview of poverty across and within the candidate countries because the overall level of national resources not only reflects the ability of countries to pay for social programmes to respond to structural causes of poverty and social exclusion – such as education, training and health programmes as well as income support from social protection systems. Additionally, the very different *levels* of GDP also mean that assumptions for poverty profiling within those countries that are furthest away from EU norms will not necessarily follow the assumptions held for the EU. Poverty in poor countries has a higher incidence of absolute deprivation and the *shape* of their income distributions can also makes using relative measures questionable.

4.2.2 International Poverty Measures

International measures of absolute income poverty using World Bank poverty lines of incomes less than two dollars a day are shown in chapter 1 of this report. A number of candidate countries have significant populations under the higher two-dollar a day poverty line. Romania, Bulgaria and Turkey have around one-fifth of their national population below this line, with poverty gaps of between 4 and 7 percent. Hungary, Latvia and Lithuania have around 7 to 8 per cent of their populations below the two-dollar a day line and poverty gaps in the regions of 2 percent. Estonia is the other country with a head count of significant size (above 2 per cent) with around 5 percent of its population under two dollars a day and an average poverty gap of 0.8 per cent[10].

[10] Poverty gap is measured as the mean shortfall from the poverty line and is expressed as a

Other indicators commonly applied to developing countries also indicate that some of the candidate countries have significant levels of acute poverty and deprivation. Chapter 3 has already shown that there are considerable differences in life expectancy at birth between Central and Eastern European countries and their Western European counterparts. Low weight birth is an indicator of maternal health and nutrition, especially in the developing world, but is also an indicator of teenage birth and smoking during pregnancy in industrialised countries. Birth weight of less than 2.5 kilos is an internationally accepted indicator of poverty (UNICEF 2002) and there is a goal set by the World summit for Children to reduce rates of low weight birth to below 10 per cent. Figure 3 gives the percentage of live births under 2.5 kilos in the candidate countries[11] together with EU comparators. Turkey stands out with over 15 per cent of births being low weight while Romania, Hungary and Bulgaria each has around 9 per cent of births low weight. The remaining candidate countries have incidence of low weight birth at or around EU levels, with Lithuania's low rate of 4 per cent matching Sweden and Luxembourg, the lowest rates among Member States.

Recent child malnutrition data exists only for Turkey and shows that 22 per cent of under-five year old children in the bottom 20 per cent of the income distribution were malnourished in 1993 and more recent data for 1998 shows that 8.3 per cent of Turkish children aged under 5 are moderately underweight while 16 per cent were under-height (stunting in UNICEF terms)[12].

UNDP human development indicators provide a consistent and comparable picture of national level poverty indicators over time and between candidate countries and the EU15. The Human Development Index (HDI) is a composite index that combines data on life expectancy, education levels and per-capita GDP and is calculated for all industrialised and developing countries. Figure 4 shows the 1990, 1995 and 2000 HDI scores for all candidate countries[13] and the EU15 average together with the highest (Sweden) and lowest (Portugal) HDI scores form member states in 2000. There are two main profiles of interest in Figure 4 – relative levels of HDI and trends over time.

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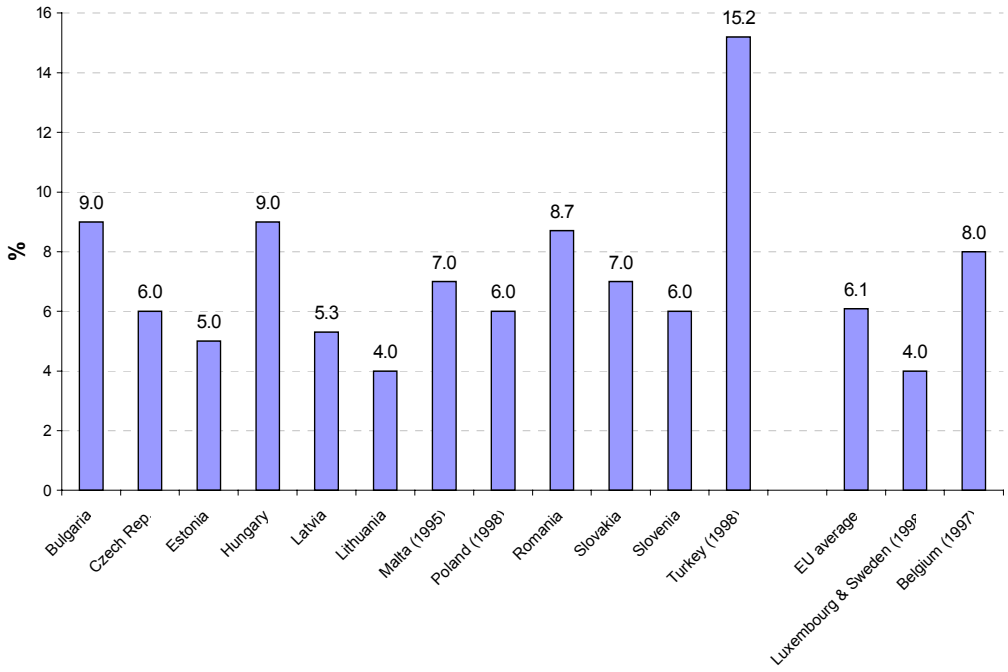
percentage of the poverty line.

[11] No data available for Cyprus

[12] Older data for Czech Republic for 1991 gives a comparison point with less than one per cent in both categories.

[13] Estonia only has an HDI score for 2000.

Figure 3 Incidence of Low-weight Birth 1999



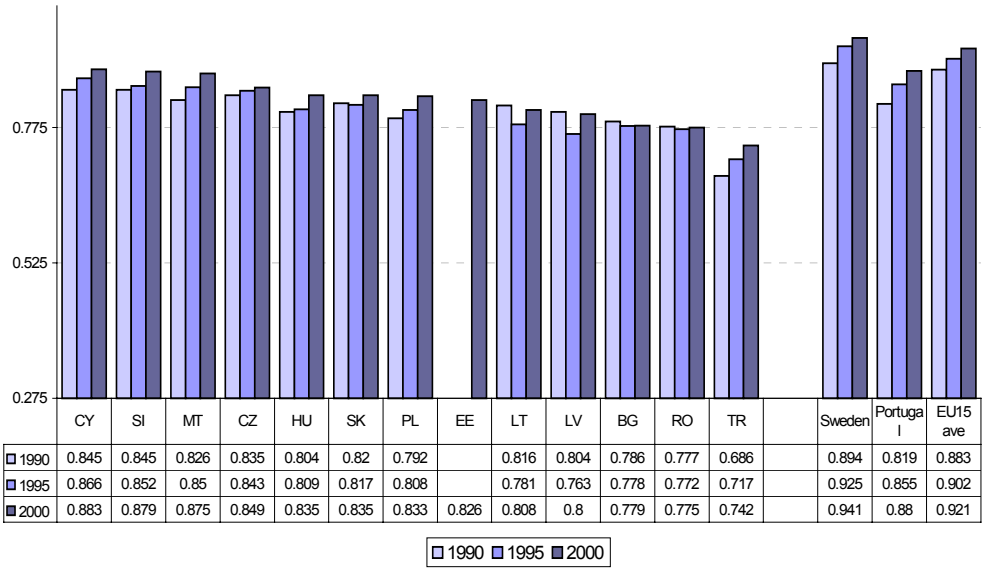
Source: UNICEF Statistics[14]

The overall picture on levels repeats much of what was previously stated above concerning per-capita GDP[15]. The candidate countries as a group have stayed consistently (with perhaps a slight fall) behind the EU15 as a group in terms of Human Development[16]. However, Figure 4 shows that the national level trends differ. The EU15 comparators show constant trend of HDI improvement over the period. Cyprus, Slovenia Malta, Czech Republic, Hungary and Poland also show clear improvement over time – although the 1990-1995 period shows relatively flatter trend growth in some countries. Turkey, the applicant country with the lowest HDI in the thirteen has had sustained trend growth. In Lithuania, Latvia, Bulgaria and Romania however the overall trend is flat with u-shaped profile in Latvia and Lithuania.

The central role of gender inequality in human development is also discernable from UNDP indices and allows a reconfiguration of HDI profiles in the candidate countries in line with the EU's commitment to gender mainstream analysis. The UNDP's Gender-related Development Index (GDI) re-weights the original HDI to reflect the amount of gendered inequality there is in the component measures.

[14] Unicef Statistics at www.childinfo.org
[15] Indeed such per-capita figures are part of the HDI.
[16] EU15 composite score was 1.10 times the Applicant Country composite score in 1990 and 1.12 in 1995 and 2000.

Figure 4 UNDP Human Development Indices 1990, 1995 and 2000



	CY	SI	MT	CZ	HU	SK	PL	EE	LT	LV	BG	RO	TR		Sweden	Portugal	EU15 ave
1990	0.845	0.845	0.826	0.835	0.804	0.82	0.792		0.816	0.804	0.786	0.777	0.686		0.894	0.819	0.883
1995	0.866	0.852	0.85	0.843	0.809	0.817	0.808		0.781	0.763	0.778	0.772	0.717		0.925	0.855	0.902
2000	0.883	0.879	0.875	0.849	0.835	0.835	0.833	0.826	0.808	0.8	0.779	0.775	0.742		0.941	0.88	0.921

Source: UNDP Human Development Report 2002[17]

Table 3 shows GDI for all of the candidate countries[18] together with equivalent EU15 comparators. Table 3 also shows the so-called "gender penalty"- the *difference* between the HDI and GDI – here expressed as a proportion of the 2000 HDI score. Table 3 shows no difference in the ranking of countries by GDI to that shown in Figure 4. The majority of candidate countries have relatively low gender penalties – 0.23 to 0.25 per cent – compared to the EU15 average of 0.35 per cent. There are two candidate countries, Malta and Turkey, with high relative gender penalties – and that hence the highest gendered inequality in human development indicators. Cyprus and the Czech Republic have a gender penalty around that of the EU15 average.

[17] Figure 3 has the HDI scale set to a minimum of 0.275 - the lowest national HDI score in the world (Sierra Leone) in 2000. 2) Candidate countries are ranked left to right by their 2000 HDI score.

[18] minus Estonia that has no GDI for 2000

Table 3 Gender-related Development Index 2000

	GDI 2000	Gender penalty as % of HDI
Cyprus	0.879	0.45%
Slovenia	0.877	0.23%
Malta	0.860	1.71%
Czech Republic	0.846	0.35%
Hungary	0.833	0.24%
Slovak Republic	0.833	0.24%
Poland	0.831	0.24%
Lithuania	0.806	0.25%
Latvia	0.798	0.25%
Bulgaria	0.778	0.13%
Romania	0.773	0.26%
Turkey	0.734	1.08%
Belgium	0.943	-0.43%
Portugal	0.876	0.45%
EU 15 average	0.918	0.34%

Source: UNDP Human Development Report 2002.

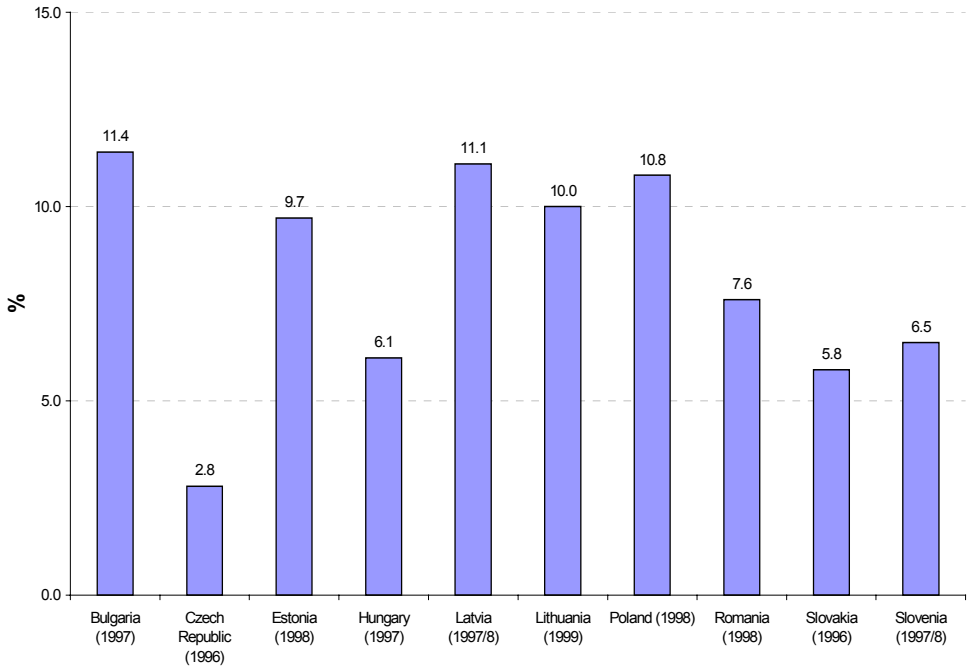
4.2.3 National Poverty Profiles

Comparing poverty levels from national level data requires consistent poverty measures. Poverty risk and poverty gaps differ according to the measures used. Evidence from national data stems from surveys undertaken during the 1990s. Surveys tend not to be regular and differ in approach in many ways – thus making both comparability and contemporaneity a problem. The ten former communist countries all have data on poverty incidence from surveys used by the World Bank and this tranche of evidence is the most consistent and comprehensive to date. Figure 5 shows consistent poverty measures in nine of the ex-communist candidate countries with a poverty line set at 50 per cent of equivalent median household consumption. Poverty measures based on consumption are preferred in many transition economies due to marked under-reporting of income, especially from illegal and semi-legal employment, and of significant levels of home production – particularly of food (World Bank 2000 p 368). Even with a harmonised definition of a poverty line, great care has to be taken to compare or rank countries using this common definition. The common equivalence scale reported here uses a 0.75 rate for children (where 1 is an adult), the preferred scale for transition countries – especially where energy prices remain subsidised and housing costs low or unidentified in the data (ibid). Readers are reminded that the data is mostly from the mid 1990s and thus may not

accurately reflect current incidence and that this data also reflects different underlying national macro-economic circumstances with countries being at different points in the overall transition process and differing points of the economic cycle.

Figure 5 shows that Bulgaria, Latvia, Poland and Lithuania all had poverty risk at 10 per cent or over in the survey years using this poverty measure. The Czech Republic shows a far lower rate than the other eight countries – at 2.8 per cent. Data from the other candidate countries varies more widely and is not consistently comparable. Cyprus reports 25.5 per cent of population below 60 per cent of median equivalent income in 1996/7[19]. Malta reports 11.8% in poverty in the Women's Welfare Study of 2000[20]. Turkey had 15.7 per cent of individuals under 50% of median income based poverty line in 1994 (World Bank 200b).

Figure 5 Poverty Risk in Nine Candidate countries: various years (50% Median Consumption)[21]



Consistent comparison – as in Figure 5 is easiest using relative poverty lines set as a proportion of median equivalent income to reflect comparable living standards. However, relative lines are not always seen within countries as an accurate or appropriate measure of poverty. The discussion

[19] From Family Expenditure Survey 1996/7 – see National Expert Report Table 4.2

[20] See the Maltese national expert report.

[21] Source: World Bank (2000a) Appendix D and World Bank (2002) for Slovakia. Equivalence scale θ=0.75; based on household consumption data except Hungary and Slovakia.

in Part 1 demonstrated how different national poverty measures were viewed and implemented and the limitations of relative poverty lines based on income or consumption become more apparent when set alongside national poverty lines. The shape of the income-distribution in many of the ex-communist countries and also in Turkey means that the majority of the population are poor and have low incomes. This leads to the situation where relative poverty lines are *below* measures of absolute poverty based on basket of goods measures or other approaches[22]. National poverty reduction programmes can be thus poorly designed if they take relative poverty measures as a basis – as many severely needy people will be missed.

Several Candidate countries stand out as having very substantial undercounting of poverty using relative measures. Bulgaria reports that several basket of goods measures report poverty risk at between 63.9 per cent to 34.7 per cent of households, where as a comparable relative measure identifies only 8.3 per cent of households – a very dramatic undercounting.[23] However, even more dramatically for Bulgarian poverty reduction programmes, the official social assistance income threshold only identifies 3.1 per cent – a point of real importance that is further discussed in Part 3's evaluation of minimum standards of income. In Turkey, 36.3 per cent of individuals are poor using a local basic basket of goods measure as against 15.7 per cent using a relative measure based on 50% of national median equivalent income (World Bank 2000b Table 1). Table 4 shows a range of Slovakian poverty measures including daily dollar purchasing power parities for individuals and households.

Table 4 Poverty Measures in Slovak Republic 1996

% Below poverty line	**Households**	**Individuals**
Minimum Subsistence Level	7.9	10.1
50% median equivalent income	5.9	5.8
US$2.15 PPP per person per day	2.1	2.6
US$4.30 PPP per person per day	6.3	8.6

Source: World Bank (2002) Table 1

Table 4 shows the extent of undercounting poverty in Slovakia when using a relative measure at 50% of median national income is only 43 per cent of poor individuals and 25 per cent of poor households defined by a minimum subsistence level. The two daily US$ poverty measures allow an estimation of the approximate value of the weekly income levels associated with this undercounting and strongly point to the relative line representing an income only between 3 and 4 dollars a day.

[22] For instance the Orshansky method – as also used in US poverty measurement

[23] Bulgarian National Report Table 4.2.

The problem of appropriate poverty measures to assist poverty reduction programmes is one that has been well rehearsed in the poverty literature. Recent discussion by UNDP and World Bank on Central and Eastern Europe and transition economies has developed robust strategies with national policy makers and analysts. A recent overview for UNDP suggests several important lessons for poverty analysis and measurement in the Central and Eastern European region[24] (Górniak 2001a):

> First, that poverty is a "layered" phenomenon and a combination of poverty lines is optimal for targeting and policy design.
>
> Second, that policy-makers' preference for a single solution should be recognised.
>
> Third, that absolute thresholds seem better suited while absolute deprivation is a widespread problem.
>
> Fourth, both relative and absolute measures have advantages and disadvantages and therefore choice should be firmly based on analysis of their relative reliability and accuracy.
>
> Fifth, much groundwork has already been done in many of the CEEC countries themselves.

The important task ahead is thus to take forward this existing work on poverty profiling, measurement and policy design as part of the Accession process and as part on an enlarged EU's policy on poverty and social exclusion.

4.2.4 EU Indicators

The development of the set of indicators to consistently measure poverty and social exclusion across the Member States has been a major advance in comparative and consistent measurement of disadvantage for the EU. The measures will provide both a benchmark and an ability to establish changes in the profile of poverty and social exclusion over time. The EU indicators adopted at the Laeken European Council in December 2001 therefore represent an important reference point for the candidate countries.

Eurostat, working with most of the candidate countries, has been able to produce a set of results that use consistent methodology and definitions to those employed for the EU[25]. Coverage of all 13 candidate countries has not been possible due to data and other difficulties.

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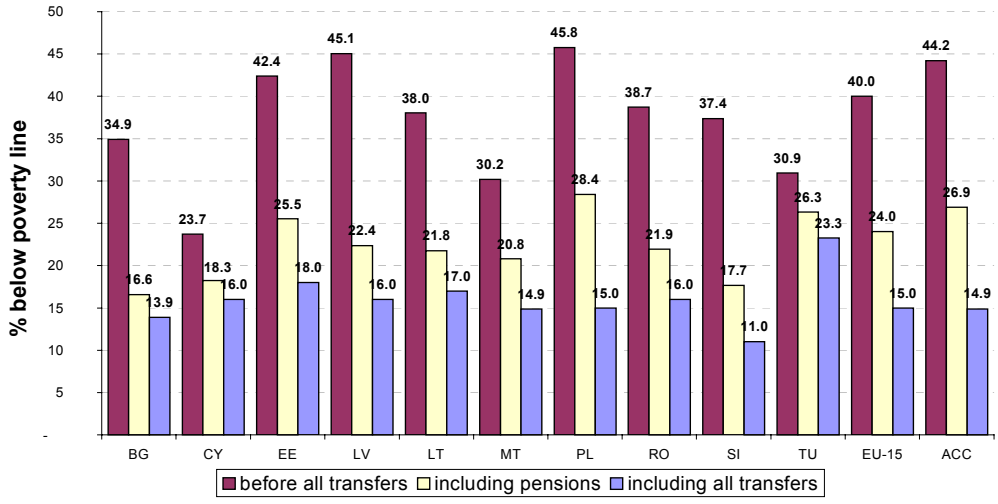
[24] and also for Central Asia

[25] See Document E2/IPSE/CC5/5/2002, "Co-operation with Candidate Countries: Statistics on Income, Poverty and Social Exclusion Results."

