Chapter 10

Welfare, social policies, and redistribution models

Emmanuele Pavolini and Antonino Sorrenti

10.1 Introduction

In the wake of a series of challenges that placed the traditional post-World War II Fordist welfare systems under strain, from the 1980s onwards Western countries sought to intervene in their social protection systems. Alongside the challenge relating to the economic sustainability of these systems (resulting from an increase in needs accompanied by a simultaneous reduction in the capacity for economic growth compared to the Glorious Thirties), three other challenges emerged: the challenge of social cohesion, linked to ensuring coverage for traditional socio-economic needs (an adequate income in the case of old age, inability to work, or unemployment); the challenge of care, linked to "old" care needs (regarding illness) and "new" ones (regarding non-self-sufficiency); the challenge of socio-cultural investment, strengthening human capital endowments (education) and the possibility to participate in the labour market (reconciliation).

These challenges gave rise to reform trajectories that not only differed substantially from country to country but also within the four development paths we have identified. The debate on the weighty transformations of the welfare systems is ongoing, and the hypothesis of a generalised trend in Europe towards the liberalisation and privatisation of these systems has yet to find unequivocal confirmation in the research. In particular, in these decades there was not so much a simple process of generalised welfare retreat, definable in terms of "liberalisation" or "privatisation", as rather a twofold process: firstly, the reallocation of resources to address some challenges before others (this process is usually referred to as "recalibration"); second, the "dualisation" of social and labour market rights, with an increasing differentiation between more protected workers and citizens, defined as "insiders", and less protected workers and citizens, defined as "outsiders" (Emmenegger et al., 2012).

The chapter is dedicated to reconstructing the dynamics and trends that occurred in the four models under review in the volume, and to shedding light on the consequences they generated in terms of social inequalities. To this end, the focus is on three social policies, chosen because each responds to

DOI: 10.4324/9781003297130-13

one of the above challenges: pension policies, health policies, and policies to support families with children.

10.2 Changes in policies

10.2.1 The overall picture

To understand the welfare model of the various countries under analysis, the data on expenditure in the three areas of social protection constitute a useful starting point: namely, pensions, health, and interventions in support of families with children (Figure 10.1). The data refer to 2015 (2018 in the case of gross expenditure as a percentage of GDP). In the case of pensions, since the reported expenditure item is more the result of past choices than of more recent policy effects, an index of the generosity of the public pension system, calculated by Scruggs, Jahn, & Kuitto (2017),[1] has also been added. "Net" public expenditure corresponds to how much the state spends annually on goods and services offered as social protection after subtracting the effect of taxation on social transfers: countries tax income from social transfers in different ways. In addition, another indicator considered is related to the per capita expenditure in terms of purchasing power parity: with this indicator we measure how much each resident of a country actually receives for his/her protection. Analysis of the data shown in Figures 10.1a, 10.1b. and 10.1c allows some preliminary considerations.

First, moving from the "gross" incidence of social protection on GDP to the "net" incidence, the eight countries considered appear much more similar

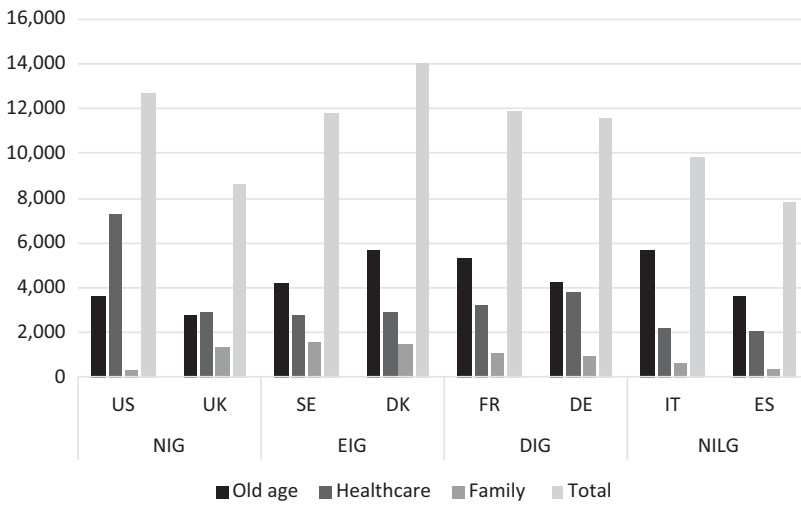

Figure 10.1a Public expenditure on social protection per capita in PPP (2015/18).

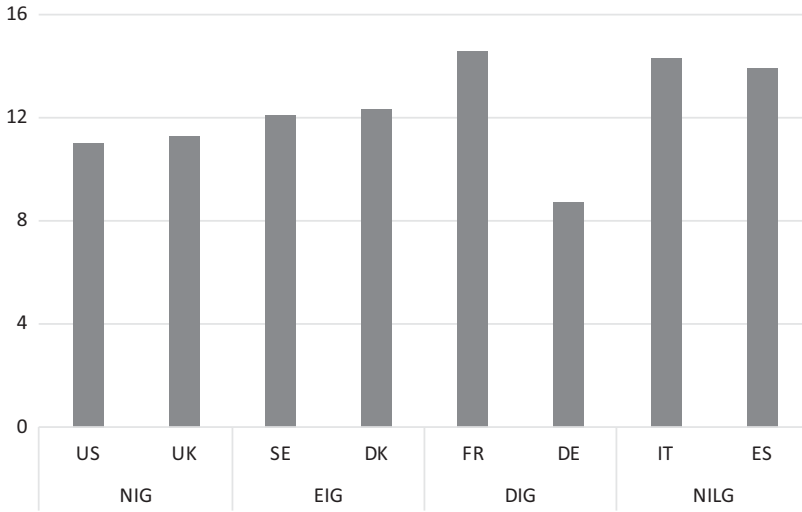

Figure 10.1b Generosity index of public pensions (2015/18).

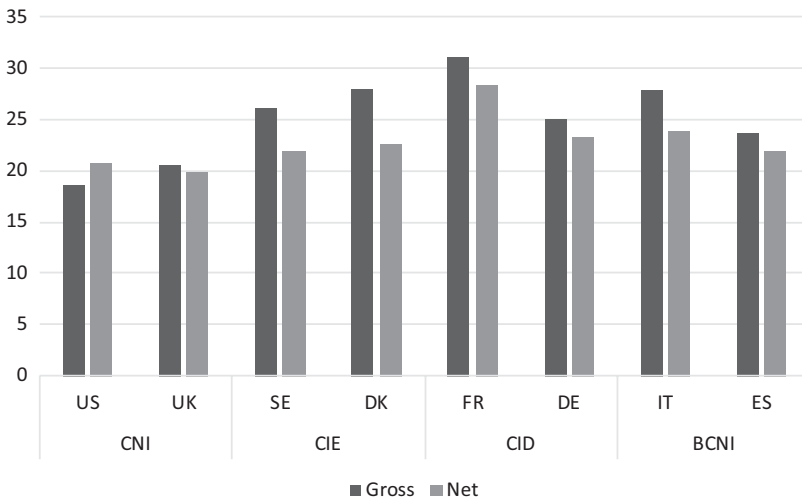

Figure 10.1c Public expenditure on social protection as a percentage of GDP (2015/18).
Source: Elaboration on OECD data and Scruggs et al. (2017).

to each other. The only real outlier is not the United States with its relatively low expenditure, but rather France (due to a relatively much higher expenditure than all the others). If we turn to public spending per capita on a par with purchasing power, Denmark is the country that invests the most per resident, followed by the United States and then, at similar levels, France, Germany, and Sweden. In order, Italy, the UK, and Spain are the countries that spend the least.

Second, the image generally offered of the United States, i.e. of a state with a "residual" welfare state, is not reflected in the one that emerges. There are basically two reasons for this. Compared to much of Europe the US reveals much higher levels of GDP per capita and GDP growth, meaning that a lower incidence on GDP corresponds in absolute terms to a substantial level of public intervention (which can be better appreciated by looking at per capita spending). Moreover, the "Obamacare" effect in the first part of this decade must be held in consideration: a comparison between the 2010 and 2015 data shows that expenditure in terms of GDP, but above all per capita expenditure, increased sharply. This change can basically be ascribed to what happened in the health sector (per capita expenditure almost doubled in five years) following the ACA (American Medical Association) reform, which will be discussed later in this section.

Third, not only countries, but also models tend to resemble each other more, or differ, depending on the welfare areas considered. In the area of pensions, the Southern European model, and to some extent the continental model (France), are the ones that apparently spend the most in terms of GDP and also in terms of the generosity index of the public pension system. However, it should be remembered that in most of the remaining countries the generosity index is not much lower, or at least it considers only public pensions and not the other pillars of social protection. In the field of healthcare, apart from the strong acceleration of the US in recent years, the main difference is between countries with systems based on compulsory health insurance in continental Europe (France and Germany) and national health systems (Nordic, UK and Southern Europe). Finally, in the field of family policies, the United States emerge as having a very limited level of development of these interventions, while on the contrary the Nordic countries invest considerably in this area. The continental countries, but also the United Kingdom, invest in resources, while Southern Europe appears to lag behind, though still remaining at a higher level than the United States.

Aside from the levels of spending on social protection, looking at what has happened in many countries over a period of 40 years represents a complex undertaking. Here we propose to outline the general lines of reform in the main fields of welfare policy, following a chronological order, decade by decade, and considering the development paths identified in the first part of our research. We will examine the development of public expenditure on social protection in the three policy areas identified above, and the

reforms and the main regulatory changes ensuing in the four models over a period of 40 years. To assess the extent of the reforms carried out, we use the well-established scheme proposed in the 1990s by Peter Hall (1993), which distinguishes between first-, second- and third-order changes. According to this scheme, first-order changes are those that concern the simple regulation of the instruments of government and intervention in the field of social protection, second-order changes concern the introduction or abolition of instruments, while third-order changes concern a paradigm shift in the functioning of welfare systems.

The last 40 years of evolution of the various national welfare systems have followed trajectories in part similar which can be framed within four phases, each of them lasting approximately ten years. In many areas of welfare policy the 1980s denote a period of substantial continuity and stability in terms of the institutional framework of policies in a socio-economic context that was undergoing radical changes. The welfare system offered, or tried to adapt, "old" answers to the new problems posed by the transition to a post-industrial society and economy while maintaining sufficient resilience in terms of institutional design to resist attempts at radical change, such as those attempted by conservative governments in Anglo-Saxon countries. During this period, essentially first- and second-order reforms were introduced.

Some of these trends of the 1980s will be considered in the context of the discussion regarding the following decade – the 1990s – which rather represents a period of far-reaching innovation and transformation in welfare systems, with the institution of radical reforms of the second (and often third) order in many policy fields. The 2000s emerge as a period in which innovations are introduced, often designed to consolidate and implement reforms of the previous decade, again of the first and second order. Owing to the diverse effects that the economic crisis and austerity had on the countries under review, study of the last decade reveals an amalgam of radical innovations in some policy areas (second and third order) while there are more incremental interventions in other spheres, as well as increasing diversification across countries and models in the type of response administered.

10.2.2 The 1980s: a frozen landscape

The analysis of the policies described in these pages is accompanied by the data contained in Figures 10.2a, 10.2b, 10.2c and 10.2d. Overall expenditure during the 1980s is seen to continue to increase consistently in all models and practically in all policy areas considered, with few exceptions.

