

5. CONCLUSION AND OUTLOOK

Introduction: The "Social Europe" at the eve of enlargement

Enlargement has become a political "reality": On October 9, 2002, the European Commission presented the progress report and strategy paper (Commission 2002) on enlargement to the public and recommended that the negotiations on accession to the European Union should be concluded by the end of 2002 with *Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic and Slovenia*. According to the progress report, these countries will be able to meet the "Copenhagen" criteria - including their implications on social politics - and join the EU by the start of 2004. As for *Bulgaria and Romania*, the Commission recommended the continued support in achieving their objectives to join in 2007. Regarding *Turkey*, the EU should enhance its support for Turkey's pre-accession preparations and provide additional resources for this purpose.

The Commission concluded that candidate countries, or the new Member states - as they are also called in the progress report - have generally reached a high degree of alignment with the *acquis* in many areas and that steady progress has also been made towards reaching an adequate administrative capacity required for implementing and enforcing the *acquis*. However, some sectors have been mentioned where alignment with the *acquis* needs to be completed in view of accession, and this is, *inter alia*, also the case for the social sector:

*"In the area of social policy and employment, while alignment with the *acquis* is well advanced, most countries still need to strengthen their administrative capacity in particular in the areas of public health and health and safety at work. In addition, social inclusion should be further promoted in the light of the common objectives set out for the Union and candidate countries need to continue translating the Union's objectives into their national employment policies. Candidate countries should strengthen their efforts in the areas of social inclusion and employment to prepare for their future participation in the open method of co-ordination at EU level and for their preparation for the future intervention of the European Social Fund. The importance of investing in sustainable health systems also needs to be underlined."*

With this October's Progress Report and the decision to enlarge the EU by 10 countries in 2004 public awareness of the enlargement process has experienced another qualitative shift in the old member states. However,

social protection in a narrow sense does not attract major attention in the debate. It is primarily migration which is a political debate in the countries having a common border with the new member states, and the issues whether the income level and labour market conditions in the accession countries will lead to considerable migration from the new to the old member states.

This Synthesis Report of the 'Study on the social protection systems in the 13 applicant countries' outlined major developments and challenges in the social protection systems in the 13 countries in a comparative perspective. Social protection has undergone significant reforms in most of the countries during the last decade, caused by changing ideologies and the orientation towards partly privatisation on the one hand, but at the same time caused by changing needs and new challenges such as unemployment and poverty. The study on the social protection system in the 13 applicant countries aim was to give an in-depth description and analysis of the social protection systems in the country reports and to summarise trends and developments in the synthesis report. Could one identify 'typical' reform paths in the accession countries? Could one talk about a candidate country model of social protection? Is there a 'social security gap' between new and old member states and how could this be defined? Will enlargement impact on the social protection landscape in the EU, and what will be the perspectives of an enlarged Social Europe? This concluding section will discuss the above questions.

The following sections will summarise the major trends and challenges identified in the area of pensions, health and poverty and social exclusion (5.2). In section 5.3 the question will be discussed whether one could talk about a new 'European' model of social protection in the candidate countries and whether enlargement will re-shape the landscape of social protection in the EU. Section 5.4. will provide an outlook on further research areas and the future of social co-operation in an enlarged Europe.

5.1. Critical areas for reforms in the social protection system of the candidate countries and major challenges

5.1.1. Pensions

In Central and Eastern Europe, the last decade was characterised by a pension reform strategy of change into a more pluralistic and decentralised system. The main issue in pension reform debate throughout the region has been – as in the European Union – determined by the discussion on different funding mechanisms and the role of PAYG vs. Capital Funded pension

schemes.¹ The reasons for introducing capital funding in the old-age security system were manifold. First, a shift towards capital funding was expected to help coping with the impact of demographic developments on the future financial sustainability of the pension schemes. Second, a diversification of risks between PAYG funding and capital funding was deemed necessary, in particular in the light of rising unemployment and a shrinking contribution base. Third, a decentralisation and limitation of former state responsibilities in the area of social protection and shift towards more private responsibility was part of an overall re-design of economic and societal transformation.

Mandatory funded elements have been introduced in five of the Central and Eastern European Countries: Latvia has been the first one with legislation, but started implementation only in 2001. Hungary started the implementation in 1998, Poland in 1999 and Bulgaria and Estonia are on their way to implement such mandatory systems. In Lithuania and Romania, the introduction of mandatory elements is on the political agenda as well. In the Slovak Republic, it is expected that after the election in September 2002 the reform of old-age security and the introduction of funded elements will be part of the envisaged social reforms.² We will pick up the issue of a possible new 'model' of old-age security in Central and Eastern Europe and whether this has an impact on European social policy in section 5.3 and 5.4.

But there have been other countries which decided to 'restructure the public pension schemes' as a recent ILO report (Fultz 2002) has put it: Countries such as the Czech Republic and Slovenia which decided not to introduce mandatory funded elements but have focused on the reform of the so-called first pillar by strengthening the contribution-benefits link and raising retirement ages. A policy issue in all Central and Eastern European Countries has been the overall low retirement ages which were increased throughout the region. In this respect, rising unemployment and the low employment prospects of the older generations probably was one of the largest policy conflicts in the transition, since a rise of the retirement age was not reflecting actual labour market chances of the elderly. Such policy methods usually did not gain large public support. The retirement ages in Central and Eastern Europe are still low. In this respect, the candidate countries have experienced policy developments like in many other EU member states in the last decade.