The headline indicator of poverty uses a relative income measure of 60 per cent of mean equivalent individual income. Results are shown in Figure 6 for incomes before and after transfers. The overall risk of poverty after transfers is very similar in average across the EU-15 and Candidate countries at 15 and 14.3 per cent respectively. Pensions are the primary source of income that reduces poverty in both sets of countries, reducing headline before transfer poverty risk from 44 per cent to 26 per cent across candidate countries and from 40 to 24 per cent in the EU-15. Turkey and Cyprus have smaller impacts of transfers on poverty than the other candidate countries.

Figure 6 Poverty Rates using Laeken Indicators: before and after transfers



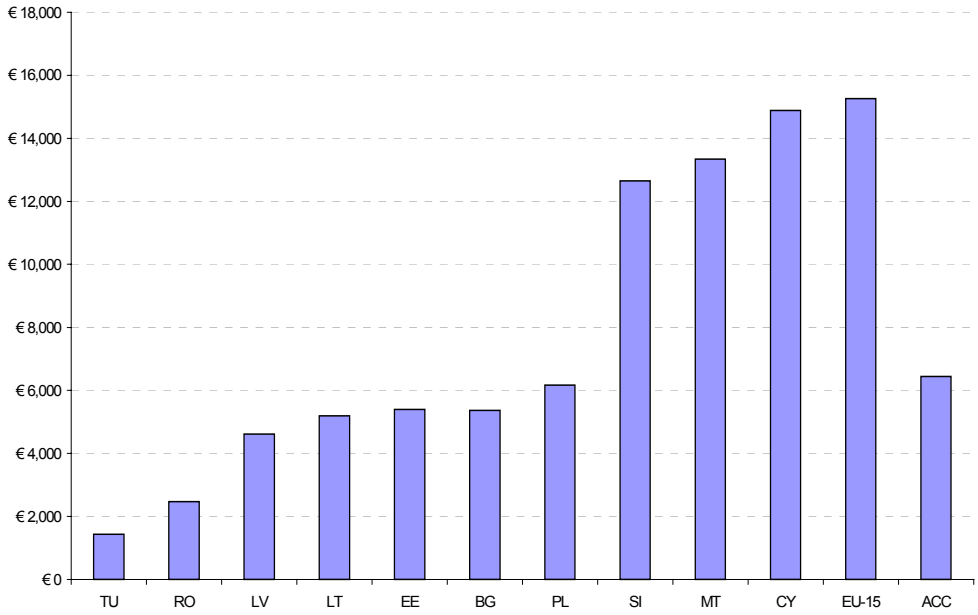
Source: Eurostat (2002c)

Figure 7 shows the monetary value of the Laeken poverty threshold in purchasing power parity Euros expressed as an annual income for a household with two adults and two dependent children. The candidate countries have been ranked in ascending order left to right with EU-15 comparator figure and a composite figure for the 10 accession countries participating in the Eurostat study. Because the Laeken indicator is a relative measure based on a proportion of median income, Figure 7 clearly shows the different relative levels of incomes in the candidate countries and shows much higher monetary poverty lines in those countries with highest incomes and living standards, Slovenia, Malta and Cyprus and the EU-15.

Previous discussion above reported disadvantages of using relative measures for some of the candidate countries was that it produces a poverty line that is below absolute levels of need. The relevance and importance of

this observation can be seen if the monetary threshold created by the Laeken poverty risk measure is compared to international absolute measures of poverty – in this case the World Bank $2 a day measure.

Figure 7 Annual Poverty Threshold in PPS Euros - Household with 2 adults and 2 dependent children



Source: Eurostat (2002c)

Notes: Year is 1999 except in Turkey (1994), Cyprus (1997), EU-15 (1998), Malta (2000)

Table 5 shows the relative value of the Laeken threshold expressed as a percentage of the $2 a day World Bank poverty line.

Table 5 Comparative Monetary Value of Laeken Indicator to World Bank $2 a day Poverty Line

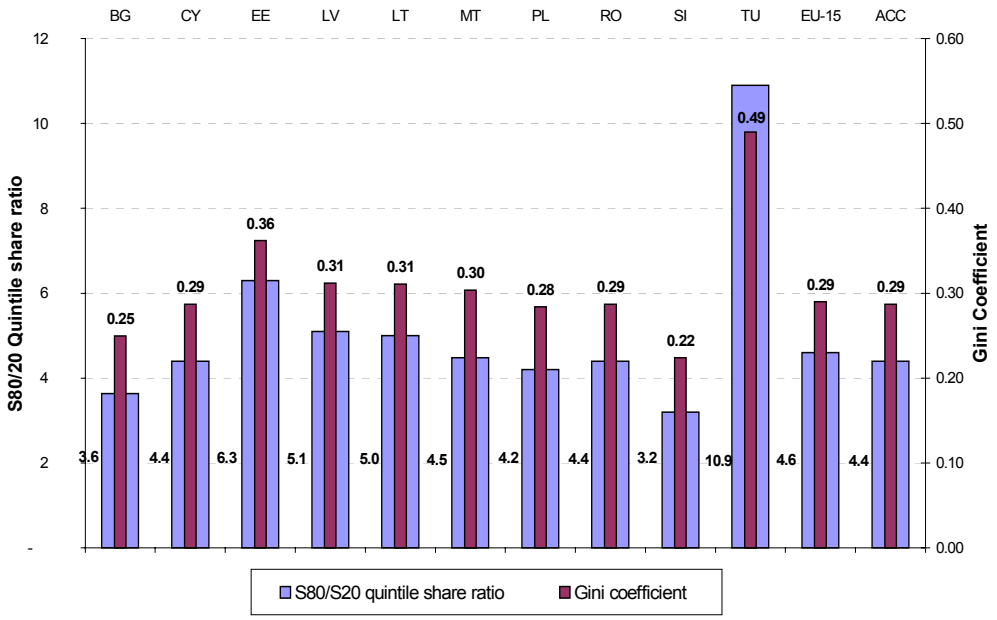
% of World Bank $2 a day Poverty Line	I adult household	Household with 2 adults& 2 dependent children
Romania 1999	208	397
Bulgaria 1999	124	236
Latvia 1999	77	146
Lithuania 1999	75	143
Estonia 2000	64	122
Poland 1999	54	103
Turkey 1994	39	74
Slovenia 1999	18	35
Malta 2000	15	28
Cyprus 1997	14	27

Source: Author's calculations from Eurostat 2002c and from World Bank data

Table 5 shows that World Bank $2 a day poverty line is above Laeken indicators in Romania and Bulgaria for one-person households. The 1994 figures for Turkey should be taken with some caution because of an apparent deterioration of living standards of the poor and high inflation since that time. Due to different assumptions about equivalence scales in part, the Laeken poverty threshold for a two adult, two child household is below the World Bank $2 a day poverty threshold in a higher proportion (six) of the candidate countries. This evidence supports the need to use a mixture of both absolute and relative measures in some of the candidate countries. It should also be remembered that national poverty lines using absolute measures will also differ from the World Bank lines and be based on other computations of necessary goods and services.

The Laeken indicators also include income inequality measures, and evidence of inequality using these indicators is also available through Eurostat's work with candidate countries. Figure 2.ggg shows two Laeken indicators of inequality: first, the ratio of the 80^{th} percentile to the 20^{th} percentile shares, shown on the left hand y-axis and second, the Gini Coefficient, shown on the right hand y-axis.

Figure 8 Income Inequality in Candidate countries



Source: Eurostat 2002c

Turkey has very high income inequality – a gini coefficient 0.49 and a ratio of almost 11 to 1 between top and bottom quintile shares. Estonia too has higher inequality than most candidate countries and higher than aggregate EU-15 levels, a gini coefficient of 0.36 against 0.29 aggregate scores across both groups of countries. However, some of the inequality measures should be treated with caution without sensitivity tests. Bulgaria's data in particular shows marked variation over years in the gini-coefficient measure that could indicate data inconsistencies and other studies have shown much higher Bulgarian inequality scores using consumption data, for instance the gini-coefficient rising from 0.27 using income to 0.41 using consumption (World Bank 2000a).

When the evidence from national and international sources is put alongside the EU Laeken approach there are several issues that arise. First, is the integration of national and international absolute measures of poverty alongside the Laeken relative measures. Such and approach is entirely consistent with the use of the EU indicators where it is acknowledged that a hierarchy of indicators should be used to develop a balanced overall view. *Primary indicators* are the comparable leading indicators of monetary poverty and related issues which cover the broad fields that have been considered to be the most important elements in leading to social exclusion. *Secondary indicators*, also commonly agreed and defined, support these lead indicators and describe other dimensions of the problem. Where appropriate

these may be supplemented by a *third level of indicators* that countries decide for themselves to highlight specific issues in particular areas and to help interpret the primary and secondary indicators. These indicators are not necessarily harmonised at EU level.

Second, the ongoing refinement and development of the EU indicators by the Indicators Sub-Group of the Council Social Protection Committee should take into account the issues new candidate countries and take forward the some of the acknowledged limitations of the current set of EU indicators in describing the situation of the Candidate Countries.

Third, there are matters of methodology and data reliability and robustness to discuss further in regard to some of the candidate countries. Initial results of the pilot project launched by the Statistics Office of the European Communities demonstrate that it is possible in the majority of the Candidate Countries to measure income in a sufficiently comparable and reliable manner with existing sources, despite the acknowledged problems in many of the candidate countries with extensive under declaration (the grey economy). However, the use of appropriate equivalence scales may also require further consideration – perhaps with candidate countries encourages to report redefined measures using other scales as third level indicators to establish a wide evidence base.

Last, the emphasis placed on relative indicators in the Primary level EU indicators should not be allowed to encourage policy makers to undercount poverty and social exclusion. Such undercounting is both potentially problematic within candidate countries themselves through promotion of a relative measure that is below absolute levels but also in the appreciation of Member States of the extent and depth of poverty in candidate countries.

4.3 Social Exclusion – Recognition, Response and Effectiveness

This section overviews evidence of areas of exclusion and poverty that match the *core challenges* identified by the Commission from the National Action Plans of Member States (European Commission 2002). There are two main underlying questions that are applied to each of the core challenge areas:

1. What are the drivers of poverty and exclusion?

2. How has social protection and other areas of social policy responded?

4.3.1 Inclusive Labour markets

Employment is a major determinant of both current and lifetime experience of poverty and social exclusion and one of the foundations for effective

social protection. The central role of employment as a macroeconomic driver of growth and of individual well being is covered in linked and accompanying policy making in and across Member States, at EU level and recently in the candidate countries. The Commission and applicant States are in discussion about employment policy that mirrors in many ways some of the policy assessment and planning in the Employment Strategy of the EU.

There are several important themes to the labour market as a driver of poverty and social exclusion based on absence from, entry into, participation in and exits from the labour market. Poverty risk tends to be linked to exclusion from the labour market in terms of employability and unemployment in the EU. Evidence of education and skills levels, duration of unemployment and inactivity, and the incentive structures of out of work benefits and taxation systems are generally seen as primary drivers of exclusion. Additionally, exclusionary processes in labour markets such as gender and racial discrimination are also taken as potentially major demand side factors. However, the issue of low pay, poor quality employment and of employment in the grey informal economy is also a widespread factor in many of the candidate countries. However, it is also important to emphasise at this point that one prevalent structural factor in labour market exclusion is a wider demand-side failure that still stems from the huge economic transition shock in the ex-communist countries. While there are some ex-communist countries that have recovered their former levels of GDP, unemployment and underemployment remain at high levels across many of them.

The overall and male and female employment rates in candidate countries are shown in chapter 1 The discussion on employment rates shows how far inactivity, and in particular, women's inactivity affect underlying assumptions about employment. When we turn to unemployment rates – measured using labour force surveys and thus as a proportion of economically active population, the disparities between national male and female profiles changes. Tables 3a/3b in chapter 1 show the rates of unemployment and gender specific rates for 2000. There is wide variation across the candidate countries but variation too between highest and lowest unemployment levels in Member States (Spain: 14.1 (men: 9.8, women: 20.6) and Luxembourg (2.4 (men: 1.9; women: 3.3)). However, unemployment levels are shown to be a poor indicator of aggregate poverty levels in many instances –Turkey and Romania have low overall unemployment rates but this is mostly due to high levels of underemployment in low-productivity agricultural sector. Turkey also under-reports unemployment in this time series because 2001 data shows unemployment rising to over 11 per cent (OECD Employment Outlook 2002). These two countries also have little difference between male and female rates but in Turkey's case we have already seen how far such small

differences in unemployment are underpinned by huge differences in gendered economic activity.

There are six candidate countries with total unemployment rates above ten per cent: they are in descending order of unemployment, Slovakia (19 per cent), Poland, Bulgaria Latvia Lithuania and Estonia (13 per cent). Amongst these, only in Poland is female unemployment higher. Of the remaining five, Latvia stands out because of a 5-percentage point lower female unemployment rate compared to an overall trend of slightly lower female rates in the others. The other candidate countries with less than ten per cent unemployment (ignoring Turkey and Romania already discussed) range from the Czech Republic (8.8 per cent) to Cyprus (4.9 per cent). In these two named countries is also the largest difference between male and, higher, female unemployment rates. Malta and Hungary on the other hand have lower female unemployment rates.

This brief discussion shows how unemployment, and gendered differences in unemployment, link to underlying participation rates in non-consistent ways. But it is also important to remember that behind the aggregate rates are different causal factors - of sectoral employment participation, educational and skill differences – (high relative female unemployment in Spain and Poland for instance will have quite different qualificational characteristics) and of age and other characteristics. Additionally, unequal opportunities to education as well as employment are in part driving low female participation rates in Turkey and elsewhere[26]. Most of the candidate countries tend to prioritise issues of unemployment rather than of inactivity. There is more concern in general about integrating high levels of young people who are out of work and unemployed people and thus of "welfare to work" considerations.

Table 7 shows the increased risk of poverty from unemployment is clear across all the candidate countries. There are three countries where relative risk of poverty for the unemployed higher than 400 per cent, that is 4 times the aggregate risk: Czech Republic has 12 times the aggregate risk, Estonia 4.5 times and Hungary 4.3 times. At the other extreme are a group of countries with relative risk levels of between 1 and three times aggregate risk of poverty: Lithuania (1.3 times), Bulgaria (2.2 times), Poland (2.3 times) and Romania (2.5 times). Similar risk figures for the other three candidate countries using different and inconsistent poverty measures show low risk. The unemployed in Cyprus have less risk of poverty (0.6) than general, while in Turkey the relative risk is just over 1 (1.06). There are many factors that influence the risk of poverty during unemployment linked to social protection coverage and other sources of household income and

[26] The skilled employed women in Turkey tend to suffer equal risk of unemployment, but are in a country with high gendered inequality. Unemployment in itself can therefore sometimes be a poor indication of underlying structural drivers of exclusion and discrimination.

employment. Household reliance on sole earners carries a greater risk of poverty from unemployment taking all other factors as constant.

A different question is how much poverty of each country is explained by unemployment. Table 7 shows consistent figures for the ten ex-communist countries and shows that over 25 per cent of Hungarian and Czech poverty is associated with unemployment, while at the other extreme under 10 per cent of poverty is thus associated in Lithuania and Poland. Explanation of these differences is far more difficult as other factors and risks will create poverty to different extents alongside unemployment – and these will be discussed later in this section. However, there do appear to be "high risk-high incidence" countries such as the Czech Republic and Hungary and "low risk-low incidence" countries such as Lithuania and Cyprus.

Table 7 Relative Poverty Risk and Shares of Poverty by Unemployment of head of household[27]

	Relative Poverty Risk %	**Share of Poor %**
Bulgaria (1997)	224	19.3
Czech Republic (1996)	1,629	26.2
Estonia (1998)	451	15.4
Hungary (1997)	433	30.4
Latvia (1997/8)	265	16.1
Lithuania (1999)	138	4.0
Poland (1998)	456	7.4
Romania (1998)	251	11.9
Slovakia (1996)**	347	-
Slovenia (1997/8)	355	9.6

Source: Author's calculation from World Bank (2000a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

[27] Risk measured as unemployed poverty incidence/aggregate poverty incidence. Measures of poverty and equivalence scales held constant to those used in Figure 4 above.

The underlying risk of unemployment itself is not equally spread and age, gender, educational/skill level and duration of unemployment are main factors in unemployment risk and employability.

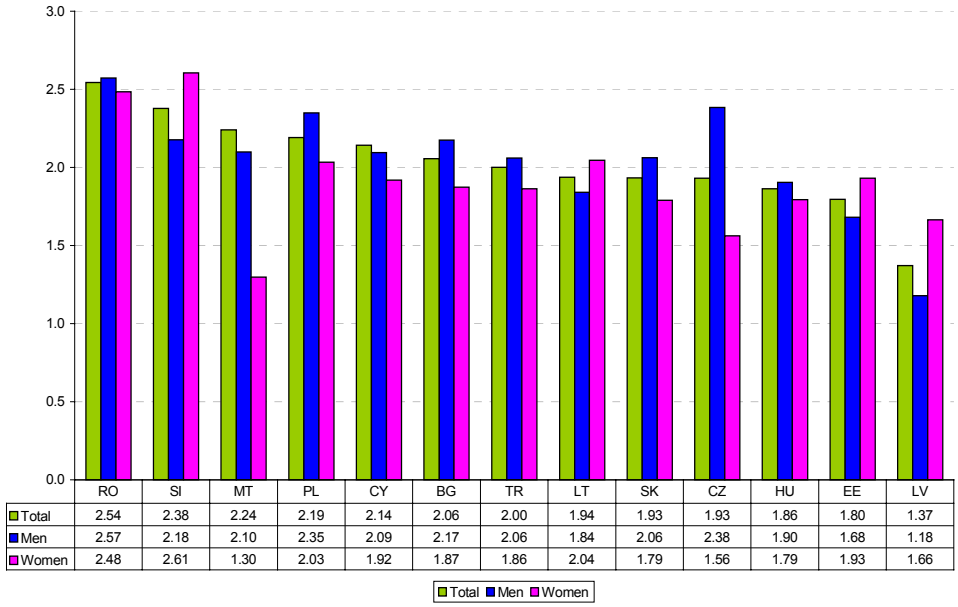
Youth unemployment, (for those aged less than 25) is more prevalent than general unemployment and the increased risk of the under-25s (calculated by ratio of under 25 unemployment rates to overall unemployment rates) is shown in Figure 9

The additional risk of youth unemployment is between 2.5 and 1.8 in all candidate countries except Latvia, where it is lower 1.4. The equivalent EU15 measure is 1.98. Young men are more at risk, compared to all male unemployment in Poland, Bulgaria, Turkey, and Hungary and especially in the Czech Republic. Young women's risk, compared to all female unemployment, is higher than the aggregate risk for young people in Slovenia, Lithuania, Estonia and Latvia. This is not a direct measure of gendered inequality, however, because the risk profile is already separated by gender. If we compare the risk of young women to young men, young women overall are less at risk of unemployment than young men in most candidate countries – except Slovenia Cyprus especially but also in Latvia and Poland.

Duration of unemployment is an important causal factor in poverty and social exclusion. Risk of unemployment rises with duration and the European Employment Strategy has taken the role of intervention through active labour market programmes to prevent long-term unemployment as a central pillar of policy. Figure 10 shows the proportion that is unemployed for more than 12 months alongside general unemployment rates for 2000. There are a group of countries with high unemployment rates and high rates of long term unemployment: Slovakia, Poland, Bulgaria and the Baltic states where unemployment is above 10 per cent and long-term unemployment makes up 45 per cent or more of this total. The group of countries with unemployment lower than ten per cent include Turkey and Romania- already distinguished above – but where long-term unemployment varies greatly – almost half in Romania and just over a quarter in Turkey. The difference between these two countries is likely to lie in social protection systems' coverage of unemployment as Turkey has no safety net social assistance benefit and unemployment insurance is limited in coverage. The remaining "low" unemployment countries have high long-term unemployment except for Cyprus – with both low unemployment and only a quarter of its unemployed over12 months.

Underlying trends are important for understanding social exclusion and poverty. Growing proportions of long-term unemployment in a stable or declining low rate of unemployment provide a very different challenge to high and growing levels of long-term unemployment in stable or growing high levels of overall unemployment.