10.2.2.1 The non-inclusive growth model of the Anglo-Saxon countries

Despite an overall increase of 26–30%, social protection expenditure in this model was comparatively low. An attempt was made to significantly reduce the

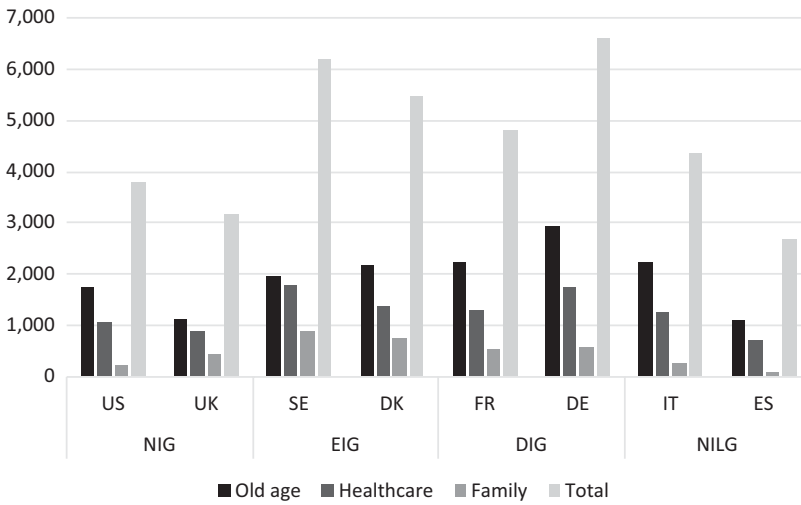

Figure 10.2a Public expenditure on social protection per capita in PPP (1980).

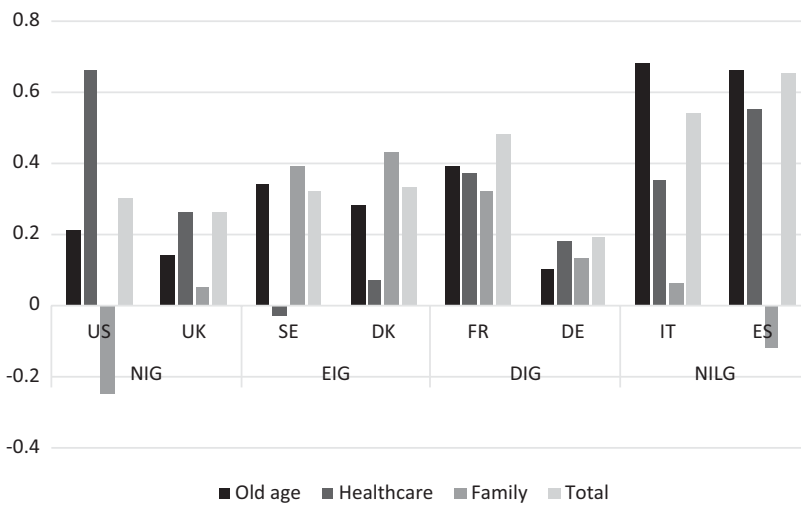

Figure 10.2b Percentage change in social protection expenditure per capita (1980/1990).

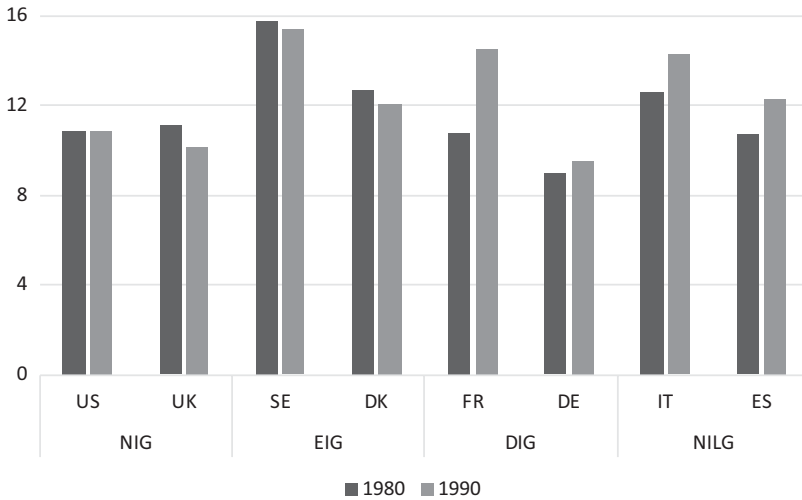

Figure 10.2c Generosity index of public pensions.

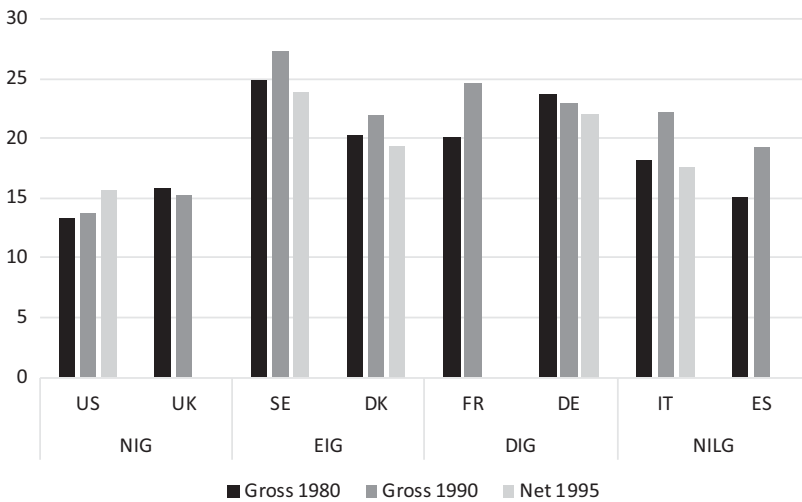

Figure 10.2d Public expenditure on social protection as a percentage of GDP.

Source: Elaboration of OECD online databank and Scruggs et al. (2017).

burden of the social security system on public expenditure with the pension reforms in the 1980s. Nevertheless, the publicly declared reform ambitions of Reagan and Thatcher were much more difficult to implement and the outcomes, in terms of retrenchment, of the changes introduced in both countries to the public pillar turned out in fact to be much more limited than they were designed to be, especially in the US (Pierson, 1994). In healthcare, too, the 1980s were characterised more by theoretical elaboration than by actual regulatory transformation. In the UK, after an initial attempt to promote alternative methods of financing the NHS, the focus shifted to promoting the efficiency of expenditure and quality of provision.

In the United States debate was inadequate; the main intervention programmes in the health sector (Medicare and Medicaid), historically much more privatised than in Europe, were not affected by any transformations worthy of note. The family policy framework in the Anglo-Saxon model was aimed in the 1980s at supporting market-based defamilisation (Woods, 2012). Besides limited spending on public services and the moderate use of monetary transfers and tax relief, this model featured little protection through maternity and parental leave (Béland et al., 2015). The almost residual nature of public interventions in this policy area is clearly visible when looking at the low level of spending and its trend (even strongly negative in the US).

10.2.2.2 The model of inclusive egalitarian growth in the Nordic countries

In the 1980s those that spent the most on social protection and where spending continued to grow at a very fast rate were the Nordic countries (+32–33%). In Sweden and Denmark, limited changes took place in the area of pensions in this period. In the area of healthcare, the problem emerged of completing a truly universalistic coverage, as well as the issue of decentralisation of competencies in healthcare. In terms of family policies, high levels of development of services for early childhood had already determined a key feature of this model, in combination with generous maternity leave, and hence the care-based policies defined in the previous decade essentially continued to be implemented: per capita expenditure increased by around 40% during the 1980s. Both countries were pioneers in introducing more generous parental leave that also incentivised fathers to take care of their children, fostering a real gender balance in the sharing of family tasks.

10.2.2.3 The dualistic inclusive growth model of continental European countries

Expenditure on social protection increased considerably in the continental model, particularly in France (+49%). In comparison with the approach that had been pursued in previous decades in the field of pensions, the 1980s represented a period of relative continuity, if not further expansion. In

healthcare, continental countries with compulsory health insurance began to face the problem of cost retrenchment (Busse & Riesberg, 2004). However, insufficient for blocking the growth rate of public expenditure, the measures introduced succeeding only in reducing it. With regard to family policy, the 1980s saw an increasing divergence between the approaches followed in France and Germany. In particular, France by the mid-1980s had a highly developed early childhood services system, almost rivalling Nordic levels (Morgan, 2003). In addition, the socialist government in France introduced paid parental leave for families with three children in 1985 and a measure to support informal care services in 1986 by adopting a contribution – *Allocation de Garde d'Enfant a Domicile* (AGED) – for families who employed qualified and registered domestic helpers. Instead, in Germany family policies focused on generous parental leave and a pension credit for one year's care, introduced by the CDU in 1986 and 1987 respectively.

10.2.2.4 The non-inclusive low growth model of Southern European countries

At the beginning of the 1980s, in terms of expenditure levels Spain and Italy appeared to be two somewhat different countries. The level of per capita expenditure in Italy was higher compared to that of Spain (the lowest of the eight countries), higher than that of the Anglo-Saxon countries and did not vary significantly from that of France. Expenditure in this model increased much faster (+54/65%) than in any other context. In the 1980s with regard to pensions Italy was still in a phase of expansion of public intervention. In contrast, in Spain the first measures of rationalisation but also of recalibration of the system were already in sight. A modernised vision of healthcare began to take shape with the substantial introduction and implementation of new national health services (NHS) (Vicarelli, 2005). In the matter of family policies, the approach adopted in Southern Europe resembled that of the Anglo-Saxon countries – lagging considerably in the development of early childhood services and with limited implementation of other reconciliation measures.

10.2.3 The 1990s: a decade of change

Overall, the considerable growth of expenditure on social protection continued during the 1990s in all four models and in practically all the policy areas analysed (see Figures 10.3a, 10.3b, 10.3c, and 10.3d).

10.2.3.1 The non-inclusive growth model of the Anglo-Saxon countries

Throughout the decade, total expenditure increased by about 32–39%. However, the level of this expenditure (both in per capita terms and as a share

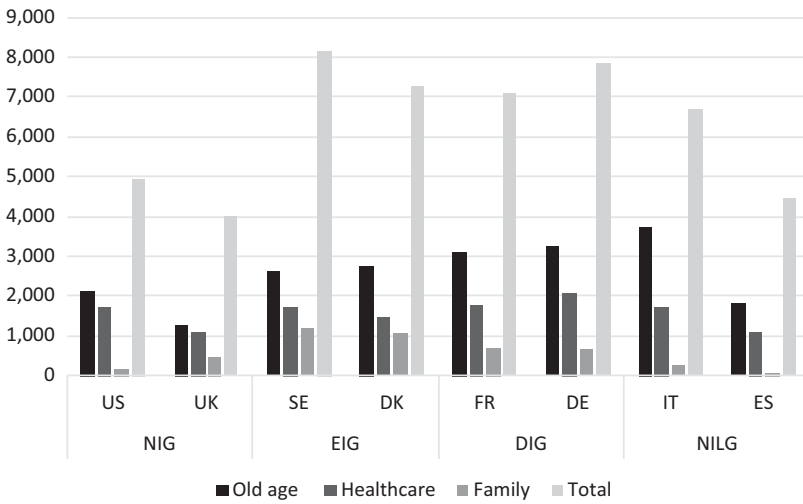

Figure 10.3a Public expenditure on social protection per capita in PPP (1990).

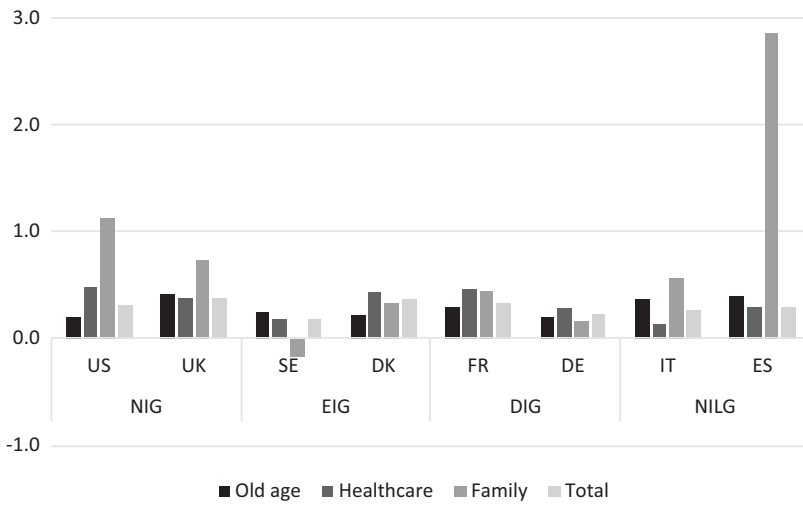

Figure 10.3b Percentage change in public expenditure on social protection per capita.