There is no uniform and clear picture on poverty in old age across the candidate countries. While pensioners in some countries seem to be less affected by poverty than the average of the population, elderly in other

¹ The debate on pension funding, stimulated by the World Bank Report 'Averting the old-age crisis' and its impact on pension reform in Central and Eastern Europe has attracted large interest in policy debate and science. See, for example, World Bank (1994), Beattie/Mc Gillivray (1995), a summary of the arguments by Barr (2000), Müller (1999; 2002).

² See the respective country studies.

countries are heavily affected. It seems that the pension level and the average replacement rate are not the only factor to explain poverty in old-age, but that the interaction between social benefits, labour market participation and the family/household composition have to be taken into account when analysing poverty incidence. The development of pensioners income and poverty in old age call for further monitoring and research, in particular because only a couple of years have been passed since the introduction of fundamental 'regime changes' in the area of pensions. Whether these new systems will meet the intended expectations, whether they will be able to cope with future financial challenges and at the same time provide secure income in old-age is, therefore, still an open question. The transition to partly funded schemes and the impact on pensioners income, transition costs and intergenerational distribution is one of the crucial questions of pension policy in an enlarged Europe.

The studies aim was also to explore the future challenges posed by enlargement, to both, the new and old member states. What will be the main challenges for the old-age security systems in candidate countries facing accession to EU?

In general one could state that probably the field of social protection in old age is the area which is the least affected directly and immediately through enlargement. Statutory pension benefits will be included in the co-ordination of social security benefits and the social security administrations in the candidate countries are requested to apply the *acquis communautaire*, the social security co-ordination rules (1408/71; 574/72). However, the number of applicants drawing benefits from more than one system will only gradually phase in. This mainly due to the fact that there is a certain time lag between contribution to the system and drawing benefits in old-age. The administrative burden to cope with the co-ordination of social security and the pro-rata calculation will of course depend on the future labour migration among the respective countries.

The social administrations in the candidate countries are well aware of the requirements in the future and they are preparing themselves for these future tasks. There are a number of PHARE twinning projects running on the future application of regulation 1408.

Other issues which are discussed in the light of enlargement are also connected to capital funded schemes: First, capital funded pension schemes require a functioning national capital and banking market and equivalent regulatory and supervisory bodies. Especially during the first years of transition, due to banking and stock market crisis and weak supervisory bodies, there was a remarkable loss of confidence in the stability of this sector, which is still a factor in some countries and which needs to be taken into consideration. It should not be forgotten, that - while introducing privately managed mandatory second tiers - the role of the state changed

fundamentally from the one of a provider to a regulator. The role of appropriate supervisory systems was largely discussed in those countries which have been introduced mandatory private pillars. Experiences on best practices which will be gained in the first years of operation in Poland, Hungary and Latvia will be of great importance for other countries which also decide to introduce mandatory pension funds.

The second issue with regard to capital funded schemes is the question of the free movement of capital after accession: Countries like Latvia and Poland, where funded pension schemes are only allowed to invest 15%, respectively 5% of the capital abroad, were already in 2001 asked to open up their capital market and to de-regulate pension fund investment rules. Pension funds in Poland and Hungary largely invested in government bonds during the first years of operation.³ At the same time, large part of the providers are owned by foreign insurance companies.⁴

One other aspect to consider is certainly the problem of revenue collection. This refers on the one side to the problem of willingness to pay contributions: As there often was - and in some countries still is - only a symbolic contribution to be paid directly by the employee, and the majority of the contribution rate being paid by the employer, the link between contribution payment and benefit calculation was not visible for the insured. Thus, the awareness and individual interest to check whether the employer has paid the respective contribution part was not existing.⁵ Strengthening the contribution-benefit link in order to raise individual control over contributions paid to the pension insurance and improve contribution compliance was one of the main objectives of pension reform throughout the region.

In general, contribution and tax evasion in the Central and Eastern European Candidate Countries is characterised by an inverse correlation between income and informality (Lindeman et al. 2000). Although there is little comparative information available on the extend of evasion⁶, recent research indicates that 'more advanced' economies in transition could catch up with the EU average with respect to the effective taxation

³ A critical comment on the fact that the pension funds mainly "stayed local" and invested in government bonds was that such investment practically is an indirect pay-as-you-go financing as well, since the increased state debt will have to be covered by the future generations.

⁴ For example in Hungary, nearly 75% of the assets of mandatory pension funds are managed by foreign providers (in 2001) – see Investment and Pensions Europe, June 2002, p. 38. Six pension funds in Poland are managed by global insurers (Business Central and Eastern Europe, July/August 2001, p.33) . Check with country study Poland on corresponding assets.

⁵ In some countries, it has become a "common and fashioned sport" for employers to develop avoidance strategies to legally evade payments of social security contributions.

⁶ See Martinez-Vazquez, Mc Nab (1997:68pp.)

(Schaffer/Turley 2001). At the same time the extend of the shadow economy, both, in transition countries as well as in Western European OECD countries has increased over the 90ies (Schneider 2002). It will be a question of further research whether these developments will have an impact on the area of social security contribution collection. However, the fact that pension benefits will be closer linked to formerly paid contribution, increase of transparency and a modernised administration, individual accounts and electronic data storage might counteract the increase of shadow economy in general and improve contribution compliance.

The problem of revenue collection not only refers to underreported wages within the candidate countries but also to individuals who are employed illegally abroad.⁷ Both groups of such "employed" persons are not contributing to the pension schemes in their respective country of origin - at least not for the first pillar. This has - of course - on the one side consequences for the revenue base of pension insurance today (Centre for Economic and Policy Research 2002) - but in the long run might cause considerable problems of income in old age, as they are not accumulating pension claims during illegal economic activities.

