Theory and Practice of the Welfare State in Europe

Sessions 10, 11 and 12

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Course web page

www.ips.uw.edu.pl/rszarf/welfare-state/

Social Assistance and Poverty

Poverty and its meanings

- Words acquire meaning from their use, and words that are used extensively are liable to acquire not a single meaning, but a range of meanings
- **Poverty does not, however, have a single meaning**. It has a series of meanings, linked through a series of resemblances
- In the social sciences poverty is commonly understood in at least **twelve discrete senses**

Poverty – economic circumstances

- The first set of definitions understands poverty as a **lack of material goods or services**. People 'need' things like such as food, clothing, fuel or shelter
- Poverty generally refers not just to deprivation, but to **deprivation experienced over a period of time**
- Poverty can be taken to refer to circumstances in which **people lack the income, wealth or resources to acquire or consume the things which they need**

Poverty – economic circumstances

- One of the most widely used approaches to the measurement of poverty is in terms **of income**
- Although the idea of a **standard of living** is intimately linked with need, it is in its nature a general concept, referring not to specific forms of deprivation but to the general experience of living with less than others… **people who cannot afford what they do not need might still be considered poor**
- People may be held to be poor because they are **disadvantaged by comparison with others** in society

Poverty – economic circumstances

- Casting the issue of poverty in terms of **stratification** leads to regarding poverty as an issue of inequality. In this approach, we move away from efforts to measure poverty line
- the poor are an **integral part of the working class** – its poorest and most disadvantaged stratum

Poverty – social circumstances

- The main description of poor people as a ‘class’ in recent years has been in terms of the ‘**underclass**’ - socio-economic status, a concept based on the linkage of class with social and occupational roles
- Poor people are sometimes taken to be those who receive social benefits in consequence of their lack of means (**dependency**)

Poverty – social circumstances

- Although a **lack of basic security** has been defined in terms directly equivalent to need, it may also be seen in terms of **vulnerability to social risks**
- the absence of one of more factors that enable individuals and families to assume basic responsibilities and to enjoy fundamental rights… chronic poverty results when the **lack of basic security simultaneously affects several aspects of people's lives, when it is prolonged**

Poverty – social circumstances

- both deprivation and lack of resources reflect **lack of entitlements**, rather than the absence of essential items in themselves… The lack of entitlement is fundamental to the condition of poverty; people who have the necessary entitlements are not poor
- Poverty can be seen as a set of social relationships in which people are **excluded from participation** in the normal pattern of social life

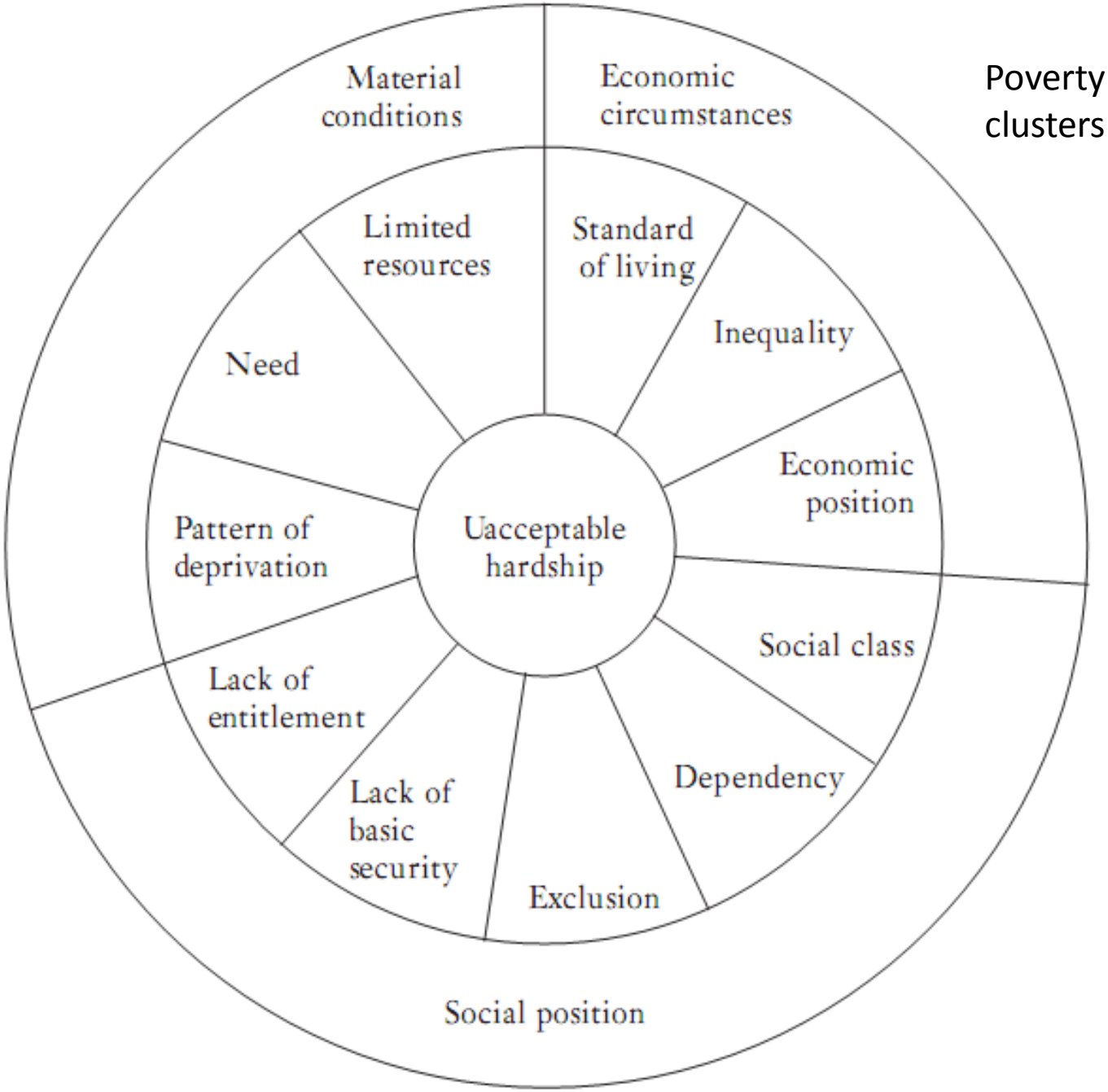
Poverty – moral concept

- poverty consists not just of hardship, but of **UNACCEPTABLE HARDSHIP**. The term ‘poverty’, ‘carries with it an implication and **moral imperative that something should be done about it**. Its definition is a value judgment and should be clearly seen to be so’
- The moral elements of the definition of poverty make it difficult to establish agreement about the elements of the concept (but Breadline Britain survey identifies a method by which it can be done)

Many meanings of poverty combined

- Serge Paugam's '**social disqualification**', which covers class, exclusion, dependency and lack of basic security
- Peter Townsend's concept of '**relative deprivation**', which incorporates elements of the standard of living, limited resources, exclusion, class and inequality

Poverty - twelve clusters of meaning

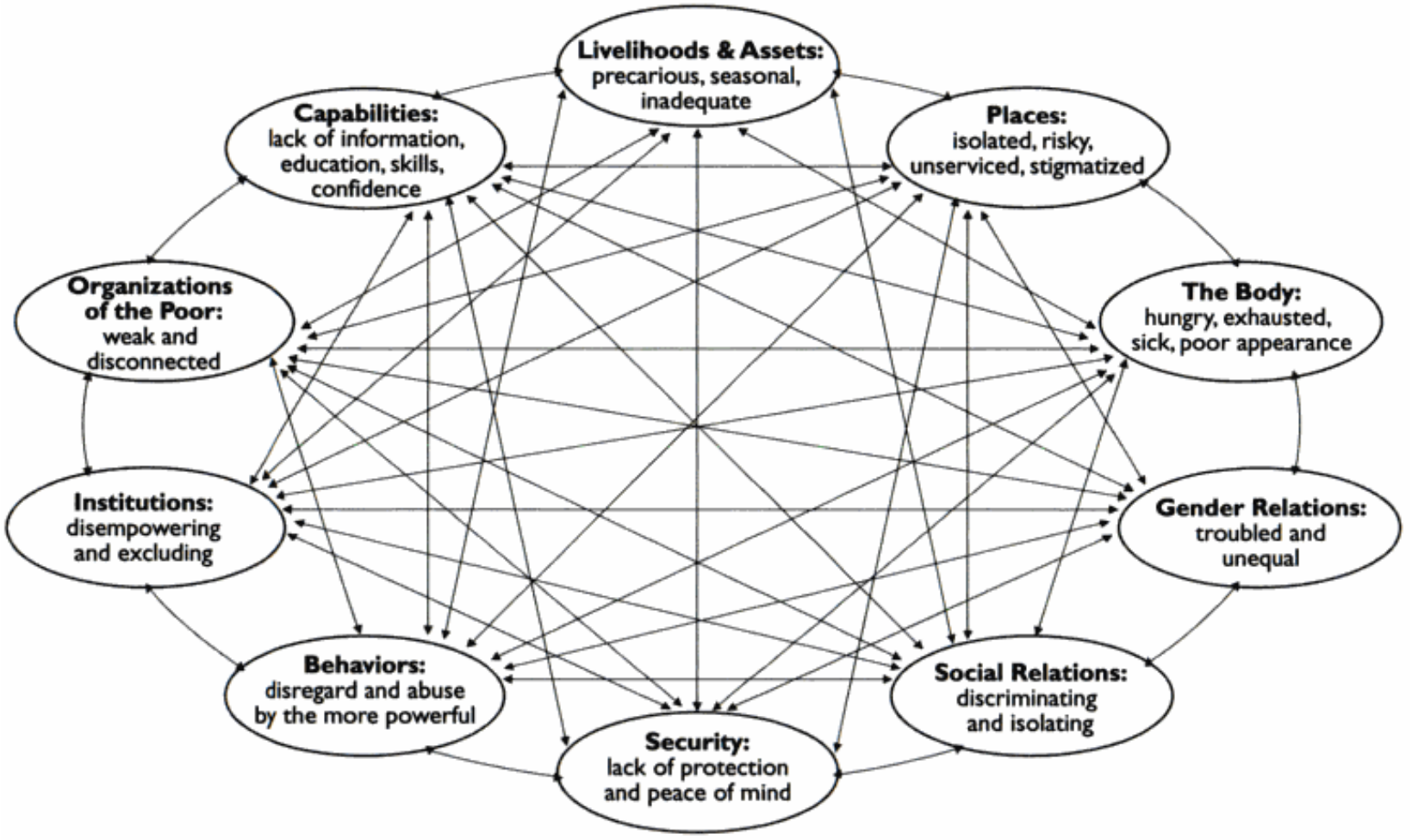


Voices of the Poor

- ten interlocking dimensions of poverty:
    1. precarious livelihoods,
    2. excluded locations,
    3. physical problems,
    4. gender relations,
    5. problems in social relationships,
    6. lack of security,
    7. abuse by those in power,
    8. disempowering institutions,
    9. weak community organizations
    10. Limitations on the capabilities of the poor.

„The dimensions of deprivation are multiple”

Figure 11.1 Dimensions of Powerlessness and Illbeing



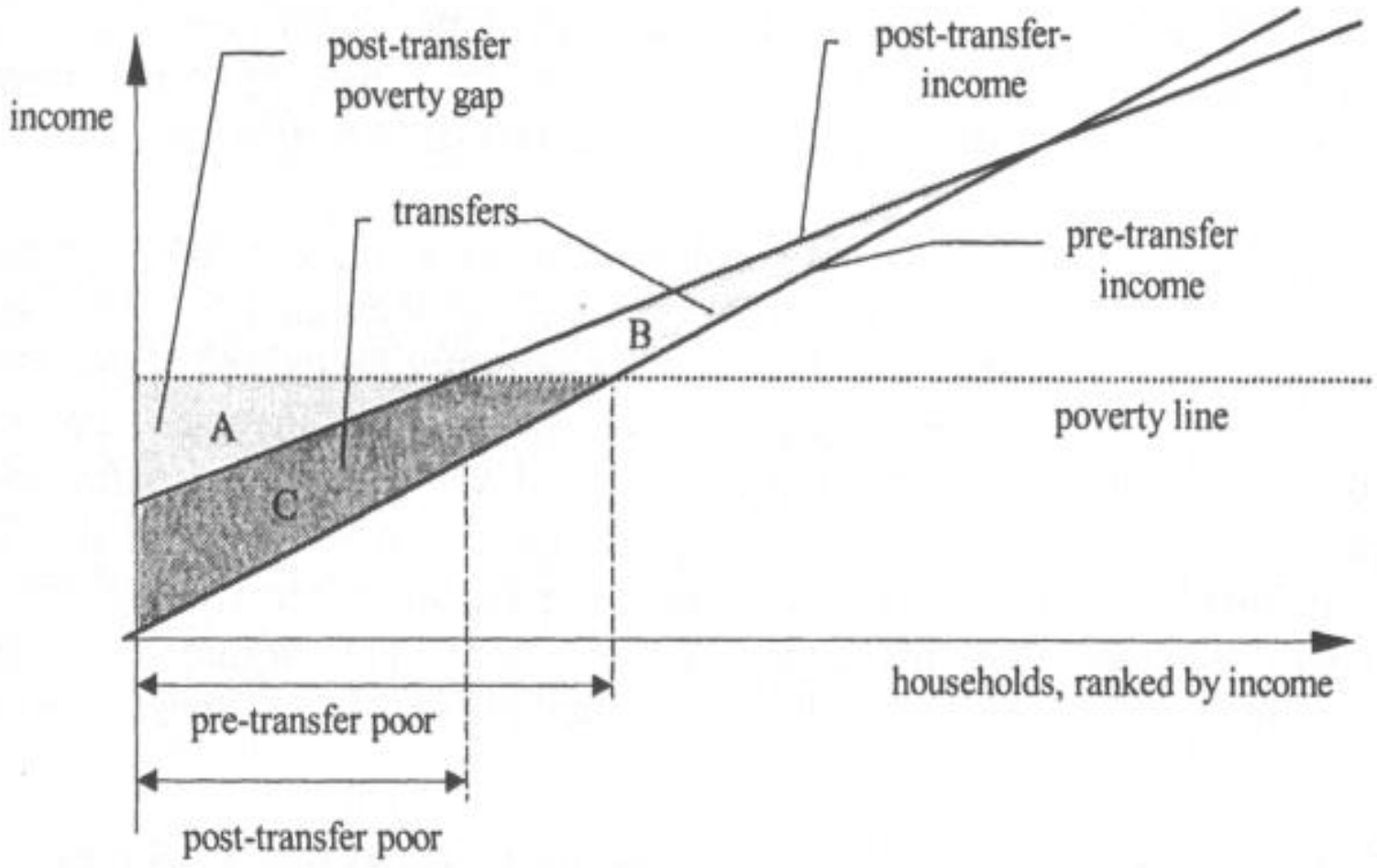
Minimum Income

- Council **Recommendation** 92/441/EEC of 24 June 1992 on common criteria concerning sufficient resources and social assistance in social protection systems which called on Member States "**to recognise the basic right of a person to sufficient resources and social assistance to live in a manner compatible with human dignity as part of a comprehensive and consistent drive to combat social exclusion**".