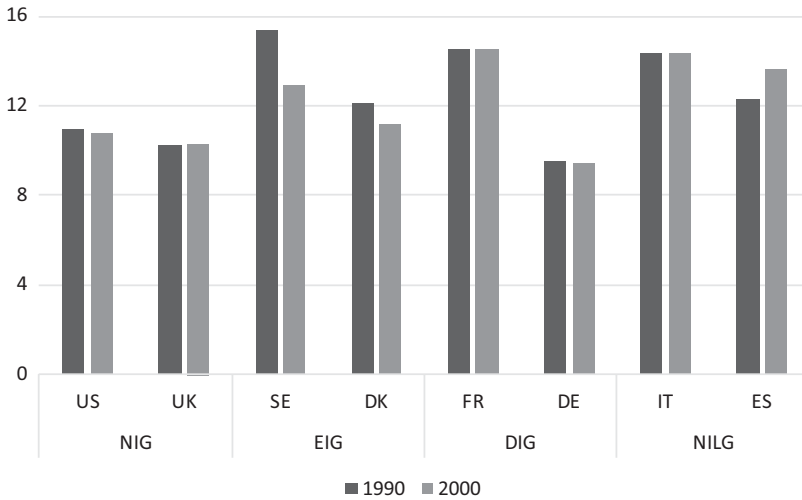

Figure 10.3c Generosity index of public pensions.

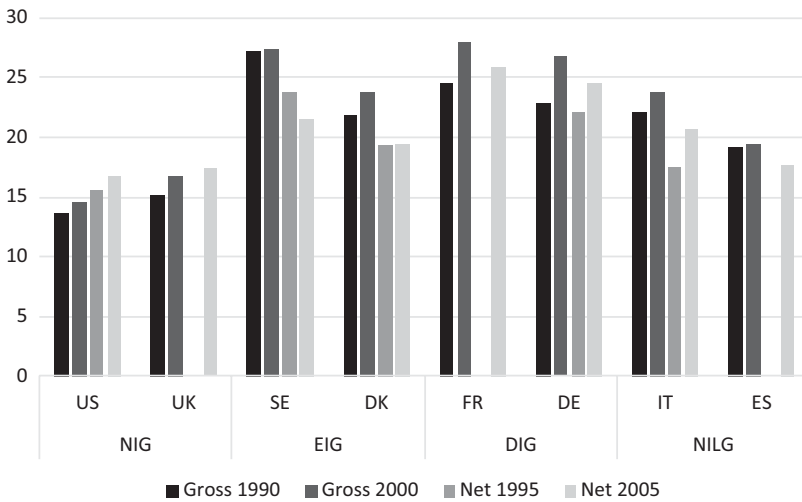

Figure 10.3d Public expenditure on social protection as a percentage of GDP.

Source: Elaboration on OECD data and Scruggs et al. (2017).

of GDP, gross or net) remained below that of the other models for the whole period under review.

In the UK, the Conservatives extended the retirement age for women from 60 to 65 in 1995 with the Pension Act, while Labour introduced a new Stakeholder Pension scheme in 1999, which made the contracting-out option more appealing to low wage-earners. In the USA, pension regulation remained unaltered in its main features. As the pension generosity index shows, there were no particular changes over the decade.

In healthcare, the 1990s were years of considerable transformation for the NHS in the UK, beginning with the radical reforms made by the Conservative government through the "NHS and Community Care Act" in 1991, which introduced the internal market, gave more power to NHS managers and reviewed administration of General Practitioner funding (Boyle, 2013). After the 1997 election, the Labour government initially focused on the accretion of public spending and regulation. 1999 was a crucial year, when the "Health Act 1999" replaced the notion of a quasi-market in the NHS with an approach of "integrated, partnership-based, performance-driven care" (Boyle, 2011). In the United States, the decade produced no new regulatory developments but public health was at the centre of one of the most heated policy debates. In particular, during the Clinton presidency, the Democrats attempted to expand public health coverage, which foundered due to Republican parliamentary opposition (Oberlander, 2016). Overall, per capita spending grew very significantly in both countries, especially in the United States (+49%).

Coinciding with the presence of centre-left governments, there was an expansionary phase in family policy. Spending increased significantly (+114% in the USA and +73% in the UK), partly as a result of starting from relatively low levels. In particular, in the UK, the Labour government launched a national strategy for children in 1998 with the aim of increasing the supply of services for early childhood with 1.6 million new places. The same government amended the tax credit legislation the following year, introducing a new instrument, namely the Working Family Tax Credit, which increased both the number of beneficiaries and the deductible threshold for care costs. In the USA in 1993, the Family and Medical Leave Act, one of the first measures adopted by the Clinton administration, introduced the right to 12 weeks of unpaid parental leave for all workers in the private sector employed in companies with at least 50 employees. The Democratic government also introduced other expansive measures, which were not particularly innovative from a regulatory perspective but were nonetheless significant in terms of disbursement (Michel, 2015).

10.2.3.2 The model of inclusive egalitarian growth in the Nordic countries

Investment of resources in welfare continued to increase in the Nordic countries, despite already relatively high levels of spending at the beginning of the

decade. Significant reforms were introduced in the field of pensions, which lowered the level of generosity of the public system, offsetting it with the expansion of a widely spread and generous second pillar (Seeleib-Kaiser & Pavolini, 2018). In Sweden, the two reforms introduced by socialist governments in the 1990s still today form the support structure of the current Swedish multi-pillar pension system. In 1994 Sweden switched to a contributory system for the calculation of pensionable earnings in the first pillar and in 1998 a second pillar called Premium Pension was introduced, also contributory but funded. In Denmark, in the early 1990s conservative governments changed the indexation of pensions to real wages (1990) and introduced occupational pensions through collective agreements with trade unions (1991). In 1996 and 1998 the Social Democratic governments extended the coverage of occupational schemes in the case of illness, maternity or unemployment.

Several important innovations took place in the health sector, within a framework that saw significant accretion in expenditure levels (Blomqvist & Winblad, 2013). On the one hand, the two healthcare systems progressively opened up to more competition from private providers and a higher level of patient choice, and on the other hand, the central state started to take back some regulatory powers after decades of decentralisation. Patients' rights in the NHS were extended in various ways, from the right to choose a general practitioner without geographical restrictions to the right to express an opinion on treatment (in cases where several treatment options are available). The bottom-up managerial changes introduced were not only related to the patient's freedom of choice and the separation of purchaser and provider (following the model of British quasi-markets), but also to various forms of performance-related payment systems including DRGs (Diagnosis Related Groups). In the field of family policies, the decade did not see any particular institutional innovations at work, but a continuous and growing investment in the network of services and leave that had been established in both countries in previous decades.

10.2.3.3 The dualistic inclusive growth model of continental European countries

Expenditure continued to grow also in continental Europe, settling at levels not too dissimilar from those in the Nordic countries. In particular, the 1990s were a period of profound transformation in the field of pensions. In France the centre-right government adopted two important reforms. The Balladur Reform in 1993 increased both the reference period for calculating pay and the years of contributions required to qualify for a pension. In addition, the same reform indexed pensions to prices and introduced a state solidarity fund to finance the increase in non-contributory pensions. In 1997 the Thomas Act introduced voluntary supplementary pension schemes for private sector employees. In Germany in 1992 the so-called "Blum I reform" was introduced, indexing pensions to net wages and raising the retirement age for

women. In 1997 the government formed by CDU and CSU introduced the Blum II reform: the introduction of the demographic factor in the indexation formula, the increase of pension credits for childcare, and the increase of the retirement age for disability pensions from 60 to 63 years.

This meant that the level of generosity of public pensions would remain largely unchanged in France while it declined in Germany (though partly offset by growth in private pensions).

In the healthcare sector, the first measures taken in the 1990s in France continued with retrenchment of costs by imposing low prices on health and pharmaceutical services and higher cost-sharing quotas (Palier & Davesne, 2013). From the mid-1990s onwards, the government strengthened state control and regulatory capacities over the financing and planning of the healthcare system. A major constitutional revision adopted in 1996 introduced the power for Parliament to determine each year the resources allocated to Sécurité Sociale funds and to set a limit on health insurance expenditure for the following year. In the hospital sector, a process of managerialisation was initiated. Reforms in Germany focused on healthcare governance with the intensification of competition between sickness funds, giving insured persons more freedom to choose between different funds, and superseding the principle of enrolment in the occupational fund closest to the worker's occupational profile (Health Reform of 1992) (Hassenteufel & Klenk, 2013).

With the expansion of state control under this reform, the traditional freedom of autonomous administration of German healthcare by health insurance funds and doctors' unions was curtailed. The other major reform of the decade, the law on the reorganisation of health insurance containing mainly cost-containment measures, came in 1997. Nonetheless, this was not sufficient to prevent per capita expenditure in these two countries from increasing substantially.

In the field of family policies, France and Germany continued to remain poles apart. A certain legislative inertia was manifested in Germany with regard to the services and reconciliation policies, despite a spread in expenditure (+17 per cent). In 1991 the French socialist government replaced AGED (the Child Homecare Allowance) with the more generous "*aide pour l'emploi d'une assistant maternelle agréé*" (AFEAMA). Moreover, the APE (*L'allocation parentale d'éducation* – Childcare Allowance) was extended to parents with two children and financial contributions were raised. A significant increase in per capita expenditure in the sector (+45%) took shape as a result of these innovations.

10.2.3.4 The non-inclusive low growth model of Southern European countries

On the whole per capita expenditure was distinguished by a continuous upsurge in Southern Europe in the 1990s (+26–30%). Here too pension reforms were introduced in the 1990s. In Italy, introduced by technical governments, these

were oriented towards curtailing the very high burden of pension expenditure on the state budget. Key changes included the gradual raising of the retirement age to 65 years for men and 60 years for women, introduced by the Amato reform in 1992, and the shift to the contribution-based method for calculating pensionable earnings, a product of the Dini reform, along with the introduction of a multi-pillar system. In Spain in 1990 the socialist government introduced non-contributory pensions for poor, elderly, and disabled people and in 1997 the government led by the Popular Party passed the Law on the Consolidation and Rationalisation of the Social Security System, providing for several measures including the increase of the reference period for the calculation of pensionable earnings from 8 to 15 years. These reforms required a long implementation phase (especially in the case of Italy), and hence the level of generosity of the public pension system remained high, even increasing in Spain.

For the Spanish NHS the 1990s were the period in which important reforms introduced in the previous decade were implemented (Fidalgo & Ventura, 2013). The decentralisation process continued steadily and the scope of health coverage was widely extended to almost the whole of the Spanish population, reaching practically universal levels. A model of provision of free services was largely maintained. In Italy, important innovations were introduced with the reforms in 1992-93, which promoted an internal market and management processes inspired by the British model (Pavolini & Vicarelli, 2013). They also granted significant managerial autonomy to hospitals and local health units, transforming these into "*aziende*". The other main innovation concerned health decision-making powers, in particular correlated to the process of decentralisation, conceding even more to the Regions. If the political changes in the first part of the decade substantially regarded the internal market and the question of "competition", in the second part of the nineties the new centre-left government chose to fortify the role of the state in NHS regulation and proposed a model of "cooperation" among providers through the legislative decree approved in 1999. In terms of per capita expenditure, Italy was the country that grew the least (+ 13%), while Spain +30% was reached.

In the sphere of family policies, development continued to lag in Southern European countries. There were timid steps forward in Italy, while in 1990, the Spanish socialist government introduced a means-tested family allowance, very similar to the one developed two years earlier in Italy. It was, above all, Spain that sought to close the gap with Central and Northern Europe, increasing its level of per capita expenditure by 286% over a decade.

10.2.4 The new century: an adjustment phase

In the 2000s, spending on social protection continued to grow everywhere, especially in the Anglo-Saxon contexts, and there is no policy area where this upward trend did not manifest (Figure 10.4).