To summarise the most acquis-relevant points, there will certainly be administrative challenges with regard to the co-ordination of social security schemes for the candidate countries and the Member states. The extend will largely depend on the future labour migration between the new and old member states. It will be, furthermore, an interesting question to what extent the structure of the new emerging pension schemes in CEE will stimulate and speed up the European development and discussion on the co-ordination of benefits of the second pillar.

5.1.2. Health Care

The development of the health care system has seen similar major changes as the pension system and can be characterised by the following: A decentralisation on the purchaser side (health insurance bodies with often newly created local entities) and provider side (regional or locally owned ambulatories or hospitals) as well as the partly privatisation of the purchaser side (introduction of private insurance) and provider side (private practices for GPs, dentist and private pharmacies).

A model quite frequently implemented is a system of independent non-state regional health insurance bodies, based mainly on the Bismarckian model, which has been introduced with a first wave at the beginning of the

⁷ There hasn't been much research on migration of labour in its effects on pension schemes in the candidate countries - reliable data are not available so far.

90ies (Czech Republic, Estonia, Hungary, Slovakia, Slovenia, Latvia, Lithuania) and a second wave in the late 90ies (Romania, Poland and Bulgaria).⁸ All countries choose different types of organisation of the funds (single/ multiple funds/ competing/ non-competing/ geographically bound or country-wide) as well as different types of their governance, of their contribution and collection system and different types of remuneration schemes which are often of a mixed nature (fee-for-service/ per capita/ lump sum - special payments or case-based/ per diems systems - with or without a national cap⁹). In recent transition years, the re-allocation of contributions between funds (in countries with multiple funds such as for example in Slovakia, the Czech Republic or in Romania) became a major topic as well as the introduction of DRG-systems/ clinical pathways and an accreditation system in the hospital sector.

Historically interesting is that for most of the former Austro-Hungarian empire countries, the introduction of the so called social health insurance model was only a return to an organisation and financing principle which had already existed in part before the introduction of the centralised integrated state model of Semashkov in the early 50ies. In most CEE candidate countries, social health insurance is administered by a national health insurance fund - more or less independent from the central government - which are in charge of setting, collecting and distributing funds. However, one main distinction which can be made here, is the type of revenue. Most countries rely on a mix of sources (taxes, social insurance contribution, voluntary insurance premium, user charges) with Bulgaria, Latvia, Poland and Romania predominantly funded by taxation and the Czech Republic, Estonia, Hungary, Slovakia and Slovenia predominantly funded by insurance contributions. Malta and Cyprus - both countries with a British tradition and thus more oriented historically to the Beveridge financing principle - as well as Turkey have mainly tax-based financing systems, although Cyprus is due to implement a social health insurance system by 2005.

As another important cornerstone - and before the background of more and more scarce financial resources in the health sector of the candidate countries - one might mention the reduction of health capacities (number of hospital beds and to a lesser extend the number of physicians and nurses) and - linked to this - a shift from a more hospital based to an out-patient treatment by using the family-medicine model. In this connection the everlasting discussion in the candidate countries about the defining of a systematic "basic benefit package" - as a counter-model to the universal

⁸ Both Lithuania and Romania had already introduced health insurance type mechanisms in the first half of the 90ies - but these had remained very limited in scope: see (Busse, 2002)

⁹ National caps exists for example for Hungary, Poland and Slovakia in the outpatient care sector; in Slovenia for the primary care sector.

coverage - emerged as well - but with less successful results in most of the CEE countries until now.¹⁰

In general, the problem of over-supply in the secondary care system has been tackled very differently: Number of beds in acute care hospitals were about one third to 100% above the EU average - with the exception of Slovenia and Poland and the Baltic Republics - the latter being at the level of Germany (Busse, 2002). Only Estonia, Romania and to a lesser extent Latvia started to reduce their hospital capacities successfully at the beginning of the 90ies. For example in Estonia, public hospitals have been transferred into non-for-profit or joint-venture companies under private law - and this proved to be quite successful and cost-efficient. In other countries, the privatisation and introduction of cost containment elements in hospitals was handed over to private investors - with the effect that in most cases the capacity problem could not be addressed successfully because of the lack of respective legislation. More frequently than privatisation, hospitals have been transferred from the central to the local government level - which made hospital reform often more difficult. In any municipality, hospitals are now a major employer - making restructuring extremely difficult politically.

As already mentioned, the question of financing of the health care system became a more and more urgent priority during the last years of transition: In most of the candidate countries health care expenditures in relation to GDP have increased during the first five years of the 1990ies, but have been relatively stable over the past five years - which is mainly due to the increasing expansion of the private sector in most of the countries. However, the level of spending varies considerably among the candidate countries. Between 1996 and 2000, candidate countries spent on average 4.5% of their GDP on health care compared to an average of 8.62% in the EU Member States. Among the candidate countries Bulgaria (4.08%), Romania (3.5%) and Turkey (4.4%) exhibit a strikingly low level of health care expenditures in relation to GDP. Higher shares could be identified for Slovenia (8.8%) and Malta (8.4%).¹¹

When looking at EU enlargement and its possible impacts on the health care systems there are a number of common aspects and critical reform areas which could be mentioned.

Very similar to the situation in the pension field, the main focus will lie on the strengthening of administrative capacity to implement effectively EU regulations, e.g. the co-ordination rules 1408/71 and 574/72 on the free movement of persons. This requires skilled and committed health administrators and health care professionals - as well as a financially sustainable health system. Preparations to respond to these needs are under

¹⁰ See chapter 3 of this report.