Active inclusion

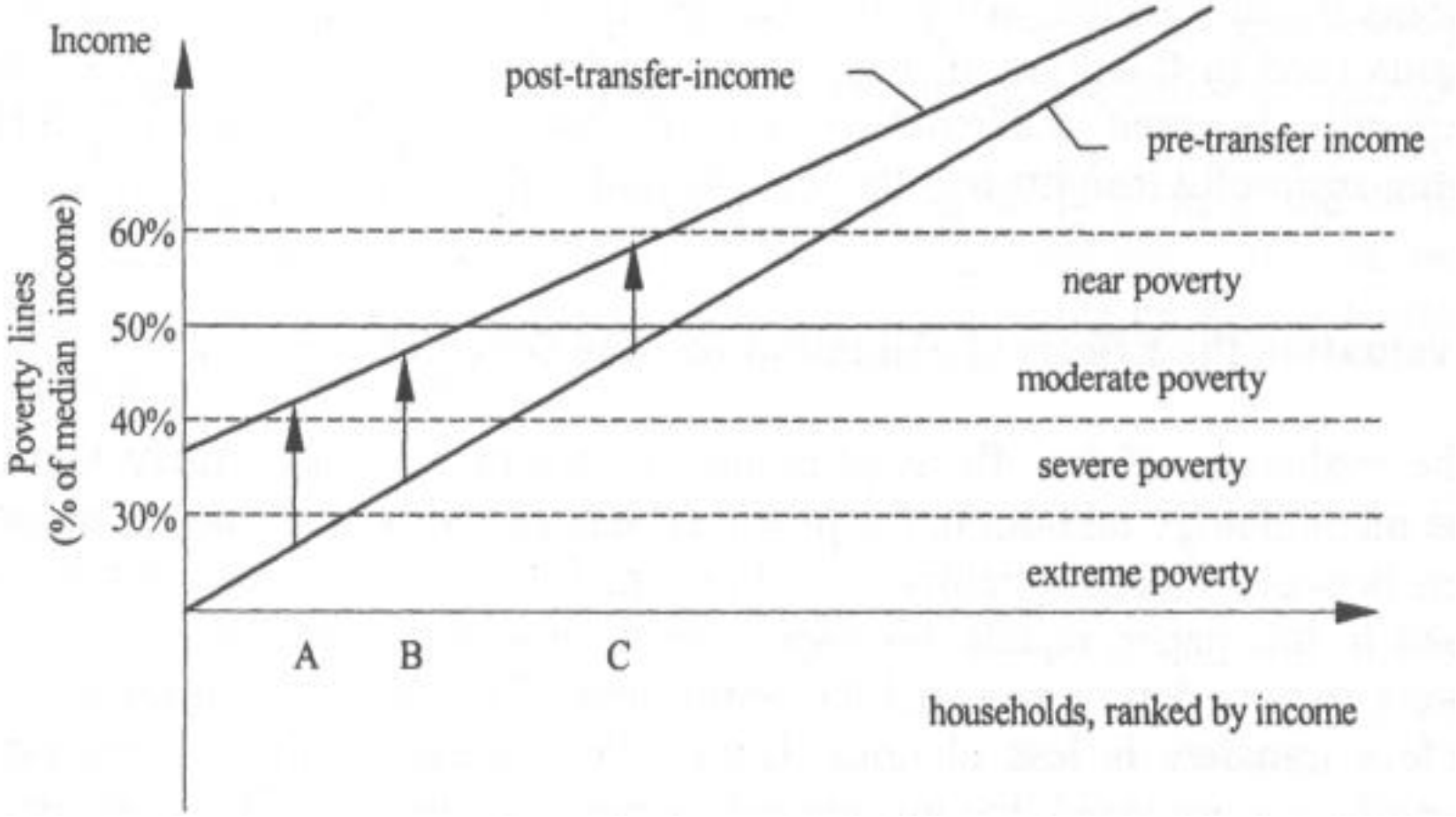
- 2008 Recommendation on active inclusion, the European Commission reiterates the same statement and declares that the Member States should “design and implement an integrated comprehensive strategy for the active inclusion of people excluded from the labour market **combining adequate income support, inclusive labour markets and access to quality services**”.

How minimum income works?



Wilfred Beckerman

How minimum income works?



Alleviation of income poverty by social transfers

Conditions of effectiveness of minimum income

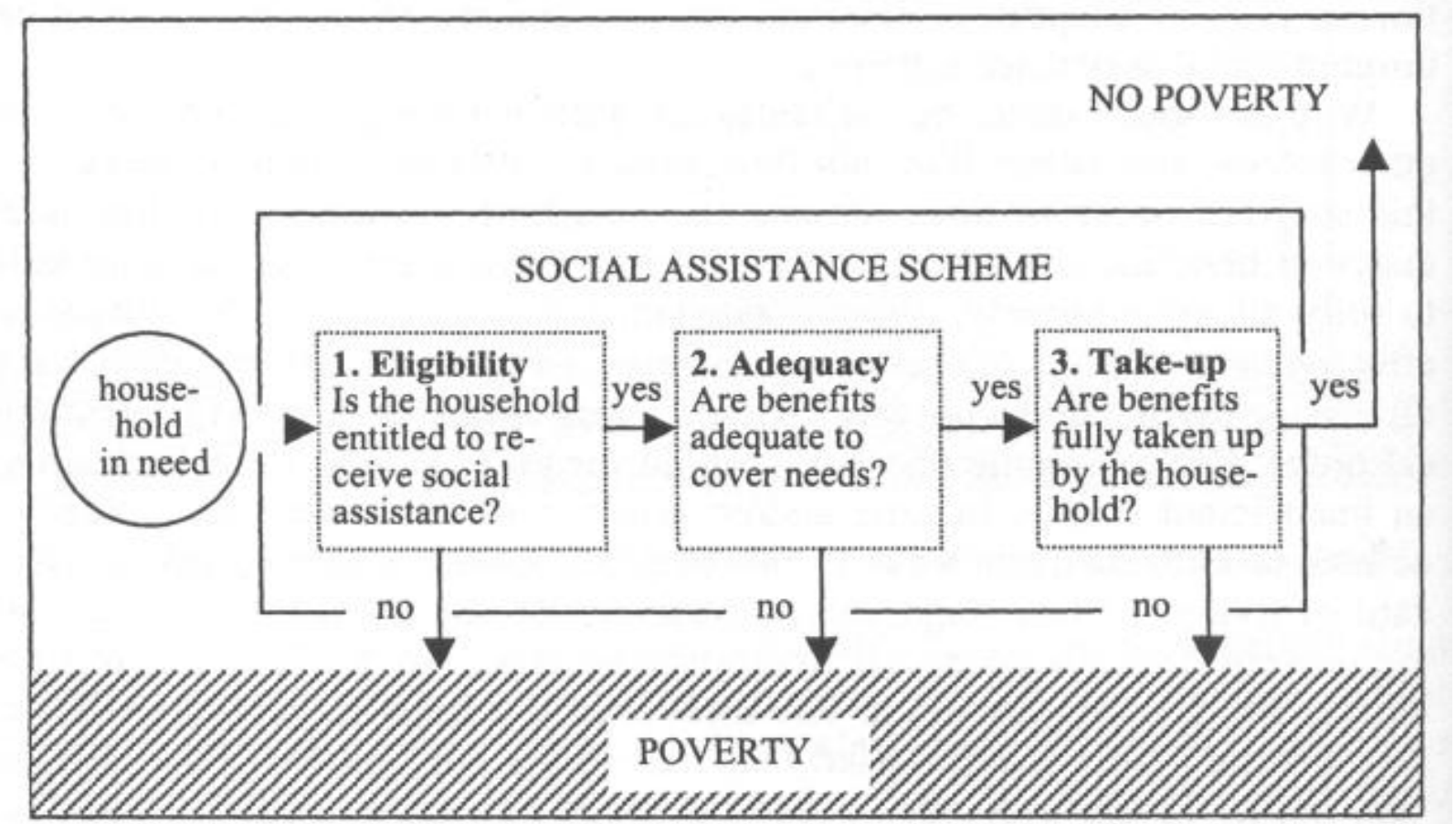
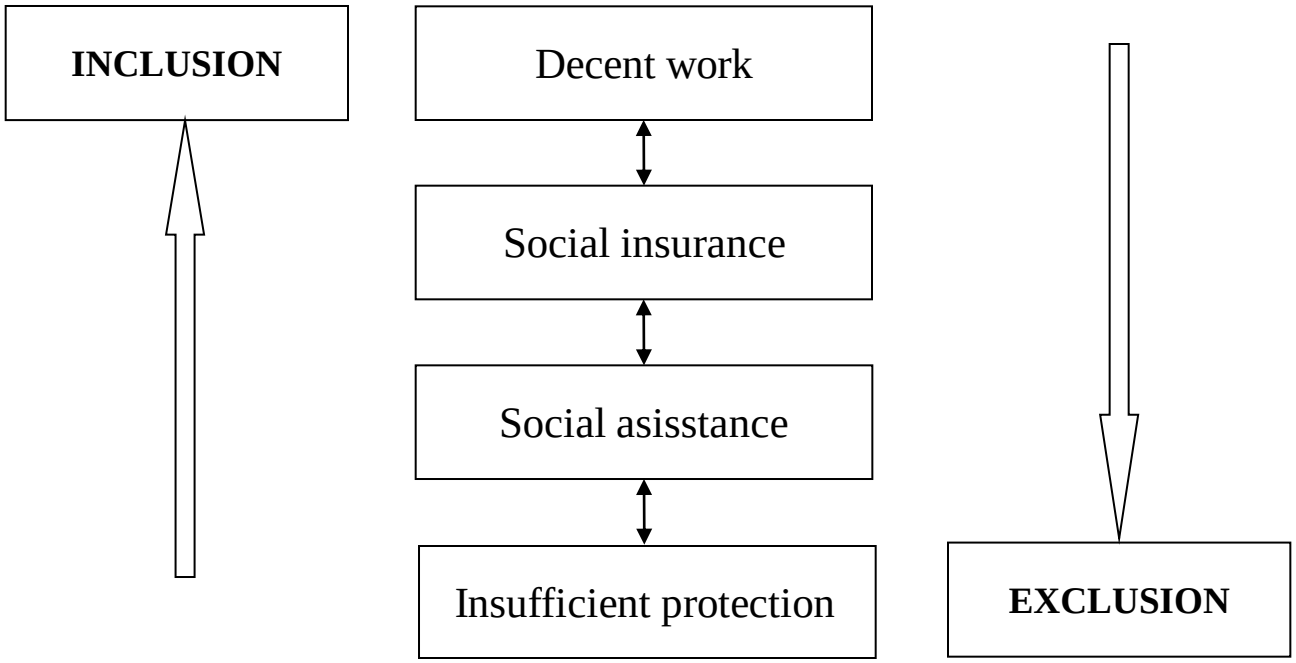


Figure 3.3 Social assistance schemes and an effective alleviation of poverty: A simplified model

Christina Behrendt

Work, social protection and inclusion/exclusion



Non take-up: I am poor and I have right to benefit but I don't claim it

Non coverage: I am poor and I claimed benefit but it was refused to me

Third possibility: I am poor, I claimed benefit and got it but I am still poor

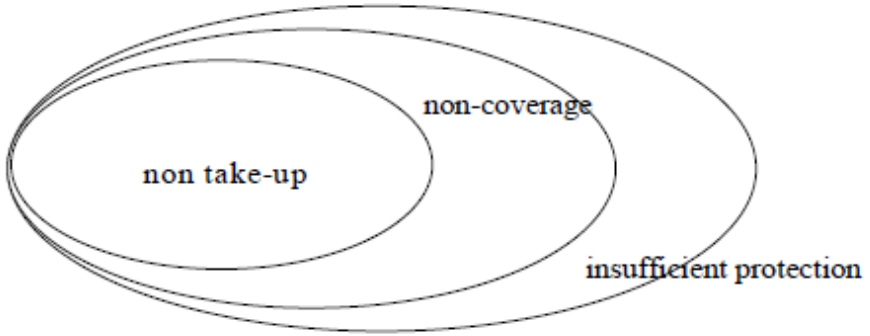


Figure 1. Insufficient protection, non-coverage and non take-up

Ides Nicaise

Minimum Income Schemes

Description	Countries
simple and comprehensive schemes which are open to those with insufficient means to support themselves	AT, BE, CY, CZ, DE, DK, FI, NL, PT, RO, SI, SE
there are those countries which, while having quite simple and non categorical schemes, have rather **restricted eligibility and coverage of people in need of financial assistance due often to the low level at which the means test is set**	EE, HU, LT, LV, PL, SK
those countries that have developed a **complex network of different, often categorical, and sometimes overlapping schemes** which have built up over time but in effect cover most of those in urgent need of support	ES, FR, IE, MT, UK
those countries who have **very limited, partial or piecemeal arrangements which are in effect restricted to quite narrow categories of people** and do not cover many of those in most urgent need of income support	BG, EL, IT

Adequacy of SA benefits

- in most Member States and for most family types, social assistance alone **is not sufficient to lift beneficiaries out of poverty**
- However, many experts also acknowledge that although MISs are insufficient to lift people out of poverty they do play a **very important role in reducing the intensity of poverty**

Why non-take-up benefits?

- **complexity** of the system leading to people being unfamiliar with the schemes
- **thinking they are not eligible**
- **lacking information about their rights to social assistance** in general or
- lacking information about what they are eligible for and how to apply or also **lacking the skills to make claims**

Why non-take-up benefits?