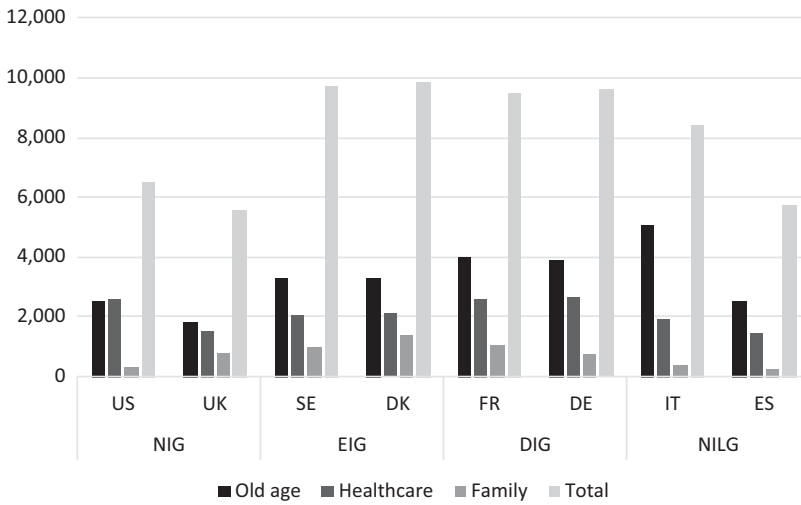

Figure 10.4a Public expenditure on social protection per capita in PPP (year 2000).

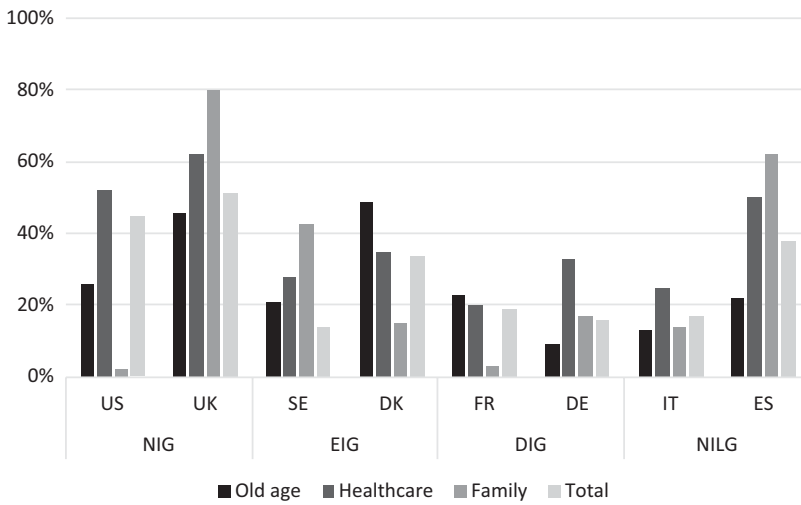

Figure 10.4b Percentage change in public expenditure on social protection per capita.

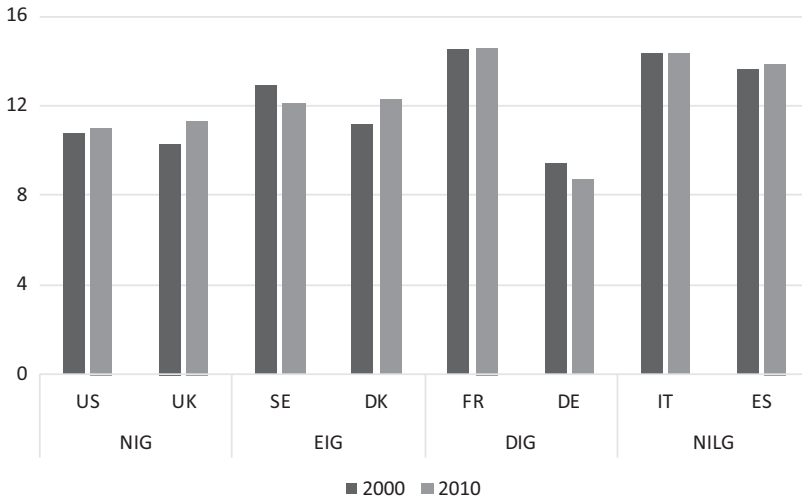

Figure 10.4c Generosity index of public pensions.

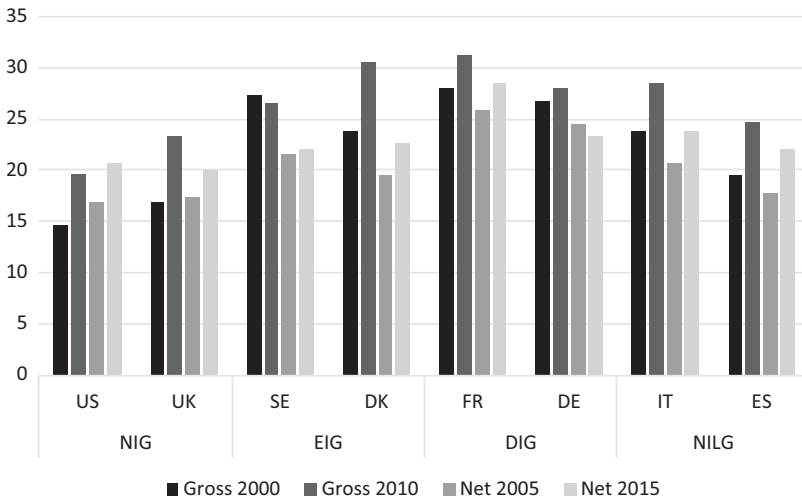

Figure 10.4d Public expenditure on social protection as a percentage of GDP.

Source: Elaboration on OECD data and Scruggs et al. (2017).

10.2.4.1 The non-inclusive growth model of the Anglo-Saxon countries

Total spending on welfare grew between 45% (USA) and 51% (UK) over the decade, generating a process of slow convergence in the levels of spending in these countries compared to those in Central and Northern Europe. In the case of pensions, there were no major changes in the US, while public intervention was expanded in the UK, as indicated by the generosity index. In 2008 important changes were introduced by the British Labour party to strengthen the first public pillar, including the abolition of contracting-out and the raising of the contribution rate linked to workers' earnings. The same reform also provided for voluntary self-enrolment in the second pillar. In the US Bush attempted a reform with a view to promoting privatisation, but the strength and resilience of the social security system outsmarted the centre-right government's aspirations and the design came to nothing (Berkowitz & De Witt, 2015).

For the British National Health Service, the decade represented a period of increasing investment of economic resources; on the one hand, the instruments of guidance and monitoring were reinforced, and on the other, decision-making power was devolved to Scotland, Wales, and Northern Ireland (Boyle, 2013). In addition, users' freedom of choice was amplified with the gradual opening up to the private sector from 2002 onwards. In the United States, there were no particular innovations. Nonetheless, public expenditure increased substantially (+52% in the USA and +62% in the UK), along with Spain, where it was relatively higher than in all other models.

With regard to family policies, in the UK the expansionary period under way since the mid-1990s continued with the promotion of four types of intervention. In 2000, a one-off cash transfer (Sure Start Maternity Grant) was introduced for each new birth. In 2002, the Child Tax Credit Act unified all previous tax credits into one single measure. In 2003, the Employment Relation Act increased both the pay and duration of the maternity grant. Finally, in 2004, the Sure Start programme allocated new resources for local governments to develop early childhood services. In the USA, the decade was largely marked by the Republican presidency and there were no particular innovations in this field (Michel, 2015). Also the trends in spending throughout the decade reflect the different choices in the two countries: virtually stable in the USA (+2%), growing by 80% in the UK.

10.2.4.2 The model of inclusive, egalitarian growth in the Nordic countries

During the decade under review, Danish expenditure continued to grow at a faster rate (+34%) compared to that in Sweden (+14%), while remaining below several other countries in terms of net impact on GDP. As far as pensions were concerned, Denmark was the only country to implement some major changes in in this period. In 2006, the Conservative government raised

the retirement age for both early retirement and the first public pillar and supplementary pensions. Overall, the level of generosity of the pension system in both Nordic countries remained relatively high.

In healthcare, patients' rights to choose were extended in the Nordic countries, the partial privatisation of the primary care sector continued and there was a re-centralisation in the governance of the healthcare system (Anell, Glenngård, & Merkur, 2012). Nonetheless, spending increased substantially in any case in both countries. In the field of family policies, the well-established Scandinavian system continued to invest resources: while in 2000 per capita expenditure was about €1,000 in Sweden and €1,400 in Denmark, over the decade it increased by 43% and 15% respectively.

10.2.4.3 The dualistic inclusive growth model of continental European countries

The first decade of the new century represented a further moment of growth for the public social protection system on the continent (+16/19%). Regulatory interventions on the pension system had little impact in France while they were more marked in Germany, as illustrated in the generosity indices. In particular, the centre-right French government adopted in 2003, stipulating that from 2020 the number of contribution years required to access a pension would be 42. In 2007, the grand coalition government in Germany raised the retirement age from 65 to 67 with a very gradual entry into force between 2012 and 2029.

The health policies of the previous decade were essentially continued in France (Palier & Davesne, 2013). In 2003, a DRG-based system was introduced in relation to hospital care and a number of national agencies were endowed with more power to assess and monitor quality standards, chiefly in hospitals. In addition, forms of cost-sharing continued to be widespread. For Germany, too, the decade represented a period of continuity and further elaboration of the reforms conceived in the 1990s (Hassenteufel & Klenk, 2013). The reinforcing of free choice and competition between funds, introduced in the previous decade, took a further step forward with first the 2004 "Modernisation of Health Insurance" law, which allowed German health insurance funds to differentiate their services more, and then the 2007 "Strengthening of Competition" legislation. Expenditure in both countries grew significantly (+20% in France and +33% in Germany).

Within the continental welfare regime, France put into effect family policies that were already at an advanced level of development, while innovations in the decade were limited to measures for promoting part-time work in 2004–2005. In contrast, highly expansive interventions in services and leave were implemented in Germany. In 2004, the Social Democratic-led government adopted a national funding plan for the development of services. During the period of the grand coalition government, both parental leave and, most

importantly, the right for every child aged one year and over to have a guaranteed place in early childhood services were introduced in 2007, representing one of the most important changes in German family policy in recent decades (2008).

10.2.4.4 The non-inclusive low growth model of Southern European countries

Expenditure trends followed different trajectories in this model: in Italy overall there was an increase of 17%, compared to 38% in Spain, (the highest relative change after the United States and the United Kingdom).

In the area of pensions, the centre-right government in Italy introduced in 2005 the "tacit consent" formula for the automatic transfer of severance pay or post-employment benefits to occupational pensions, later to be modified by the centre-left in 2006. Moreover, between 2009 and 2010 the centre-right government promoted an increase in the retirement age of female public sector workers from 60 to 65 with a phase-in period scheduled between 2010 and 2018. In Spain, the centre-right government took action in 2002 to encourage people to stay in the labour market beyond the age of 65 and to dissuade early retirement. Overall, in terms of generosity, the level of the pension system remained high in Italy while increasing only slightly in Spain.

In healthcare, Spain and Italy exerted more force in pushing towards the political-administrative decentralisation of the respective national health services. In particular, in Spain in 2002 the transfer of power to all the Regions was completed, with the role of the central government increasingly limited to ensuring equal access to health services throughout the country (Fidalgo &Ventura, 2013). Also in Italy the decade opened with another acceleration towards decentralisation, following the 2001 constitutional reform that ceded further power to the regions (Pavolini & Vicarelli, 2013). In the following years, however, the problem arose, in the absence of true fiscal autonomy, of how to avoid this transfer of powers turning into a mechanism generating autonomy at the local level but without accountability in terms of expenditure (Pavolini, 2011). To this end, the legislation of the past decade introduced the so-called "Deficit Recovery Plans", i.e. agreements between regions with health deficits and the central government, whereby the former committed themselves to implementing structural interventions in the network of health services in exchange for substantial aid from the latter to cover deficits. In terms of expenditure, Spain continued to invest more and more public resources (+38%) in comparison with Italy (+17%).

As far as family policies were concerned, Spain implemented more expansive interventions in the 2000s than Italy, as the relative change in per capita expenditure shows: +50% and +25% respectively. In 2007, the Zapatero government extended maternity leave to unemployed women and introduced a

four-week paternity leave paid at 100%. In the same year, the same government adopted an expansion plan for early childhood services. In Italy, in 2001 the government introduced more flexibility in the use of maternity leave and adopted parental leave. In 2005, the centre-right government introduced a one-off monetary transfer (baby bonus) for all children born between 2003 and 2006.