¹¹ see Chapter 3

way since a couple of years and with the help of PHARE Twinning project as well as through bilateral contacts between Member state institutions and institutions from the candidate countries.

The free movement of patients from the candidate countries to the Member states and from the Member states to the candidate countries will have several implications for the health systems. One main problem in this area will be that expenditure on health care services is still significantly higher in EU Member states than in the candidate countries.

For example: The patients in the candidate countries will be able to undergo treatment abroad - thus in the framework of Article 22 (1) (a)¹² or Article 22 (1) (c)¹³ of regulation 1408/ 71. The treatment is offered at the national rates which is to be reimbursed by the health insurance bodies of the candidate country - with the consequence of increasing costs for the health system of this country. Due to still existing significant differences in the economic potential of the health systems, the additional costs incurred might put such a financial strain on the health systems in the candidate countries that should not be neglected.

On the other hand, certain candidate countries, for example Hungary, Malta, Cyprus and to some extent also the Baltic states are expected to benefit from patients from the Member States. Spa treatment, dental services and plastic surgery are expected to be the main areas of health services where an increasing demand is noticeable already now. It is likely that most of the treatment will be paid out-of-pocket or through private insurance.

Free movement of services, the second basic freedom of the European Union, will have an impact on the health systems in the candidate countries. It is expected that to an increasing extent medical devices, in particular in the field of dentistry, which can be produced abroad at lower prices might become a growing industry in the candidate countries with positive effects for the economy.

A further issue is the price development of drugs and medical devices. The increasing costs for these goods put a further strain on health care costs in the candidate countries.

¹² Article 22 (1) (a) states that insured employed or self-employed persons and their family members have the right to immediate health benefits during a temporary stay within another Member state (E-111).

¹³ Article 22 (1) (c) states cases in which the employed or self-employed persons and their family members have obtained permission from their respective insurance institution to receive appropriate treatment in another Member state (E-112): this applies in cases where waiting lists exist or a quality treatment in the resident state can not be provided.

A number of candidate countries state that an unfavourable economic situation and a low social status of health professionals - and this concerns paramedical staff as strongly as doctors - might lead to emigration to Member States after enlargement. This issue has been raised in particular in some of those countries with a border to the Member States, for instance in Hungary and the Czech Republic.

In addition, as the Commission mentions explicitly in the progress report of October, also the following aspect will have a clear impact on enlargement within the Union's health care sector: *"Attention should be paid to the area of mutual recognition of professional qualifications, where legislative alignment with respect to the health care professions still needs to be completed and, in some cases, curricula and training adapted to the Community requirements."*

Increasing possibilities for taking up employment abroad and considerable differences in salary between Member States and also among candidate countries for specialist staff might lead to shortages of certain specialists in some candidate countries (brain-drain). In order to counteract this development, competitive salaries might be the answer - with again the consequence of increasing costs for health care.

But we do not only observe differences in doctors wages between Member states the Candidate countries - but also considerably differences of wage between the health professions and other professions within the candidate counties. Financial and social incentives for health professionals are still low in some countries¹⁴, which has two major consequences for the situation of health care in the a number of the candidate countries: Access to health care and quality differs enormously between regions. These problems can particularly be observed in those countries which have rural areas that are not easily accessible such as in Turkey, Romania and Bulgaria. It is there, where we usually find an under-supply of medical service facilities and staff compared to the capitals and bigger towns. A second consequence of this situation is a frequent practice of informal co-payments in quite a few countries which still leads to a situation that patients are confronted with expenses they have often not calculated with while seeking for treatment.

In conclusion: Despite political and also technical difficulties, governments will need to ensure that limited resources in the health care sector are targeted more effectively in order to secure access to basic services for all - especially for the poorest and neediest. One strategy, which is applied in many countries already is to shift resources from secondary/tertiary care to primary care. Another instrument which has been used is to define more limited entitlements instead of applying universal coverage

¹⁴ With the slight exception of Slovenia, Hungary and the Czech Republic where wages increased considerably in the mid-90ies due to the political will to counteract this problem.

rules. Contribution collection mechanisms of purchasers have been strengthened - but need still more support in terms of trained personnel and better information system settings. The resource allocation of contribution revenue should be based on risk adjustment models with a more clear focus on the adjustment of differences between poor and rich regions. And - as observed as a major danger in the old-age security systems of the candidate countries - contribution compliance is also a topic in health care: This may be even more, as the co-relation between contributions and health services obtained is often not transparent to the patient. Thus, the awareness and individual interest to check whether the employer has paid the respective contributions is hardly existing - which opens up the door for contribution evasion in the health sector as well. Incidentally, this applies also to the contribution part of the employee as the insured have now to pay for something which was "for free" in former times. Therefore, lack of compliance in the health sector is likely only to be solved if corruption in the wider economy is reduced.

The financing of the health care system in the candidate countries is the "weak flank" in light of enlargement - and demands a well-conceived and long-term health care sector reform strategy - beyond the year 2004.