- people subjectively thinking they do not need it or only need it for a short period and that the information and administrative costs are too high, thus **making a rational cost-benefit calculation that the benefit is too low compared to time and efforts** involved in the application procedures
- **lack of sufficient social workers** to support the application process

Why non-take-up benefits?

- **discretionary nature of benefits** (i.e., benefits are not dependent on established criteria but rather on discretionary assessment)
- **fear of being stigmatised** or facing an unsympathetic bureaucracy
- poor administration of schemes: lack of awareness about people's rights, **failure to inform claimants correctly** failure or inconsistent application of legal regulations and **refusal to award benefits**

Disincentives to take up work

- **high benefit withdrawal rates** can create significant disincentive effects in certain instances
- the lack of a systematic process for monitoring and redressing the **erosion over time in the value of the earnings disregards** (i.e., the part of income that is not taken into account when assessing MIS applicants eligibility) and eligibility thresholds

Disincentives to take up work

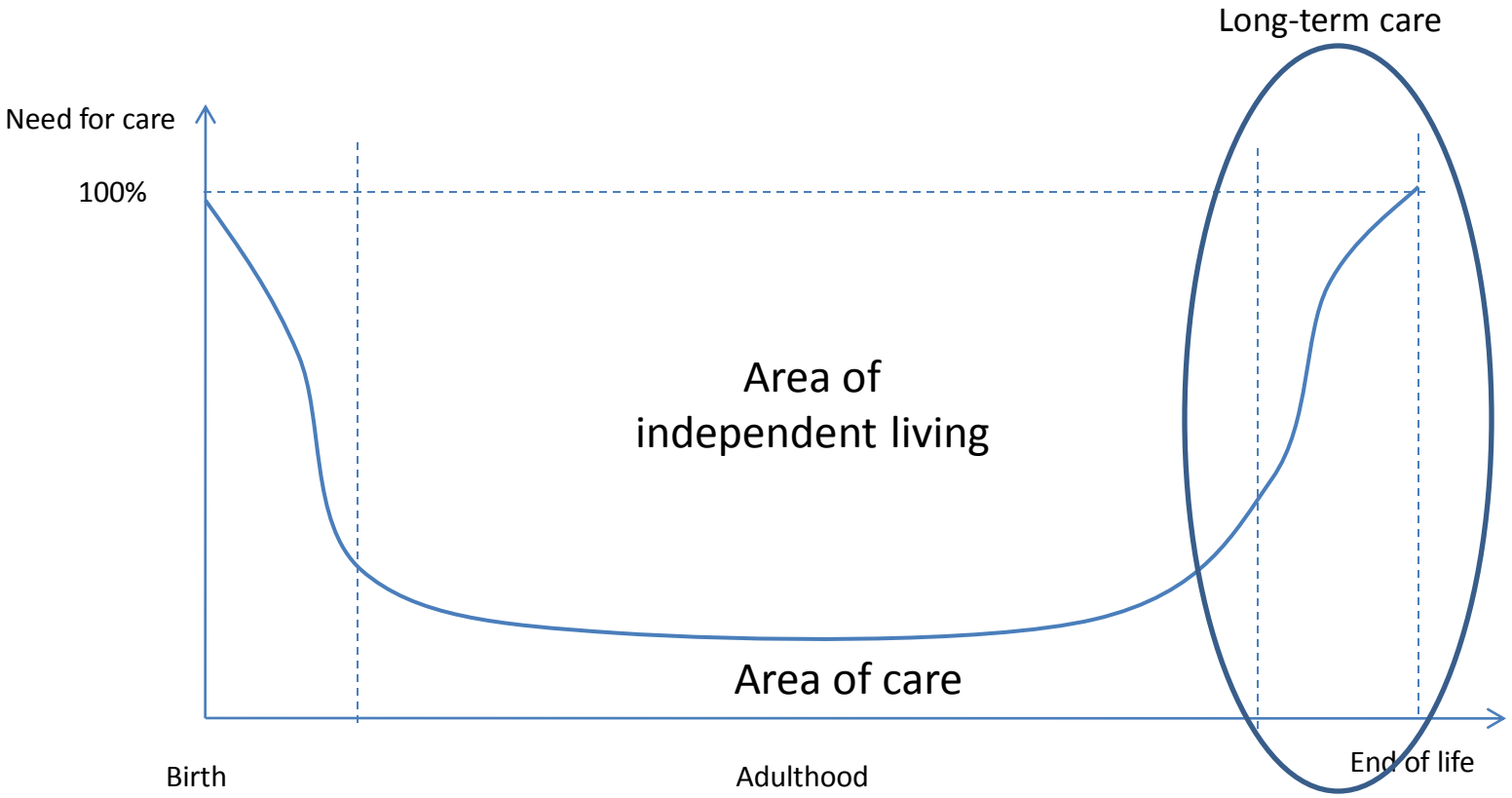
- where people on social welfare live on low incomes, they are **vulnerable to debt and low self-esteem** and they are less likely to have the motivation and means to progress their lives
- the **absence of taper adjustment regarding additional earned income**, and regulations on eventual refund of benefits, which a former beneficiary may be obliged to pay (tapering out, topping up benefits)
- the **additional expenditure involved in employment**, such as transport, eating out, child care etc

And some trends in reforms

- Making payments **conditional on agreeing to some sort of insertion contract** is becoming increasingly common
- Tendency in many countries **to increase conditionality and introduce restrictions** in the access to social benefits and services. The condition which has been most commonly reinforced is availability for work

Social Care

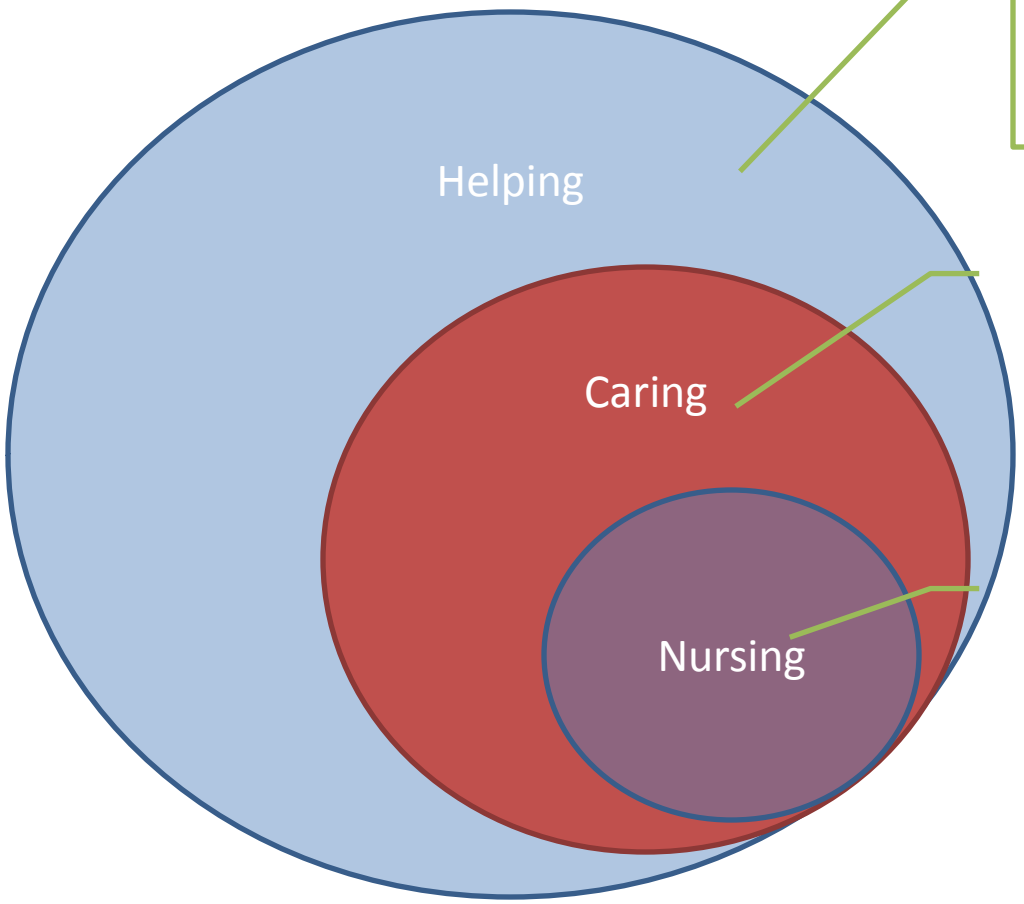
Need for Care in Life Course



Need for care in young age

Need for care in old age

Helping, Caring, Nursing



Help but without care and nursing elements – help to self-help

Caring help but without nursing

Help with caring and nursing ingredients

High potential to independent living

Very low potential to independent living

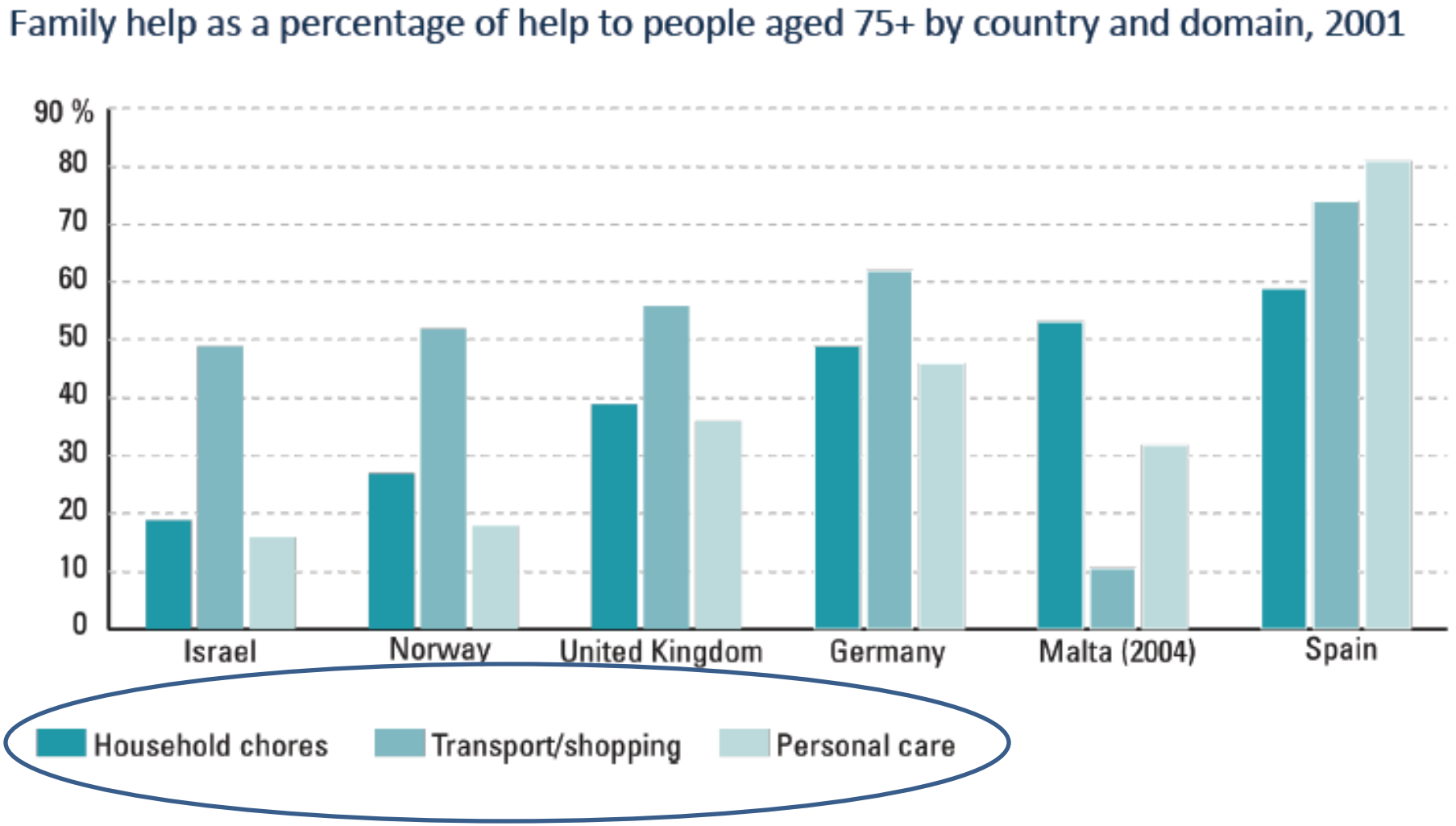
Some Types of Care

- Short-term care
  - Health
  - Other non-health care
- Long-term care
  - Child care (developmental needs, developmental care)
  - **Elderly care, aged care**
  - Disabled care (disabled children, elderly or adults)
    - Mentally disabled care
    - Non-mentally disabled care