Figure 9 Increased Risk of Unemployment for the Under 25s 2000 (unemployment rate for under 25s over total unemployment rate)

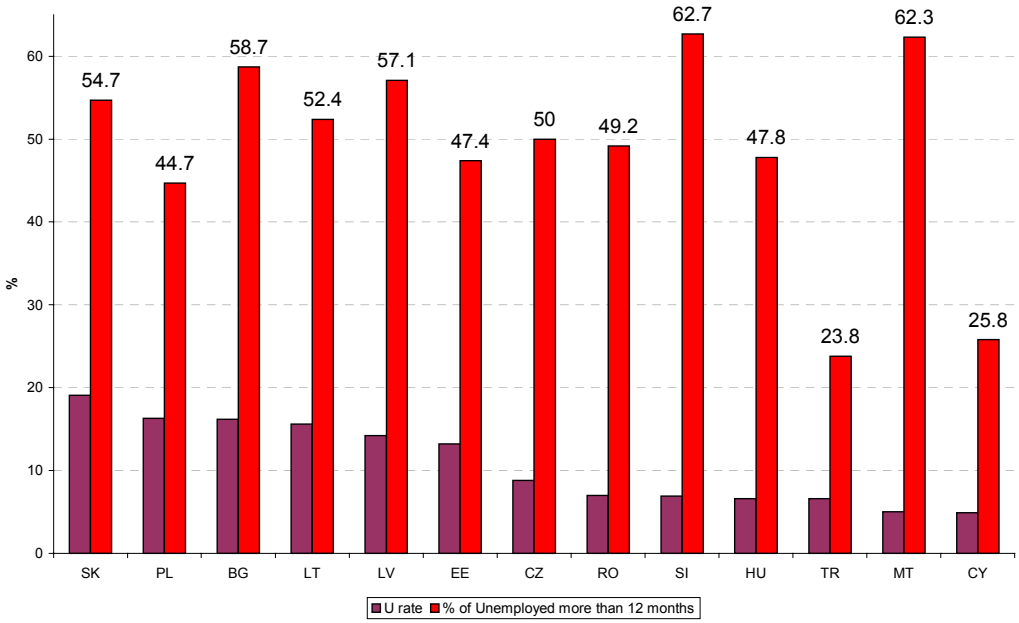


	RO	SI	MT	PL	CY	BG	TR	LT	SK	CZ	HU	EE	LV
Total	2.54	2.38	2.24	2.19	2.14	2.06	2.00	1.94	1.93	1.93	1.86	1.80	1.37
Men	2.57	2.18	2.10	2.35	2.09	2.17	2.06	1.84	2.06	2.38	1.90	1.68	1.18
Women	2.48	2.61	1.30	2.03	1.92	1.87	1.86	2.04	1.79	1.56	1.79	1.93	1.66

Source: Author's calculations from Eurostat (2002b)

Note: Countries ranked left to right in descending order by total ratio

Figure 10 Long Term Unemployment (12 months or more) 2000



Source: Eurostat (2002b)

Note: countries ranked left to right by descending underlying unemployment rate.

Table 8 summarises the trends and divides the candidate countries into different groups depending on their current and trend growth in overall unemployment and then additionally shows the trend growth in long-term unemployment[28].

Poland, Lithuania and Estonia each have current employment rates of over 10 per cent and have experienced growth of unemployment, on average, nine per cent or over in recent years. The growth in unemployment has decreased the proportion of long-term unemployment in Poland and Latvia – pointing to high levels of growing frictional unemployment. Estonia however has also experience growth in the proportion of long-term unemployed and this is of more concern. Of course, declining proportions of long-term unemployment does not necessarily mean a decrease in numbers – and as Figure 10 shows all these countries have around half of their unemployed of 12 month duration or over.

Latvia has high but stable unemployment rates at around 14 per cent and has maintained a fairly steady level of long-term unemployed. The Czech Republic has low but growing unemployment[29] over recent years. This growth has been accompanied by a growth in the proportion of long-term unemployed. Malta and Slovenia on the other hand have low and stable unemployment over all and rising proportions of long-term unemployed.

These profiles suggest different approaches and experiences of the long-term unemployed in recent years – in many countries they will have fallen along with unemployment more generally, but slower declines point to the need to prioritise active labour market programmes to assist those with greatest difficulty.

Gendered inequality in long-term unemployment is shown in Table 9 measured as the ratio of female long-term unemployment to all long-term unemployment. Table 10 ranks candidate countries in descending order by proportion of overall long-term unemployment and shows the majority of countries have ratios close to unity, but with women having less risk of long-term unemployment in most cases. Malta stands out as having particularly low risk of long-term unemployment and, given high gendered inequality in employment participation shown above, this may be due to women leaving unemployment to inactivity. Cyprus and Turkey stand out as having high ratios of female long-term unemployment.

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[28] Trend data is not consistently available across countries

[29] OECD data shows that 2001 unemployment rate fell to 8.2%

Table 8 Unemployment and Long-term Unemployment Growth

	2000 Unemployment rate %	**Average annual growth in all unemployment %**	**Average annual growth long-term unemployment %**
High (>10%) current and growing u			
PL	16.3	14.0	-1.0
LT	15.6	11.7	-8.7
EE	13.2	8.6	6.5
High current and stable/declining u			
LV	14.2	-1.0	0.7
Low (<10%) current and growing			
CZ	8.8	27.0	15.7
RO**	7	8.4	0.8
Low (<10%) current and stable/declining			
MT	5	0.0	12.4
SI	6.9	0.0	5.8
TR**	6.6	-0.4	-15.2
Notes: ** Turkey and Romania require careful contextualisation *Average growth measured over at least 3 but no more than 5 years			

Source: Author's calculations from Eurostat (2002b)

The final element of unemployment risk and employability discussed here is the level of education and skills. Low education and skill is strongly linked to unemployment and to long-term unemployment. However, education levels are also linked to age with younger cohorts tending to be better qualified and illiteracy levels tending to rise in the older population.

Table 9 Long-term Unemployment & Gender 2000

%	Female Proportion long-term unemployed	Female long term unemployment/ all long-term unemployment
SI	62.7	0.96
MT	62.3	0.64
BG	58.7	1.00
LV	57.1	1.00
SK	54.7	1.00
LT	52.4	0.90
CZ	50	1.01
RO	49.2	0.98
HU	47.8	0.91
EE	47.4	0.98
PL	44.7	1.09
CY	25.8	1.25
TR	23.8	1.34

Source: Author's calculations from Eurostat (2002b)

In work Poverty

Unemployment and inactivity are not the only labour market drivers of poverty and exclusion. Table 10 shows poverty in work in the ten ex-communist candidate countries. In-work poverty affects many workers – employees, self-employed and farmers. Romania has the highest rate with 28 per cent in poverty, while Czech Republic has only 5 per cent of workers poor. The relative risk of poverty is also highest in Romania, and lowest relative risk is in Bulgaria. Even the Czech Republic with only 5 per cent of workers poor, still has a high relative risk of poverty in employment[30]. More striking is the high share of poverty from households where the head is in work. In –work poverty is over 70 per cent of poverty in Poland and Lithuania and over 40 per cent in all ex-communist countries except for Bulgaria where it is 25 per cent. Similarly, 37 per cent of Turkish employed people are in poverty and such employed poverty has an over 88 per cent share of all Turkish poverty (World Bank 200b). There is very low poverty risk for those in work in Cyprus – around 4 per cent, but a higher 11 per cent risk for self employed.[31] Agricultural workers, farmers and self-employed people are the main groups of in-work poor in many of these countries and

[30] Relative risk is the risk of the in-work poor compared to the overall risk for the whole population.

[31] See national expert report on Cyprus Table 4.8

this is also relevant in rural poverty profiles discussed below. The other main reason is that single earner households do not reduce poverty risk in the Central and Eastern European Countries as much as in the EU and low pay is a real driver of poverty. Overall it is estimated that double the rate in the EU or 22 per cent of full-time workers in these countries have earnings below the conventional threshold of low pay – two thirds of median earnings.

Employment Policy

All candidate countries report active employment programmes and employment policies and many have recently developed such programmes to reflect the EU Employment Strategy. There has been the development of Public Employment Services and social assistance and unemployment benefit have had activation programmes introduced or prioritised. Many governments reduced coverage and duration of unemployment benefits in the mid 1990s and coverage of unemployment insurance, where data is available, shows that coverage varies greatly from 22.9 per cent in Poland to 73.6 per cent in 1998 Hungary in 1998 (Riboud, Sánchez-Páramo & Silva-Jauregui 2002, Table 23.3). The unemployed thus rely to different extent on unemployment assistance and social assistance as such schemes have expanded, along with informal sources of income and family support. Not only can coverage poor and benefits low with significant problems in local administration of assistance, but spending on active employment programmes is also very low when compared to EU and OECD averages – with Central and Eastern European countries spending under one quarter of EU levels as a proportion of GDP (ibid Table 23.4).

Table 10 Risk of Poverty and Shares of Poverty in Employment & Self-Employment

	Risk of poverty%	**Relative risk %**	**Share of Poor %**
Bulgaria (1997)	9.1	79.8	25.1
Czech Republic (1996)	5.0	178.6	43.7
Estonia (1998)	17.4	179.4	45.2
Hungary (1997)	7.6	124.6	43.9
Latvia (1997/8)	16.8	151.4	43.8
Lithuania (1999)	9.0	90.0	73.9
Poland (1998)	10.5	97.2	75.6
Romania (1998)	28.0	368.4	55.5
Slovakia (1996)	9.0	82.6	
Slovenia (1997/8)	4.1	63.1	42.5

Source: Author's calculations from World Bank (2000a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

Maintaining financial incentives to work through duration limited benefits and low replacement ratios is difficult for many of these countries where low-pay and underemployment are common and where studies have found that exhaustion of benefits can lead to the unemployed leaving the workforce rather than returning to work (Boeri, Burda, and Köllo 1998).

4.3.2 Adequate Incomes/Resources

Very few Candidate countries report sizeable populations who lack basic amenities and utilities. Lack of drinkable water in Turkey is mentioned as a problem for two percent of the population. Other countries with significant Roma populations report problems of water and other utilities in some unplanned/non-legal Roma settlements. Often problems of utility coverage are linked to older property in rural areas and to some older residents – for instance in Cyprus.

However, coverage and adequacy of social protection to ensure minimum adequate resources is a problem in Central and Eastern European countries and in Turkey. The high incidence of poverty in working age from the causes of unemployment and low earnings mostly affects working age people and children. The elderly have, in general, low relative poverty risk in these countries but higher relative risk in Cyprus and Malta.

The coverage and adequacy of social protection systems for non-pensioners in Central and Eastern Europe is largely a reflection of family and child benefits and means-tested social assistance[32]. Family and child benefits became key components of poverty reduction programmes over the 1990s and countries have varied approaches to targeting – either using income or family composition or having a universal approach. Price subsidies for utilities were in general withdrawn and poverty cash assistance programmes grew, but tended to be devolved to local municipal authorities and to have administrative and financing problems. In general these and other programmes for non-pensioners tended not to command the same level of resources as pension systems.

Evidence on coverage and performance of social assistance schemes tends to be for the mid 1990s and data for five Central and Eastern European Countries is shown in Table 11. It shows a very wide range of coverage of the poor by social assistance schemes – from 50 per cent in Latvia and 43 per cent in Hungary to 10 per cent and below in Bulgaria, Estonia and Poland. Much under-coverage of the poor may well be related to targeting the non-working population when high proportion of poverty is explained by low pay in work.

However, there is also poor targeting that means that some benefits go to the non-poor. Indicators of targeting efficiency are difficult to establish and

[32] or non-means-tested categorical benefits in a few instances.

there is little evidence from World Bank studies to how much goes to those at the margins of poverty or to recipients who have recent experience of poverty. The adequacy of benefits tends to be low and Table 11 shows that benefits make up between 22 per cent and 4 per cent of poor households' expenditure. However, social assistance operates alongside family allowances and other schemes and the combined impact of the package of programmes is probably a better indicator of overall effectiveness and efficiency of social protection in coverage and adequacy.

Table 11 Coverage, Effectiveness and Adequacy of Social Assistance

	Poland	**Hungary**	**Bulgaria**	**Estonia**	**Latvia**
% of households below national poverty line	38	8	2	3	15
Coverage % of poor	6	43	10	10	50
Assistance as % of recipients' household spending	22	5	4	15	20

Sources: Braithewaite, Grooteart and Milanovic (1998), World Bank (2000c)

Table 12 shows the share of cash benefit transfers by the bottom 20 per cent (quintile group) from both social assistance and child and family allowances for more recent years in four Central and Eastern European Countries. This shows higher proportions of Romanian spending going to the poorest 20% than in the other three countries, but overall effectiveness and efficiency is difficult to gauge without fuller understanding about the spread of spending across higher quintiles and the population composition of the bottom half of the income distribution.

Table 12 Percentage Share of Spending of Cash Transfers on Bottom Quintile of Income Distribution

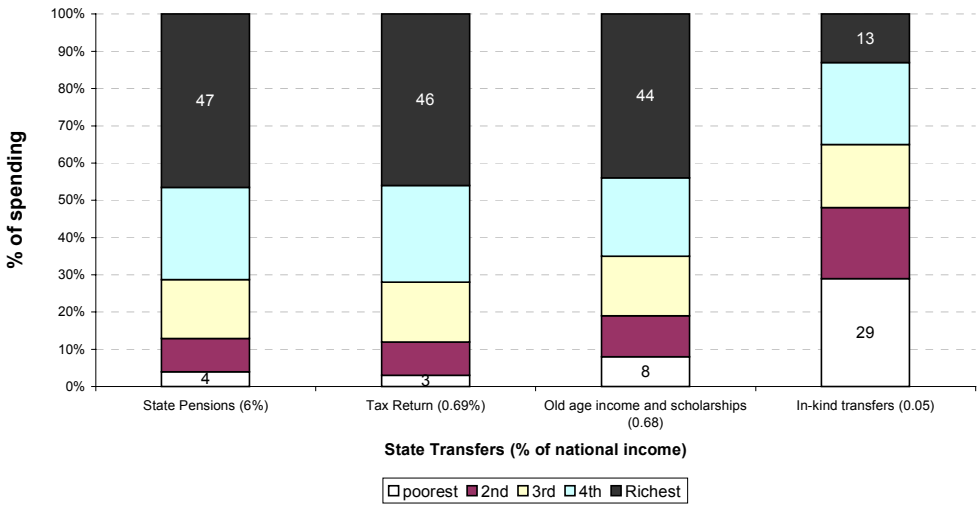
% Share	Social Assistance	Child & Family Allowances
Latvia (1998)	20	29
Romania (1997)	79	51
Hungary (1997)	46	20
Estonia (1995)	44	20

Source: World Bank (2000a) Table 9.4

Current evidence, mostly from World Bank poverty assessments and policy overviews, focuses on the extremes rather than the margins of efficiency and while it gives clear evidence of apparent under-performance for the very poorest, it is not clear how far this is compensated by categorical targeting that effectively reaches groups across the lower bands of the income distribution or of how far the same part of the income distribution contains households who would benefit from greater in-work

support – through taxation, benefit system and minimum wage or other interventions.

Figure 11 Distribution of Turkish State Transfers by Income Quintile



Source: World Bank 2000b Table 6

Turkey has no social assistance safety net and a social protection system that is mainly directed at employed urban populations leaving many outside. This not only leads to a problem of coverage and to social exclusion in the original meaning of the term – that many have no rights to social protection and social assistance - but also of overall efficiency and effectiveness of social protection in preventing or responding to poverty. Analysis shows that Turkish cash transfers from social protection disproportionately favour the better off populations. Figure 11 shows the proportion of Turkish income transfers going to each quintile (raked 20% of the income distribution) in 1994. For instance, only four per cent of state pensions, the largest programme representing a sum around 6% of national income, go to the poorest 20% of the population, while 47 per cent go to the richest 20 per cent. Only the very small programme of in-kind transfers provides a proportional coverage close to the underlying population in the quintiles with 29 per cent of spending going to the bottom fifth. The effect of the Turkish social protection system on poverty is thus minimal; indeed by increasing overall inequality such transfers make relative poverty worse at the same time as being poorly targeted on both relative and absolute poverty.

The example of Turkey shows several important questions for assessment of minimum incomes and social protection across the thirteen countries in terms of coverage and adequacy.

Overall the evidence on coverage and adequacy of incomes in Malta and Cyprus explores issues of relative deprivation, possession of goods and household amenities and experience of debt and financial difficulty and

there is a wealth of data available from the Women's Welfare Study of 2000 in Malta and the 1996/97 Family Expenditure in Cyprus.

4.3.3 Educational Disadvantage

Discussions of unemployment have already shown the important influence of skills and education in the working age population and the link to unemployment and low pay. The evidence of the associated link between low education and poverty has been demonstrated and explored in many of the Candidate countries. National studies such as in Latvia[33] have made such links apparent to policy makers. However, the impact on poverty is not only the additional risk but also the overall population size of low educational achievement in the adult population. Evidence on adult literacy shown in Table 13 gives very high adult literacy rates for the former communist countries – all at 98 per cent and above and with little difference in male and female literacy rates. Adult literacy and discrepancies between male and female literacy rates are more pronounced in Cyprus where the overall rate is 97.1 per cent but female rate is 95.4 per cent; in Malta where the overall rate is 92 per cent with equal or slightly higher female rate, and most pronounced in Turkey with 85.1 per cent overall and 76.5 per cent female adult literacy[34] .

Table 13 Adult Literacy Rates 2000

	Adult literacy	**Female adult literacy**
BG	98.4%	97.9%
CY	97.1%	95.4%
CZ		
EE	99.8%	
HU	99.3%	99.2%
LV	99.8%	
LT	99.6%	99.5%
MT	92.0%	92.7%
PL	99.7%	99.7%
RO	98.1%	97.3%
SK	100.0%	
SI	99.6%	99.6%
TR	85.1%	76.5%

Source: UNDP World Development Report 2002

[33] See Latvian national report and its discussion of Gassman's study "Who and Where are the Poor in Latvia?"

[34] No assessment of gender related inequality has been calculated because illiteracy rates are higher in the older population and thus affected by longevity as well as by discriminatory lifetime experience of and access to education

However, there is stronger evidence of differences between countries of the prevalence of low educational achievement within adult populations. Figure 12 shows the percentage of the population who have less than primary education and who are aged 15 and over in nine of the candidate countries. Bulgaria has 46 per cent of its population with schooling at primary level or below and the levels in Lithuania and Cyprus are around 12 per cent. Table 14 shows the resulting relative risk of poverty by having primary education level only or less[35]. The relative risk of poverty due to low education level is higher than 1 in all countries shown and highest in Slovenia, where having primary or middle level education only makes a person nearly eight times more likely to be poor on average. Relative risk of poverty is also high in Romania (4.9 times more likely) and Poland (3.1 times more likely). People with such low education level make up more than 50 per cent of the poor population in adult levels of education and literacy have strong links to poverty due to employability, earning capacity and unemployment.

Combating educational disadvantage in the adult population is primarily through training and employment programmes and through adult education provision.

However, the remainder of this section considers present drivers of exclusion for current children in the school system – the potential next generation of potential poor adults.

Pre-school coverage in the ex-communist countries has been rising since the mid 1990s. However, coverage in 1999 still varies greatly, from around 50 per cent of the 3-6 year old population in Poland to over 87 per cent in Hungary. Primary school enrolment is in general high in all candidate countries but Bulgaria and Latvia had enrolment rates of 95 and 92 per cent in 1999 – low by European and other CEEC standards[36] and compared to Turkey's low overall rate of primary enrolment, 91 per cent, is also characterised by large differences between girls and boys, with lower girl enrolment not only at primary level but throughout Secondary and Lycee levels.