5.1.3. Poverty and Social Inclusion

According to existing poverty literature, the 13 candidate countries form two groups. The ten ex-communist countries of Central and Eastern Europe represent one group that share a common background - as in former socialist countries, poverty issues were not explicitly on the political agenda. High employment, labour centred welfare systems and subsidised prices largely prevented extreme forms of poverty in those countries. Poverty was mainly seen as social pathology – experienced by individuals who for some reason could not work. The transition shock and economic collapse experienced by all these countries in the early 1990s fundamentally changed such assumptions about poverty. Many people lost work and had no income, and the majority of those employed continued with low wages and little entitlement for state benefits. Living standards fell for the majority and the incidence of poverty became widespread. The policy response required a combination of contributory, categorical and safety net income maintenance programmes to be introduced and sequenced appropriately. Differences within the first group largely reflect the design and sequencing of this response alongside their underlying demographic and macro-economic profiles.

By contrast, the other three countries, Cyprus, Malta and Turkey have fundamentally different policy histories and experiences of poverty.

Grouped as “Mediterranean” countries, they are characterised as having more recent and lower profile development of poverty measurement and policy than Northern European countries. Accordingly, poverty research in Turkey and in other North African and Arab countries in the region is particularly poorly developed - in Turkey the last reliable data dates back to 1994 - and poverty and social exclusion have low priority despite its widespread incidence. For example, housing seems to be a key problem in Turkey, with large urban areas of ‘squatter’ housing where approximate one quarter of the urban population lives. Cyprus and Malta, having strong family solidarity systems and low unemployment rates, are less affected by poverty issues. Thus, poverty in Malta is being taken care of by voluntary organisations and, in particular, Caritas. Poverty in Cyprus has a low overall relative profile and incidence.

Since the Lisbon European Council of March 2000, promoting social inclusion has been a key aim of European policy as some 18% or over 60 million of the EU’s population were at risk of poverty. Consequently, the concept of ‘Social Exclusion’ observed a broader scope than poverty and material deprivation. It includes the risk of marginalisation and exclusion of individuals and groups in several areas of life, including poverty. Difficulties of these groups to access the education, health, service, or pension system further aggravate the process of exclusion. Hence, a whole range of factors contribute to social exclusion, and policies of inclusion need to address these areas simultaneously.

Especially in the Middle and Eastern candidate countries, deteriorating labour markets and rising unemployment went together with the State’s inability to cope with its dependent population of old age, orphaned or abandoned children, or handicapped persons who were formerly looked after by the government or state institutions. New groups at risk are also young people as well as families with children (less in Cyprus and Malta). For example, declining life expectancy for men in Lithuania, Bulgaria or Romania already resulted in dire living constraints of their remaining families with a tendency of perpetuation. Marked geographical poverty pockets were identified in Romania, Bulgaria and Turkey.

The breakdown of support services such as company owned crèche centres for women workers with children, or a lack of resources to maintain old age homes and orphanages led to neglect and further marginalising of the most vulnerable groups of society. The situation often aggravated with family breakdowns, high incidence of domestic violence, and lack of access, in particular for women with children, to the remaining health education and support services (Micklewright/ Stewart, 2000).

Economic and social pressure on families with children increase risks of disaggregating, school dropout, and deprivation of care. Increasing numbers of children in institutions during the early nineties reflected these problems.

Young people who are unemployed, and come in conflict with the law, as well as teenager pregnancy, substance abuse and prostitution constitute a part of the marginalisation process in a number of candidate countries as monitored by UNICEF over the years (UNICEF, 2000).

Grey labour markets where labours standards are not sufficiently observed are obviously on the rise, while long-term formal unemployment further accelerates impoverishment. Studies in the Czech Republic have demonstrated the adverse effects of such development, whereas Hungary and Lithuania seem to have coped more successfully with the problem (Sengenberger, 2001). This issue may likewise be a problem in EU member countries and probably needs further detailed study with regard to prevailing sectors and statistical data available on informal labour markets.

It is clear however that employment creation and access to the welfare system have to go hand in hand during adjustment and transition processes. Therefore, employment programmes in the candidate countries are already now high priority - addressing especially poverty which is linked to unemployment. However, there is also evidence of a greater scale of the labour market as a poverty driver as this does not only operate through unemployment but also through low pay and underemployment.

Besides poverty and unemployment, the exclusion of large parts of the population from social and economic activities in candidate countries is also based on ethnic discrimination and denied access to labour, the health and education system or social protection services: Roma populations are estimated at up to around nine per cent of population in Bulgaria, Romania and Slovakia or less than one per cent in Poland, Slovenia and Turkey. Direct data from poverty surveys suggest very high levels of poverty – 84 per cent of Bulgarian Roma lived in poverty in 1999, 79 per cent of Romanian Roma lived in poverty in 1997, and Roma minorities made up one-third of the long-term poor in Hungary (Ringold, 2000). Dependency on social protection cash benefits is high. 80 per cent of Slovak Roma are estimated to rely on social protection benefits and large proportions of the adult population qualify for disability benefits due to ill health. Specific programmes targeted at Roma populations have been introduced in the meanwhile in a number of the candidate countries.

A crosscutting issue in poverty and social exclusion analysis is the high proportion of women being affected by a deteriorating employment situation, decreasing maternal benefits and withdrawal of social protection during transition. Reducing gender inequality in the access to social services, but particularly in employment opportunities, payment and labour standards remains a high priority with most candidate countries. The discrimination of women at the work place may be apparent in job-seeking, and at the work place itself. Sexual harassment, and discrimination during

pregnancy or motherhood seem to be the most often reported issues which need to be addressed.

Many candidate countries still have a large population (up to 50 %) living in rural areas, more than half are women. Where agricultural sectors are characterised by low productivity, for example in Romania, Bulgaria, Poland and Turkey, income disparities and poverty close to subsistence prevail. Although the population involved in agriculture keeps falling, the proportion of women as farm workers remains high while men are taking up work in other occupations. Farming remains a sideline and security for many women. As rural areas are comparatively less well equipped with public, health and educational facilities, social services and employment opportunities, rural women evidently need to be addressed by government and non-government support systems, and family benefits, especially, if they have dependent children and elders living with them.