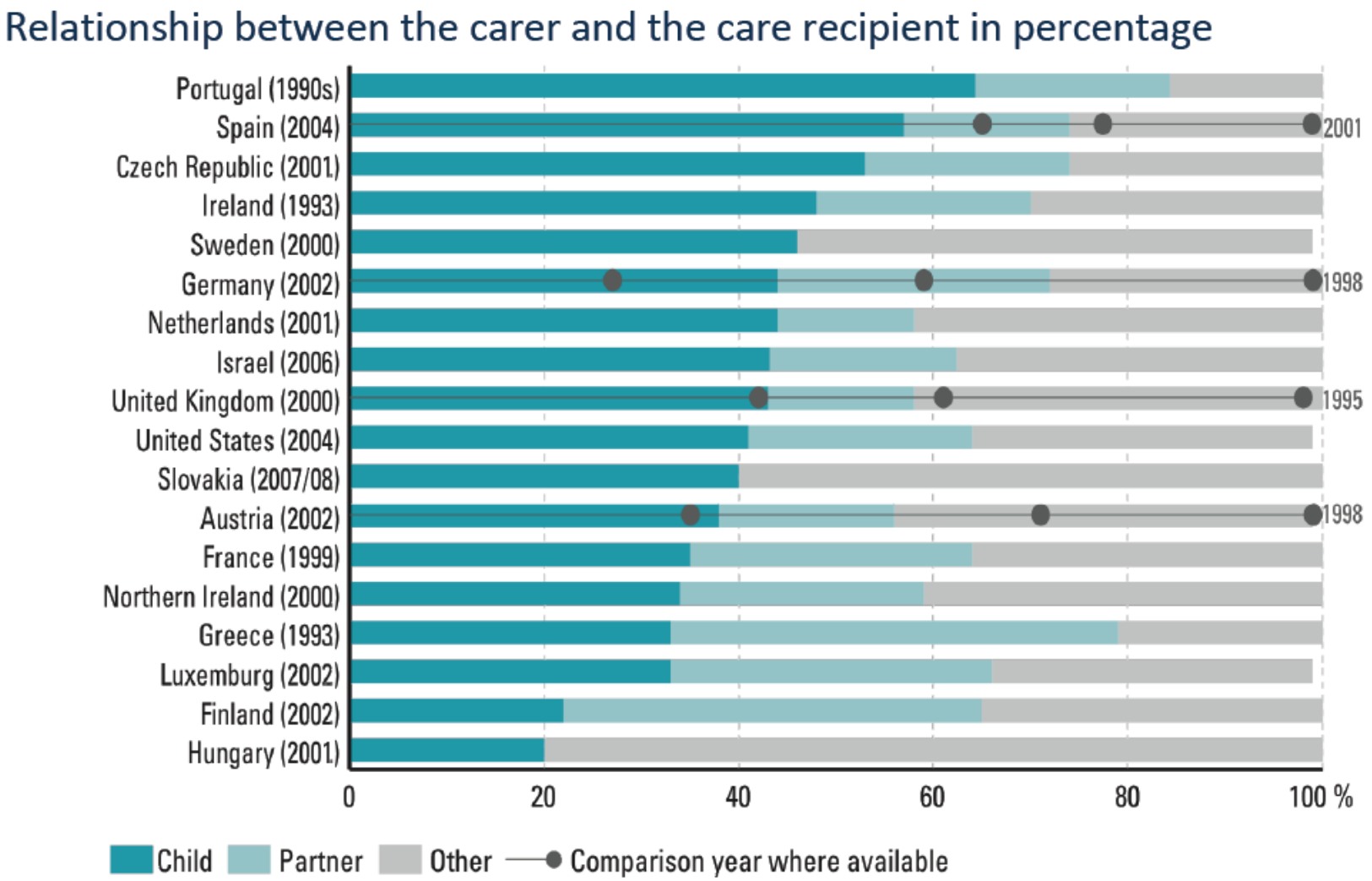
Some Types of Care

- Long-term care
  - *Where?*
    - Residential (e.g. nursing homes, care homes)
    - Non-residential (home care - helping you in your home)
  - *Who pay for it?*
    - Public money (taxes, social insurance contributions)
    - Private money
  - *Who is a caregiver?*
    - Nurse, professional caregiver
    - Family member, informal caregiver

Domains of Care



Who are informal Carers to Care-recipients?



Residential / Institutional Care

- Residential care is for people **who cannot continue living in their own home**, even with support from home care services
- It can help you to continue living safely, whilst **giving your family or carer peace of mind** knowing you are in a safe and supportive environment.
- Residential care and nursing homes should provide you with:
  - day to day support
  - a comfortable and safe environment to live in
  - activities of real interest and enjoyment
  - privacy and dignity
  - support for your physical, spiritual, intellectual, emotional and social needs

UK public information, quality care standards

Ageing , Care, Public Finances and Family

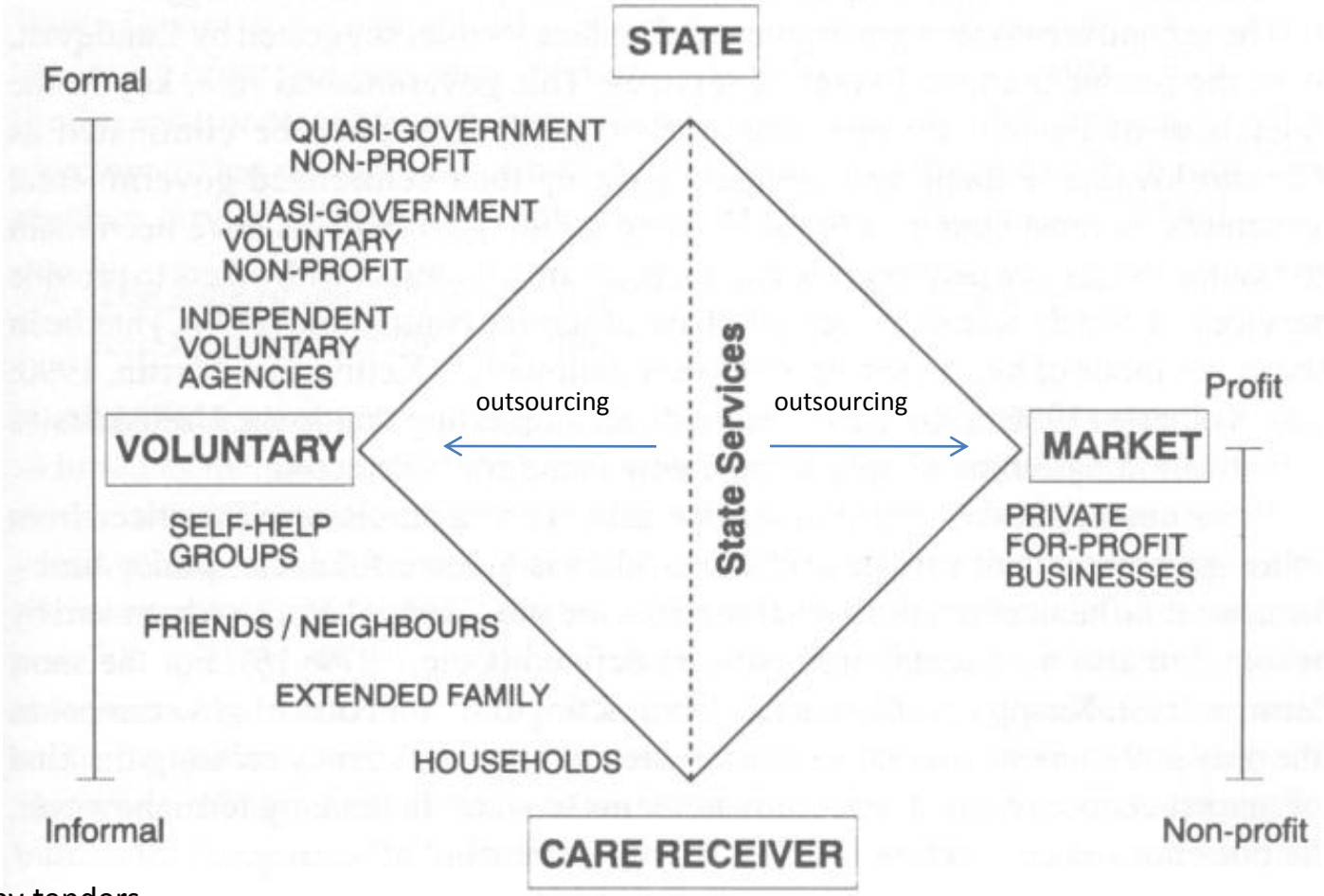
- Faced with the problems associated with an **ageing society**, many European countries have adopted **innovative policies** to achieve a better balance between the **need to expand social care** and the **imperative to curb public spending**
- **Progressive decrease in the ability of family networks to provide support** (living alone)
- **To date dependence has been a social risk not adequately covered by welfare systems**

Long-term Care Reforms

- A tendency to **combine monetary transfers to families with the provision of in-kind services**
- the establishment of a **new social care market based on competition**
- the **empowerment of users through their increased purchasing power**
- the introduction of **funding measures intended to foster care-giving through family** networks

New Social Care Market

Web of potential sources of care



Outsourcing by tenders
- Competitive tenders
- Tenders with social requirements (social clauses)

A. M. Gross, in Evers, Svetlik (eds.)
Balancing Pluralism, p. 235

And Criticism

- Introduction of **social care markets** and the greater division made between funding and service provision have given rise to a gradual **‘commodification of care’**
- Emergence of policies that promote the **refamilialization of care** by use of care allowances without considering the impact of these cash measures on female labour-market participation

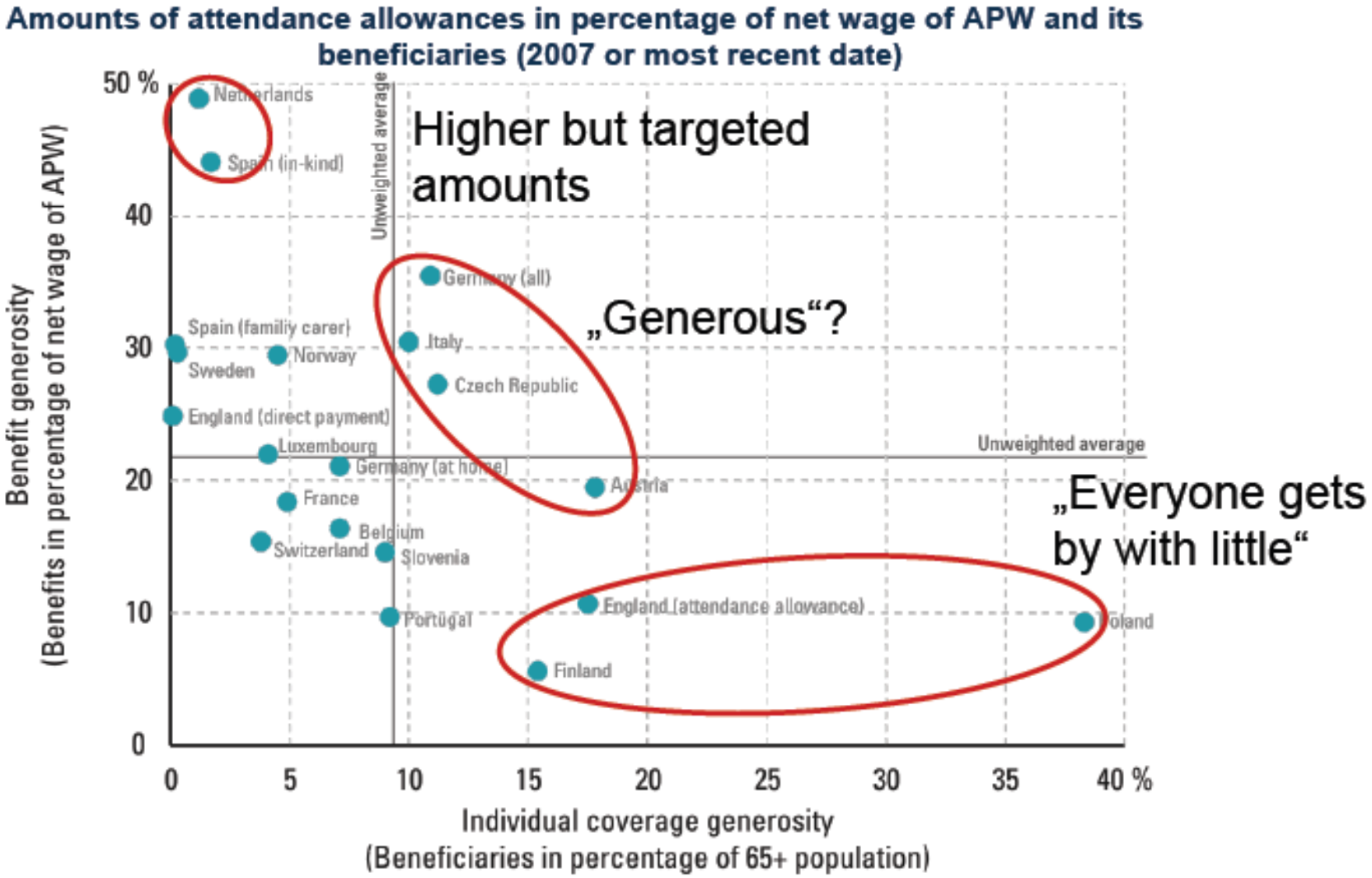
Different Approaches and Hybrid Models of LTC

- Different approaches to long-term care
  - Cash benefits (Austria, Germany, Italy, Czech Republic);
  - Means-test (UK);
  - Public provision of care services (Sweden, Denmark).
- Hybrid rather than pure models of care
  - Cash benefits: within the tax envelope (Austria, Czech Republic) or through social insurance (Germany);
  - Regulated (France) and unregulated allowances (Italy);
  - Universal public provision of care (Denmark) or targeted "universalistic" provision of care (Sweden);
  - Provision of care (institutions): public (Sweden), private "for profit" (Spain, UK), private "non-profit" (Germany).