[35] Using the same consistent poverty measures previously shown in Figure 4 and in subsequent tables on poverty risk

[36] UNICEF TransMONEE database

Figure 12 % of Population aged over 15 with Education Levels at Primary Level or Less

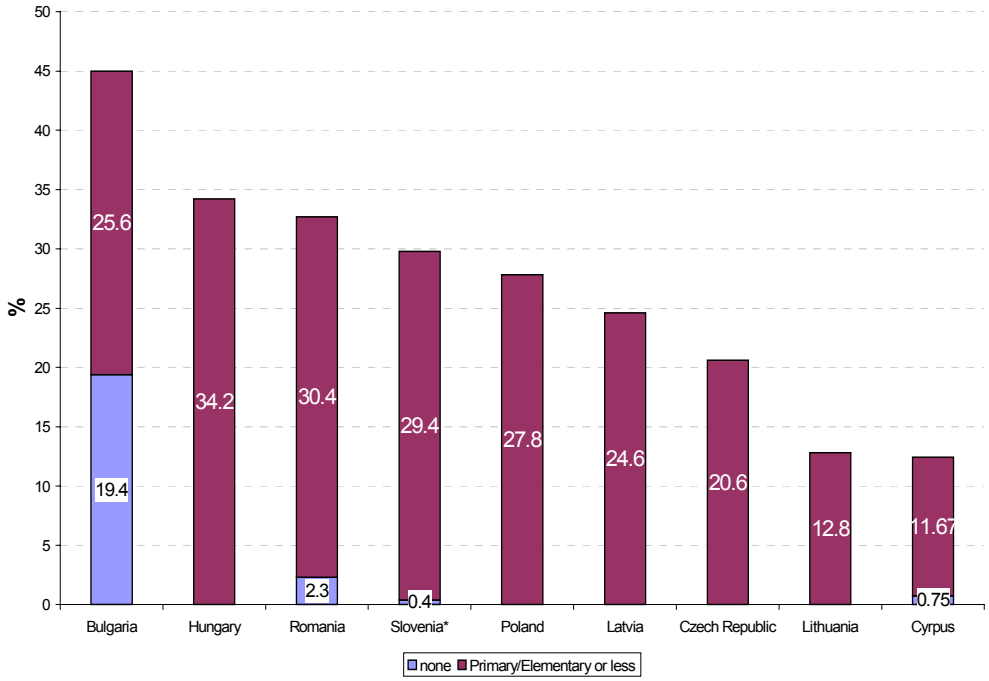


Table 14 Risk and Composition of the Poor by Education at Primary level or less

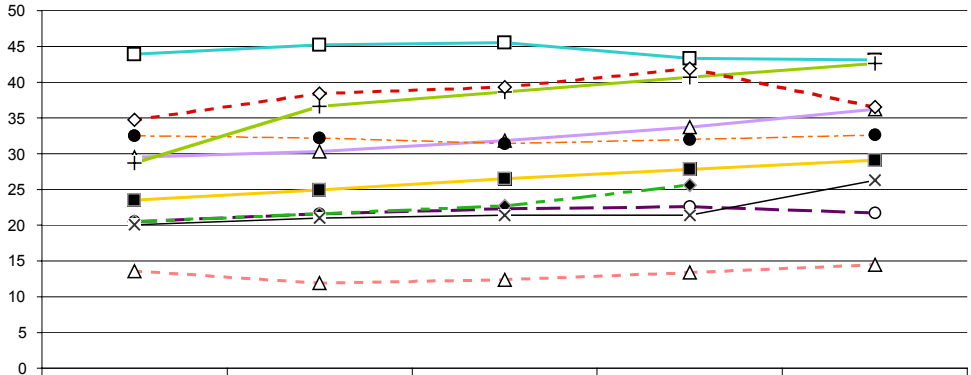
%	Poverty Risk	Relative Poverty Risk	Share of the Poor
Bulgaria (1997)	15.2	133.3	58.3
Czech Republic (1996)	3.3	117.9	24.4
Estonia (1998)			
Hungary (1997)	9.4	154.1	52.7
Latvia (1997/8)	15.3	137.8	33.9
Lithuania (1999)	14	140.0	17.3
Poland (1998)	33.2	307.4	33.2
Romania (1998)	37.1	488.2	43.5
Slovakia (1996)	--	141.6	
Slovenia (1997/8)*	50.8	781.5	51.2

Source: World Bank (2000a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

There are marked differences in enrolment rates at Secondary level for 16 to 18 year olds between some candidate countries as shown in Figure 13.

Figure 13 Secondary School Enrolment 16 to 18 year olds 1995 –1999



	1995	1996	1997	1998	1999
Czech Republic	13.6	11.9	12.4	13.4	14.5
Slovakia	20.5	21.6	22.3	22.6	21.7
Poland	29.5	30.3	31.8	33.7	36.2
Hungary	23.5	24.9	26.5	27.8	29.1
Slovenia	20.5	21.6	22.7	25.6	
Bulgaria	32.5	32.2	31.4	32	32.6
Romania	20.1	21	21.4	21.4	26.3
Estonia	43.9	45.2	45.5	43.3	43.1
Latvia	28.7	36.6	38.6	40.7	42.6
Lithuania	34.7	38.4	39.3	41.9	36.5

Source: UNICEF Innocenti TRANSMonee Database

Figure 13 shows the enrolment rates for 16 to 18 year olds in education and provides clearer differences in educational outcomes than general schooling. Enrolment rates range from the low of around 14 per cent in the Czech Republic to 43 per cent in Estonia.

Combating Educational Disadvantage

There has been little data available on the link between household poverty and educational performance or attendance of children – particularly attendance at Secondary and post-compulsory levels. Neither has there been data made available on the performance of schools. Policy to combat educational disadvantage focuses on several areas: improving access and coverage, improving quality of provision, and providing programmes that particularly target poor populations to counter the effects of poverty on educational performance.

Dropping out of school is recognised widely as highly disadvantageous and a growing body of evidence is showing the effects and causes of such early departure from school – for instance the Bulgarian study that has

linked early school drop out to illegal child labour and school standards of provision[37].

Investment in pre-school education is a major determinant of future educational attainment and overall rates of enrolment previously discussed are seen as too low in many of the candidate countries. Geographical inequality in provision exists. Lithuania reports urban areas have almost five times the level of pre-school provision than rural levels. Problems of school and teaching quality are highlighted by the poor provision of books and library facilities in many countries including Lithuania and Bulgaria. Declining provisions at schools is also reported in the Czech Republic – with decentralised budgeting making inconsistent levels of provision alongside more systematic withdrawal of some services such as school meals. Alongside these trends have been Czech programmes to ensure integrated education and access for the socially and physically disadvantaged. Malta has a growing private school sector and there is widespread parental preference for Church or other private provision and such schools are seen as reinforcing advantaged children with better provision and potential to advance.[38]

4.3.3 Family Solidarity and Children

Evidence of increased risk of poverty for families with children is consistent across the majority of candidate countries. Evidence of higher risk of poverty linked to family break-up is also prevalent – particularly for lone parents across all countries – but also for divorced women, and widows in Cyprus. Table 15 shows the poverty risks and shares of poverty for households with children in the majority of ex-communist countries[39]. Households with children are a large proportion of all poor households – over 95 per cent in the Czech Republic to 44 per cent in Bulgaria. Lone parent households have much higher risk of poverty than other households with children in most countries – except Bulgaria and Latvia and the reasons for these exceptions are not clear. Data from Turkey confirms that households with children have increased risk of poverty – especially children aged under 10 (World Bank 2000b). Children in Cyprus have low risk of poverty – between 4 to 5 per cent are poor (a relative poverty risk of less than 1 - around 0.18). Similarly, in Malta two parent families with children have low incidence of poverty and poverty is more evident in separated and widowed families with and without children

There thus seems to be two different fundamental drivers of poverty in the candidate countries – low incomes that are insufficient to maintain life-cycle

[37] See discussion in Bulgarian National Report Section 4.2.3
[38] See discussion in Maltese National Report Section 4.2.3
[39] Using the same consistent poverty measures previously shown in Figure 4 and in subsequent tables on poverty risk

needs of families with children, which are important drivers of poverty in the ex-communist countries but not in Cyprus and Malta, and additionally specific drivers of poverty that come from death and separation of families or from single parenthood, which are drivers of poverty across all thirteen countries.

Table 15 Poverty Risk and Shares of Poverty for Households with Children

%	Lone parent Households		Other Households with Children		Total Share of Poor for all Households with Children
	Risk of poverty	Relative risk	Risk of poverty	Relative risk	
Bulgaria (1997)	11.5	100.9	12.1	106.1	44.0
Czech Republic (1996)	21.1	753.6	2.1	75.0	95.5
Hungary (1997)	10.5	172.1	9.2	150.8	68.1
Latvia (1997/8)	13.2	118.9	13.7	123.4	59.0
Lithuania (1999)	21.0	210.0	11.9	119.0	68.4
Poland (1998)	21.3	197.2	14.0	129.6	84.4
Romania (1998)	15.3	201.3	10.1	132.9	72.1
Slovakia (1996)	--	275.2	--	175.2	66.6
Slovenia (1997/8)	7.4	113.8	6.2	95.4	48.4

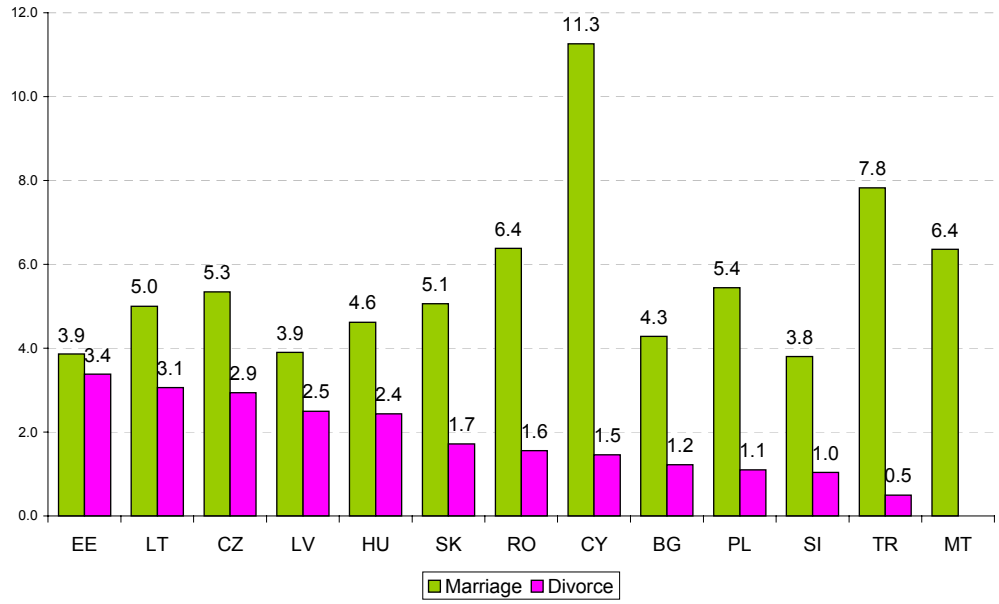
Source: World Bank (2002a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

Figure 14 shows the crude marriage and divorce rates for the candidate countries ranked left to right by divorce in descending order and suggests that divorce is highest in the Baltic States, Czech Republic and Hungary. On the other hand there are a group of countries, Malta, Turkey Cyprus and Poland that are high marriage low divorce countries, indeed divorce is illegal in Malta. Fertility, differs substantially between country and Figure 14 suggests that the countries with higher fertility are those high marriage and low divorce countries identified earlier–Turkey, Cyprus, Malta and, to a lesser extent, Poland.

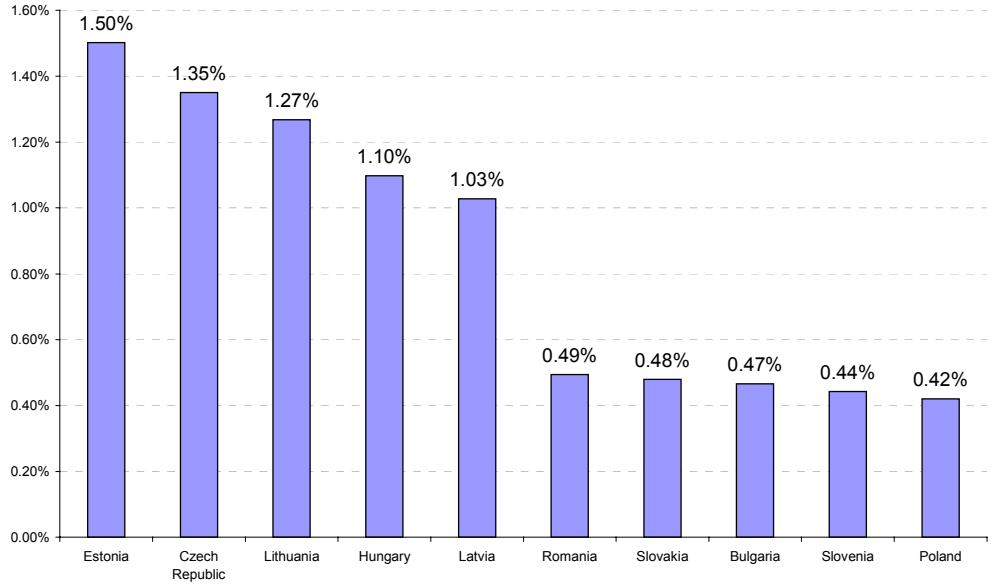
Poverty and social exclusion is linked to income and other measures of deprivation that arise from such general trends. One important factor, especially for the higher levels of deprivation that is associated with lone parenthood, is the number of children affected by divorce. Figure 15 shows this as a percentage of all children in the ten ex-communist countries and shows that the countries previously identified as having high divorce rates, the Baltic States and Czech Republic together with Hungary have over one percent of children involved in divorce, whereas Poland, a low divorce and high marriage country has a similar rate of children, around 0.5 to 0.4 per cent, involved in divorce to Bulgaria, Romania, Slovakia and Slovenia.

Figure 14 Marriage and Divorce per 1,000 Population (average 1996-2000)



Source: Author's calculations from Eurostat (2002b)

Figure 15 Rate of Children involved in divorce (average 1995-1999)



Source: UNICEF Innocenti Centre TransMONEE data base

Policy to counter poverty and social exclusion in families and in broken families rests on fundamental systems of social protection in the first instance. The basic familial needs for social protection due to the increased

demands of having children run across several areas: income supplementation in the form of birth benefits, child benefits and family allowances, tax allowances and education-related benefits; employment-based provision through maternity and paternity arrangements and "family friendly" practices to assist work while care for children limits full working capacity and lastly the provision of in-kind services such as nursery, pre-school and school-based services. Evidence from the candidate countries is difficult to assess across these boundaries. Cash benefits for children have proven a difficult and contentious area for many of the ex-communist countries as fiscal pressure has put pressure on universal family allowance schemes despite the high levels of targeting efficiency based on the presence, age and number of children. Policy has tended to fluctuate between universal schemes and schemes targeted on income or composition and age of children in families. See previous discussion in 4.3.2 for details of poverty impact of child and family allowances.

Evidence of specific policy towards lone parents is difficult to find. Slovenia reports the setting up of alimony funds and that this has been well received and most targeted to the poorest of separated families. The evidence in Turkey is based more on orphanhood and abandonment and suggests that traditional forms of solidarity such as the obligations of wider kin and community step in to provide.

Table 16 Children in Institutional Care as % 0-17 year olds

	Average rate 1995-1999	**Growth in rate of institutionalisation**
Bulgaria*	1.48%	
Romania*	1.42%	8.5%
Lithuania	0.87%	33.1%
Czech Republic	0.86%	20.8%
Poland	0.76%	10.5%
Hungary	0.66%	-8.1%
Slovakia	0.61%	-13.9%
Latvia	0.59%	44.5%
Estonia	0.48%	29.8%
Slovenia*	0.30%	-8.8%

Source: UNICEF Innocenti Centre TransMONEE data base

Notes: * incomplete series

Child protection, orphanhood and abandonment are issues that give rise to potential institutional care and there is very wide variation in the prevalence of institutional care for children across the candidate countries. The ex-communist countries in general have a particular legacy of state-run poor quality institutions and high rates of institutionalisation.

Bulgaria and Romania have the highest rates of child institutionalisation but all of the ten countries shown in Table 17 show growth in the institutionalisation rate except Hungary, Slovakia and Slovenia. Such rates are largely based on abandonment and on the linked problem child disability in the higher prevalence countries, but also on the underlying capacity of families to receive support – financial and otherwise – to maintain children in the family home. The same ten countries also show increasing rates of adoption and fostering and the average rate is almost 1.5 per cent in Poland. Latvia and Estonia have strong growth in fostering and around one percent of children fostered or with guardians.

Table 17 Children in Foster/Guardian Care as % 0-17 year olds

	Average rate 1995-1999	**Growth in rate of fostering & guardianship**
Poland	1.48%	22.5%
Latvia	1.17%	62.0%
Estonia	0.98%	84.5%
Slovenia	0.79%	13.5%
Lithuania	0.72%	40.0%
Hungary	0.36%	4.3%
Czech Republic	0.36%	19.0%
Romania	0.27%	109.4%
Slovakia	0.17%	23.1%
Bulgaria	Na	na

Source: UNICEF Innocenti Centre TransMONEE data base

4.3.4 Accommodation

Urban street homelessness is recognised as a problem across the candidate countries but there is as yet no common definition and data on prevalence is scarce. This is also the situation in the EU, where the Statistics Office of the European Communities has only recently launched an expert group in this area.

Slovenia estimates 300 rough sleepers in Ljubljana where there are 30 temporary beds in hostels designed to respond. Slovakia estimates 2,000 homeless people. The causes of homelessness are often linked to rent pricing policies – in particular since privatisation in transition economies – However, family break-up, substance abuse, and ex-prisoner status is common as a contributing factor. Malta reports that young people are over-represented in the homeless as a result of family break up. Poland has found high levels of homelessness in unemployed ex-state farm employees. Responding to homelessness is largely left to local government and/or

NGOs. For instance, major local government intervention in Romania in winter sets up shelters and feeding programmes while Riga municipality in Estonia runs hostels. Caritas and the Salvation Army run hostels and services in the Czech Republic.

Turkey and Cyprus can be seen as two ends of the spectrum in terms of housing and poverty issues among the candidate countries. Cyprus reports negligible problems of homelessness and only small proportion of its stock without basic amenities, mostly on rural areas and occupied by elderly owner-occupiers. Cyprus also has a comprehensive rent allowance scheme that prevents rent- driven poverty and extends this to mortgage payers. On the other hand, poor quality of housing is a major issue in Turkey with large urban areas of "Gecekondu" – favela type squatter housing - where approximate one quarter of urban populations live. These areas often lack adequate water and sanitation facilities. Policies to enforce planning and other laws against these illegal settlements tend have not been successful on the whole. Earthquakes damaged approximately 100,000 dwellings in the 1999 in Marmara and Duzce . Turkey's plan under Habitat II remains a long way from full implementation.

Large post-war building programmes across the Central and Eastern European Countries should mean that much of the basic stock is reasonably sound but Slovakia estimates that 50 per cent of its stock is nevertheless of uneven quality. Fiscal constraints in recent years mean that spending on repair and renovation has fallen behind ongoing deterioration in many countries – for instance Latvia where qualitative evidence highlighted interrupted water supply and disrepair as a major concern of the poor. Bulgaria too reports 30 per cent of its stock as requiring major repair.

Malta has around 6 per cent of its stock as substandard and concentrations of poor housing stock in certain areas account for a large proportion. Three per cent of Romanian housing lacks any utilities and services while 6.2 per cent of Romanians have less than four square metres of space. One fifth of poor households in Slovenia lack bathrooms, almost one half have no central heating, and 17 per cent have no main sewerage. Lithuania estimates that 37 per cent of households have no hot water or toilet. Polish evidence on the other hand points to long-term low income rather than current poverty as a main driver of poor housing conditions, indeed cross-sectional studies of poverty fail to show large differences in housing conditions for the poor and non-poor.

Housing finance and affordability is seen as a major driver of poverty, overcrowding and eviction. Romania reports large housing shortages and resulting huge problems of affordability of existing stock as social housing is now scarce. Overcrowding is thus a major problem in Romania. Tenants in not-for profit housing in Slovenia have twice the national poverty rate and rents have risen to 19% of household expenditure for poor households.

Estonian studies confirm that even the cheaper rents chosen by poor households are often unaffordable.

Policy responses to problems of affordability and quality tend to be a combination of housing subsidises for rent and to reduce the costs of building. Slovenian policy in recent years has implemented social rent setting programmes that restrict rent levels for 25 per cent of the social minimum, but access to and coverage of this scheme is limited. In 1991 to 2001 Slovenian state schemes reduced the housing accommodation gap by almost 8 percent through subsidised building, while the non-state social sector produced a higher volume of building .18 per cent of its short-fall. Slovenian social housing allocation policies favour low-income tenants and families with children. Polish housing policy is seen as poorly targeted at the poorest as it has continued to subsidise repair and rehabilitation in existing co-operatives and to support middle income owner occupation rather than direct provision at poor and low income provision. The elements of Polish housing policy most targeted at the poor are local authority run housing allowance schemes of small overall scale. By contrast, around five per cent of Malta's housing stock serves those most at risk of poverty and social exclusion through government allocation and subsidies. While a further 1.3 per cent are social housing provided by church-based organisations.

Rent allowance schemes are usually linked to social assistance – either as a stipulated element of benefit or as supplementary schemes to assist those with incomes at or close to the levels of social assistance.

4.3.5 Ethnicity

Ethnicity as a factor in social exclusion and poverty is linked to the process of discrimination – either active or passive – as well as to the relative position of ethnic groups to the majority population and their experience of levels of deprivation. In any assessment of profiles of social exclusion questions of civil and human rights become highly pertinent when considering ethnicity.