The country study on Romania states in its conclusions that “extreme and long-term poverty generates certain immunity to economic growth and becomes an obstacle to development. Poverty is responsible for a serious deterioration in society: the loss of professional skills, erosion of the educational level, reduced accumulation of property and savings and social disintegration. All of these lead, over time and in various ways to social exclusion. The effects of present poverty thus become the causes of its reproduction in the future.”

The consequences of long-term poverty and exclusion amongst larger parts of the population show in an increasing need for social protection. Where education, health and pension systems have been working well in the past, it has now become necessary for the government to define policies to prevent deprivation, ensure accessibility of basic services, or equality in payment.

Discussing the effects of poverty and social exclusion on enlargement, we can conclude that these issues probably represent the most serious challenge of future EU enlargement at different levels. The fact that poverty and social exclusion is largely influenced by the situation of the labour market stresses even more what importance employment policies will have in an enlarged Europe.

In addition, the large share of the Roma population being at risk of poverty in part of the candidate countries represents a clear new challenge for the European Union. In some of the candidate countries, in particular in Romania and Bulgaria, as well as in the Czech and Slovak Republic, this is one of the most serious challenges with regard to social inclusion.

Incidences of poverty in the candidate countries will probably affect the financial flows of the structural funds within the EU. It is also expected that

the level of poverty and inequality between the old and new members states of the EU will affect migration flows in the future - and in some research literature, the term "beggar-my neighbour policy" is already used again (CEPR, 2002).

Migration as a consequence of poverty and social exclusion has a long tradition in Europe, and its policies, as for example laid down in the Schengen Agreement, probably has to be reconsidered in future.

The necessity to formulate policies and implement strategies of social inclusion is a rather new concept for the candidate countries, and may require a substantial change of perspective from governments and society with regard to its most vulnerable groups of population. However, in the absence of modern social welfare legislation (Czech Republic), or limited resources for state budget financed social protection services (Bulgaria, Romania) major reforms of legislation and policy implementation are inevitable.

These reforms even require a further major change: from a centralised distribution system to decentralised and need based service provision at local levels. Devolution processes have made substantial progress in recent years, for example in Bulgaria, Slovenia, or Lithuania. With the assistance of a large number of PHARE, TACIS and Twinning Projects co-funded by the EU, legislation and administrative reforms were taken forward to reach municipalities and local communities.

In Bulgaria, for example, Child Welfare Reform promoted de-institutionalisation and the creation of counselling services and private support provision linked to social welfare administration at municipality levels. The new Bulgarian legislation in the field of social assistance provides for regular monthly benefits to households living below the guaranteed minimum income and targeted benefits for particular needs (e.g. heating, appliances for disabled, family benefits and parental leave for uninsured parents). The social assistance scheme allows targeting the poorest groups and ensures relatively broad coverage of the groups at risk, such as children and dependent people through need based assessment.

On the other hand the Lithuania country study concludes that: "The draft programme on the implementation of a poverty reduction strategy in 2002-2004 is based on the new approach to poverty reduction and social inclusion. This approach is based on better targeting and more active measures (reduction of unemployment, toughen the legal and material responsibility of the parents with regard to the use of the allocated benefits, etc.). Nevertheless, the pension insurance remains without essential changes and will hardly cope with the problem of poverty and social exclusion."¹⁵

¹⁵ See Country report, Lithuania

The fact that measurement of progress and risk reduction of social inclusion policies strongly depends on precise indicators and comparable statistical information has been an issue in the EU since the mid nineties. The *Joint Report on Social Inclusion* of the European Commission provides latest insight in this area (Commission, 2002a). In the following of the Lisbon European Council meeting (2000), which stressed the importance of reliable and coherent statistics, efforts for better data collection have been developed to encourage EU member and candidate states to better monitor their policies of social inclusion. It is now hoped that new instruments, such as the European Social Survey, will contribute to improved complementary data analysis.

For the envisaged interim reports on social inclusion policies it will be equally important to assess, how far investments in education, health and the reduction social and economic inequality have been successful. Some studies suggest that a number of candidate countries have successfully maintained or rebuilt standards in education, health and the social sector. Child poverty rates for example are equally low Czech Republic and Slovakia as in Sweden and Finland, in Hungary not higher than in Germany (Micklewright/ Stewart, 2000).

Even if the problems of social exclusion, linked or not linked to poverty, are still largely invisible in the thirteen countries' political agenda, the promotion of inclusion through specialised programmes and poverty reduction measures is an emerging issue. It comes via health and insurance promotion, or pension systems reform. While Hungary for example introduced its most progressive social protection reform in 1995, it did not deal in much detail with issues of social exclusion in policy formulation. Of course, perceptions of poverty and anti-exclusion are not very attractive for the aspirations of governments to join the EU.¹⁶ Competing poverty reduction concepts and policies by the World Bank, UNDP, OECD or EU are probably adding to hesitation at national level of the candidate countries to deal too extensively with the issue, in particular since poverty lines are based on varying definitions of either low incomes (< US\$ 2 per day), human development indices, or consumption averages, etc. To overcome such reluctance and increase co-operation with among the countries, and with future EU partners would be a desirable strategy in favour of the concerned vulnerable groups.

¹⁶ see Chapter 4 of this report.