10.2.5 The last decade: new acceleration and paradigm shifts

The decade that has just ended was one in which, for a short period in some countries and for a much longer time in others, the policy framework was marked by the crisis and the desire to introduce austerity policies. Compared to the periods considered so far, expenditure varied far less, and not only for the obvious reason of having been able to consider a five-year period (2010–2015) and not a decade. With the exception of the United States (and solely regarding public investment in the new health system), in all the other contexts the per capita expenditure increased at a very contained rate and even decreased in Southern Europe (Figures 10.5a, 10.5b, and 10.5c).

10.2.5.1 The pattern of non-inclusive growth in the Anglo-Saxon countries

Overall spending on social protection followed very different patterns in the Anglo-Saxon countries: strong growth in the USA (+34%) as opposed to virtually no growth in the UK (+3%).

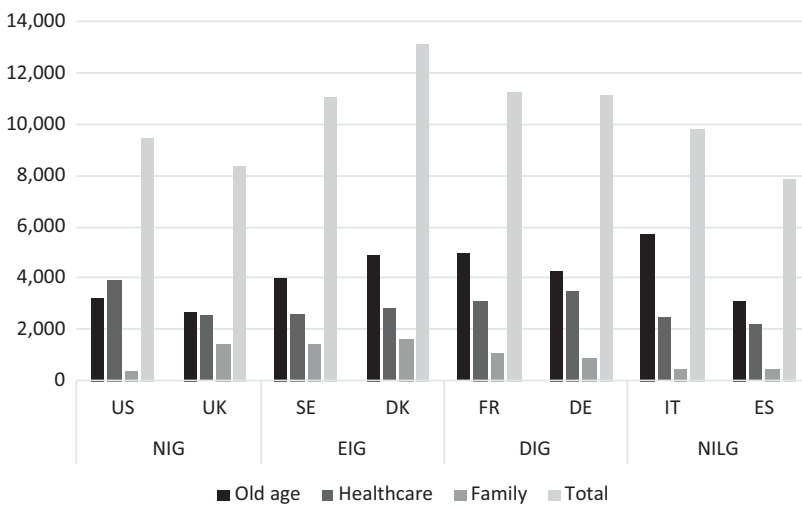

Figure 10.5a Public expenditure on social protection per capita in PPP 2010 (2015/18).

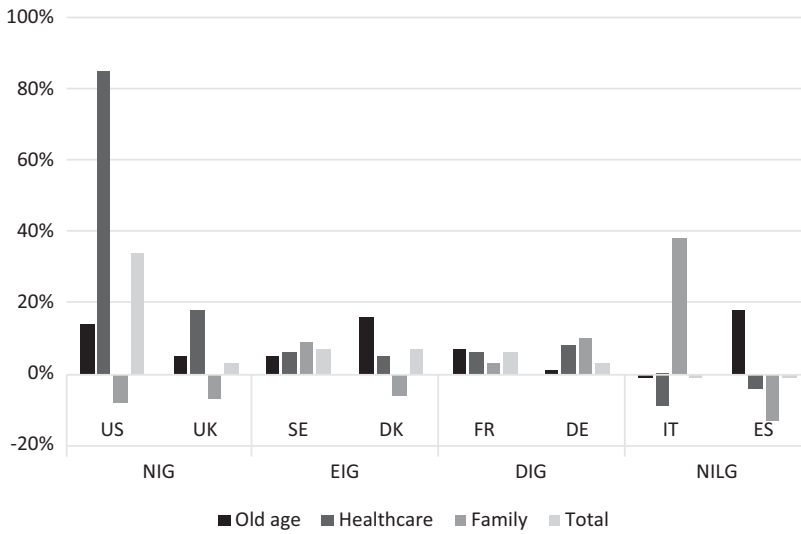

Figure 10.5b Percentage change in social protection expenditure per capita (2015/18).

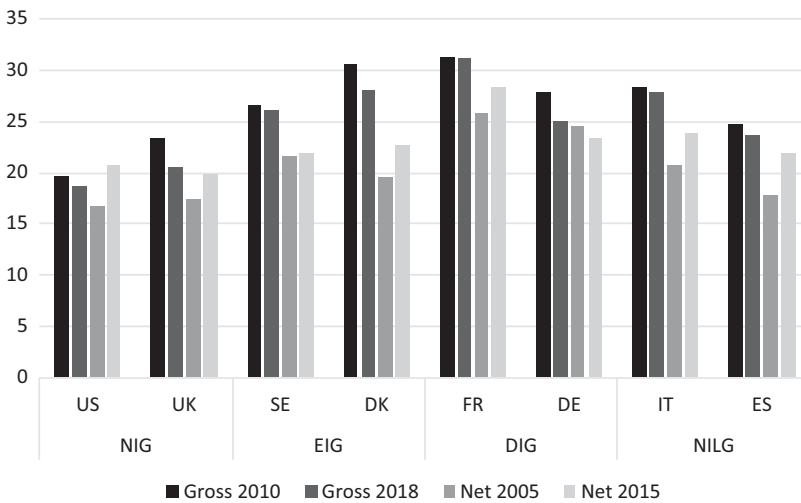

Figure 10.5c Public expenditure on social protection as a percentage of GDP.

Source: Elaboration of OECD data *online* and Scruggs et al. (2017).

In the area of pensions, the British Conservative government intervened in the first public pillar, raising the retirement age for men and women to 66 (Pension Reform 2011) and the number of contribution years to 35 (Pension Act 2014), while in the US there were no innovations.

Also in the health field the level of dynamism in the two countries followed opposite trends. In England the then Liberal–Conservative government decided to reintroduce innovations to the NHS with the reform "Health and Social Care Act 2012", again pushing the accelerator on quasi-markets in a version closer to that of the early 1990s. In the USA the most important public health reform since the 1940s was introduced: the Affordable Care Act (ACA) of 2010, mainly implemented from 2014 onwards. The goal of this reform was to significantly reduce the number of uninsured US residents (partly achieved with a reduction of more than half of the uninsured over a few years). The reform did not introduce a "European-style" healthcare system (either an NHS or mandatory health insurance), but it did allow for an increase in coverage through a combination of regulation and economic incentives that facilitated the expansion of eligibility for Medicaid and changes in individual insurance markets and Medicare. The ACA came up against strong political opposition from the Republicans, that persisted in the implementation phase of the legislation, even after the US Supreme Court's decision to allow individual states to opt out of Medicaid expansion. In family policies, there were no particular changes, except for cuts in the case of the UK: the expansionary period, which began in the mid-1990s, was interrupted between 2012 and 2013, when the then Conservative government retrenched funding for this type of intervention by around 32% as a result of the austerity measures it had launched. In both countries, per capita spending fell by around 7–8% over the five-year period.

10.2.5.2 The model of inclusive egalitarian growth in the Nordic countries

Expenditure on social protection in the Scandinavian countries increased by about 7% over a five-year period. This increase affected almost all policy areas considered here. In the field of pensions, only Denmark made some significant regulatory changes: the Social Democratic government in 2011 brought forward the increase in the retirement age for first-pillar pensions to the period between 2019 and 2022.

In healthcare, the agenda of the last decade in both countries focused more on quality of care, countering social exclusion and on patients' freedom of choice than on costs. In Sweden in 2010 the guarantee of a maximum waiting list, introduced in 2005, was made mandatory for the whole territory by setting a maximum waiting time of three months (Anell, Glenngård, & Merkur, 2012). Once this time limit has been exceeded, the patient may look for another facility and treatment costs are covered by the facility that did not comply with the waiting time. In 2015, a new patient protection law

was introduced to widen the scope of patient autonomy and participation. Expenditure went up by about 5–6%.

With a consolidated tradition in the field of family policies, the Nordic countries have continued their efforts to make their system of intervention through early childhood services increasingly universalistic: this occurred especially in Sweden, where spending continued to rise (+9%), while it diminished in Denmark (to note: the level in 2010 was significantly higher than in all the other countries under review).

10.2.5.3 The dualistic inclusive growth model of continental European countries

Continental countries maintained a positive yet far more restrained pace of growth in overall spending compared to the previous decade. Changes in pensions were introduced only in France, where the 2014 socialist reform increased the contribution period required to access a pension by one year for those born from 1973 onwards.

Health insurance systems were characterised by a fair level of expenditure growth throughout the decade. In both cases, the agenda was centred more around access to and quality of care than (merely) cost control and efficiency. In France in 2016, the law for the "Modernisation of the health system" intervened in three directions: a reinforcing of prevention, the improvement of access to health services, especially in terms of their proximity (in rural areas) and opening hours of primary care, and the strengthening of territorial coordination between health facilities. In Germany, the increase in available healthcare resources was accompanied by regulatory interventions with the aim of reducing inequalities in access. Here too action was taken to ensure better access to health services in rural areas and to promote innovative interventions in healthcare (Busse & Blümel, 2014).

In both countries family policies showed substantial continuity from the previous decade: in France because the system was already sufficiently structured, while in the case of Germany spending increased by 10% over a five-year period as a result of the need to implement the major reform introduced at the end of the 2000s.

10.2.5.4 The non-inclusive low growth model of Southern European countries

The countries most affected by austerity were those in Southern Europe, where spending fell in the first five years. With regard to pensions, Italy introduced a drastic increase in the retirement age. To mitigate the effects of this reform, the subsequent Poletti-Renzi reform of 2016–2017 introduced the possibility of early retirement under certain conditions and only for some disadvantaged workers. In Spain, the 2011 reform adopted in the midst of the financial crisis

increased the retirement age from 65 to 67 for retirement and from 61 to 63 for early retirement, as well as introducing the state of public finances and life expectancy into the pension indexation formula.

Both countries implemented stringent retrenchment in expenditure on healthcare. While in the case of Italy, the legislator intervened chiefly on the law of stability, providing for a reduction in spending in real terms at least until the middle of the current decade, in Spain the economic cuts were accompanied by some regulatory changes relating to rights of access to the NHS. In particular, in 2012 a fairly insurance-based logic was reintroduced in the right to access services. Irregular immigrants (with the exception of minors and pregnant women) were excluded from the system, except in cases of emergency or infectious diseases. Those with an annual income of more than €100,000 who were not part of the social security system, including family members, were considered not "insured" and excluded from the NHS. However, in 2016 the Spanish Constitutional Court declared this limitation illegal, reintroducing the universalism of the system through the courts. Other regulatory interventions in recent years have intervened on spending by providing new prescription charges, i.e. co-payments, and above all an automatic mechanism (as of 2014) that sets a maximum limit to the increase in public health spending, which cannot be higher than the medium-term Spanish GDP spending projections.

Lastly, family policies revealed a deceleration in spending in Spain and limited innovation in both countries.

10.3 Institutions and politics

How the reforms described in the previous paragraphs came about is not simple to interpret. Here the main actors operating in the field of welfare policies must be considered: the political ones in the strict sense (national parties and governments), the "traditional" social actors, historically recognised as counterparts in these fields (associations representing the interests of workers and enterprises), regional and local administrations, bureaucratic apparatuses, civil society and financial actors (insurance companies and banks).

The discourse here pertains to cases where institutions and actors, in particular politicians, have played a decisive role both in fostering and preventing institutional development. To start with, the various policy sectors should be examined, distinguishing between policy outputs, i.e. regulatory reforms actually adopted or significant increases/cuts in expenditure, and policy outcomes, that is, the more general effects that these policies have in relation to dimensions such as the universalism of enforceable social rights, the level of inequalities in access. The next concluding paragraph is devoted to the issue of outcomes. As far as policy outputs are concerned, we can distinguish three types of situations:

- *Institutional stability*: those cases in which despite governments' intentions and attempts at reform, they do not succeed in bringing about particular

regulatory innovations (using Hall's terms, no third-order changes take place and only some first- and second-order changes are approved).
- *Incremental change*: those cases in which the regulations implemented simply try to adapt welfare systems to changed needs, without the aim of introducing deeper transformations (these are mainly first and second order changes).
- *Radical transformation*: those cases in which a combination of relevant changes are introduced to the institutional design of the social protection system, which change its overall functioning and logic (mainly third order changes).