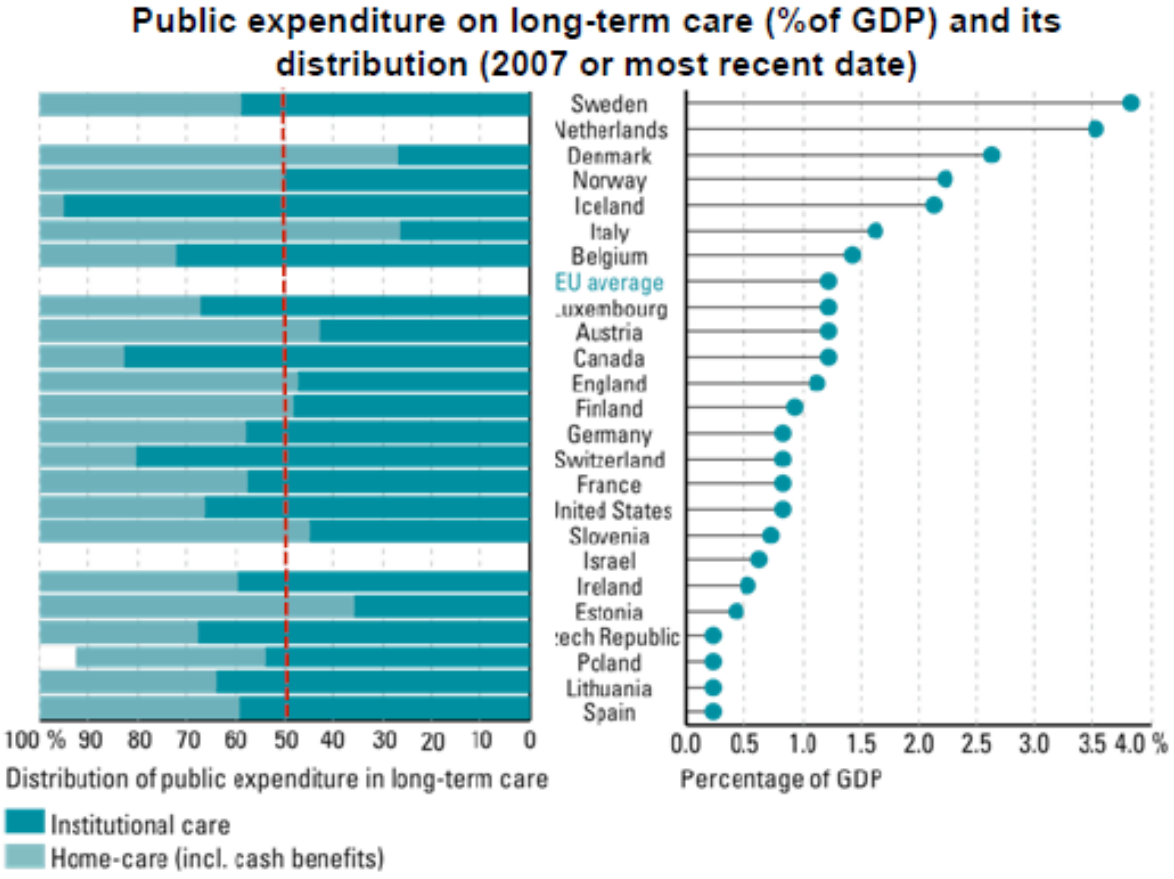
Attendance Allowances (example of UK)

- Attendance Allowance is a tax-free benefit for people aged **65 or over who need someone to help look after them because they are physically or mentally disabled**. You may get it if
  - you have a physical disability (including sensory disability, such as blindness), a mental disability (including learning difficulties), or both
  - your disability is severe enough for you to need help caring for yourself or someone to supervise you, for your own or someone else's safety
  - you are aged 65 or over when you claim

Generosity of Attendance Benefits



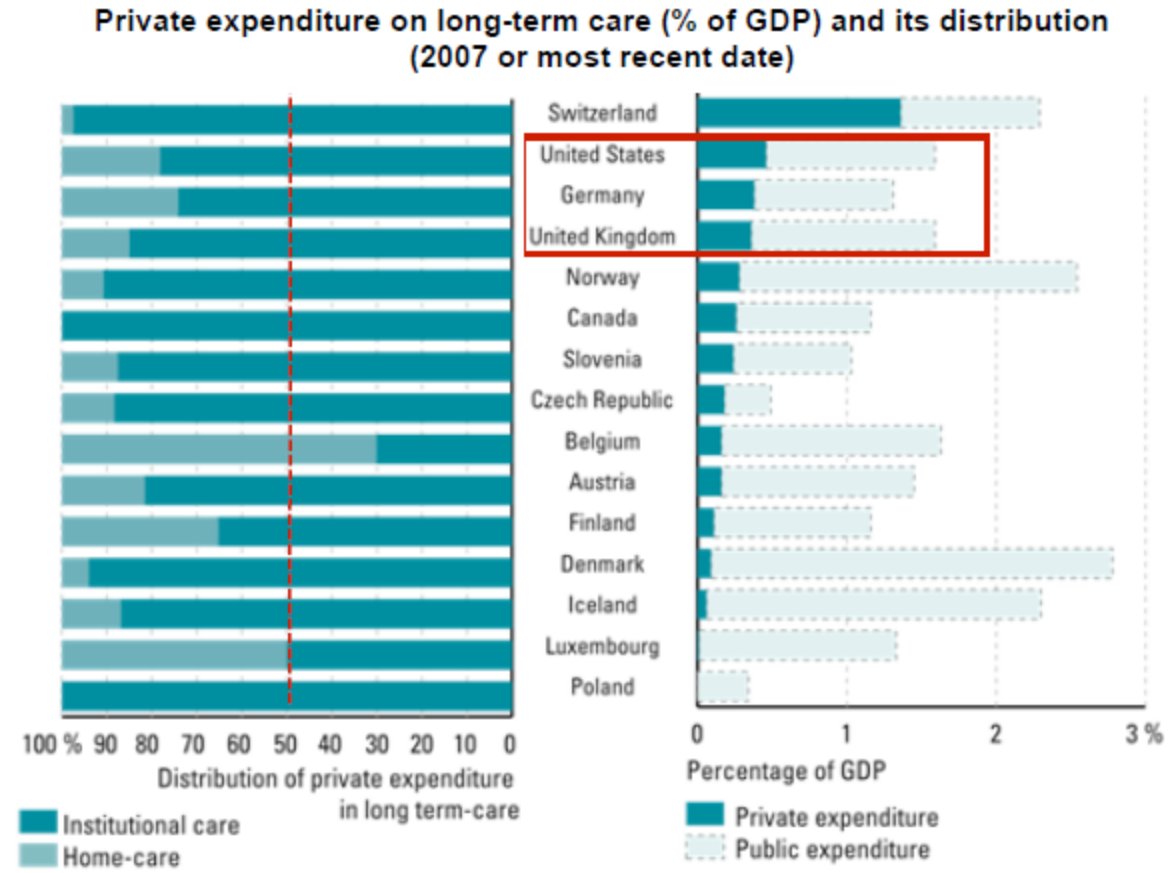
Public Spending on LTC



Source: Own calculations based on national sources, NOSOSCO and OECD. Huber *et al.* (2009, forthcoming).

- Public resources for long-term care still low: EU15 spends 7.6% on health and 9.1% on old-age pensions;
- Marked differences in expenditure;
- Where is the money going? Mostly to institutional care;

Private Part



Source: Own calculations based on OECD, NOSOSCO and national sources. Huber *et al.* (2009, forthcoming).

- Private expenditure: co-payments; means-testing; supplementary payments;
- Different public-private mixes;
- Means-tested = heavier burden?
- Institutional care: user's fees are standard procedure.

Elderly Care Policies Models

Sweden | The Netherlands | UK | France | Germany | Italy

Services-led model

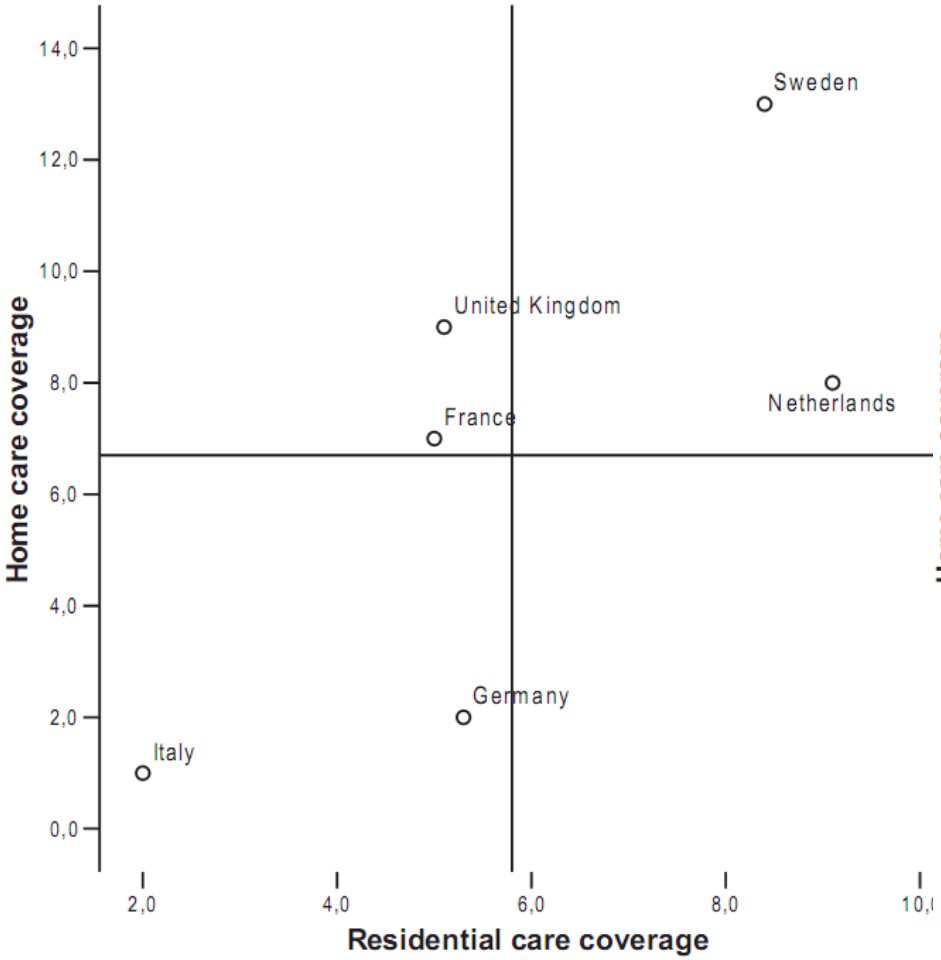
Government support is provided through the **creation of facilities for the widespread provision of services** designed to take the place of families, at least partially, in care giving activity. Economic support is more limited, while measures are developed (such as leave from work for care giving) to make family care giving compatible, for limited periods, with holding down a job… the goal is high level of regular employment in the care giving sector and to meet the care needs of those dependent

Informal care-led model

Limited direct commitment to the provision of services and it involves a certain level of cash transfers. Government responsibility is largely limited to meeting (according to a compensation logic) part of the supplementary costs resulting from dependency. Public intervention is designed to support the income of persons in need of care rather than to provide them with the LTC services that they need… little public provision of home care services

Comparisons in two dimensions of coverage and two points in time

Level of residential and home care coverage (% of over-65s receiving services)



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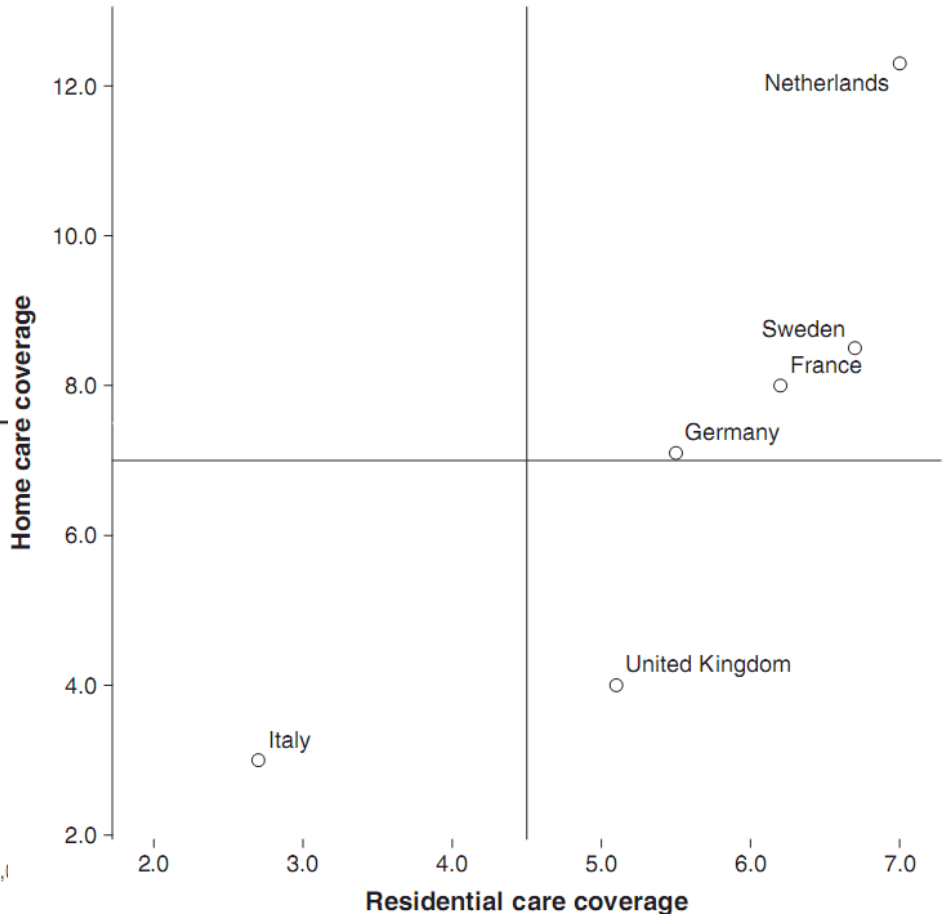


2000.