Within candidate countries there are different ethnic and linguistic minorities but one group stands out in trans-national profiles of ethnic minorities – the Roma in several countries in Central and Eastern Europe. Table 13 chapter 1 shows that Roma populations can be up to around nine per cent of population in Bulgaria, Romania and Slovakia or less than one per cent in Poland, Slovenia and Turkey. Direct data from poverty surveys suggest very high levels of poverty – 84 per cent of Bulgarian Roma lived in poverty in 1999, 79 per cent of Romanian Roma lived in poverty in 1997 and Roma made up one-third of the long-term poor in Hungary (Ringold 2000). Low educational qualifications and 39 per cent of Roma population

were found to be illiterate in Romania. School attendance can also be problematic – Romanian evidence showed in 1992 that only around 30% of Roma children were enrolled in primary and only 17 per cent in secondary schools. Dependency on social protection cash benefits is high. 80 per cent of Slovak Roma are estimated to rely on social protection benefits and large proportions of the adult population qualify for disability benefits due to ill health.

However, abuse of human and civil rights has also been widespread and discrimination in access to services and employment is common. One problem is poor rates of holding identity papers but ethnic tension and widespread anti-Roma discrimination and abuse are prevalent. Violent, racially motivated attacks against Roma are also reported in many of the countries.

Specific programmes targeted at Roma populations together with wider political initiatives to counter discrimination and to promote Roma participation and representation has been introduced. National programmes of action have often come about following participation in the Convention of the Council of Europe on Protection of National Minorities. Bulgaria's National Programme for Equal Participation of Gypsies, adopted in April 1999, the Slovak Strategy to Solve Problems of the Roma Ethnic Minority of 1999 and the Czech Plan for Roma Integration, adopted in June 2000 are examples. The Romanian strategy centres on a central Department for Protection of Minorities and Roma programme is financed by EU aid. In many other instances there have been high level appointments of commissioners and other state representatives to co-ordinate cross-cutting action to improve Roma civil and social rights.

Low enrolment and early leaving of school by Roma children has been addressed in Bulgaria targeted pre-school programmes to decrease drop out in areas with high Roma populations such as Lom and Montana have been associated with dramatic falls in non-attendance at subsequent schooling – down from twenty to two percent. Breakfast provision in school in the Faculetro neighbourhood Sofia was introduced to improved attendance and did so in the short term– but underlying funding was non-sustainable and gains in attendance lost.

Other trans-national minorities include the Russians in Baltic States who appear to have higher overall unemployment risk but lower or equal poverty risk in these countries but the reasons for this are unclear. The Turkish minority in Bulgaria, around 8.5 per cent of the population, however do have higher risk of poverty –about 126% the overall rate but also tend to have much larger poverty gaps. The large Kurdish minority in southeast Turkey present a regionally specific problem of poverty, human rights and regional development. Other linguistic or ethnic minorities such as the Hungarians in Romania and the Slovaks in Czech Republic tend not to have ethnically

differentiated poverty risk in the applicant states. Malta and Cyprus are small homogenous states and poverty and ethnicity is linked to illegal employment in Cyprus.

4.3.6 Geographical Location and Regeneration

There are several overlapping drivers to geographical factors influencing poverty and social exclusion. There are urban – rural differences that reinforce underlying infrastructural, sectoral and overall employment patterns; there are regional or area-based macro-economic readjustment factors in production, especially where single industry towns or areas face economic decline and there are other regional and area-based demographic and cultural factors. Such differences lead to different profiles of poverty risk and of social and geographical exclusion across all candidate countries. However, some countries are too small in area to be divided into geographically defined "regions" such as the NUTS2 classification. The evidence from national profiles however, suggests that larger geographic concerns appear to outweigh concerns about neighbourhoods or other small area concentrations of poverty, crime and deprivation. Combating poverty and social exclusion however often bears heavily on municipal authorities – through the provision of social assistance and social services and these levels of government have experience many problems of revenue and competence in the ex-communist countries.

Urban-rural differences in poverty risk are common across all candidate countries. Table 18 shows rural poverty risk and shares of poverty and population for seven Central and Eastern European ex-communist countries using consistent poverty measures to that given in previous evidence above. Only the Czech Republic has a lower relative poverty risk for rural households from the seven shown but still has 30 per cent of poor in rural areas. Romania on the other hand has over 66 per cent of poor in rural areas and Lithuania, Poland and Romania have the highest relative poverty risk between the seven.

Evidence in Estonia and Lithuania points to a gradation of poverty risk by size of settlement with villages having the highest relative risk of poverty (156 per cent) and the city the lowest (92 per cent). The capital city in other

Table 18 Risks and Shares of Rural Poverty

%	Poverty Risk	Relative Poverty Risk	Rural Share of the Poor	Rural share of Population
Bulgaria (1997)	14.6	128	42.6	32.9
Czech Republic (1996)	2.5	89	30.4	33.7
Hungary (1997)	9.1	149	57.0	38.0
Latvia (1997/8)	16.2	146	41.9	30.8
Lithuania (1999)	17.2	172	55.3	32.1
Poland (1998)	17.3	160	62	38.9
Romania (1998)	11.2	147	66.8	45.5

Source: World Bank (2000a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

countries is seen to have lower poverty rates and relative poverty risk than other urban areas. For instance, in Poland poverty in Warsaw is only 1.7 per cent, a relative risk of less than 1 (16 per cent), whereas other urban areas have a risk of 7.1 per cent, which is still a relative risk of less than 1 (41 per cent) and can be compared to rural Polish poverty rates of 17.3 per cent shown in Table 18. The Czech Republic on the other hand shows lower poverty risk in Prague, with highest risk in other towns and urban areas, and lower risk in villages[40].

[40] See Tables in Appendices in World Bank (2000a)

Table 19 Regional and Urban-Rural Differences in Poverty Risk in Slovakia 1996

% Region	Urban Poverty Risk	Rural Poverty Risk	Regional Poverty Risk	Relative Regional Poverty Risk
Bratislava	9.0	20.8	9.4	93
Trnave	7.0	8.6	7.6	75
Trencin	13.0	8.6	12.2	121
Nitra	11.6	7.1	9.9	98
Zilina	7.9	10.5	8.6	85
Banska Bystrica	8.5	10.4	8.9	88
Presov	10.1	7.6	9.7	96
Kosice	13.5	16.4	14.3	142
All Slovakia	10.1			

Source: World Bank (2002) Table 1.10

Notes: Individual poverty measured as minimum subsistence level. Regional relative poverty risk measured as proportion of national aggregate poverty risk.

Some countries of small size report only urban rural differences, such as Cyprus where almost 18 per cent of men and over 23 per cent of women are poor compared with 11 and 16 per cent respectively in urban areas. Turkey also has large differences in rural and urban poverty rates and per capita income is 192 per cent higher in urban areas in 1994 and poverty rates are 260% higher in rural areas. However, declines in poverty have mainly been attributed to rural-urban migration since the mid 1980s (World Bank 2000b). The potential effect of migration, both intra-and international, in reducing urban –rural poverty differences in candidate countries is substantial.

However, urban rural differences also cut across wider geographical/regional differences in poverty risk. Table 19 on Slovakia shows how urban and rural poverty risk differs within regions and shows higher urban than rural poverty in some regions. Rural poverty risk is higher in Bratislava, Trnava, Zilina, Banska Bystrica and Kosice but urban poverty risk is higher in the other regions.

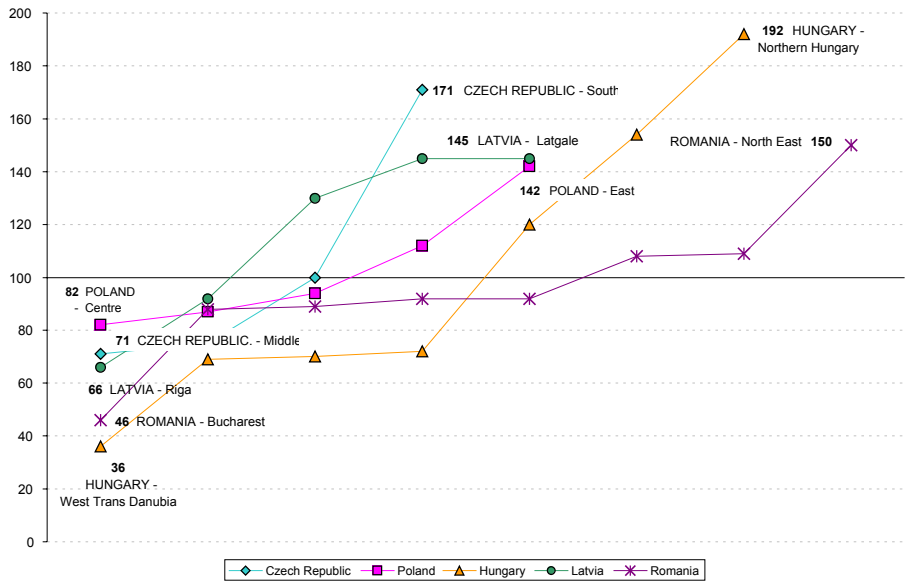
Regional differences in other countries will also cut across urban-rural risk profiles and will bring together various element of poverty risk previously discussed above – especially the risks from unemployment, under-employment and low pay in the labour market.

Figure 16 shows regional relative poverty risk for five ex-communist countries using the consistent poverty measures introduced in Figure 5 above and used subsequently. The five countries have different numbers of regions and not all regions are NUTS2 equivalent. Regional inequality in poverty risk is common and substantial to all five. It is most apparent in

Hungary – where Northern region has over 1.9 times higher risk of poverty and West Trans-Danubia has under 0.4 times the overall risk of poverty in Hungary. Poland has the least difference in between highest and lowest relative regional risk. The Latvian area of Latgale, with almost 1.5 times overall risk of poverty, has only 59 per cent of Riga's per-capita disposable income. Similarly, Slovenia has no consistently defined regions but has far greater levels of poverty in the northeast. However, urban industrial areas in Slovenia have taken the brunt of poverty and unemployment from economic restructuring.

Malta is a case where geographic differences exist between islands and between urban areas due to economic restructuring and the departure of British military bases in the late 1970s – especially for the Cottonera urban areas. Overall low-income households are found either in the inner-city neighbourhoods of Valetta or on the islands of Gozo and Comino.

Figure 16 Regional Differences in Relative Poverty Risk



Source: author's calculations from World Bank (2000a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

Regional and other locational economic differences and concentrations of poverty are subject to a large range of policies and programmes across the candidate countries – however, there is little evidence of programme development and implementation and little evaluation to assess their effectiveness at present. Regeneration policy has many potential elements – infrastructural development, fiscal incentives for business development and regional planning and partnerships all feature. Malta emphasises improving transport and social infrastructures combined with fiscal incentives to invest.

Slovenia emphasises the development of regional development partnerships and of targeted assistance in improving skills and higher education levels. Slovenia also identifies low labour mobility as an underlying problem that is inflating local skills shortages and regional imbalance. Lithuanian national plans include a range of programmes aimed at improving the efficiency and productivity of the rural economy through subsidies and training programme and additionally there are plans that respond to industrial restructuring in particular locations. Latvia, Romania and Turkey also run regional development funds.

4.3.7 Other Groups

The poor elderly figure most highly in poverty profiles in Malta and Cyprus. Around 46 per cent of Maltese aged 65 and over are below the poverty line used in the Malta Values Study in 1999. The same age group in Cyprus has poverty risk of 62 per cent if male and almost 66 per cent if female in 1996/7 – around 2.5 times higher risk of poverty than average. However, single person households aged over 65 in Cyprus had almost 91 per cent poverty risk – 3.6 times the average risk of poverty in Cyprus. Poverty for pensioners and the elderly in Turkey was low – only 48 per cent of overall poverty risk in 1994 based on the status of household head (World Bank 2000b). Elsewhere, in the ex-communist countries, as already mentioned, poverty rates for the elderly are low compared to working age and children.

Table 20 Poverty Risk and Shares of the Elderly

%	Poverty Risk	Relative Poverty Risk	Share of Poor
Bulgaria (1997)	14.7	129	22.9
Czech Republic (1996)	0.3	11	1.4
Estonia (1998)	11.3	116	36.3
Hungary (1997)	3.5	57	8.1
Latvia (1997/8)	9.1	82	13.7
Lithuania (1999)	9.9	99	13.8
Poland (1998)	6.2	57	6.3
Romania (1998)	5.9	78	9.9
Slovakia (1996)	9.4	--	4.4
Slovenia (1997/8)*	10.8	166	21.5

Source: World Bank (2000a)

Note: Common consistent poverty measure with Figure 5 above – 50% of median consumption with equivalence scale θ=0.75

Individuals aged 65 or over – except Estonia where status of retired household head

Table 20 shows the poverty risks of being aged more than 65 in the ten ex-communist candidate countries. Relative poverty risk is only greater than 1 in Bulgaria, Estonia and Slovenia, where it is highest at around 1.7

times the average national risk of poverty. Only in Estonia are the over 65s more than one third of the total poor, while in Czech Republic and Slovakia they are less than 5 per cent. The reasons for this are the current pension arrangements discussed in Chapter 3 above and further discussion will not be entered into here.

Disabled people are recognised across many of the candidate countries as a group that suffers disproportionate poverty and social exclusion. Anti discrimination policy and the promotion of employment and retention of disabled people has been introduced in Slovenia. Disability as a women's issue has been highlighted in Maltese evidence because of high levels of female poverty that arise from disability itself or from informal caring responsibilities. Lack of transport facilities were also identified as a major excluding force for such women. The treatment of the mentally ill has a particular policy history in the ex-communist countries and the position of the mentally ill gives concern in Latvia where a devolved system of care is being developed for municipalities. For a wider discussion see Chapter 3 for discussion of such problems and also the more widespread problem of access to health care which was also identified as a major component of social exclusion and linked and contributing to poverty by national rapporteurs.

There are also smaller groups who suffer very deep social exclusion from particular abuses of human rights – such as children and women who are trafficked and exploited. Romanian evidence points to a growing incidence and awareness of violence and abuse against children and women.[41] Child labour is a widespread problem in Turkey and linked to household production and family employment in many instances. Trafficking of women from Bulgaria has also recently been recognised as a severe emerging problem.

Other groups with high risk of social exclusion tend to be smaller groups with multiple disadvantage – such as the homeless, ex-offenders, ex-armed forces personnel and people who abuse drugs and alcohol - and such groups have been identified in Poland, Czech Republic and Lithuania as a major focus for programmes of assistance with employment and other social rehabilitation. Such groups and especially alcohol and drug abusers have also proven a focus for Lithuanian programmes. However, evidence from Government and official sources for such groups is very limited and NGOs form a major focus for intervention and monitoring in many countries.

4.3.8 Administration, Delivery and Accountability

Social assistance at local level is highly constrained by lack of finance and poor administrative capacity in many of the ex-communist countries. 50 per

[41] See UNDP report Poverty in Romania 2001 – and national expert report

cent of Bulgarian municipalities have deficits in such spending and many are unable to meet demands adequately. Cyprus and Malta report no problems in local funding or administration of services and social assistance benefits.

NGO involvement and coverage is by its nature inconsistent within and between countries. The Caritas Malta organisation is a major lobby group and provider for the poor, but it is rare for a national NGO to have this scope and potency in other countries. NGOs often became involved in the provision of services when the old state run organisations were broken up and privatised in the ex-communist countries. However, long-term effective and efficient models for financing and providing services are still problematic in the Czech Republic and reform has proven politically difficult. Increased activity by NGOs also brings particular problems of co-ordination, especially where very different delivery and management models co-exist

The combined result of underdeveloped administration, general poor quality of local administration, fiscal restraint and a growing diversity in programme delivery by NGOs in the majority of the ex-communist candidate countries has been structural problems in co-ordination of policies and interventions[42].

The levels of corruption are a non-trivial but largely unmeasured aspect of implementation of public services and inclusionary programmes in the ex-communist countries. These informal restrictions on policy operate alongside problems of consumer and customer focus and rights. Access to justice and the ability to obtain redress in poor provision of social protection services is an important part of ensuring inclusionary implementation of programmes. The Czech Republic have appointed an Ombudsman to investigate maladministration and problems of administrative law can be taken to the newly formed Supreme Court but overall access to redress and compensation as well as the enforcement of social rights remains a policy problem.

4.4 Poverty and Social Exclusion after Enlargement

4.4.1 Evidence of and Approaches to Poverty and Social Exclusion

How are poverty and social exclusion viewed by the candidate countries and with what resulting poverty national poverty measures and indicators? There is wide diversity in approaches to poverty and social exclusion but a growing communal language between policy makers as discussions on Accession progress. Overall the Central and European countries seem to

[42] See discussion in Czech and Slovakian national reports in particular.

have high public support for solidaristic approaches to poverty but also tend to see the avenues to escape poverty as more frustrated by internal social and political forces. However, there is great range across the ten ex-communist countries, with Czech attitudes being more individualistic. The Mediterranean countries, Malta and Cyprus seem to fit alongside existing EU assumptions more easily – especially those in the Southern European countries. Turkey fits neither group easily – it is the applicant country with highest incidence of international measures of poverty using development-based measures but also the country where it is least easy to identify discernable anti-poverty policy.

The differences in defining and measuring poverty tend to focus on the divide between countries that still regard standards of absolute deprivation as the priority for policy and those that regard poverty and social exclusion as more a reflection of relative living standards. Perhaps the greatest difficulty here is for European policy makers to understand that this is *not a difference between poverty standards* and that in many of the candidate countries an absolute poverty levels are above relative measures. This will be difficult for policy makers in Northern Europe to accept, especially where the "relative versus absolute poverty debate" has been one of developing progressive social policy to ensure participation in common lifestyles and social processes as well as basic needs.

What evidence is there of poverty and social exclusion in the candidate countries and how does this compare to EU experience? There are some candidate countries with relatively low national income and very high incidence of absolute poverty. Others look more like the EU norm. The most important distinction however is not between national income and wealth but about how best to develop inclusionary programmes that meet existing EU commitments to growth without growing poverty and social exclusion. There need be no choice of standard or argument about which approach to measuring poverty is "correct". One important task however is to ensure that the needs of consistent comparable international measurement are happily coinciding with development of national anti-poverty and inclusion programmes of best coverage and adequacy. In this respect, relative measures are perfect for standardising poverty measurement across countries but extremely dangerous for their current potential to undercut more generous absolute lines used for policy development in many of the candidate countries. This means that further thought will have to be given to the EU indicators of social exclusion, but not necessarily their amendment. Further development and some reprioritisation of third level indicators along with greater transparency could be considered where such national level measures lead to more accurate and/or higher levels than first and second level indicators.

4.4.2 Drivers, Priorities and Responses

What are the drivers of poverty and social exclusion – and how far do they reflect the EU's core challenges identified for Member States? The main themes of the current EU's core challenges to social inclusion have much resonance across the thirteen candidate countries. There is much shared experience of the main drivers of poverty and social exclusion. However, there is also evidence of greater scale of labour market drivers and that these not only operate through unemployment and inactivity but also through low pay and underemployment. Adequacy and coverage of social protection is also a greater problem overall than in the EU15. While school-based provision is based on very high enrolment rates at primary levels in most countries except Turkey, there appears to be considerable problems in ensuring staying on in secondary education and evidence of poor financing of schools more widely and that these problems disproportionately affect the poor. Locational drivers of social exclusion are also very marked in many of the candidate countries with high levels of regional inequality and urban-rural inequality.

All in all the evidence of programme effectiveness in countering the drivers of poverty and social exclusion is small and the need to build evaluative evidence base across the thirteen and the EU is a pressing concern.

4.4.3 Enlargement, Poverty and Social Exclusion

Enlargement will lead to new policy problems for both candidate countries and Member States. The overall profile of income inequality and regional inequality across and enlarged group of members will rise very significantly. Social and economic inclusion will depend on a range of macro-economic drivers such as investment, labour costs and labour mobility. Targeting mechanisms for regional, sectoral and other subsidies will require significant thought if the needs of poor and socially excluded people are to be adequately addressed across an enlarged EU. Some of the assumptions about how to set targets may have to be reconsidered even where the underlying drivers of social exclusion are similar between Member States and the applicant states.

The ability to target poverty and social exclusion well depends on accurate data on both incidence of the policy problem and the effectiveness of interventions and are these two areas that stand out as needing further consideration. The current evidence is considerable, and only a small portion of national level evidence on poverty and social exclusion has been addressed here, but much of it is not consistently comparable – and consistent measures will have to be developed further and build on the excellent start made by EU indicators. For instance, low earnings appear

such an important driver of poverty in Central and Eastern Europe and Turkey, especially in the agricultural sector, that an indicator could be needed alongside unemployment and inactivity.