In all the models the pension systems considered were subjected to strain linked to common phenomena (longer life expectancy, ageing of the population, etc.), which could have led to significant second- and third-order changes in the institutional design. If, however, we look at what has happened, we see that the various countries are distributed along all three of the situations indicated above: *institutional stability* in the US case where, despite the ambitions and attempts at reform by two Republican presidents (Reagan in the 1980s and Bush in the first decade of the new century), there have been no radical transformations in the system; *incremental change* in the cases of France and Denmark where the choices adopted over the 40-year period have had the effect of trying to adapt their respective pension systems to changed needs, without, however, introducing any III order transformations; *radical transformations* in Sweden, Germany, Italy, Spain and, to some extent, the United Kingdom (the latter astride the line between incremental change and radical innovation), have brought about a variety of significant changes to the institutional design of the pension system, both in terms of contribution and access to benefits and in terms of the nature of the system itself (with the shift from a single-pillar public model to a multi-pillar model, or the strengthening of the multi-pillar model, where already present). However, it should be borne in mind that in Southern Europe the shift to the multi-pillar model has in actual fact run aground.

In the field of healthcare, there have been no cases of institutional stability but rather of *incremental change.* This has led to the introducing of managerialisation, forms of competition between providers, also opening up to the private sector, decentralisation (and then re-centralisation) of the administration of the system, which have affected practically all European healthcare systems. Furthermore, it has also brought more radical transformation in the case of the United States, thanks to the reforms introduced in the past decade with Obamacare, and in the case of Spain, where in the 1980s the universalist model introduced in the Spanish Constitution at the end of the 1970s began to be implemented.

In the area of family policies, again all three types of situation emerge. *Institutional stability* can be found in the Anglo-Saxon model and to a large

extent in the Italian model (with the latter and the British model on the line between *stability* and *incremental change*). In these countries, over a period of 40 years, few changes have been made to a public system that has only been able to support families with children to a residual (USA) or limited extent (Italy and the UK). The concept of *incremental change* accurately describes the situation in the Nordic countries, where innovations produced in the 1970s continued to be implemented and developed in the following decades. (At times more) *radical transformations* have occurred in the continental model (in France since the 1980s and in Germany since the 2000s) with a fair level of success, and in Spain, where less rewarding attempts have been made to promote ambitious policies to broaden public intervention both through services and through monetary transfers and leave. In the latter country, the aspiration to create a robust system of family support, developed in the 2000s, has been confronted with the cuts and austerity of the past decade, collocating the country somewhere between *incremental change* and *radical transformation*.

This brief synthesis of complex processes over a 40-year period affords a number of reflections (Table 10.1). First, there is no model among those considered that has not been affected by radical changes in at least one policy field. Second, incremental change remains the most widespread type of output in the field of welfare policy. Nonetheless, cases of radical transformation are numerous. Third, substantial institutional stability is the situation found least frequently (also because a relatively long time span is considered), but there are important cases (such as the US pension system) where reform ambitions have had to give way to the status quo.

What role have actors and institutions had in the various situations? The strength of institutional path dependency has been very intense in some cases (as in the case of the US pension system) and considerable in many others where policies have followed incremental changes. What has often been decisive is the initial institutional imprinting of the models. Institutions, and the actors associated with the status quo, undoubtedly set the course along

Table 10.1 Policy sectors and types of institutional change: a comparative view

	Institutional stability	*Incremental change*	*Radical Transformation*
Pensions	USA	Denmark, (United Kingdom), France	Sweden, (United Kingdom), Germany, Italy, Spain
Health		Nordic, continental and South European models, (United Kingdom)	USA, (Spain)
Family	USA, (United Kingdom), (Italy)	Nordic model, (United Kingdom), (South European model)	Continental Model (Spain)

which many policies evolved or remained relatively stable. However, this does not detract from the fact that parties, coalitions and social partners have not attempted to change the policy framework.

Generally, within the centre-right parties, there have been two major traditions relating to welfare during these decades: neo-liberal/conservative and Christian/conservative. The former has traditionally preferred, whenever possible, to attribute a more limited role to the state in terms of social protection, especially by framing welfare not as a tool for the redistribution and countering of inequalities, but rather as a way of collectively addressing social needs. In contrast, the latter has been more careful to mix conservative values with a focus on solidarity-based support for the less well-off. In the course of these decades, the parties that have embodied these two traditions have learned from the experience of attempted and sometimes failed reforms, especially those more oriented towards a neo-liberal/conservative perspective. In particular, the "revolutionary" attempts to dismantle welfare promised by Reagan and Thatcher in the 1980s met with frontal defeats (pension reform in the USA and to an extent in the UK) or were scaled down with respect to the objectives initially set (the health reform of the 1990s or the attempt to move to a model based on the Big Society in the UK). This was also due to the fact that many needs covered by welfare policies, in particular the three considered here (income in old age, health, and childcare), had the characteristic of not being typical only of certain social classes rather than others and this triggered consequences for the choices of political parties in terms of policy (ibid.). It was hence more problematic for centre-right parties to propose restrictive reforms in these areas. If anything, it was easier to resist raising expenditure and satisfying hitherto unprotected needs (again, the case of family policies in the USA).

This led to a change in the strategies of many of these parties, based on a twofold line of action. The first was an attempt to introduce changes (of first and second order) that had the capacity to transform the functioning of social protection systems in the medium term, without, however, having to openly promote unpopular reforms with precarious outcomes in terms of electoral support (through forms of *policy drift*). The second entailed transferring public resources as much as possible from direct management by the state or the social partners (as in the case of various systems based on compulsory social insurance with trade unions and employers' associations among the managers), to private actors and the market through various forms (tax concessions instead of services, competition for the management of services between public and private managers, etc.).

Looking at the situation of the left-wing parties, the picture appears just as convoluted for other reasons. In more recent decades, the electoral strength of these parties has often not been sufficient on its own to win elections, and coalitions with forces of the centre have been required, or there has been the necessity to propose electoral programmes capable of bagging a less

progressive or more liberal electorate. This is partly due to how the social (and therefore electoral) structure of Western countries has changed over recent decades, with a crisis and a decline in industrial labour (the heart of factory unionism but also of a sizeable part of the electorate of left-wing parties) and a rise in both intellectual and professional work, perhaps self-employed, as well as in unskilled manual work. However, an explanation that is based exclusively on the transformations in the composition of the electorate overlooks an element that has been present in this policy field for a long time: at least in the most advanced experiences of universalistic welfare, or in any case welfare based on generous benefits, this goal has often been achieved through the construction of coalitions between left-wing forces and other more moderate political forces, in those cases where left-wing forces and socio-cultural conditions have made such coalitions possible. This ballgame occurred repeatedly in the Scandinavian case with alliances between left-wing and agrarian parties as early as the first half of the last century (Esping-Andersen, 1990). In contrast, it was precisely this inability to create such alliances in Southern Europe that made the competition in welfare between left and right more polarised (Manow, 2015) and also more difficult to achieve reforms in a universalist sense.

On the whole, therefore, in recent decades participation of the left-wing parties in reformist seasons has taken place but nonetheless in economic conditions that have since changed in comparison with the past (fewer resources to redistribute), and in the presence of a considerable rise in social needs. This changed context has often required more than just an expansionary policy, as was the case until the 1970s (and partly the 1980s); rather it has necessitated a policy of recalibration and readjustment, based on complex balances between what needs to be covered and to what extent. Overall, the strength of the left-wing parties seems to have carried weight above all in the initial phases of construction or consolidation of post-war welfare (up until the 1980s), while the different institutional setups achieved in those decades strongly influenced the subsequent evolutionary path.

The Anglo-Saxon model (above all the USA) is the one in which the different orientations between centre-left and centre-right governments are most clearly visible in terms of social policies, also because of the government systems and party structure that make the comparison and positions more coherent. Obamacare, amidst a thousand limitations and compromises, represented a clear victory for the reformist forces and a defeat for the conservatives who, even after the reform was approved, continued to fight to neutralise it.

In the Nordic countries the universalist tradition of welfare (and also citizenship that has acquired extensive social rights) made it extremely difficult for right-wing forces to try to change the institutional path, meanwhile paving the way for left-wing forces to continue in an inclusive but also reformist and pragmatic tradition, open to coalitions with centre forces (the development of

family policies took place much earlier here than in any other country among those considered).

Continental Europe seems to have been able to count on a mix of strong welfare institutions but also on centre-right parties, often of Christian/conservative rather than neo-liberal inspiration, traditionally attentive to the needs of social protection, which have been accompanied by reformist, left-wing social-democratic parties to pursue a path of reform that is increasingly opening up to comply with "new" social needs (see the German reforms in the family sphere, in the wake of those already undertaken by the French).

The Southern European situation is the most challenging to construe. In this context, a traditionally unbalanced welfare system, to the advantage of some social groups (Ascoli & Pavolini, 2015) combined with the historical ideological opposition between the right (partly reactionary) and the left (partly maximalist) have made it more difficult to see reformist parties, both centre-right and centre-left, at work in recent decades and seriously motivated to find a common ground. In comparative terms, Italy is a country where many reforms have not been carried out, or in which the passage from one coalition of a certain political orientation to another has led to a significant change of direction in many welfare policies. Spain, for a whole series of reasons that are too intricate to summarise here, seems instead to have found its own way of promoting reforms in a more pragmatic and consensual way than Italy (Guillén & León, 2014). However, the reformist season in this country was forced to put the brakes on as a result of the crisis and austerity of the last decade (Burroni et al., 2021). Undoubtedly, the crisis and consequential austerity hit both countries with a force not seen in the other cases studied here, giving rise to a real exogenous shock in terms of the functioning of the social protection system.

10.4 The outcomes of welfare policies

By way of conclusion, some reflections can be made on the outcomes of the policies and in particular on the level of inequalities, as well as on the coverage of needs and on expenditure. In the course of a 40-year period, spending on social protection has continued to increase everywhere, both in relation to GDP and in per capita terms (Table 10.2).

In particular, it has at least doubled, if not tripled (Spain and the United States) in per capita terms in all four models, and the ratio to GDP has increased by several percentage points. Moreover, with the exception of Germany and Sweden, in all other countries and models the increase in welfare spending over almost four decades has been much greater than the increase in GDP. In relation to this phenomenon, Germany and Sweden show a more moderate growth in welfare spending, largely because they were already relatively "big spenders" on welfare in 1980 in comparison with all the other countries and, therefore, it is reasonable that these countries grew at a fast pace (Sweden

Table 10.2 Trend of public expenditure on social protection (1980–2018)

	Per capita at constant prices and at PPP				*% on GDP (gross)*	
	1980	*2015*	*Variation % 1980–2015*	*Variation % GDP 1980–2015*	*1980*	*2018*
United States	3.794	12.722	+235%	+153%	13.2	18.7
United Kingdom	3.177	8.654	+172%	+121%	15.8	20.6
Sweden	6.176	11.847	+92%	+110%	24.8	26.1
Denmark	5.464	14.058	+157%	+83%	20.3	28.0
France	4.802	11.884	+147%	+86%	20.1	31.2
Germany	6.592	11.548	+75%	+103%	23.6	25.1
Italy	4.339	9.798	+126%	+50%	18.2	27.9
Spain	2.681	7.832	+192%	+117%	15.0	23.7

Source: Elaboration on OECD data.

almost doubled its per capita spending), yet less intensively than the others. Overall, differences in expenditure levels between countries in the various models have declined over time: the coefficient of variation was seen to fall in the period from 1980 to 2015 (not shown in Table 10.2).

This trend in expenditure is not attributable only to demographic factors, such as the ageing of the population: while pension expenditure has certainly increased over a period of 40 years as a result of the progressive increase in life expectancy of individuals, all the other policy areas considered here have seen an increase in the level of real per capita expenditure (this figure is not shown in the table, but it may be obtained by comparing the graphs illustrated so far).