Health Care

Health Care as a Right

- **Article 11 of European Social Charter (1961) – The right to protection of health**
- With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or **in cooperation with public or private organisations**, to take appropriate measures designed *inter alia*:
  - to remove as far as possible the causes of ill-health
  - to provide advisory and educational facilities for the **promotion of health and the encouragement of individual responsibility in matters of health**
  - to prevent as far as possible epidemic, endemic and other diseases

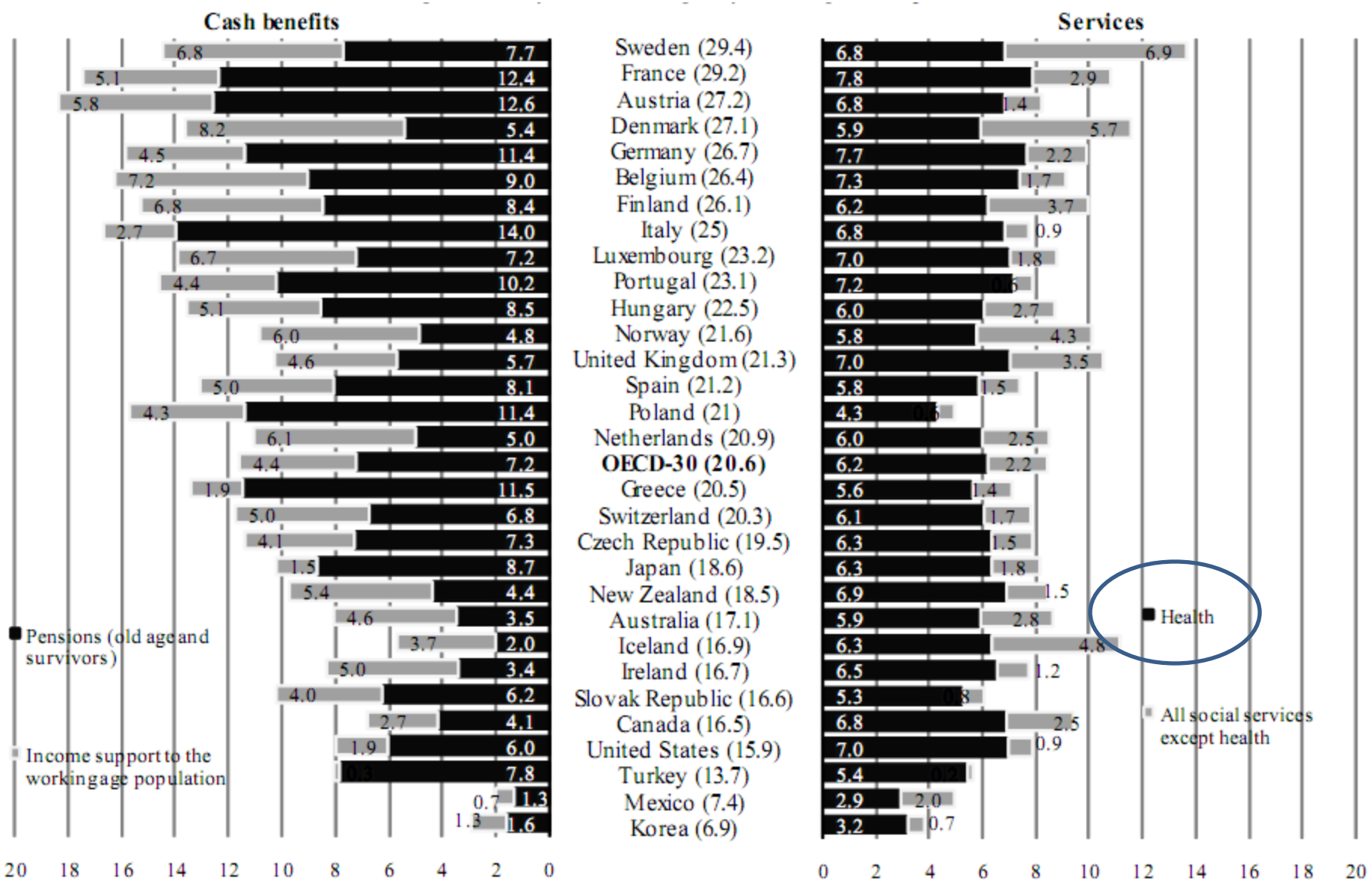
Health Care as a Right

- **Article 35 of Charter of Fundamental Rights of The European Union** (2000)
- Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities

Health Care systems

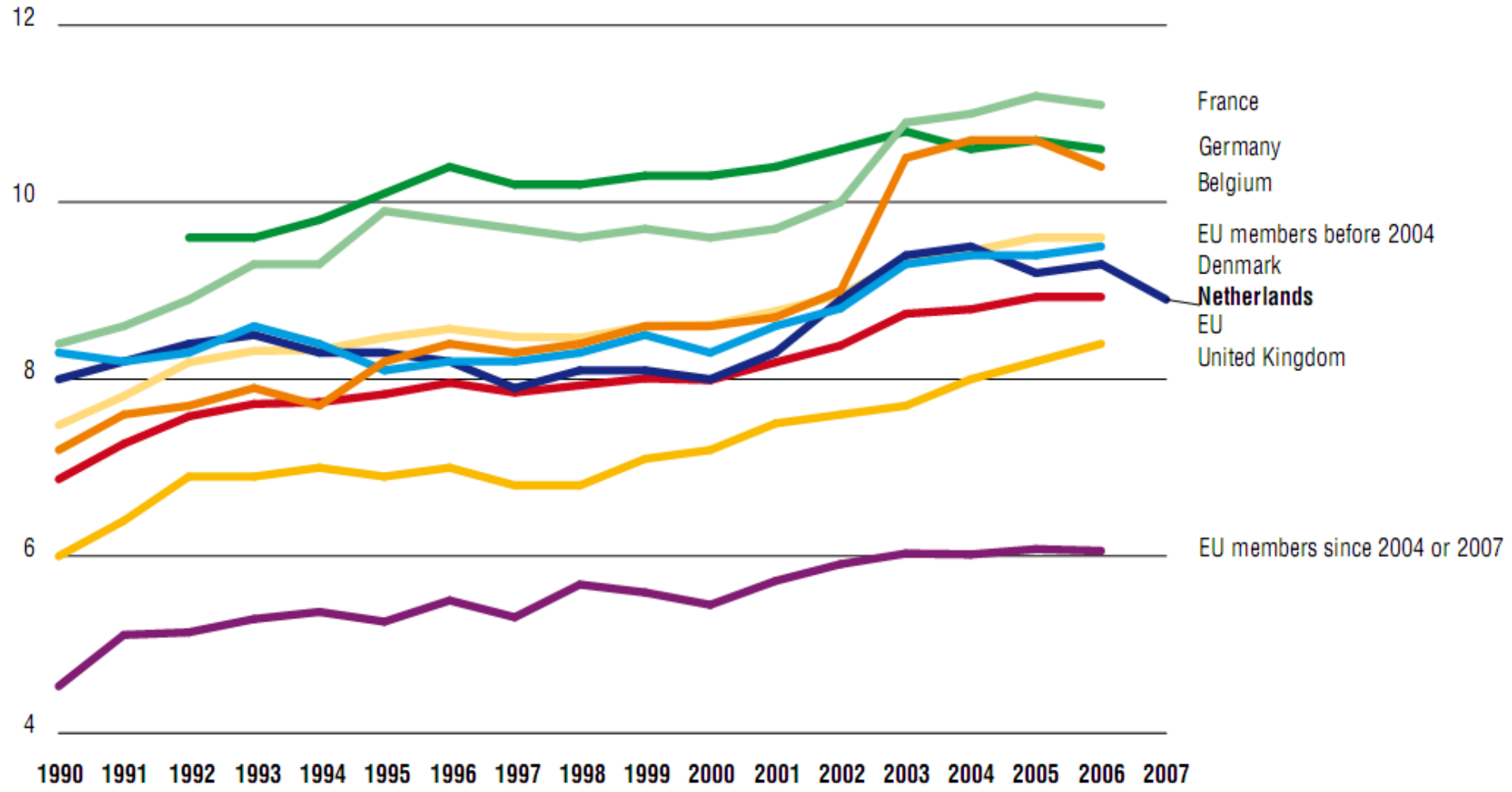
- Healthcare systems provide **security against major life risks**: ‘Not often, but sometimes, it is a matter of life and death
- More usually it represents a **powerful means of alleviating the anxiety, discomfort, and incapacity that come from sickness and ill health**’