5.2. A Candidate Country ‘Social Model’? What is the social security gap between Candidate Countries and Member States?

The discourse on enlargement and the perspective of future social policy developments is largely determined by the question whether it is possible to identify ‘a’ Candidate Country model of social protection and whether this will influence the future shape of European Social Policy in any respect (Scharpf 2002:5, Brusis 1998)

One would probably have to deny a general statement such as ‘a single’ Candidate Country model. This, over and above all due to the fact that the 13 Candidate Countries comprise a group of ten Central and Eastern European Countries plus Malta, Cyprus and Turkey. The former look back on a more or less common socialist history during the second part of the last century, the latter have been in particular influenced by Great Britain as in the case of Malta or Cyprus.

If one focus on the ‘transition accession countries’, i.e. the Central and Eastern European countries, there are a number of common developments and features with regard to their social protection schemes – however, a considerable number of differences as well. Some of the striking similarities and differences will be discussed in the context of the discourse of different models of the welfare state.

It is quite difficult to talk about a European welfare model as such (Abrahamson 2000, Ebbinghaus 1999, Wickham 2002, Lindbeck 2002). The classification of different models of welfare in Europe and the world is discussed along the responsibilities of the state, the market and the individual/family, the method and share of financing for different sectors, the relative weight of cash transfers and social services and the question whether social protection is tied to labour market participation or provide ‘universal’ benefits. Industrial relations and the role of trade unions and employers in social policy and provision of social benefits is also identified as an differentiating factor.¹⁷ The reform of Central and Eastern European Welfare States has often been characterised as an ideological confrontation between a European conservative-corporatist approach versus a liberal residual welfare regime as it is found in the Anglo-American countries (Brusis 1998). However, while this was obviously a more theoretical discussion in the beginning of reforming socialist welfare states, the last decade of reform has been characterised by a ‘redesign’ of existing structures rather than a radical change of the social protection system.

¹⁷ The most famous publication in this respect in recent times probably has been ‘The three worlds of welfare capitalism’ by Gösta Esping-Anderson (1996). This approach has attracted broad reception and further developments.

Talking about social protection reform in Central and Eastern Europe, one always should take into account that all of those countries look back on a long history of social protection. In many of the transition countries, social security development was influenced by German and Austrian developments of social security in the late 19th century. This history and tradition is seen as one of the influencing factors for the redesign of social protection in a number of countries (Eichenhofer 1995, Horstmann/Schmähl 2002).

Due to this largely common history, both, in pre-communist times and during socialism, the Central and Eastern European Countries were faced with many similar challenges with regard to their social protection schemes. Partly privatisation of a formerly state dominated system, as outlined in section 5.2 on the one hand – in health care and old-age security – has been a general trend in the transition countries. A development of a basic social safety net which supplements labour-centred social security was a second trend. A closer orientation of the insurance system by strengthening the contribution-benefit link in old age security and the introduction of an insurance based financing in the health sector has been a main feature throughout the region. Strengthening financial accountability of social protection by separating the social insurance budget from the general state budget was another. Looking at social reforms in the transition economies and the objective to shift policies towards a social insurance based cash transfer oriented social protection system, one could clearly state that the transition economies resemble the ‘continental’, ‘Middle European’ ‘Bismarck’ model of social protection.¹⁸

However, taking the share of social expenditures in GDP as one indicator of the role and extend of the welfare state we could state a lower overall level of social expenditures basically caused by a comparatively low share of spending on health care, whereas the spending on pensions is quite comparable to those of the EU member states (see chapter one, Table 1.12). So this is where differences start to begin. The ‘medium’ level of social expenditures combined with a tendency to increase private funding, in particular in old-age security tends more to a typology of a anglo-saxon than continental welfare state.

Another important difference between Central and Eastern European Candidate Countries and the continental typology relates to industrial relations. Taking social partnership, the role of trade unions and bargaining coverage as another indicator to describe the design of the welfare regime, we also could identify considerable differences. Weak employer organisation and the former political functions of trade unions has led to a still weak role of social dialogue and corporatism in the transition countries.

¹⁸ See for a further discussion of the European Social Model and its various definitions Abrahamson (2000)

If we look at the social protection system and its separate fields, we might observe more convergence between the transition economies than it is possible to identify among current EU member states.

In the area of old-age security, there is an obvious trend towards the introduction of a mandatory second pillar based on funded financing (see chapter 2 and section 5.2.1). The fact that this second pillar is a) limited in its future role of replacing former labour income and b) is combined with an earnings-related first pillar marks visible differences to the ‘classical’ model of the World Bank which has been promoted by the famous document ‘Averting the old-age crisis’. The emerging structure of the public-private mix in old-age security is probably one of the most striking similarities in the post communist re-construction of pension schemes in Central and Eastern Europe. But at the same time it is necessary to state that even if the overall structure in many of the reformed systems is similar, a closer look would again result in differences in detail (see chapter 2).

In the health care sector, the introduction of health insurance with health insurance contribution and privatisation of at least the outpatient sector might give the impression of a comparable development of convergence. However, since the actual design (national health insurance with regional branches vs. competition between public, regional sectoral and occupational health insurance funds) differs quite considerably and, in particular the role and influence of the state seems to be rather different across the countries.

The third area of social protection which is part of this study – social protection against poverty and social exclusion is characterised by similarities of problems rather than similar policy developments. Newly established last social safety nets still struggle with financial and administrative uncertainties.