In net opposition to the idea of a generalised retrenchment of social protection as a result of neo-liberal policies, the picture that emerges from these pages is, instead, of a largely resilient welfare state that has absorbed an increasing share of public economic resources over time. In conclusion, however, our question concerns the effect on reducing inequality. Two types of exercises can be carried out here: one is to analyse the current level of inequality in access to welfare benefits, after decades of investment in public protection systems, while the other consists in considering the studies that offer information in relation to the policy areas discussed here.

The comparative analysis on distributional effects has been carried out by considering a series of indicators related both to the single policy areas considered (pensions, health, and family support policies) and to the total amount of resources transferred through welfare. Starting with the latter, we refer to Chapter 5 for a comparative understanding of how much the set of monetary transfers to households through public welfare in its various forms (from pensions to unemployment benefits to transfers for dependent family

members), helps households to limit the risk of being poor. Here it is useful to bear in mind that the continental and Nordic one model, thanks to its welfare, reduces the risk of poverty the most, while the Anglo-Saxon model, in particular the United States, is that which manages to change people's starting conditions the least.

In the sphere of pensions, one way of appreciating the extent of generosity, but also fairness, of the social protection system is to consider the net replacement rates of pensions, i.e. how much pension income corresponds to when compared to the average salary obtained during the last years of work (Table 10.3). Two countries, Denmark and France, manage to achieve very low poverty rates among the elderly thanks to medium to high replacement rates, achieved in partially different ways. In Denmark an inclusive multi-pillar system is implemented (almost all active people on the labour market are covered), and higher net replacement rates for lower paid workers. France applies a slightly higher but similar average replacement rate among different profiles of workers within a system mainly centred around the public pillar. More horizontal redistribution takes place in Denmark than in France. The results in these two countries should hardly be surprising given the significantly higher per capita level of pension expenditure compared to all the remaining countries except Italy. This last country's result is, nonetheless, somewhat unexpected: while spending extensively on pensions, Italy has a significantly higher poverty rate among the elderly compared to the previous two countries. This is linked to the fact that of the eight countries surveyed, it has the highest replacement rates, with no greater attention paid to lower income earners (indeed the highest replacement rate is among workers with wages of 150% of the average wage). Hence, Italy emerges as a country that spends a considerable amount but fails to reduce poverty among the elderly and also inequality among pensioners in proportion to its expenditure. Denmark succeeds in both objectives, while France succeeds in reducing poverty but curtails inequality to a lesser extent.[2] The other countries are in different situations. The two Anglo-Saxon countries and Spain are characterised by substantial poverty rates among the elderly, which can be linked both to lower levels of public spending and also to a limited redistribution of resources among different profiles of workers (as can be deduced from replacement rates that grow as the worker's salary increases and, in the Anglo-Saxon countries, from the spread of the multi-pillar centred in the strongest sectors of the labour market[3]). Germany and Sweden lie somewhere between the latter group and the former.

Turning to family policies, in order to measure the diffusion but also the distributional effects of these interventions, it is useful to divide them into early childhood services (Table 10.4) and parental leave (Table 10.5). These services cover a relatively high percentage of children between 0 and 2 years of age in Denmark and France (around 55%), but require a certain economic sacrifice from families (especially couples) in order to be able to send their

Table 10.3 Income, pensions, and poverty

	Net replacement rate of pensions (men; %) (2018)						*Coverage rate of supplementary pensions (% active population 15–64 years) (2016)*			*Poverty rate among elderly (2016)*	*Per capita at fixed prices and at PPP (2015)*
	Public pillar			*Public and private pillars*			*Almost-compulsory*	*Occupa-tional*	*Indivi-dual*		
	50% of average salary	*100% of average salary*	*150% of average salary*	*50%of average salary*	*100% of average salary*	*150% of average salary*					
United States	61.2	49.4	42.7	94.1	83.7	79.0	0%	44%	19%	23.1	3.655
United Kingdom	51.0	28.4	20.2	82.3	61.0	47.4	46%	5%		15.3	2.806
Sweden	60.7	53.4	68.9	60.7	53.4	68.9	100%	24%		11.3	4.162
Denmark	104.5	70.9	63.3	104.5	70.9	63.3	85%	18%		3.0	5.713
France	71.4	73.6	69.0	71.4	73.6	69.0	0%	25%	8%	3.4	5.315
Germany	56.1	51.9	51.4	68.6	68.0	67.5	0%	70%		9.6	4.309
Italy	92.0	91.8	94.4	92.0	91.8	94.4	0%	21%		10.3	5.673
Spain	78.6	83.4	82.8	78.6	83.4	82.8	0%	26%		9.4	3.681

Source: OECD.

Table 10.4 Net costs for parents sending their children to early childhood education services (% of net household income) (2015)

	Single parent with 2 children		*Couple with 2 children and partner salary at 100% of average*		*Couple with 2 children and partner salary at 67% of average*		*Children aged 0–2 in socio-educational services for early childhood (%) (2017)*
	Main income earner with 100% of average salary	*Main income earner with 67% of average salary*	*Main income earner with 100% of average salary*	*Main income earner with 67% of average salary*	*Main income earner with 100% of average salary*	*Main income earner with 67% of average salary*	
United States	27	34	24	29	17	21	28.0*
United Kingdom	21	19	54	69	41	34	37.7
Sweden	5	4	3	4	4	5	46.6
Denmark	7	3	8	10	9	11	55.4
France	6	4	12	11	9	8	56.3
Germany	6	2	4	5	5	6	37.2
Italy	5	4	4	4	5	5	29.7
Spain	7	9	4	5	4	5	36.4

Source: OECD.

Note: * Data refers to 2011.

Table 10.5 Regulation of leave (2018)

	Length of leave (weeks)		*Replacement rate of monetary transfer linked to maternity leave*		
	Maternity leave	*Parental leave*	*50% of gross average salary*	*100% of gross average salary*	*150% of gross average salary*
United States	0	0	–	–	–
United Kingdom	39	0	48.4	31.1	25.4
Sweden	18	32	77.6	77.6	56.3
Denmark	12.9	42.9	100.0	53.3	35.5
France	16	26	100.0	100.0	98.8
Germany	14	44	100.0	100.0	100.0
Italy	21.7	26	80.0	80.0	80.0
Spain	16	0	100.0	100.0	100.0

Source: OECD.

children to nursery school or kindergarten. These countries are followed by Sweden, where around 47% of children go to nursery school and where the cost for families to access these services is lower for all family profiles compared to France and Denmark. Germany, the United Kingdom, and Spain provide coverage for about 37% of children but do so with different burdens on household budgets: in Germany and Spain through low levels of household expenditure, in the United Kingdom much higher levels, especially for families with lower incomes. The United States and Italy are in last place for the provision of early childhood services, but, at least in the case of Italy, families do not have to bear a high cost of accessing them.

A comparison of leave legislation shows a more easily classifiable situation. On the one hand, the two Anglo-Saxon countries reveal there is little or no incentive to take maternity leave (in the UK there are 39 weeks for maternity leave but with relatively low rates of replacement) or none at all (in the US, as pointed out in the previous paragraph). Spain comes closest to the Anglo-Saxon countries given the limited duration of maternity leave (although much better compensated for all worker profiles) and the absence of parental leave. The other countries are characterised by an overall broad coverage in terms of duration, adding up the different types of leave, and of the wage replacement rate, without differentiating between worker profiles (except for the Scandinavian countries where the replacement rate diminishes as the worker's wage increases).

In the case of healthcare, finally, it is useful to take up the main results of a recent OECD study (2019) dedicated specifically to the theme of access to healthcare according to economic situation, using the comparison between people belonging to the lowest quintile of income and those belonging to the highest quintile (Table 10.6). The United States, as it was easy to hypothesise,

Table 10.6 Inequalities in terms of access to health services (2018)

	Need-based standardised probability for care or visiting a doctor per income quintile (%)		*Need-based standardised probability of hospitalisation per income quintile (%)*		*Access to preventive (screening) services for breast cancer by income quintile (%)*		*Access to prevention (screening) services for colorectal cancer by income quintile (%)*	
	I quintile	*V quintile*	*I quintile*	*V quintile*	*I quintile*	*V quintile*	*I quintile*	*V quintile*
United States	59*	74*	12*	9*	71*	87*	51*	71*
United Kingdom	76	77	8	8	51*	62*	50*	45*
Sweden	62	65	6	8	74*	93*	43*	22*
Denmark	82*	76*	10	7	83	80	46	49
France	86*	91*	13	13	79*	90*	53*	67*
Germany	84*	88*	17*	14*	70	72	71*	77*
Italy	75*	83*	8	9	55*	75*	31*	50*
Spain	81	81	8	8	68*	86*	19*	35*

Source: OECD (2019).

Note: * Difference between I and V quintile statistically significant by 5%.

represents the context in which social class counts the most in significantly differentiating access to health services, including specialist facilities, hospitals and, above all, preventive care units. It should be remembered that this is the only country among those considered in this chapter in which a sizeable part of the population is not covered, except for emergency services (through the Medicaid programme). The country most similar to the United States is Italy where, in spite of the presence of the NHS, we find significant and wide differences per social class in all services, with the exception of hospitals. At the opposite end of the spectrum from the United States (and Italy) we find the Nordic countries, where no differences by social class can be observed. In the continental countries, with compulsory insurance systems, the differences are present but limited in the specialist-hospital field, while they become more marked in the field of prevention, especially in France. Two of the three remaining NHS systems (the UK and Spain) show no particular differences by social class in the specialist-hospital field, while these differences become more marked in the field of prevention, especially in Spain.

10.5 Concluding remarks

To summarise the results of the above tables, the data analysis confirms the traditional image of the various welfare systems, with some limited differentiations. The Anglo-Saxon welfare systems, especially the US and Southern European ones, are the contexts in which the social protection system succeeds least in reducing (or intends least to reduce) poverty and social inequalities. The Nordic countries are the opposite, followed by the continental countries.

Bearing in mind, however, that the data discussed concern the current phase, in which a high level of maturity has been reached in most of the social protection systems under review (also in terms of expenditure), it is difficult to imagine that in the past decades (at least since the 1980s), the inequalities created or not alleviated by welfare systems could have been greater than they are today, with some exceptions. In particular, in the field of pensions, the reforms that have affected European countries since the 1980s, and especially since the 1990s (in the USA very little has happened, as illustrated in the previous paragraph), have mainly concerned two aspects: the establishment of complementary pension schemes with (semi-)voluntary membership (the so-called multi-pillarisation) and the adoption of measures such as raising the retirement age or the years of contribution required to access a pension, with the aim of curtailing costs and guaranteeing the financial sustainability of pension systems. These reforms have not affected the universalism and overall largesse of the pension schemes in the Nordic countries or in France, but they have had different effects in other contexts. In particular, in the UK and Germany they have increased differences in the conditions of access to benefits on the basis of social class, creating the basis for the process of dualisation referred to in the introduction to this text, while in Southern

Europe the net effect they have had is not clear, although it would seem most likely to be that of increasing inequalities, at least in the case of Italy (Raitano & Jessoula, 2016).

In the sphere of family policies, with the sole exception of the Anglo-Saxon model (in particular the US) and, to a small degree, Italy (Pavolini et al., 2016), the expansion of interventions over the decades has brought with it greater universalism. More precisely, Daly and Ferragina (2018) identify the "founding phase" of family policies in the period between 1960 and 1980 in which welfare states mainly developed maternity leave for pregnant women in conjunction with monetary transfers and tax relief for families. From 1980 onwards, however, what Daly and Ferragina (2018) call the "consolidation phase" of family policies began, in which new policy instruments, such as care services, were introduced in addition to those already developed during the founding phase, forming the articulated range of family policies that includes: monetary transfers, care services, leave, promotion of flexible and part-time work. Over the years and decades, such interventions have become increasingly widespread in Europe.

A similar reasoning may be held as feasible also for healthcare. In this case, the United States represents a positive case starting from the phenomenon of "Obamacare", given the increase in coverage in the potentially universalistic direction of this intervention. All the other countries have seen an increase in the overall level of coverage and universalism over time, with Italy probably being the only European country among those considered where the combination of territorial inequalities between North and South in the functioning of the NHS and heavy spending cuts over the last two decades have in fact undermined the universalism of the system (Pavolini & Guillén, 2013; Pavolini & Seeleib-Kaiser, 2018).