Public social expenditure by broad social policy area, 2005

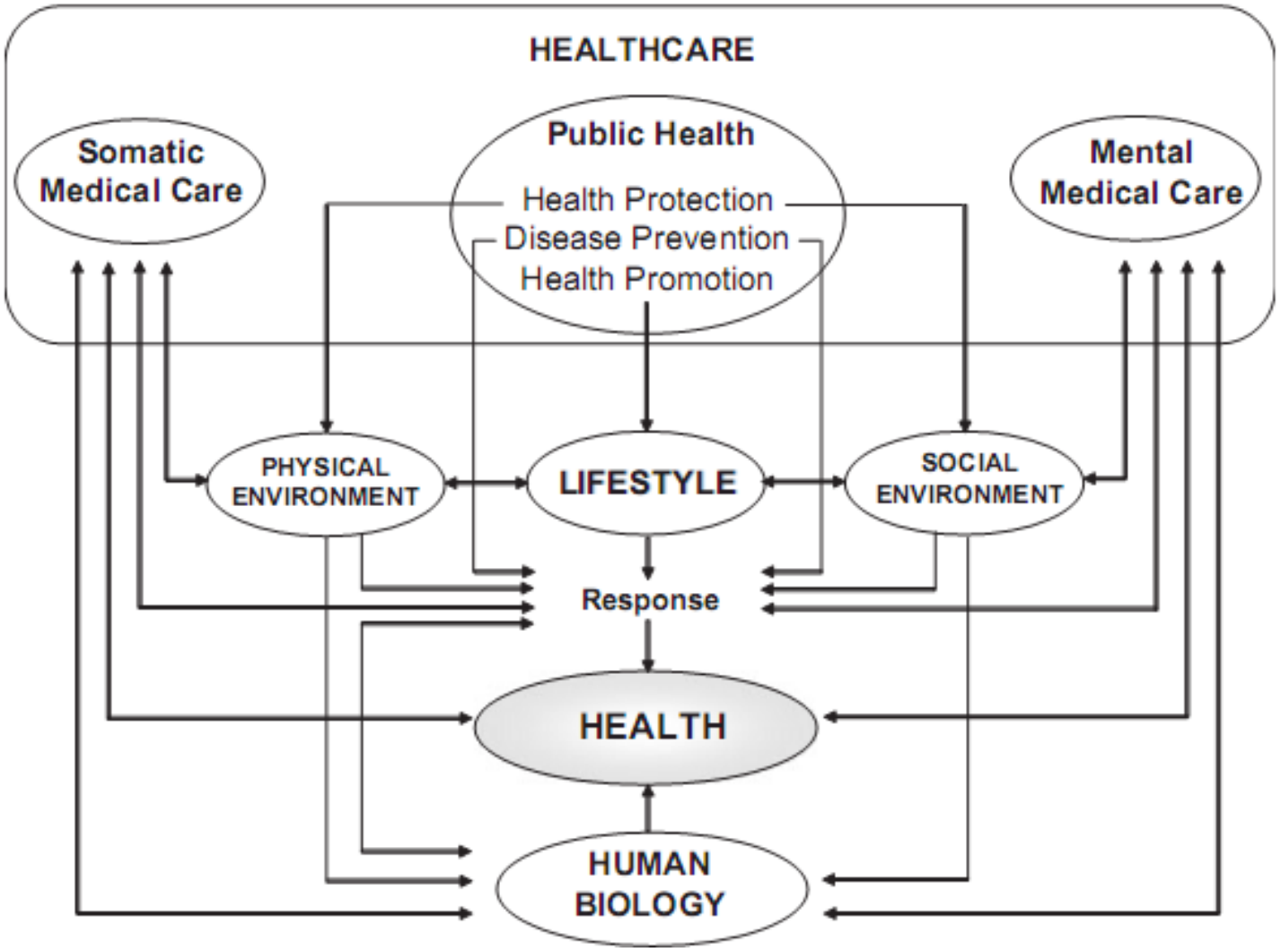


Adema, Ladaique, OECD, 2009

Trends in health care expenditures as a share of GDP

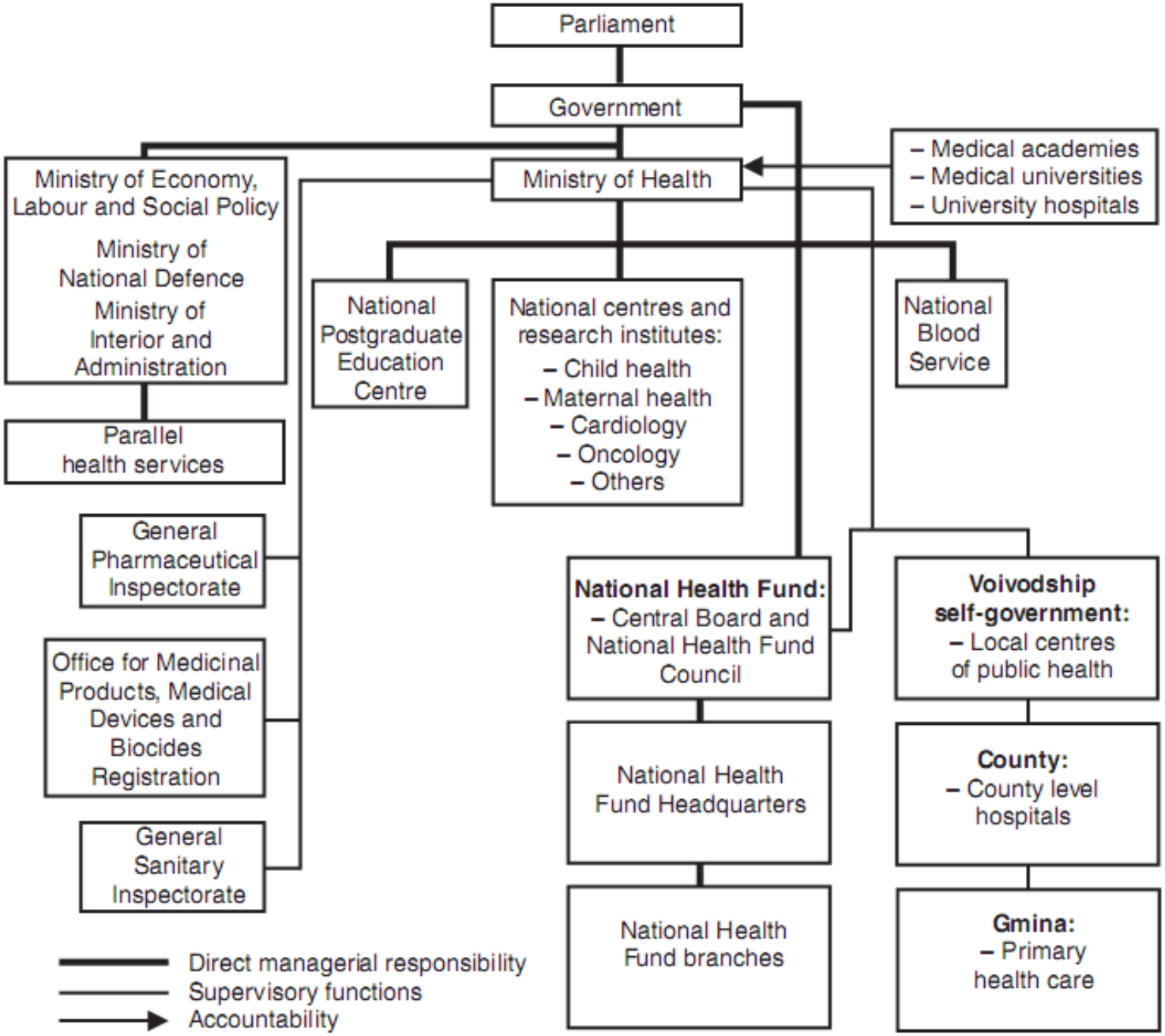


Health Determinants

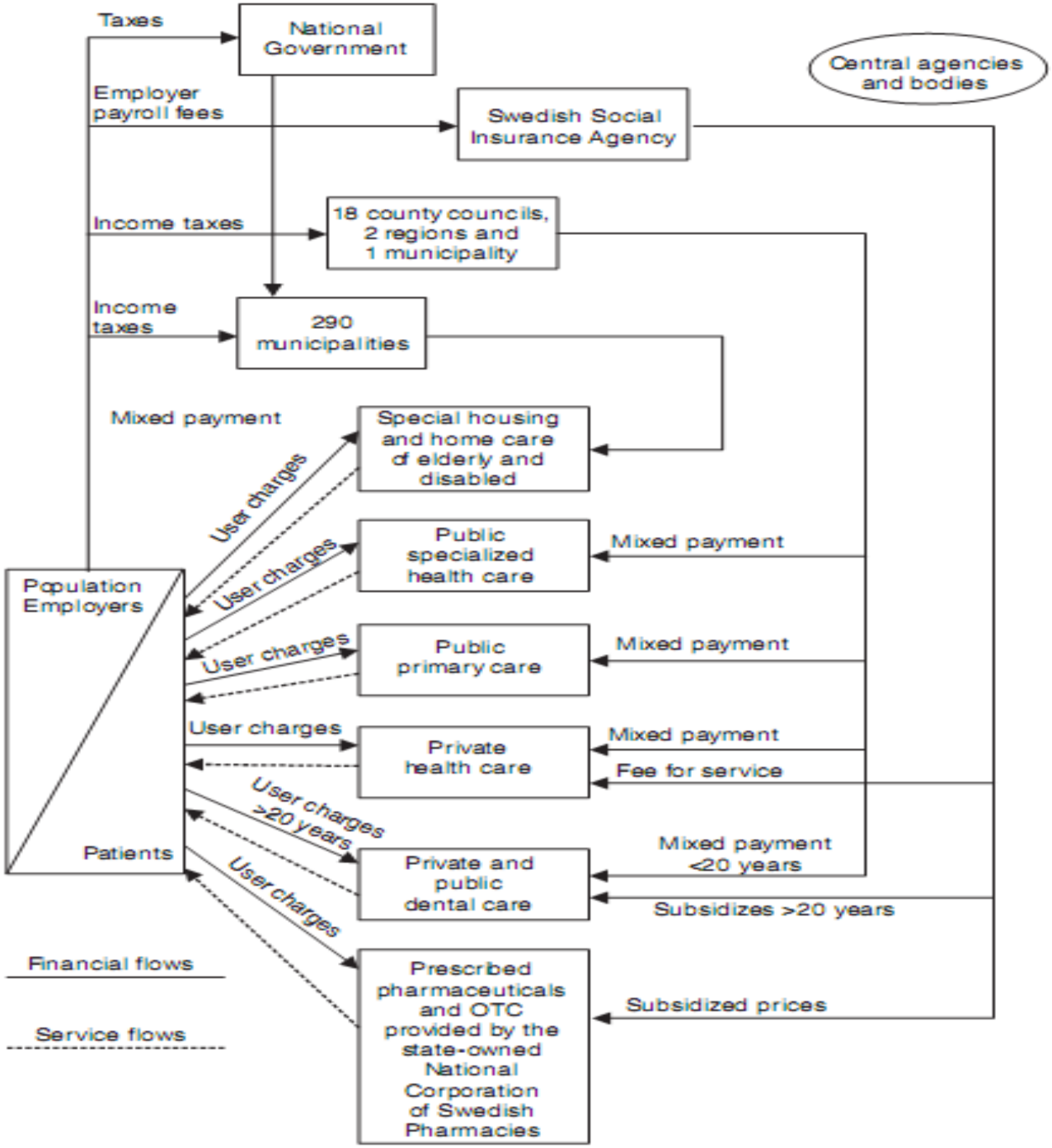


O.A. Arah i in., *A conceptual framework for the OECD Health Care Quality Indicators Project,* 2006, s. 6

Overview of the health care system in Poland (2005)

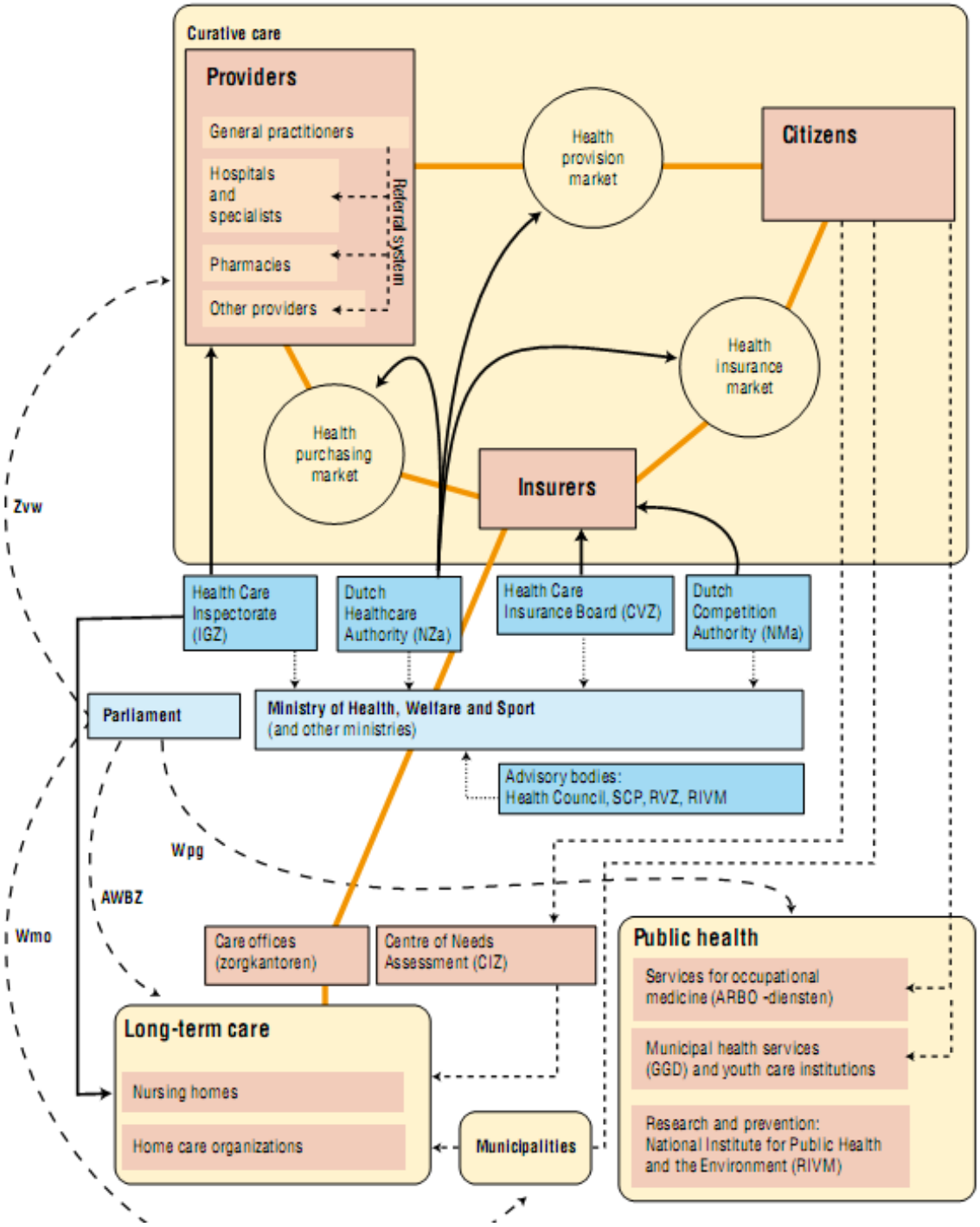


The European Observatory on Health Systems and Policies



Overview of the health care system in Sweden (2005)

Overview of the health care system in Netherlands (2005)

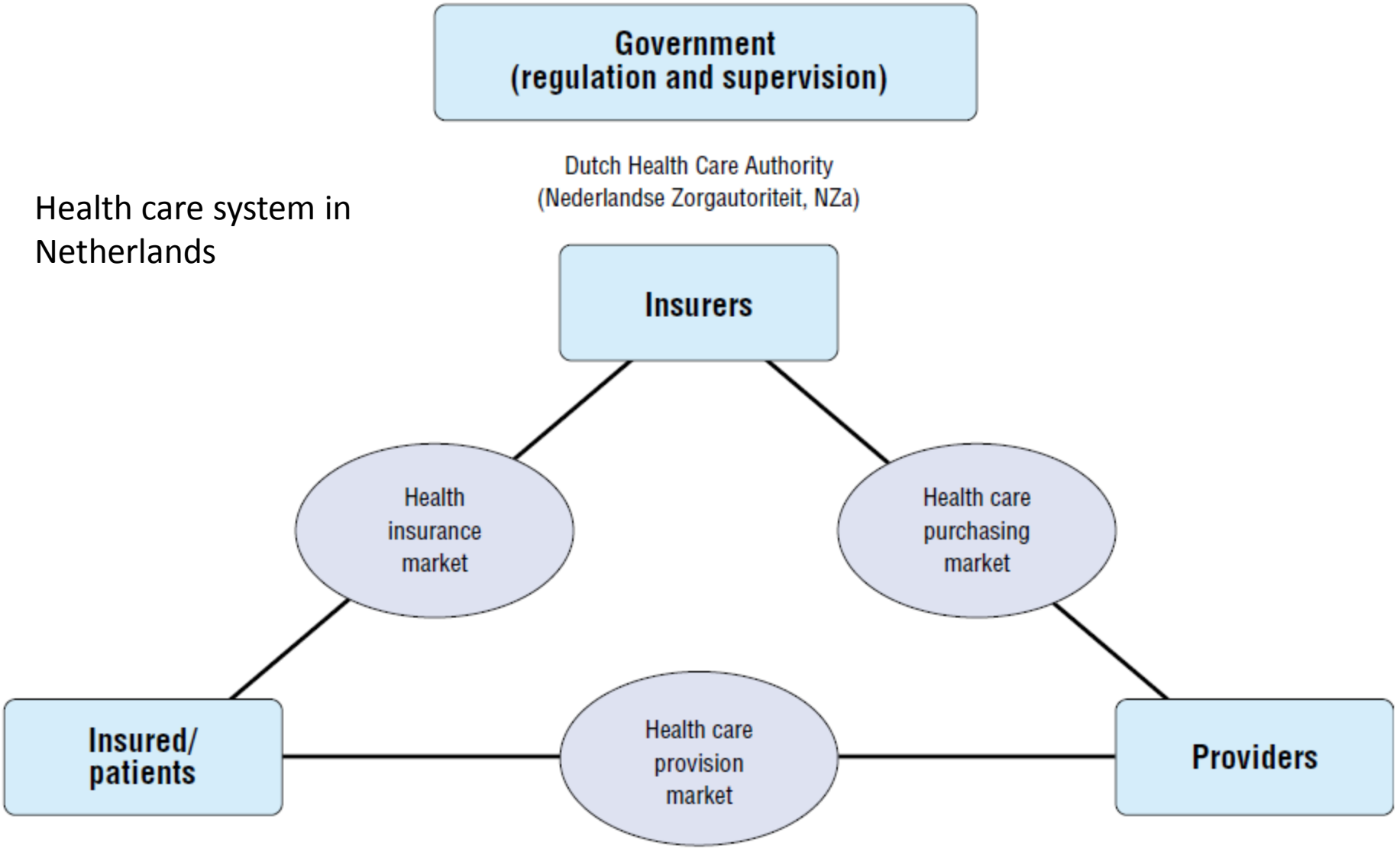


Quality control
Contractual relationship
Patient flow (referral system)
Advice
Acts

The European Observatory on Health Systems and Policies

And the Market…

Health care system in Netherlands



Relations between financing agencies, service providers and (potential) beneficiaries

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Between (potential) beneficiaries and financing agencies:

(a) coverage: the inclusion of (parts of) the population in public and/or private healthcare systems

(b) system of financing: the financing of healthcare by public (taxes, social insurance contributions) and/or private (private insurance contributions, out-of-pocket payments) sources

Between financing agencies and service providers:

(c) remuneration of service providers: the specific system of provider compensation

(d) access of (potential) providers to healthcare markets: access to financing agencies

Between service providers and (potential) beneficiaries:

(e) access of patients to service providers

(f) benefit package: the content and range of services offered to patients

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Classifying Healthcare System Types

- Of these 27 types, three instances of *ideal-types can be identified on the* basis of uniform features across all dimensions of healthcare
  - ***state healthcare systems***, in which **financing**, **service provision** and **regulation** are carried out by state actors and institutions
  - ***societal healthcare systems***, in which societal actors take on the responsibility of healthcare financing, provision and regulation
  - ***private healthcare systems***, in which all three dimensions fall under the auspices of market actors

	Healthcare system type	Regulation	Financing	Provision
1	*Ideal-type: State Healthcare System*	*State*	*State*	*State*
2	State-based mixed-type	State	State	Societal
3	State-based mixed-type	State	State	Private
4	State-based mixed-type	State	Societal	State
5	State-based mixed-type	State	Private	State
6	State-based mixed-type	Societal	State	State
7	State-based mixed-type	Private	State	State
8	Societal-based mixed-type	State	Societal	Societal
9	Societal-based mixed-type	Societal	State	Societal
10	Societal-based mixed-type	Societal	Societal	State
11	*Ideal-type: Societal Healthcare System*	*Societal*	*Societal*	*Societal*
12	Societal-based mixed-type	Societal	Societal	Private
13	Societal-based mixed-type	Societal	Private	Societal
14	Societal-based mixed-type	Private	Societal	Societal
15	Private-based mixed-type	State	Private	Private
16	Private-based mixed-type	Private	State	Private
17	Private-based mixed-type	Private	Private	State
18	Private-based mixed-type	Societal	Private	Private
19	Private-based mixed-type	Private	Societal	Private
20	Private-based mixed-type	Private	Private	Societal
21	*Ideal-type: Private Healthcare System*	*Private*	*Private*	*Private*
22	Pure mixed-type	State	Private	Societal
23	Pure mixed-type	State	Societal	Private
24	Pure mixed-type	Private	State	Societal
25	Pure mixed-type	Private	Societal	State
26	Pure mixed-type	Societal	State	Private
27	Pure mixed-type	Societal	Private	State

Classification of healthcare systems – actors, dimensions and theoretical possibilities