The priority of poverty and social exclusion issues in an enlarged EU should rise with the addition of several countries with relatively high risk of absolute poverty. The overall inequality between EU members will also increase with enlargement – especially at the regional level and between urban and rural areas. This potentially larger role of poverty reduction programmes and other inclusionary policies is not only the case of having more ground to cover but also may need some reflection of how to respond to issues of inclusion for countries with very different characteristics of poverty and social exclusion. The sharing of policy design and prescription could need to be enhanced by a greater role for applied analysis – firstly, to assess the causes of and groups most affected by poverty and social exclusion and how they are common across or peculiar to countries; and secondly, to assess the effectiveness of interventions.

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5. Outlook: Enlargement & Social Protection

Martina Pellny and Sabine Horstmann

Introduction: 'Social Europe' on the eve of enlargement

Enlargement has become a political "reality": On October 9, 2002, the European Commission presented to the public the progress report and strategy paper on enlargement (Commission 2002) and recommended that the negotiations on accession to the European Union with *Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic* and *Slovenia* should be concluded by the end of 2002. According to the progress report, these countries will be able to meet the "Copenhagen" criteria - including their implications for social policy - and join the EU by the start of 2004. As for *Bulgaria* and *Romania*, the Commission recommended continued support for the achievement of their aim to join in 2007. The EU was to enhance its support for Turkey's pre-accession preparations and provide additional resources for this purpose.

The Commission concluded that the candidate countries, or the new Member states as they are called in the progress report, have generally reached a high degree of alignment with the *acquis* in many areas and that steady progress has also been made towards reaching the administrative capacity required to implement and enforce the *acquis*. However, the report also mentions some sectors where alignment with the *acquis* needs to be completed with a view to accession, and one of these is the social sector:

"In the area of social policy and employment, while alignment with the acquis is well advanced, most countries still need to strengthen their administrative capacity in particular in the areas of public health and health and safety at work. In addition, social inclusion should be further promoted in the light of the common objectives set out for the Union and candidate countries need to continue translating the Union's objectives into their national employment policies. Candidate countries should strengthen their efforts in the areas of social inclusion and employment to prepare for their future participation in the open method of co-ordination at EU level and for their preparation for the future intervention of the European Social

Fund. The importance of investing in sustainable health systems also needs to be underlined."

With the October 2002 Progress Report and the decision to enlarge the EU by 10 countries in 2004, public awareness of the enlargement process has experienced another qualitative shift in the old member states. However, social protection in a narrow sense does not attract major attention in the debate. The main political issue in those countries which share a border with one or more of the new member states is the movement of people, and whether or not the income levels and labour market conditions in the accession countries will lead to considerable migration from the new to the old member states.

This Synthesis Report of the 'Study on the social protection systems in the 13 applicant countries' outlines major developments and challenges in the social protection systems of these 13 nations from a comparative perspective. Social protection has undergone significant reforms in most of these countries during the last decade, due partly to changing ideologies and the trend towards (at least partial) privatisation, and partly to changing needs and new challenges, such as unemployment and poverty. The aim of the study was to give an in-depth description and analysis of the social protection systems in the country reports and, having done this, to summarise in the synthesis report perceptible trends and developments. Can one identify 'typical' reform paths in the accession countries? Can one talk of a 'candidate country model' of social protection? Is there a 'social security gap' between new and old member states and if so, how could this be defined? Will enlargement impact on the social protection landscape in the EU, and what is the outlook for social welfare in an enlarged Europe? This concluding section will discuss these questions.

The following sections will summarise the major trends and challenges identified in the areas of pensions, health, and poverty and social exclusion (5.1). Section 5.2 deals with the concept of a new 'European' model of social protection in the candidate countries and tackles the question of whether enlargement will re-shape the landscape of social protection in the EU. Section 5.3. will provide an overview of further areas for research and discuss the future of social welfare co-operation in an enlarged Europe.

5.1. Critical areas for reforms in the social protection systems of the candidate countries and major challenges

5.1.1. Pensions

In Central and Eastern Europe, the last decade has been characterised by a pension reform strategy involving change towards a more pluralistic and

decentralised system. The main issue in the pension reform debate throughout the region – as in the European Union itself – has been the different funding mechanisms and the role of PAYG vs. Capital Funded pension schemes.[1] The reasons for introducing capital funding into old-age pension systems were manifold. Firstly, a shift towards capital funding was expected to help cope with the impact of demographic developments on the future financial sustainability of pension schemes. Secondly, a diversification of risks between PAYG and capital funding was deemed necessary, particularly in the light of rising unemployment and a shrinking contribution base. Thirdly, decentralisation and a limitation of state responsibility in the area of social protection and a shift towards more private responsibility were part of an overall re-design of economic and societal structures.

Mandatory funded elements have been introduced in five of the Central and Eastern European countries: Latvia passed the first legislation, but only began implementing it in 2001. Implementation started in Hungary in 1998, in Poland in 1999, and is currently in process in Bulgaria and Estonia. In Lithuania and Romania the introduction of mandatory elements is also on the political agenda. In the Slovak Republic after the election in September 2002 the reform of old-age pensions and the introduction of funded elements will be part of the envisaged social welfare reforms.[2] We will pick up the issue of a possible new 'model' for old age pensions in Central and Eastern Europe and whether this has an impact on European social policy in sections 5.2 and 5.3.

However, other countries have also decided to introduce parametric reforms and to 'restructure the public pension schemes', as a recent ILO report (Fultz 2002) put it: Countries such as the Czech Republic and Slovenia, which decided not to introduce mandatory funded elements, have focused on reform of the so-called first pillar by strengthening the link between contributions and benefits and raising retirement ages. One policy issue in all Central and Eastern European countries has been an increase in the low retirement ages which were common throughout the region. In this respect, rising unemployment and the low employment prospects of the older generations have probably been one of the greatest policy conflicts of the transition phase, since a rise in the retirement age did not reflect the actual labour market chances of the elderly. Consequently, such policy changes have usually failed to gain wide public support. The increase of employment rates among the elderly age groups is thus a still a policy issue with high priority in many of the candidate countries.

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1 The debate on pension funding stimulated by the World Bank Report 'Averting the old-age crisis' and its impact on pension reform in Central and Eastern Europe has attracted large interest among policy makers and scientific researchers. See, for example, World Bank (1994), Beattie/Mc Gillivray (1995), a summary of the arguments by Barr (2000) , Müller (1999; 2002).

2 See the respective country studies.

There is no uniform and clear picture of poverty in old age across the candidate countries. While pensioners in some countries seem to be less affected by poverty than the average of the population, the elderly in other countries have been hit hard. It seems that the pension level and the average replacement rate are not the only factors accounting for poverty in old age, but also, and perhaps more, the interaction between social benefits, labour market participation and family/household composition. Further monitoring of, and research into, the development of pensioners' incomes and poverty in old age is called for, not least in view of the relatively short interval since the introduction of fundamental 'regime changes' in the area of pensions. Whether these new systems will meet expectations, be able to cope with future financial challenges and still provide secure income in old-age thus remains an open question. The transition to partly funded schemes and the impact on pensioners' incomes, transition costs and intergenerational distribution will be crucial pension policy issues in an enlarged Europe.

What will the main challenges be for the old-age pension systems in candidate countries acceding to the EU?

In general, social protection for the elderly is probably the area least immediately affected by enlargement. Statutory pension benefits will be included in the co-ordination of social security benefits, and the social security administrations in the candidate countries are required to apply the *acquis communautaire* and the social security co-ordination rules (1408/71; 574/72). However, the number of applicants drawing benefits from more than one system will increase only gradually. This is mainly due to the time lag between contribution to the system and the drawing of benefits in old-age.

The administrative burden involved in coping with the co-ordination of social security and pro-rata calculation will of course depend on the extent and nature of future labour migration between countries. The social welfare administrations in the candidate countries are well aware of future requirements and are preparing themselves for these tasks. There are a number of current PHARE twinning projects on the future application of regulation 1408. Many of the accession countries are practising the cross-border provision of pension benefits already today according to bilateral agreements on social security between member states and candidate countries. In fact, in particular bilateral agreements which have been concluded recently do more or less mirror EU regulations on co-ordination of social security benefits.

Pension insurance administrations in the candidate countries do expect an increasing administrative burden. However, they do not expect that a

considerable additional financial burden will emerge in the area of pension benefits.[3]

Other issues under discussion in the light of enlargement are connected to capital funded schemes. First of all, capital funded pension schemes require a functioning national capital and banking market and the appropriate regulatory and supervisory bodies. Especially during the first years of transition, due to banking and stock market crises and weak supervisory bodies, there was a remarkable loss of confidence in the stability of this sector. This remains a factor in some countries and needs to be taken into consideration. It should not be forgotten that - with the introduction of privately managed mandatory second tiers - the role of the state has changed fundamentally from that of provider to that of regulator. The role of the corresponding supervisory systems was widely discussed in those countries which introduced mandatory private pillars. Experience in best practice gained in the first years of operation in Poland, Hungary and Latvia will be of great importance for other countries which also decide to introduce mandatory pension funds.

The second issue with regard to capital funded schemes is the question of the free movement of capital after accession. Countries such as Latvia and Poland, where funded pension schemes are only allowed to invest 15% and 5% respectively of the capital abroad, were already asked in 2001 to open up their capital markets and to de-regulate pension fund investment rules. Pension funds in Poland and Hungary largely invested in government bonds during the first years of operation.[4] At the same time, a large proportion of the providers are owned by foreign insurance companies.[5]

A further aspect deserving of consideration is certainly the problem of revenue collection. This is a question first of all of willingness to pay contributions. As often only a symbolic contribution was - and in some countries still is - paid directly by the employee, with the majority of the contribution rate being paid by the employer, the link between contribution payment and benefit calculation was not apparent to the insured. Thus there was no awareness of the need to check, and no individual interest in checking, whether the employer had paid his part of the contribution.[6] Strengthening the contribution-benefit link in order to raise individual

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3 The situation is quite different in the area of health care and family benefits where it is expected the export of benefits according to the EU co-ordination rules will also have a considerable financial impact.

4 A critical comment on the fact that the pension funds mainly “stayed local” and invested in government bonds was that such investment is practically an indirect pay-as-you-go financing system, since the increased state debt will have to be covered by future generations.

5 For example in Hungary, in 2001 nearly 75% of the assets of mandatory pension funds were managed by foreign providers.

6 In some countries, it has become a "common and fashionable sport" for employers to develop strategies for legally avoiding the payment of social security contributions.

control over contributions paid to the pension insurance and improve contribution compliance was one of the main objectives of pension reform throughout the region.

In general, contribution and tax evasion in the Central and Eastern European candidate countries is characterised by an inverse correlation between income and informality (Lindeman et al. 2000). Although there is little comparative information available on the extent of evasion[7], recent research indicates that 'more advanced' transition economies have been able to catch up with the EU average for effective taxation (Schaffer/Turley 2001). At the same time, the extent of the shadow economy, both in transition countries and in western European OECD countries, increased during the 90s (Schneider 2002). It remains a question for further research whether these developments will have an impact on social security contribution collection. However, the fact that pension benefits will be more closely linked to contributions paid, an increase in transparency and a modernised administration, individual accounts and electronic data storage may counteract the detrimental effects of the growth of the shadow economy in general and improve contribution compliance.

Another variation of the contribution compliance issue includes both underreported wages and individuals who are employed illegally abroad.[8] Neither group of such persons is fully contributing to the pension schemes in their country of origin - at least, not for the first pillar. This not only has consequences for the revenue base of pension insurance today (Centre for Economic and Policy Research 2002) but might also in the long run cause a considerable income shortfall for the workers themselves in old age, as they are not accumulating pension entitlements during their illegal economic activities.

5.1.2. Health Care

The health care systems have seen major changes similar to those in the pension systems and characterised by the following developments: decentralisation on the purchaser side (health insurance bodies often with newly created local branches) and provider side (regional or locally owned clinics or hospitals), as well as the partial privatisation of the purchasers (introduction of private insurance) and providers (private practices for GPs and dentists and private pharmacies).

A model frequently implemented is a system of independent non-state regional health insurance bodies, based mainly on the Bismarckian model and introduced in a first wave at the beginning of the 90s in the Czech

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7 See Martinez-Vazquez, Mc Nab (1997:68pp.)

8 There has not been much research on the effects of labour migration on pension schemes in the candidate countries. Reliable data are not yet available.

Republic, Estonia, Hungary, Slovakia, Slovenia, Latvia and Lithuania, and subsequently, in a second wave in the late 90s, in Romania, Poland and Bulgaria.[9] All countries have chosen different ways of organising the funds (single or multiple; competing or non-competing; regional or national) as well as different forms of governance, different contribution and collection systems and different types of remuneration schemes. These last are often of a mixed nature, with a specific combination of fee-for-service, per capita, lump sum and special payments, case-based or per-diem systems - with or without a national cap[10]. In recent years, the re-allocation of contributions between funds (in countries with multiple funds such as, for example, in Slovakia, the Czech Republic and Romania) has become a major issue, together with the introduction of DRG systems, clinical pathways and an accreditation system in the hospital sector.

In most CEE candidate countries, social health insurance is administered by a national health insurance fund - more or less independent from central government - which is responsible for setting and collecting contributions and distributing funds. And from an historical perspective it is interesting to observe that for most of the countries which once belonged to the Austro-Hungarian empire, the introduction of the so-called social health insurance model has only been a return to an organisation and financing principle which had already existed in part before the introduction of the centralised integrated state model of Semashkov in the early 50s.

However, one main distinction which can be made is in the type of revenue. Most countries rely on a mixture of sources (taxes, social insurance contributions, voluntary insurance premiums, user charges) with the systems in Bulgaria, Latvia, Poland and Romania predominantly funded by taxation and the systems in the Czech Republic, Estonia, Hungary, Slovakia and Slovenia primarily financed by insurance contributions. Malta and Cyprus, both countries with a British tradition and thus historically more oriented towards a centralised National Health Service using the Beveridge financing principle, have mainly tax-based financing systems, although Cyprus is due to implement a social health insurance system by 2005.

A further common element, especially in view of the increasingly scarce financial resources in the health sectors of the candidate countries, is the reduction of provider capacity (the number of hospital beds and, to a lesser extent, the number of physicians and nurses) and, linked to this, a shift from hospital-based to out-patient treatment using the family-medicine model. In addition, controversy has raged in the candidate countries over the definition of a systematic "basic benefit package" to be introduced to replace universal

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[9] Both Lithuania and Romania had already introduced health insurance type mechanisms in the first half of the 90s - but these had remained very limited in scope: see Busse, 2002

[10] National caps exist, for example, in Hungary, Poland and Slovakia in the outpatient care sector; and in Slovenia for the primary care sector.

coverage, without any conclusions being reached so far in most CEE countries.[11]

In general, the problem of over-supply in the secondary care system has been tackled very differently: the number of beds in acute care hospitals was about one third to 100% above the EU average - with the exception of Slovenia, Poland and the Baltic Republics, these last being at the level of Germany (Busse, 2002). Only Estonia, Romania and, to a lesser extent, Latvia started to reduce their hospital capacities successfully at the beginning of the 90s. In Estonia, for example, public hospitals have been transferred into not-for-profit or joint-venture companies under private law - and this has proved to be quite successful and cost-efficient. In other countries, privatisation and the introduction of cost containment elements in hospitals was put in the hands of private investors, with the effect that in most cases the capacity problem could not be addressed successfully due to a lack of legislative incentives. More frequently, rather than being privatised, hospitals have been transferred from the central to the local government level, which has often made hospital reform more difficult. In any municipality, hospitals are now a major employer, making restructuring a political hot potato.

As mentioned above, the question of the financing of health care systems became an ever more urgent priority during the last years of transition: In most of the candidate countries health care expenditures in relation to GDP increased during the first five years of the 1990s, but have been relatively stable over the past five years, mainly due to the increasing expansion of the private sector. However, the level of spending varies considerably among the candidate countries. Between 1996 and 2000, candidate countries spent on average 4.5% of their GDP on health care compared to an average of 8.62% in the EU Member States. Among the candidate countries Bulgaria (4.08%), Romania (3.5%) and Turkey (4.4%) exhibit a strikingly low level of health care expenditure in relation to GDP, whereas Slovenia (8.8%) and Malta (8.4%) had spending close to, or even above, the EU average.[12]

Turning to the possible impacts of EU enlargement on the health care systems, there are a number of common aspects and critical reform areas to be mentioned.

In a situation very similar to that in the field of pensions, the main focus will lie on the strengthening of administrative capacity to effectively implement EU regulations, e.g. the co-ordination rules (directives 1408/71 and 574/72) on the free movement of persons. This requires skilled and committed health administrators and health care professionals - as well as a financially sustainable health system. Preparations to respond to these needs

[11] See chapter 3 of this report.

[12] See Chapter 3

have been in progress for several years with the help of PHARE Twinning projects as well as bilateral contacts between Member state institutions and institutions from the candidate countries.

The free movement of patients from the candidate countries to the Member states and vice versa will have implications for the health systems. One main problem in this area will be that expenditure on health care services is still significantly higher in EU Member states than in the candidate countries.

For example, patients in the candidate countries will be able to undergo treatment abroad within the framework of Article 22 (1) (a)[13] or Article 22 (1) (c)[14] of regulation 1408/ 71. The treatment is offered at the national rates and is to be reimbursed by the health insurance bodies of the candidate country, thus increasing costs for the health system of that country. Due to the remaining significant differences in the economic strength of the health systems, the additional costs so incurred may put a financial strain on the health systems in the candidate countries that cannot be ignored.

On the other hand, certain candidate countries, such as Hungary, Malta, Cyprus and to some extent also the Baltic states, are expected to benefit from patients from the old Member States, especially for spa treatments, dental services and plastic surgery, where there has already been a perceptible increase in demand. It is likely that most of these treatments will be paid for out-of-pocket or through private insurance.

A number of candidate countries have expressed fears that an unfavourable economic climate and the low social status of health professionals - and this concerns paramedical staff as much as doctors - might lead to emigration to the old Member States after enlargement. This issue, which regards the free movement of professionals, has particularly been raised in some of those countries which share a border with current Member States, for instance in Hungary and the Czech Republic.

In addition, as the Commission mentions explicitly in the progress report of October 2002, *"Attention should be paid to the area of mutual recognition of professional qualifications, where legislative alignment with respect to the health care professions still needs to be completed and, in some cases, curricula and training adapted to the Community requirements."*

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13 Article 22 (1) (a) states that insured employed or self-employed persons and their family members have the right to immediate health benefits during a temporary stay within another Member state (E-111).

14 Article 22 (1) (c) states cases in which the employed or self-employed persons and their family members have obtained permission from their respective insurance institution to receive appropriate treatment in another Member state (E-112): this applies in cases where waiting lists exist or treatment of sufficient quality cannot be provided in the country of residence.

Increasing opportunities for specialist staff to take up employment abroad and considerable differences in salary between old Member States and candidate countries, and even among candidate countries, might lead to a skills- and brain-drain and shortages of certain specialists in some candidate countries. The competitive salaries which might counteract this development would again have the consequence of increasing costs for health care.

However, salary differentials are not only observed between doctors in current Member states and those in the candidate countries; there are also considerable differences in pay between the health professions and other professions within the candidate countries. Financial and social incentives for health professionals are still low in some countries[15], which has two major consequences. Access to, and the quality of, health care differs enormously between regions, a problem which can be observed particularly in those countries, such as Turkey, Romania and Bulgaria, which have relatively inaccessible rural areas. It is there that we usually find a scarcity of medical facilities and staff compared to the capitals and bigger towns. A second consequence of this situation is the frequent practice of demanding 'informal co-payments', which in not a few countries means that patients are confronted with expenses they had not reckoned with when seeking treatment.

Apart from the free movement of persons, two other basic freedoms of the European Union, the free movement of services and goods, will also have an impact on the health systems in the candidate countries. It is expected that there will be a growing market in current Member States for medical devices, particularly in the field of dentistry, which can be produced abroad at lower prices. This will have positive effects on the economy of the candidate countries. On the other hand, the price development of drugs and medical devices will put a further strain on health care costs in those countries. Just recently, in 2001, Slovakia has for example taken steps to control costs of prescription drugs - by amending authorised drug lists and the introduction of generic brands.