Notes

1 To note: as this is an index covering only public compulsory pensions, it underestimates the level of generosity provided in those systems that have traditionally been multi-pillar (e.g. the UK) or that have become so in recent decades (e.g. Germany).
2 Other Eurostat data, not reported here and referring only to EU countries, show that Italy and France are among the Western European countries with the highest concentration of pension incomes in the highest quintiles of pensioners.
3 On this point see Seeleib-Kaiser and Pavolini (2018).

References

Adema, W., Fron, P., & Ladaique, M. (2011). *Is the European welfare state really more expensive?: Indicators on social spending, 1980–2012; and a manual to the OECD social expenditure database (SOCX)*. OECD Social, Employment and Migration Working Papers, No. 124. Paris: OECD Publishing.

Anell, A., Glenngård, A.H., & Merkur, S. (2012). Sweden: Health system review. *Health Systems in Transition*, 14(5), 1–159

Anderson, K.M. (2005). Pension reform in Sweden: Radical reform in a mature pension system. In G. Bonoli (Ed.), *Ageing and pension around the world* (pp. 94–115). Cheltenham: Edward Elgar.

Anderson, K.M., & Immergut, H. (2007). *Sweden: After social democratic hegemony*. In E. Immergut, K., Anderson & I. Schulze (Eds), *Handbook of West European pension politics* (pp. 349–395). Oxford: Oxford University Press.

Ascoli, U. & Pavolini, E. (2015) (Eds). *The Italian welfare state in a European perspective*. Bristol: Policy Press.

Ascoli U. & Pavolini, E. (2016) (Eds). *The Italian welfare state in a European perspective: A comparative analysis.* Bristol: Bristol University Press.

Béland, D., Blomqvist, P., Andersen J.G., Palme J., & Waddan, A. (2015). The universal decline of universality?: Social Policy change in Canada, Denmark, Sweden and the UK. *Social Policy and Adminstration*, 48(7), 739–756. doi.org/10.1111/spol.12064

Berkowitz, E. & De Witt, L. (2015). Social security. In D. Beland, C. Howard, & K. Morgan (Eds), *The Oxford handbook of US social policy* (pp. 261–278). Oxford: Oxford University Press.

Boyle, S. (2011). *Health system in transition: United Kingdom (England)*. Brussels: European Observatory on Health System and Policies.

Boyle, S. (2013). England: Health reforms have improved the NHS. In E. Pavolini & A.M. Guillén (Eds), *Health care system in Europe under austerity* (pp. 31–56). London: Palgrave Macmillan.

Blome, A. (2017). *The politics of work-family reforms in Italy and Germany*. London: Routledge.

Blomqvist, P. & Winblad, U. (2013). Sweden: Continued marketization within a universalist system. In E. Pavolini & A.M. Guillén (Eds), *Health care system in Europe under austerity* (pp. 9–30). London: Palgrave Macmillan.

Bradshaw, R.J., Glendinning, C., Maynard, A.K., & Bennet F. (2015). *ESPN thematic report on social investment: United Kingdom*. Brussels: European Social Policy Network.

Burroni, L., Pavolini, E., & Regini, M. (2021) (Eds). *Mediterranean capitalism revisited: One model, different trajectories*. Ithaca: Cornell University Press.

Busse, R. & Blümel, M. (2014). Germany: Health system review. *Health Systems in Transition*, 16(2), 1–296.

Busse, R. & Riesberg, A. (2004). Health care systems in transition: Germany. *Health Systems in Transition,* 6(9), 1–234.

Chulià, E. (2007). Spain: Between majority rule and incrementalism. In E. Immergut, K. Anderson, & I. Schulze (Eds), *Handbook of West European pension politics* (pp. 499–554). Oxford: Oxford University Press.

da Conceicao-Heldt, E. (2007). France: The importance of electoral cycle. In E. Immergut, K. Anderson, & I. Schulze (Eds), *Handbook of West European pension politics* (pp. 150–202). Oxford: Oxford University Press,

Daly, M. & Ferragina, E. (2018). Family policy in high-income countries: Five decades of development. *Journal of European Social Policy*, 28(3), 255–270. doi:10.1177/0958928717735060

Emmeneger, P., Häusermann, S., Palier, B., & Seeleib-Kaieser, M. (2012). *The age of dualization: The changing face of inequality in deindustrializing society*. Oxford: Oxford University Press.

Esping-Andersen, G. (1990). *The three world of welfare capitalism*. Cambridge: Polity Press.

European Commission (2015). *The 2015 pension adeguacy report: Current and future income adeguacy in old age in the EU. Volume II*, Joint Report Prepared by the European Commission (DG EMPL) and the Social Protection Committee (SPC)

Ferrera, M., & Jessoula, M. (2005), Reconfiguring Italian pensions: From policy stalemate to comprehensive reforms. In G. Bonoli (Ed.), *Ageing and pension around the world* (pp. 24–46). Cheltenham: Edward Elgar.

Ferrera M., & Jessoula, M. (2007). Italy: A narrow gate for path-shift. In E. Immergut, K. Anderson, & I. Schulze (Eds), *Handbook of West European pension politics* (pp. 396–453). Oxford: Oxford University Press.

Fidalgo, E. & Ventura, J. (2013). Spain: Quo vadis? From cost containment to structural reforms. In E. Pavolini & A.M. Guillén (Eds), *Health care system in Europe under austerity* (pp. 82–101). London: Palgrave Macmillan.

Green-Pedersen, C. (2007). Denmark: A "world bank" pension system. In E. Immergut, K. Anderson & I. Schulze (Eds), *Handbook of West European pension politics* (pp. 454–498). Oxford: Oxford University Press.

Guillén, A.M. & León, M. (2014) (Eds). *The Spanish welfare State in European Context*. Farnham: Ashgate.

Guillén, A.M. & Pavolini, E. (2017). Spain: Regaining the confidence and legitimacy to advance social policy. In P. Taylor-Gooby, B. Leruth, & H. Chung, *After austerity: Welfare state transformation in Europe after the Great Recession* (pp. 136–154). Oxford: Oxford University Press.

Hall, P. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics*, 25(3), 275–296.

Hassenteufelf, P. & Klenk, T. (2013). Germany: Mixing rescaling, privatization and managerialism. In E. Pavolini & A. M. Guillén (Eds), *Health care system in Europe under austerity* (pp. 122–146). London: Palgrave Macmillan.

Hills, J. & Stewart, K. (2005) (Eds). *A more equal society? New Labour, poverty, inequality and exclusion.* London: Policy Press.

Hinrics, K. (2005). New century – new paradigm: Pension reforms in Germany. In G. Bonoli (Ed.), *Ageing and pension around the world* (pp. 47–73). Cheltenham: Edward Elgar.

Jansen, C. (2014). *The right and the welfare state.* Oxford: Oxford University Press.

Jessoula, M. & Raitano, M. (2016). I nervi scoperti del sistema pensionistico Italiano. *Il Mulino*, 3, 503–511.

Lewis, J. (2009). *Work-family balance, gender and policy*. Cheltenham: Edward Elgar.

León, M., Pavolini, E., Miro y Artigas, J., & Sorrenti, A. (2021). Policy change and partisan politics: Understanding family policy differentiation in two similar countries. *Social Politics: International Studies in Gender, State & Society*, 28(2), 451–476. doi.org/10.1093/sp/jxz025

Mandin, C. & Palier, B. (2005). The politics of pension reform in France: The end of exceptionalism? In G. Bonoli (Ed.), *Ageing and pension around the world* (pp. 74–93). Cheltenham: Edward Elgar Publishing.

Manow, P. (2015). Workers, farmers and Catholicism: A history of political class coalitions and the South-European welfare state regime. *Journal of European Social Policy*, 25(1), 32–49. doi:10.1177/0958928714556969.

Michel, S. (2015). Care and work-family policies. In D. Beland, C. Howard, & K. Morgan (Eds), *The Oxford handbook of US social policy* (pp. 491–509). Oxford: Oxford University Press.

Morgan, K. (2003). The politics of mothers' employment: France in comparative perspective. *World Politics*, 55(2), 259–289. doi:10.1353/wp.2003.0013

Morel, N., Palier, B., & Joakim, P. (2012). *Towards a social investment welfare state?* Bristol: Bristol University Press.

Naczyk, M. (2017). France: Squarinq the circle of unification in a fragmented pension system. In D. Natali (Ed.), *The new pension mix in Europe recent reforms, their distributional effects and political dynamics* (pp. 73–98). Brussels: Peter Lang.

Naldini, M. (2003) (Ed.). *The family in the Mediterranean welfare state*. London: Routledge.

Oberlander, J. (2016). Implementing the Affordable Care Act: The promise and limits of health care reform. *Journal of Health Politics, Policy and Law*, 41(4), 803–826. doi:10.1215/03616878-3620953

OECD (2019). *Health at a glance*. Paris: OECD.

Palier, B. & Davesne, A. (2013). France: Squaring the health spending circle?. In E. Pavolini & A.M. Guillén (Eds), *Health care system in Europe under austerity* (pp. 102–125). London: Palgrave Macmillan.

Pavolini, E. (2011) (Ed.). *Il cambiamento possibile/; La sanità in Sicilia tra nord & sud*. Fondazione RES, Rome: Meridiana Libri-Donzelli

Pavolini, E. & Guillén, A.M. (2013) (Eds). *Health care system in Europe under austerity*. London: Palgrave Macmillan

Pavolini, E. León M., Guillén M., & Ascoli, U. (2016). From austerity to permanent strain? The European Union and welfare state reform in Italy and Spain. In C. De La Porte, & E. Heins (Eds) *The sovereign debt crisis, the EU and welfare state reform* (pp. 131–157). London: Palgrave Macmillan.

Pavolini, E. & Seeleib-Kaiser, M. (2018). Comparing occupational welfare in Europe: The case of occupational pensions. *Social Policy and Administration*, 52(2), 477–490

Pavolini, E. & Vicarelli, M.G. (2013). Le due italia della sanitá. In S. Vassallo (Ed.), *Il divario incolmabile: Rappresentanza politica & rendimento istituzionale nelle regioni Italiane*,(193–222). Bologna: Il Mulino.

Pierson P. (1994). *Dismantling the welfare state?: Reagan, Thatcher and the politics of retrenchment*. Cambridge: Cambridge University Press.

Sabatinelli, S. (2017). *Politiche per crescere. La prima infanzia tra cura & investimento sociale*. Bologna: Il Mulino.

Sacchi, S. (2013). *La riforma del welfare nella crisi del debito Italiano: Pensioni, lavoro, ammortizatori sociali*. In A. Di Virgilio, & C. Radaelli (Eds), *Politica in Italia: I fatti dell'anno & le interpretazioni* (pp. 217–236). Bologna: Il Mulino

Saraceno, C. (2003). *Mutamenti della famiglia & politiche sociali in Italia*. Bologna: Il Mulino.

Seeleib-Kaiser, M. (2016). The end of conservative German model. *Social Policy and Administration*, 50 (2), 219–240. doi.org/10.1111/spol.12212

Scruggs, L., Jahn, D., & Kuitto, K. (2017). *Comparative welfare entitlements dataset 2. Version 2017-09.* University of Connecticut & University of Greifswald

Suarez Corujo, B. (2014). *El sistema público de pensiones: Crisis, reforma y sostenibilidad*. Valladolid: Lex Nova, Thomson Reuters.

Vicarelli, M.G. (2005). Control, competition and cooperation in European health systems: Points of contact between health policy and industrial policy. In M. Di Tommaso & S. Schweitzer (Eds), *Health policy and high-tech industrial development* (pp. 59–76). Cheltenham: Edward Elgar.

Weaver, R.K. (2005). Public pension reform in the United States. In G. Bonoli (Eds), *Ageing and pension around the world* (pp. 230–251). Cheltenham: Edward Elgar.

Whiteside, N. (2017). Britain's pension reform: A new departure. In D. Natali (Eds), *The new pension mix in Europe recent reforms, their distributional effects and political dynamics* (pp. 183–206). Brussels: Peter Lang.

Woods, D.R. (2012) (Ed.). *Family policy in transformation: US and UK policies.* London: Palgrave Macmillan.