Typologies of National Health Care Systems

	Dimensions	*Types of healthcare systems*	*Classification of countries*
OECD (1987)	• Coverage • funding • ownership	1. National health service 2. Social insurance 3. Private insurance	1. Great Britain 2. Germany 3. United States
Moran (1999); classification of countries: see also Burau and Blank (2006)	• Consumption • provision • production	1. Entrenched command-and-control state 2. Supply state 3. Corporatist state 4. Insecure command-and-control state	1. Great Britain, Sweden 2. United States 3. Germany 4. Greece, Italy, Portugal
Wendt et al. (2009)	Role of the state, societal and market actors in: • financing • service provision • regulation	Taxonomy of 27 health systems with three ideal types: 1. State healthcare system 2. Societal healthcare system 3. Private healthcare system	1. Great Britain, Scandinavian countries 2. No ideal-type; Germany represents a societal-based mixed type 3. No ideal-type: United States represents a private-based mixed type
Typology in 'Mapping European Healthcare Systems'	• Health expenditure • Public–private mix of financing • Privatization of risk • Healthcare provision • Entitlement to care • Payment of doctors • Patients' access to providers	1. Health service provision-oriented type 2. Universal coverage – controlled access type 3. Low budget – restricted access type	1. Austria, Belgium, France, Germany, Luxembourg 2. Denmark, Great Britain, Sweden, Italy, Ireland 3. Portugal, Spain, Finland

Three Types of Health Care Systems

- ***Health service provision-oriented type***. This type is mainly characterized by its high level and unquestioned importance of service provision especially in the outpatient sector
- ***Universal coverage – controlled access type.*** This type of healthcare system is mainly characterized by its universal coverage
- ***Low budget – restricted access type.*** This type of healthcare system is characterized by a low level of total health expenditure (per capita)

Euro Health Consumer Index – indicators for benchmarking of health care systems

Sub-discipline	Indicator
1. Patient rights and information	1.1 Healthcare law based on Patients' Rights
	1.2 Patient organisations involved in decision making
	1.3 No-fault malpractice insurance
	1.4 Right to second opinion
	1.5 Access to own medical record
	1.6 Register of legit doctors
	1.7 Web or 24/7 telephone HC info with interactivity
	1.8 Cross-border care seeking financed from home
	1.9 Provider catalogue with quality ranking
	Subdiscipline weighted score
2. e-Health	2.1 EPR penetration
	2.2 e-transfer of medical data between health professionals
	2.3 Lab test results communicated direct to *patients* via e-health solutions?
	2.4 Do patients have access to on-line booking of appointments?
	2.5 on-line access to check how much doctors/clinics have charged insurers for
	2.6 e-prescriptions
	Subdiscipline weighted score
3. Waiting time for treatment	3.1 Family doctor same day access
	3.2 Direct access to specialist
	3.3 Major non-acute operations <90 days
	3.4 Cancer therapy < 21 days
	3.5 CT scan < 7days
	Subdiscipline weighted score
4. Outcomes	4.1 Heart infarct case fatality
	4.2 Infant deaths
	4.3 Ratio of cancer deaths to incidence 2006
	4.4 Preventable Years of Life Lost
	4.5 MRSA infections
	4.6 Rate of decline of suicide
	4.7 % of diabetics with high HbA1c levels (> 7)
	Subdiscipline weighted score

5. Range and reach of services provided	5.1 Equity of healthcare systems
	5.2 Cataract operations per 100 000 age 65+
	5.3 Infant 4-disease vaccination
	5.4 Kidney transplants per million pop.
	5.5 Is dental care included in the public healthcare offering?
	5.6 Rate of mammography
	5.7 Informal payments to doctors
	Subdiscipline weighted score
6. Pharmaceuticals	6.1 Rx subsidy
	6.2 Layman-adapted pharmacopeia?
	6.3 Novel cancer drugs deployment rate
	6.4 Access to new drugs (time to subsidy)
	Subdiscipline weighted score

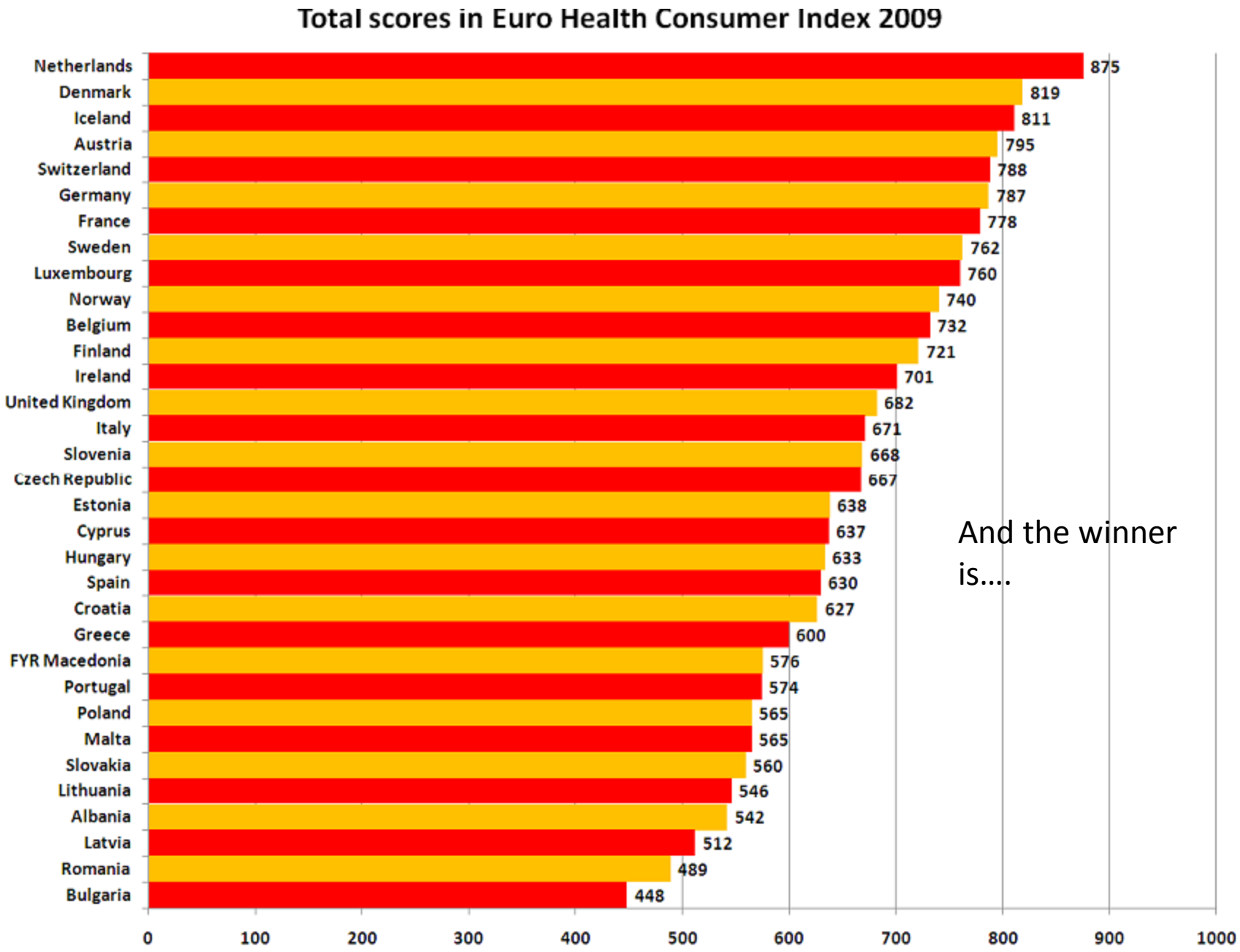
Euro Health Consumer Index – indicators for benchmarking of health care systems cont.

Benchmarking Results

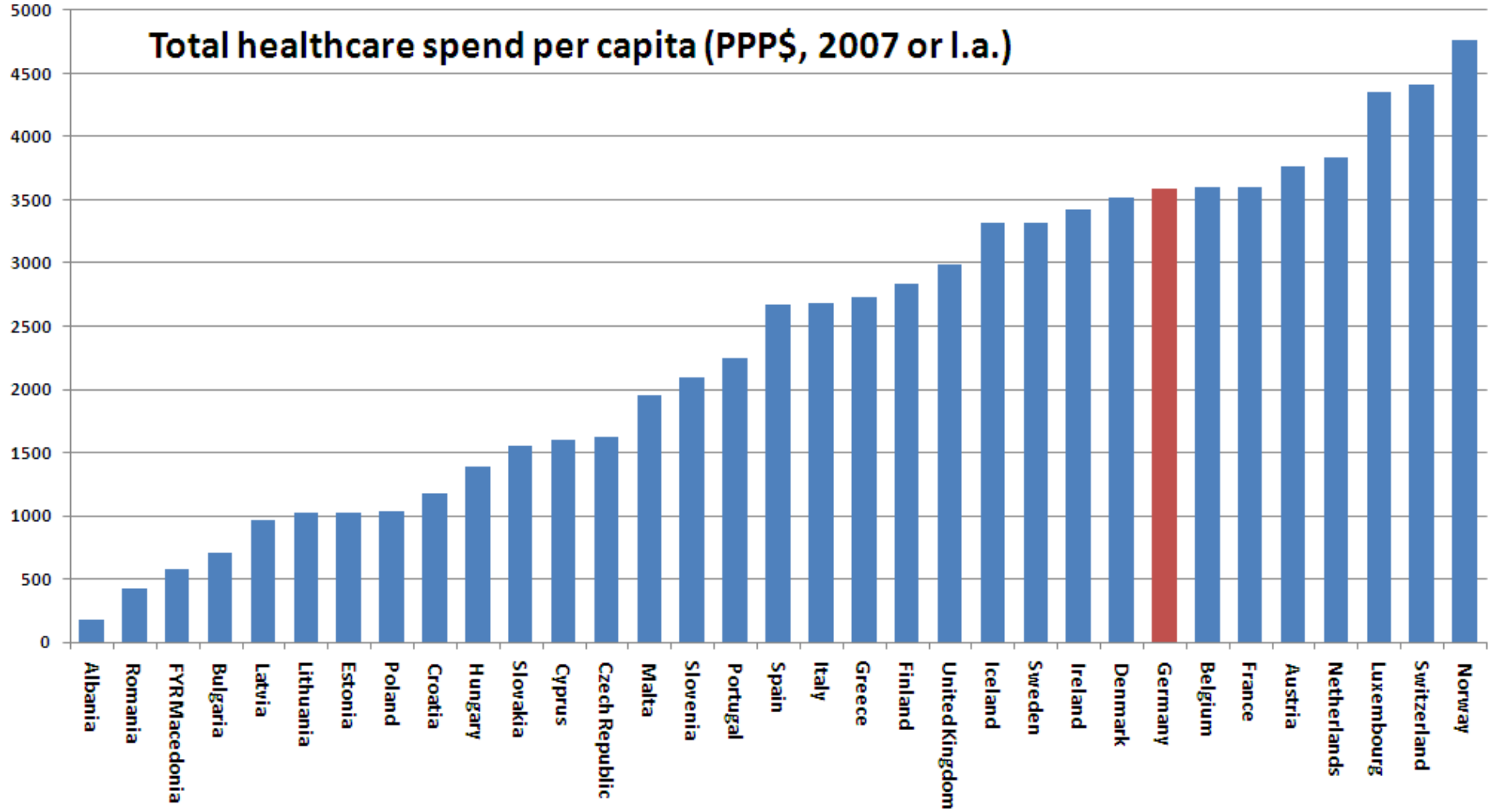
Sub-discipline	Albania	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	FYR Macedonia	Germany	Greece
1. Patient rights and information	117	149	130	84	117	110	84	175	130	143	143	110	123	84
2. e-Health	29	50	38	42	54	38	38	63	46	50	33	50	38	25
3. Waiting times	187	173	187	120	120	160	133	120	120	93	173	160	187	147
4. Outcomes	95	190	155	95	143	155	190	202	143	226	202	107	214	190
5. Range and reach of services	64	107	136	57	93	100	121	121	100	121	114	86	100	79
6. Pharmaceuticals	50	125	88	50	100	75	100	138	100	88	113	63	125	75
Total score	542	795	732	448	627	637	667	819	638	721	778	576	787	600
Rank	30	4	11	33	22	19	17	2	18	12	7	24	6	23

Benchmarking Results cont.

Sub-discipline	Latvia	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Switzerland	United Kingdom
1. Patient rights and information	91	136	136	97	162	136	117	110	91	104	149	84	117	136	123
2. e-Health	29	38	38	29	63	50	38	46	25	29	38	42	54	46	54
3. Waiting times	120	120	173	120	147	107	107	80	120	133	120	93	93	187	80
4. Outcomes	131	131	202	131	238	226	131	131	107	95	155	179	250	214	179
5. Range and reach of services	79	71	136	100	129	121	86	107	71	86	107	107	136	93	121
6. Pharmaceuticals	63	50	75	88	138	100	88	100	75	113	100	125	113	113	125
Total score	512	546	760	565	875	740	565	574	489	560	668	630	762	788	682
Rank	31	29	9	26	1	10	26	25	32	28	16	21	8	5	14


Total scores in Euro Health Consumer Index 2009
Netherlands 875
Denmark 819
Iceland 811
Austria 795
Switzerland 788
Germany 787
France 778
Sweden 762
Luxembourg 760
Norway 740
Belgium 732
Finland 721
Ireland 701
United Kingdom 682
Italy 671
Slovenia 668
Czech Republic 667
Estonia 638
Cyprus 637
Hungary 633
Spain 630
Croatia 627
Greece 600
FYR Macedonia 576
Portugal 574
Poland 565
Malta 565
Slovakia 560
Lithuania 546
Albania 542
Latvia 512
Romania 489
Bulgaria 448
0 100 200 300 400 500 600 700 800 900 1000
And the winner is....

At what cost?


Total healthcare spend per capita (PPP$, 2007 or l.a.)
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Albania
Romania
FYR Macedonia
Bulgaria
Latvia
Lithuania
Estonia
Poland
Croatia
Hungary
Slovakia
Cyprus
Czech Republic
Malta
Slovenia
Portugal
Spain
Italy
Greece
Finland
United Kingdom
Iceland
Sweden
Ireland
Denmark
Germany
Belgium
France
Austria
Netherlands
Luxembourg
Switzerland
Norway