In conclusion, despite political and also technical difficulties, governments will need to ensure that limited resources in the health care sector are targeted more effectively, in order to secure access to basic services for all - especially for the poorest and neediest. One strategy already applied in many countries is to shift resources from secondary and/or tertiary care to primary care. Another is to define more limited entitlements in place of universal coverage. Care purchasers' contribution collection mechanisms have been strengthened - but need still more support in terms of trained personnel and better information systems. The allocation of contribution

[15] With the minor exception of Slovenia, Hungary and the Czech Republic, where salaries increased considerably in the mid-90s due to the political will to tackle this problem.

revenue to resources should be based on risk adjustment models with a clearer focus on the adjustment of differentials between poor and rich regions. Contribution compliance, already described above as a major problem in the old age pension systems of the candidate countries, is also a source of concern in health care. Indeed it may be an even more severe problem in this sector, as the correlation between contributions and health services obtained is often not clear to the patient. Thus, here too there is little awareness of the need to check, or no individual interest in checking, whether the employer has paid his part of the contribution. This opens the door for contribution evasion in the health sector as well. Moreover, the employee's part of the contribution is equally at risk as the insured now have to pay for something which used to be "free". Therefore, lack of compliance in the health sector is only likely to be solved if corruption in the wider economy is reduced.

In the light of enlargement the financing of the health care systems in the candidate countries is the "weak flank" and requires a well-conceived and long-term health care reform strategy going well beyond the year 2004.

5.1.3 Poverty and Social Exclusion

According to existing poverty literature, the 13 candidate countries form two groups. The ten ex-communist countries of Central and Eastern Europe represent one group that share a common background: in former socialist countries poverty issues were not explicitly on the political agenda. High employment, labour-centred welfare systems and subsidised prices largely prevented extreme forms of poverty in those countries. Poverty was mainly seen as social pathology – experienced by individuals who for some reason could not work. The transition shock and economic collapse experienced by all these countries in the early 1990s fundamentally changed such assumptions about poverty. Many people lost their jobs and had no income, and the majority of those employed continued with low wages and little entitlement to state benefits. Living standards fell for the majority and poverty became widespread. The political response required a combination of contributory and safety net income maintenance programmes to be introduced and appropriately interlinked. Differences within the first group largely reflect the design and sequencing of this response in relation to their differing underlying demographic and macro-economic profiles.

By contrast, the other three countries, Cyprus, Malta and Turkey have fundamentally different political histories and experiences of poverty. Grouped as "Mediterranean" countries, they are characterised as having more recent and lower profile development of poverty measurement and policy than Northern European countries.

Poverty research in Turkey and in other countries in the region is particularly poorly developed (in Turkey the last reliable data dates back to 1994) and poverty and social exclusion have low priority despite their widespread incidence. For example, housing seems to be a key problem in Turkey, with large areas of 'squatter' housing sheltering approximately one quarter of the urban population.

Cyprus and Malta, having strong family solidarity systems and low unemployment rates, are less affected by poverty issues. Thus, poverty in Malta is taken care of by voluntary organisations, in particular, Caritas. Poverty in Cyprus has a low overall relative profile and incidence.

Since the Lisbon European Council of March 2000, when some 18% or over 60 million of the EU's population were seen as threatened by poverty, promoting social inclusion has been a key aim of European policy. The inverse concept of 'social exclusion' is of broader scope than poverty and material deprivation. It includes the risk of marginalisation and exclusion from mainstream society of individuals and groups in various situations, including poverty. The difficulties experienced by these groups in accessing the education, health, social service or pension systems further aggravate the process of exclusion. In short, a whole range of factors contribute to social exclusion, and policies of inclusion need to address these areas simultaneously.

In general, but especially in the central and eastern European candidate countries, deteriorating labour markets and rising unemployment coincided with the State's inability to cope with its dependent population of the elderly, handicapped, and orphaned or abandoned children who were formerly looked after by the government or state institutions. New groups at risk include both young people and families with children (less in Cyprus and Malta). For example, the declining life expectancy for men in Lithuania, Bulgaria and Romania has already resulted in severe material constraints on their surviving families with a tendency to perpetuation. Marked geographical pockets of poverty were identified in Romania, Bulgaria and Turkey.

The collapse of support services such as company-owned crèches for working mothers, or a lack of resources to maintain old people's homes and orphanages led to neglect and further marginalising of the most vulnerable groups of society. The situation was often aggravated by family break-ups, high incidence of domestic violence, and lack of access, in particular for women with children, to the remaining health education and support services (Micklewright/ Stewart, 2000).

Economic and social pressure on families with children increases the risk of disaggregating, school dropout, and deprivation of care. The increasing numbers of children in institutions during the early nineties was a reflection of these problems. Youth unemployment and concomitant juvenile

delinquency, teenage pregnancies, substance abuse and prostitution have all formed part of the marginalisation process in a number of candidate countries as monitored by UNICEF over the years (UNICEF, 2000).

Grey labour markets, where labour standards are not sufficiently strictly observed are obviously on the rise, while long-term formal unemployment further accelerates impoverishment. Studies in the Czech Republic have demonstrated the adverse effects of such developments, whereas Hungary and Lithuania seem to have coped more successfully with the problem (Sengenberger, 2001). This issue may likewise be a problem in EU member states and probably needs further detailed study including the collection of (available) statistical data on informal labour markets.

It is clear, however, that employment creation must go hand in hand with access to the welfare system during adjustment and transition processes. For this reason, employment programmes - especially aimed at poverty stemming from unemployment - now already have high priority in the candidate countries. However, there is also evidence of the labour market being a cause of poverty on an even greater scale, operating not only through unemployment but also through low pay and underemployment.

Besides poverty and unemployment, the exclusion of large parts of the population from social and economic activities in candidate countries is also based on ethnic discrimination and consequent denial of access to labour, the health and education system or social protection services. Estimated Roma populations vary from up to nine per cent of the total in Bulgaria, Romania and Slovakia to less than one per cent in Poland, Slovenia and Turkey (see chapter 1). Direct data from poverty surveys suggest very high levels of poverty – 84 per cent of Bulgarian Roma lived in poverty in 1999, 79 per cent of Romanian Roma lived below the poverty line in 1997, and Roma minorities made up one-third of the long-term poor in Hungary (Ringold, 2000). Dependence on social protection cash benefits is high. 80 per cent of Slovak Roma are estimated to rely on social protection benefits and large proportions of the adult population qualify for disability benefits due to ill health. Specific programmes targeted at Roma populations have now been introduced in a number of candidate countries.

A crosscutting issue in poverty and social exclusion analysis is the high proportion of women affected by the deteriorating employment situation, decreasing maternity benefits and withdrawal of social protection during the transition period. Reducing gender inequality in access to social services, but particularly in employment opportunities, payment and labour standards remains a high priority with most candidate countries. Discrimination against women is apparent in job-seeking, and at the work place itself. Sexual harassment, and discrimination during pregnancy or motherhood seem to be the most frequently reported issues needing to be addressed.

Many candidate countries still have a large population (up to 50 %) living in rural areas, more than half of whom are women. Where agricultural sectors are characterised by low productivity, for example in Romania, Bulgaria, Poland and Turkey, income disparities and poverty close to subsistence prevail. Although the population involved in agriculture continues to fall, the proportion of women farm workers remains high, as it is largely the men who are taking up work in other occupations. Farming remains a sideline and source of security for many women. As rural areas are comparatively less well equipped with public health and educational facilities, social services and employment opportunities, rural women evidently need to be addressed by government and non-government support agencies, and family benefits systems, especially if they have dependent children and elderly family members living with them.

The consequences of long-term poverty and exclusion amongst larger parts of the population show an increasing need for social protection. Where education, health and pension systems have worked well in the past, it has now become necessary for governments to draw up policies to prevent deprivation, ensure accessibility of basic services and equality in wages.

Concerning the effects of poverty and social exclusion on enlargement, we can conclude that these issues probably represent the most serious challenge presented by future EU enlargement at different levels. The fact that poverty and social exclusion is largely influenced by the situation in the labour market stresses even more what importance employment policies will have in an enlarged Europe.

In addition, the large proportion of the Roma population threatened by poverty in some candidate countries represents a clear new challenge for the European Union. In some of the candidate countries, in particular in Romania and Bulgaria, as well as in the Czech and Slovak Republics, this is one of the most serious challenges with regard to social inclusion.

Incidences of poverty in the candidate countries will probably affect the financial flows of the structural funds within the EU. It is also expected that poverty levels and the inequality between the old and new members states of the EU will affect migration flows in the future - and in some research literature the term "beggar-my-neighbour policy" is already back in use (CEPR, 2002).

Migration as a consequence of poverty and social exclusion has a long tradition in Europe, and policies such as those laid down in the Schengen Agreement for example, will probably have to be reconsidered in future.

The necessity to formulate policies and implement strategies of social inclusion is a rather new concept for the candidate countries, and may require from governments and society a substantial change in how they view

the most vulnerable groups in the population. However, in the absence of modern social welfare legislation (Czech Republic), or limited resources for social protection services financed out of the state budget (Bulgaria, Romania) major reforms of legislation and its implementation are unavoidable.

These reforms will require a further major change: from a centralised distribution system to decentralised and need-based service provision at local levels. Devolution processes have made substantial progress in recent years, for example in Bulgaria, Slovenia and Lithuania. With the assistance of a large number of PHARE and Twinning projects funded by the EU, legislation and administrative reforms have been taken forward to reach municipalities and local communities.

In Bulgaria, for example, Child Welfare Reform promoted de-institutionalisation and the creation of counselling services and private support provision linked to social welfare administration at municipality levels. The new Bulgarian legislation in the field of social assistance provides for regular monthly benefits to households living below the guaranteed minimum income and targeted benefits for particular needs (e.g. heating, appliances for the disabled, family benefits and parental leave for uninsured parents). The social assistance scheme allows targeting of the poorest groups and ensures relatively broad coverage of the groups at risk, such as children and dependent people, through need-based assessment.

On the other hand, the Lithuania country study ends with a caveat: "The draft programme on the implementation of a poverty reduction strategy in 2002-2004 is based on the new approach to poverty reduction and social inclusion. This approach is based on better targeting and more active measures (reduction of unemployment, toughening the legal and material responsibility of the parents with regard to the use of the allocated benefits, etc.). Nevertheless, the pension insurance remains without essential changes and will hardly cope with the problem of poverty and social exclusion."[16]

The fact that measurement of the progress and risk reduction of social inclusion policies strongly depends on precise indicators and comparable statistical information has been an issue in the EU since the mid-nineties. The *Joint Report on Social Inclusion* issued by the European Commission provides the latest insights in this area (Commission, 2002a). In the aftermath of the Lisbon European Council meeting (2000), which stressed the importance of reliable and coherent statistics, considerable efforts have been made to improve data collection to encourage EU member and candidate states to better monitor their policies of social inclusion. It is now hoped that new instruments, such as the European Social Survey, will contribute to improved complementary data analysis.

[16] See Country Study Lithuania.

For the envisaged interim reports on social inclusion policies it will be equally important to assess the success of investments in education, health and the reduction of social and economic inequality. Some studies suggest that a number of candidate countries have successfully maintained or rebuilt standards in education, health and the social sector. Child poverty rates, for example, are as low in the Czech Republic and Slovakia as in Sweden and Finland, whilst in Hungary they are no higher than in Germany (Micklewright/ Stewart, 2000).

Though the problems of social exclusion, whether linked to poverty or not, may remain largely invisible in the thirteen countries' political agendas, the promotion of inclusion through specialised programmes and poverty reduction measures is an emerging issue. This promotion concerns health and social insurance and pension systems reform. While Hungary, for example, introduced its most progressive social protection reform in 1995, it did not deal in much detail with issues of social exclusion in policy formulation. Of course, perceptions of poverty and exclusion are not very attractive for governments aspiring to join the EU.[17] The competing poverty reduction concepts and policies developed by the World Bank, UNDP, OECD and EU are probably adding to the hesitation of the candidate countries to deal too extensively with the issue at national level, particularly since the definitions on which poverty lines are based vary from low incomes (< US$ 2 per day), through human development indices, to consumption averages, etc. A strategy to overcome such reluctance and increase co-operation among the candidate countries, and with their future EU partners, would be of great benefit to the vulnerable groups concerned.

5.2. A candidate country 'social welfare model'? What is the social security gap between candidate countries and Member states?

The debate on enlargement and future social policy developments is largely determined by the question of whether it is possible to identify a single candidate country model of social protection and whether this will influence the future shape of European social policy in any respect (Scharpf 2002:5, Brusis 1998)

All in all, the prospect of a single Candidate Country model being developed is unlikely. This is due above all to the diversity of the 13 candidate countries themselves. The ten Central and Eastern European countries look back on a more or less common socialist history during the second part of the last century, whilst Malta and Cyprus have been particularly influenced by Great Britain. Although also a 'Mediterranean'

[17] See Chapter 4 of this report.

country, Turkey's historical development differs in turn from those of Malta or Cyprus.

If one focuses on the 'transition accession countries', i.e. the Central and Eastern European countries, there are a number of common developments and features apparent in their social protection schemes. There are, however, a considerable number of differences as well. Some of the most striking similarities and differences will be discussed below in the context of the different models of the welfare state.

It is quite difficult to talk about a European welfare model as such (Abrahamson 2000, Ebbinghaus 1999, Wickham 2002, Lindbeck 2002). [18] The classification of different models of welfare in Europe and the world is discussed in terms of the responsibilities of the state, the market and the individual/family, the method and share of financing for different sectors, the relative weight of cash transfers and social services and the question of whether social protection is tied to labour market participation or provides 'universal' benefits. Industrial relations and the role of trade unions and employers in social policy and the provision of social benefits is also identified as a differentiating factor. The reform of Central and Eastern European welfare states has often been characterised as an ideological confrontation between a continental European conservative-corporatist approach and a liberal residual welfare regime as it is found in the Anglo-Saxon countries (Brusis 1998). However, while there was obviously a more theoretical discussion when reform of the socialist welfare states was beginning, the last decade of reform has been characterised by a 'redesign' of existing structures rather than a radical change of the social protection system.

In discussing social protection reform in Central and Eastern Europe, it should be borne in mind that all of these countries can look back over a long history of social protection. In many of the transition countries, early social welfare systems were influenced by German and Austrian social security developments in the late 19th century. This history and tradition is seen as one of the factors influencing the redesign of social protection in a number of countries (Eichenhofer 1995, Horstmann/Schmähl 2002).

Due to this largely common history, both in pre-communist times and during socialism, the Central and Eastern European countries were faced with many similar challenges with regard to their social protection schemes.

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18 The most famous publication in this respect in recent times is probably 'The three worlds of welfare capitalism' by Gösta Esping-Anderson (1996). This distinction between three welfare state models has received broad acceptance and inspired further developments.

19 The most famous publication in this respect in recent times is probably 'The three worlds of welfare capitalism' by Gösta Esping-Anderson (1996). This approach has received broad acceptance and inspired further developments.

Partial privatisation of a formerly state-dominated system, as outlined in section 5.1 in terms of health care and old-age pensions, has been a common trend in the transition countries. The development of a basic social safety net to supplement labour-centred social security was a second shared trend. A tightening of the insurance system by strengthening the contribution-benefit link in old age pensions and the introduction of insurance-based financing in the health sector have been major features throughout the region. Strengthening financial accountability in social protection by separating the social insurance budget from the general state budget was another. The nature of the social welfare reforms in the transition economies and their aim of shifting policies towards a social-insurance-based protection system, make it clear that the transition economies' systems resemble the 'continental', 'Central European' or 'Bismarck' model of social protection.[20]

However, if we take social welfare expenditures as a proportion of GDP as one indicator of the role and extent of the welfare system in the state, we find a lower overall level of social welfare expenditures. This is caused primarily by a comparatively low proportion of spending on health care, whilst the spending on pensions is quite comparable to that of the EU member states (see chapter one, section 1.3). It is at this point that important differences emerge. The 'medium' level of social welfare expenditures combined with a tendency to increased private funding of old age pensions in particular is more typical of an Anglo-Saxon than a continental welfare system.

Another important difference between Central and Eastern European candidate countries and the so-called 'continental' typology relates to industrial relations. If we take 'social partnership', the role of trade unions and employers' associations, as another indicator defining the design of welfare regimes, we find that this also reveals considerable differences. Weak employer organisation and the former political functions of trade unions have led to the role of 'social dialogue' and corporatism in the transition countries remaining weak.

Turning to the social protection system and its separate fields, we can observe more convergence between the transition economies than it is possible to identify among current EU member states.

In the area of old age pensions, there is an obvious trend towards the introduction of a mandatory second pillar based on funded financing (see chapter 2 and section 5.1.1). The fact that this second pillar is a) limited in its future role of replacing former labour income and b) combined with an earnings-related first pillar, marks visible differences to the World Bank's

[20] For a further discussion of the European Social Model and its various definitions see Abrahamson (2000)

'classical' model promoted in their document 'Averting the old-age crisis'. The emerging structure of a public-private mix in old age pensions is probably one of the most striking similarities in the post communist re-construction of pension schemes in Central and Eastern Europe. Yet even here, though the overall structure in many of the reformed systems may be similar, a closer look would again reveal differences in detail.

In the health care sector, the introduction of contribution-based health insurance and the partly privatisation of the outpatient sector might give the impression of a comparable convergence. However, the actual design differs quite considerably, with national health insurance and regional branches in some countries, competition between public, regional, sectoral and occupational health insurance funds in others. The role and influence of the state in particular seems to vary to a marked degree across the countries.

The third area of social protection covered by this study, social protection against poverty and social exclusion, is characterised by similarities in the problems rather than in the policies developed to solve them. Newly established social welfare safety nets are still facing financial and administrative uncertainties.

The overall conclusion to be drawn from an examination of the characteristics of Central and Eastern European welfare systems must be that they are to a large extent 'insurance-based' and contribution-financed and in this respect resemble the "central European" "continental" Bismarck model – which is no surprise from a geographical perspective. At the same time, these countries' welfare systems clearly include elements of the Anglo-Saxon model. The latter might be explained in terms of an explicit political objective, to partially privatise the social protection system without in general neglecting social insurance traditions and retaining a clear commitment to the largely state-dominated social protection system.

This conclusion, that Central and Eastern European welfare systems could be classified by mixed traditional characteristics of the different European models leads us in turn to consider the 'social security gap' between the candidate countries and the old Member states. While a comprehensive analysis of this issue must await the results of further research, we can assert with some certainty that it will not be possible to derive a single overall social security gap, but that a distinction must be made between structural issues and benefit levels. Some Central and Eastern European countries have carried out comprehensive and far-reaching structural reforms in old age pensions during the last decade. At the same time many of them are still struggling with structural problems, in particular in the health sector. That is one basis for measuring a 'gap'. On the other hand, the comparison of absolute and relative benefit levels (e.g. replacement rates of cash benefits, level of minimum benefits) might also be a necessary and useful distinction when social protection in candidate countries is compared with that in the

member states. In fact, the problems the social protection systems in Central and Eastern Europe are currently faced with are probably due less to structural design than to a lack of financial resources and an overall lower economic performance compared with the member states.

However, while Central and Eastern European countries were reforming their social protection systems, the landscape of social protection in the Mediterranean countries as well as in the EU member states changed as well. Financial pressure and the increasingly evident consequences of ageing populations compounded by ill-designed structures have evoked new reform needs in the member states. Consequently, the experience gained from engineering processes in Central and Eastern Europe might prove useful for social reforms in the member states as well. To what extent enlargement will cause qualitative changes in the development of "Social Europe" is an issue that will be discussed in the following section.

5.3. Outlook on an enlarged Social Europe

Much has been written about the term "Social Europe", or EU social policy, its meaning and how it has changed since the creation of the European Community by the Treaty of Rome in 1957 (Leibfried/Pierson 1995, Rhodes/Mény 1998). Naturally, this topic has also been a topic of discussion during the last ten years of transformation in the candidate countries as the countries have often been confronted with conflicting concepts – depending, for example, on whether German, British or Scandinavian consultants were visiting their countries. Now, on the eve of enlargement, things are getting practical. Based on their present social security systems as described in chapter 5.2, the accession negotiations with the European Commission have clearly focused not only on the principles which are laid down in the Treaty, i.e. the "hard" *acquis,* but also on principles which have been developed since the Lisbon and Nice European Councils and which belong to the so-called "soft" *acquis*. Taking the special focus of this study into consideration, we will now seek to establish how the candidate countries will be integrated into, and may even enhance, those structures and elements which define our Social Europe today.

A Social Europe

Literature about this topic (Vandenbroucke 2002, Ana Guillén et al. 2001) tends to distinguish between concepts of European social welfare based on either the "hard" or the "soft" *acquis.* The instruments of the "hard" *acquis* comprise the application of the fundamental freedoms provided by the Treaty in the field of social welfare: *de facto* integration brought about by the free movement of people, goods, services and capital, by the forces of economic competition in an integrated, single (social) market; and *de jure*

integration brought about by the direct imposition of market compatibility requirements (within the social sector) by the European Court of Justice.

However, the building of a social Europe is increasingly being influenced by a new policy co-ordination instrument which belongs to the realm of the so called "soft law/ *acquis*": the open method of co-ordination which was established by the European Council in Lisbon in March 2000 as the main tool of co-operation in the social welfare area. Since then, the open method of co-ordination has been seen as an instrument for closing the gap between a market-driven (supranational) Europe and a social Europe which remains primarily in the responsibility of municipalities, regions and the national level of the respective Member states: "Economic performance and social cohesion are not mutually exclusive, but mutually reinforcing objectives, between which a new equilibrium has to be found"(Vandenbroucke 2002).

Leaving for the moment the level of policy instruments, there are clearly other perspectives than the strictly vertical and horizontal ones which contribute to the building and understanding of a Social Europe today. For example, social welfare integration between the relevant stakeholders occurs not only via the central European institutions but consists very often of specific and direct regional constellations with a "variable geometry" of participants.

Another aspect which undoubtedly contributes to the successful implementation of a Social Europe is the growing awareness among national actors and institutions of their European context. The literature refers to a process of "polycentric horizontal Europeanisation, in which the horizons of perception and action of national actors are beginning to transcend national borders in the same way as their social contracts." (Streeck 1999). This "Europeanisation" is, to a certain extent, interdependent with the introduction of the "soft" EU social policy, such as the EU social discourse and EU recommendations in the fields of, for example, the fight against poverty, the promotion of social inclusion, the closing of gaps in social protection networks for the benefit of vulnerable groups and the pursuit of equality between women and men. This has already led to the strengthening of civil societies, enhanced potential for interest groups to exert pressure and the fostering of opportunities for redistribution in many old member states, especially in southern Europe (Guillén et al. 2001), and will certainly have an effect on the new member states as well.

Whilst it is too early, on the eve of the enlargement of the Union, to attempt to predict how the integration of ten candidate countries into a Social Europe will proceed, we can nevertheless pick out some of the elements of a "Social Europe" mentioned above and attempt an extrapolation of developments in the light of enlargement. Needless to say, there is still a major need for further research on this subject.

Elements of the "hard" acquis vis-à-vis "social" enlargement

a) Possible impact of "social" enlargement on EC legislation
As outlined in chapters 5.1.1 and 5.1.2. above, the administrative implementation of directive 1408/71 is already in preparation in the candidate countries and will be successfully adopted in the medium to long term. In the short term, some obstacles may be encountered, mainly due to administrative bottlenecks. This is equally the case for most of the directives and regulations issued in the fields of labour and working conditions, equality of treatment for women and men, health and safety at work and public health - although in some cases, candidate countries have negotiated or agreed to transitional arrangements with the European Union. Generally speaking, the accession negotiations have prepared the candidate countries well in the alignment of EU legislation, whilst the candidate countries themselves have made considerable progress in this field. Thus, with respect to the implementation of EC legislation, the most important effect of enlargement might result simply from the greater number of members: administrative procedures tend to become more complex, and more susceptible to confusion, the more "players" are involved. The following example – itself not connected with enlargement - will illustrate the need to simplify and clarify current EU procedures - this even more in the light of enlargement.

The procedure of 1408/71 in the health care system allows patients mobility (subject to certain conditions), yet it preserves the internal cohesion of nation systems. On the other hand, the Kohll and Decker ruling of the ECJ[21] introduces a freedom which is basically unlimited and might disrupt the internal cohesion of national systems (Vandenbroucke 2002). The consequences of this duality could be increasing inequalities in access to health care and problems in guaranteeing patients a certain quality standard of care. Both of these objectives, equal access[22] and guaranteed quality standards, have been included in the initial preparations for the introduction of the open method of co-ordination in the health sector, and which may become yardsticks for the success of enlargement in this sector.

Consequently, in the field of EU legislation, enlargement could lead to a certain pressure for simplified and more consistent legislation - a task which has been referred to, and is currently being discussed in the on-going Convention.

b) Possible impact of "social" enlargement on the free movement of persons
During the accession negotiations with the European Union, most of the candidate countries have been familiarised with the European internal

[21] European Court of Justice, C-158/96, Judgement of 28/04/1998: Kohll vs Union des caisses de maladie and European Court of Justice, C-120/95, Judgement of 28/04/1998: Decker vs Caisse de maladie des empolyés privés.

[22] See also the principle of equal treatment, stated in art. 51 of the EC Treaty

market rules, which have been - or are being - transposed into their national legislation. Candidate countries are therefore not unprepared - nor they do they lack experience. It should not be forgotten that they have been facing market forces since the early 1990s, when the "cold war" borders were opened up and people started to move. This was the case between Estonia and Finland, for example, where a considerable number of Estonian health care professionals migrated to Finland in search of better pay and employment conditions. Many of these doctors and nurses, however, returned after 2-5 years abroad, usually because they wished to work in their own language and live in their home country again (Jesse, 2002).

However, like many research studies in this field (Brückner 2000, Sinn et al. 2000, Bauer/Zimmermann 1999)[23], this example clearly reveals that enlargement and the new membership of countries with a far lower GDP per capita than the current member states present a two-fold danger, especially in the social field. On the one hand, candidate countries may experience a "brain-drain", losing a significant proportion of their most skilled and best educated population. This would apply to the health sector and its professionals, and - as a side effect - the loss of their contributions would later affect old age pensions, for example. On the other hand, current member states, especially those with a geographical proximity to the new member states, may face an influx of migrants, which will put considerable pressure on their labour markets and, indirectly, their social security systems.

To counter this "enlargement effect" a political compromise has been reached. For the free movement of workers from the new to the current member states, there will be a transitional period of five years, which will be subject to an automatic review after two years. During this transition period, current member states of the Union can either restrict or open their labour markets for citizens of new EU member states on a bilateral basis. Countries experiencing shortages in their labour markets will also be allowed to recruit the citizens of new members states on a preferential basis. At the end of the general transition period of five years, the current member states can apply for an additional transitional period of two years in order to further protect their national labour market. Taking the beginning of 2004 as the accession date, restrictions will thus last until, at the latest, 2009-11. By then, the situation may well have changed. Demographic forecasts indicate that western Europe will then be experiencing labour shortages and would welcome migrants as a supplementary workforce. On the other hand, the labour force in the Central and Eastern European countries will also decline after the year 2010, because by then the smaller cohorts born after 1989-90 will be leaving secondary school. Employment opportunities will thus rise at home.

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[23] According to Bauer/ Zimmermann (1999), Poland, Romania and Bulgaria show the highest projected emigration rates per year due to the considerable differences in GDP per capita and unemployment rates. Slovenia has the lowest projected rate (ca. 2%).

It is tempting to conclude that, taking this transitional arrangement into account, in the short run enlargement will not have any considerable effect on the mobility of workers - at least, not "from East to West". However, economists have recognised the potential danger of increased mobility leading in the long run to a loss of tax base - or even to "tax competition" between member states, as citizens declare their income where taxes are lowest. This again might have the effect of reducing the capacity of certain member states to finance their social welfare programmes (Vandenbrouke 2002).[24]

Apart from the free movement of professionals, the possible impact of enlargement on the *free movement of patients* is currently in the focus of discussions: The most interesting question here is whether enlargement will create opportunities by offering new solutions, or whether problems will simply be exported from one country to another (welfare shopping[25]). As outlined in chapter 3 and chapter 5.1.2, the financing of the health care system is the "weak flank" in the enlargement process and thus the major problem to be 'exported'. This applies particularly to the candidate countries and their health systems, but it also true for more and more current member states, especially in view of their ageing populations. The balance between expenditures and the quality of care - which are two sides of the same coin - is a very fine one in every current member state - and possibly even more fragile in the candidate countries. If this is the case, then the free movement of patients in an enlarged Europe might even raise the "*Leidensdruck*" in the new members states, putting pressure on policy makers to find new "efficient solutions".[26]

Basic approaches to those "efficient solutions" are already known in the current members states and - if we think, for example, of cross-border care in Euregios, which are supported by the Interreg programmes of the European Union - to some extent already practised. They are aimed at supporting measures to promote co-operation in health care, particularly the sharing of resources and facilities on a cross-border basis. Under the Euregio

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24 This argument was used when Spain, Portugal and Greece joined the EU - but in practice the phenomenon did not occur to a significant extent. This time, however, borders are longer and average income differences bigger, thus the effect might lie in the greater opportunities.

25 See also the discussion in Boeri, 2002, p.11

26 From an economic point of view, efficient solutions for the provision of public goods are discussed, for example, in the theory of fiscal federalism: The economic theory of fiscal federalism is based on the theory of public goods and concentrates on the regional or geographical scope of such goods. On the basis of allocation (principle of fiscal equivalence, principle of subsidiarity, provision for regional spill-overs etc.), distribution, short-term and long-term stability, criteria are developed that help to decide whether a certain public good would be better provided at a more central or a more local level.

Rhine-Waal Project, for example, covering eastern parts of the Netherlands bordering Germany, patients living and insured in Germany have access to the University Hospital in Nijmegen for certain specialities for which they would otherwise have to travel a much greater distance in Germany to get treatment (High-Level Committee on Health, 2001).

Interreg projects will be open to the candidate countries once they are members of the European Union and there are already examples where this practice can be easily adopted or further developed, both between new Member states and between new and current Member states, with the advantage of economies of scale. For example, there are currently negotiations on cross-border collaboration between the border regions in Slovenia and Italy. The initiative is aimed at co-ordinating the utilisation of inpatient and outpatient treatment facilities on both sides of the border - the exchange of medical teams, the co-ordination of mandatory services such as emergency services and other activities (Kramberger, 2002). Another cross-border co-operation in the far north of Europe - between Latvia and Sweden - involves an education programme for people working with mentally handicapped persons and is supported by the EC PHARE programme.

A further example of an "efficient solution" which might be of special interest to the smaller candidate countries is the idea of establishing "centres of excellence". This concept was recently presented by the Chairs of the High Level Committee on Health: "The purpose of centres of excellence is to deal with the problems of uneven health care and outcome in rare and exceptional disorders and to deal with the uneven adoption of new technologies for such conditions. Centres of excellence may also serve as knowledge centres updating and/or contributing to the latest scientific results and implementing them on patients. They may be real institutions accepting patients from all over Europe or in cases of more than one centre for the condition in question from certain parts of Europe" (Chairs, 2002)

As most of the smaller candidate countries would not be able to provide such highly specialised and technology-charged medical capacities on a permanent basis themselves, the idea of sharing not only the financial burden but also the highly qualified personnel and expertise involved, presents itself as an appropriate solution in view of the present scarce resources in those countries.

The development of such "efficient solutions"- and thus in a way the practical implementation of a new quality of "variable geometry" – might even be further accelerated after enlargement by the increase in the number of smaller countries within the Union. With Estonia, Latvia, Lithuania, Slovenia, and Malta and Cyprus (though these last are islands without literal borders to cooperate across), six out of ten of the candidate countries can be considered small, and thus potential frontrunners for new and closer forms

of co-operation in the social sector in Europe[27]. This can already been observed, for example, with Luxemburg and the Netherlands, whose citizens have to a certain extent been the health policy pioneers of the EU 15.

c) Possible impact of "social" enlargement on the economic and budgetary policy of the EU

Budget policies and the principles of the Stability and Growth Pact have indirect impact on the financing of the national social security systems of the Member states: Sound and sustainable public finances are a *conditio sine qua non* for a sound and sustainable social policy - especially in the light of our ageing populations. However, the focus on financial prudence always carries a certain danger for the social sector. In order to lighten budgetary burdens, national governments tend to shift costs to the private sector. This is already the case in many of the current member states and might become the favoured strategy in the candidate countries once they are members and especially once they start to prepare for membership of the monetary union. Consequently, as the private social welfare sector is usually run by benefit-oriented market rules, values such as equal access and quality might lose in importance - or at least become less affordable. Here once again, for finding a balance in the trade-off between the quality and costs of social investments, "efficient solutions" may be the only way out (Vandenbroucke, 2002).

Alternatively, as future members of the monetary union facing the stability criteria, new member states might find themselves in the same situation that some very prominent old member states currently find themselves in, namely asking for the stability criteria to be softened. In this respect, "social enlargement" might in the long run also initiate within the European Union a re-think of the balance between its financial and its social policies.

d) Possible impact of "social" enlargement on voting rules

The requirement that decisions in the Council on important areas of social policy - and especially in the realm of social protection co-ordination (Hanau/ Steinmeyer/ Wank, 2002) – be unanimous entails the risk of paralysis in the field of social welfare. Granting veto power to a single country could deadlock decision-making.[28] This is sometimes already the case with 15 Member states and will be even more of a danger with a European Union of 25 members. In any case, with a larger number of Member states, decision-making costs will increase. This then, might be the most important effect of enlargement.

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[27] An interesting idea for the field of old-age pensions is that smaller countries like the Baltic states could share the administration of their old age pensions systems and/or pension funds.

[28] A first challenge might be the revision of regulation 1408. In case the revision has not been finalised before enlargement (which is quite likely given the current state of progress), unanimous approval of all old and new Member states will be necessary.

Yet even if the unanimity rule is abandoned in favour of qualified majority voting at the next Intergovernmental Conference, it is clear that a broad coalition of the candidate countries, possibly supported by one or two of the current Member States, could easily block decision-making. Or, on the other hand, majority voting may just end-up providing the worse of each welfare system as countries with the best social policies in place might always be in minority.

To prevent such "East-West" factions or in the latter case the "race to the bottom", it will be of the utmost importance that candidate countries receive appropriate financial support to continue the reform of their social protection systems - and this beyond the accession date of 2004.[29] However, 2004 - 2006 will be critical years, as the "Berlin financial framework" only expires at the end of 2006, and transitional payments, as well as the "Institution Building Facility", do not seem to be especially dedicated to fields such as social inclusion, public health, a sustainable health and social protection system or health and safety at work. Candidate countries might even face a deterioration in their net position from 2003 to 2004.[30]

The open method of co-ordination in an enlarged single (social) market

Since the summit of Lisbon in March 2000, the open method of co-ordination has been seen as a new instrument of "Social Europe" and can be defined as follows: "The open method of co-ordination is a process whereby common objectives are fixed at the EU level. Progress in the Members States towards achieving these objectives is determined through indicators"(Busse 2002) and bench-marking systems and should enable EU member states to compare practices and learn from each other. This method respects local diversity and is flexible, and it aims to promote progress in the social sphere: in the fields of social exclusion and poverty, employment and

[29] See also CEPR, 2002: "Most of the conditionality that has been imposed on candidates in the course of the accession process is concerned with the *acquis communitaire* of product quality standards and health and safety regulations. This is legitimate since such legislation is essential for the single market to operate effectively. But ensuring appropriate welfare standards in the CEECs is equally important. (...) ..following accession, newcomers cannot be treated differently from other members". The authors of this paper go even further: (page 17) "one way of discouraging the CEECs from using beggar-my-neighbour policies is to use the process of Eastern enlargement to ensure that on joining the EU, they have an appropriate level of social protection."

[30] See (Mayhew 2002): "When the first year of membership of these countries is considered, the risk of short-term financial instability appears to be considerable". The author also mentions another interesting point in this respect (p.3): "For the candidate countries, the issues of equality of treatment and no distinction between old and new members of the Union are at least as important as the level of transfers they will receive. With the need to win referenda on accession, they cannot afford to agree to a clearly unfair settlement with the Union."

pensions (where the institutional set-up is already in place) and health care (where a high-level committee has recently been established).

Candidate countries are in general well prepared to take part in the open method of co-ordination. Particularly in those fields where intensified co-operation among the EU Member states has been developed during the last years, namely in the fields of employment and of poverty and social exclusion, the co-operation between the candidate countries and the European Commission - not lastly due to the accession negotiations - is quite advanced as well.

Open co-ordination and employment
Since 1999 there has been co-operation in the area of employment. The so-called Joint Assessment Papers – JAPs – include a review of the employment situation and identify priority areas for reform. These papers are drafted by national authorities and the Commission. The spring 2003 synthesis report on employment for the European Council will for the first time include developments in the candidate countries.

Open co-ordination and social inclusion
Since 2002 there has also been co-operation in the area of social inclusion between the European Commission and the candidate countries. A series of joint workshops involving national governments and representatives of the Commission began in April 2002. Following these meetings, so-called Joint Inclusion Memorandums are currently being drafted for a number of countries. The objective is for such a memorandum to be signed with each of the candidate countries before accession. The statistical offices in the relevant countries are in contact with Eurostat and are working on collecting data for the 18 indicators developed. Once the candidate countries become members, they will fully participate in the EU's five-year action programme, launched at the beginning of 2002, to encourage co-operation between Member states on the combating of social exclusion. This action programme is aimed at supporting and monitoring the achievement of the objectives agreed for the open method of co-ordination.

Open co-ordination and pensions
In December 2001 the Council agreed on 11 common objectives and a working method involving the production of national strategy reports on the future of pension systems by September 2002. These common objectives refer to the adequacy of pensions, the financial sustainability of pension systems and their modernisation in response to changing societal needs. For instance, the first common objective states that Member states should ensure that the elderly are not placed at risk of poverty and can enjoy a decent standard of living; that they share in the economic well-being of their country and can accordingly participate actively in public, social and cultural life. As we have seen in some of the country studies, this objective may well become one of the most crucial - once the candidate countries fully join the

open method of co-ordination in this field. It is planned - depending on the further development of comparable databases in the pension field - to integrate candidate countries into the synthesis report in 2003.

Open co-ordination and health care

The European Commission has recently launched a new initiative on this topic. However, Member states and their institutions in this field are still quite reluctant to participate in open co-ordination in health care. Many health care researchers and stakeholders in the health care systems maintain that the "information on health care presently available in the Member States is not sufficient for the open method of co-ordination" (Schneider 2002). This applies especially to the possible objectives currently being discussed - "achieving a high population health status", "designing and functioning of health systems according to justified population health needs and expectations", "access to needs-based and effective health technologies" and "assuring a fair and sustainable financing" - which are then to be used to compare the different systems. In the light of enlargement, this discussion takes on an even more difficult focus. Most of the candidate countries have only recently started to adapt their existing health statistics to the European standards and most data - which are already difficult to access in some old Member States - are not available. In addition to this more technical problem, which is the focus of some of the recent PHARE Twinning projects, such as in Hungary, another, more political aspect has to be taken into consideration. Given the financial problems within most of the candidate countries' health systems, the danger of compromise on the lowest possible standards and objectives has become more apparent in the light of enlargement.

Conclusion

Candidate countries are already participating in the open method of co-ordination. Although this is mainly accession-driven, candidate countries have one distinct advantage: they have joined the process at a stage where the re-structuring of their own social protection systems is still in progress, which, from an economic point of view, is more efficient. In old Member states the possibility of accessing new data and implementing monitoring systems which will have an indirect impact on the functioning of the social systems is sometimes limited or hindered by the systems' various stakeholders and pressure groups - and thus often more expensive to change. By contrast, the candidate countries have an historic opportunity to establish a system of co-ordination and to implement quality indicators in their systems all at once. As far as the technical requirements are concerned they could even become the frontrunners in an enlarged Europe.

However, it should be recalled that the enlargement of the EU to 25 member states will certainly make the process of monitoring and evaluation in the open method of co-ordination more complex, opening up the risk not

only of output inefficiency, but also of actor frustration.[31] This trend is further amplified by the inevitable temporal and personal overlaps between the various ongoing processes themselves (Ferrera/ Hermerijck/ Rhodes, 2000). The practical handling of such a process with 25 governments will therefore require simplification and revision of its frequency.

With respect to the more political requirements of the open method in the light of enlargement, mention should be made of one potential weakness of this method. The open method of co-ordination is an intergovernmental collaboration which is highly dependent on the political constellation of the social affairs ministers of the Member states at anyone time. Not being part of the formal *acquis*, it is subject to change and at the mercy of political shifts. New political constellations, especially in the new Member states, favouring other policy fields after accession, could endanger the quality of the outcomes of open co-ordination - or even the validity of the 'soft' *acquis* as a whole. Given the ambition to establish a coherent and simplified new Treaty within the on-going Convention, it might be argued that the open method of co-ordination should be included as one of the formal instruments of the Union - in light of, and because of, enlargement.

Soft and open co-ordination seems to be a promising institutional mechanism for advance in all the "grey areas" of a common 'socially protected' Europe. If it can be made to operate at its best, the whole process may create an optimal mixture of "Europeanisation" and nationalisation in an enlarged 'Social Europe'.

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[31] This refers to the "deepening-for-widening" argument.

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