An overall conclusion from the characteristics of Central and Eastern European Welfare States would be that these are to a large extent ‘insurance based’ and contribution financed and in this respect resemble the “central” “continental” Bismarck model – which is no surprise in a geographic perspective -, but that at the same time the countries are characterised by elements of an anglo-saxon model. The latter might be mainly explained by an explicit political objective to partly privatise the social protection system without neglecting in general social insurance traditions and a clear commitment to mainly state dominated social protection system.

Accordingly, this conclusion that Central and Eastern European Welfare States could be classified by mixed traditional characteristics of the ‘European models’ leads us also to the question what actually the ‘social security gap’ is between the new accession states and the old member states. While a comprehensive analysis of this issue is up to further research, one could probably not derive an overall social security gap, but should distinct

between structural issues and the gap in benefit levels. Some of the Central and Eastern European Countries have carried out comprehensive and far-reaching structural reforms during the last decade in old-age security. At the same time many of them are struggling with structural problems, in particular in the health sector. The comparison of absolute and relative benefit levels (e.g. replacement rates of cash benefits, level of minimum benefits) might also be a necessary and useful distinction when social protection in the member states and in candidate countries is compared. The problems the social protection systems in Central and Eastern Europe are currently faced with are probably to a lesser extent caused by the structural design, but due to a lack of financial resources and an overall lower economic performance when compared with the member states.

However, while Central and Eastern European Countries were reforming their social protection systems, the landscape of social protection in the three other candidate countries and in the EU member states changed as well. Financial pressure and more and more evident consequences of ageing population as well as ill-designed structures have evoked new reform needs in the member states. Consequently, the experiences gained from engineering processes in Central and Eastern Europe might be useful for social reforms in the member states as well. To what extent enlargement will cause qualitative changes in the development of a "Social Europe" is an issue that will be discussed in the following section.

5.3. Outlook on an enlarged Social Europe

Much has been written about the term "Social Europe" or EU social policy, its meaning and its process of change since the creation of the European Community by the Treaty of Rome in 1957 (Leibfried/Pierson 1995, Rhodes/Mény 1998). Naturally, this topic has also been an issue of discussion during the last ten years of transformation in the candidate countries as the countries have often been confronted with inconsistent concepts - depending for example if they had a German, British or Scandinavian consultant visiting their countries. Now, at the eve of enlargement, things get practical: Based on their now existing social security systems as characterised in chapter 5.4., the accession negotiations with the European Commission have clearly focused on principles which are laid down in the Treaty, thus the "hard" *acquis* - but as well on principles which have been recently developed since the Lisbon and Nice European Council and which belong to the so called "soft" *acquis*. Taking the special focus of this study into consideration, we will now try to seek for answers how the candidate countries will integrate into - or may be even enhance those structures and elements which define our Social Europe today.

A Social Europe

Literature about this topic (Vandenbroucke 2002, Ana Guillén et al. 2001) tend to divide mainly between - on the one hand - a social Europe build by instruments of the "hard" *acquis*: This comprises the application of the fundamental freedoms provided by the Treaty in the social field: the *de facto* integration through the free movement of people, goods, services and capital by the forces of economic competition in an integrated, single (social) market and the *de jure* integration through the direct imposition of market compatibility requirements (within the social sector) by the European Court of Justice.

On the other hand, building a social Europe is being more and more influenced by a new policy co-ordination instrument which belongs to the realm of the so called "soft law/ *acquis*": the open method of co-ordination which has been established by the European Council in Lisbon in March 2000 as the main tool of co-operation in the social area. Since than, the open method of co-ordination is seen as an instrument to close the gap between a market-driven (supranational) Europe and a social Europe which remains primarily in the responsibility of municipalities, regions and the national level of the respective Member states: "Economic performance and social cohesion are not mutually exclusive, but mutually reinforcing objectives, between which a new equilibrium has to be found"(Vandenbroucke 2002).

If one is prescinding from the level of policy instrument, there are clearly also other aspects than the strictly vertically and horizontally ones which contribute to the building and understanding of a Social Europe today: For example, the social integration between relevant stakeholders does not only occur via the central European institutions but consists very often of specific and direct regional constellations with a "variable geometry" of participants.

Another aspect which contributes undoubtedly to a successful implementation of a Social Europe is the growing awareness of national actors and institutions of their European context. Literature refers to a process of "polycentric horizontal Europeanization, in which the horizons of perception and action of national actors are beginning to transcend national borders in the same way as their social contracts." (Streeck 1999). This "Europeanization" is - to a certain extend - interdependent with the introduction of the "soft" EU social policy such as the EU social discourse, EU recommendations or demonstration effects in the fields, for example, of fighting against poverty, promoting social inclusion, closing the gaps in social protection networks (vulnerable groups) and pursuing equity between women and men. Thus, this has led to reinforce civil societies, to enhance the possibility to exert pressure on the part of interest groups and to foster the opportunity for redistribution in many, especially the southern member states (Guillén et al. 2001) in the past and will certainly have their effects on the new member states as well.

Now, at the eve of enlargement of the Union, the history of the integration of ten candidate countries into a Social Europe has still to be written. Nevertheless, we will - at this stage - pick out some of the mentioned elements of a "Social Europe" in the light of enlargement and try to extrapolate - unnecessary to mention that there is still major need for research in this matter.

Elements of the "hard" acquis vis-a-vis "social" enlargement

Implementation of EU regulations: As outlined in the chapters 5.2.1 and 5.2.2., the administrative implementation of the directive 1408/71 is already under preparation in the candidate countries and will be successfully adapted in the mid and long term. At a shorter notice, there might be some obstacles which will mainly be due to administrative capacity problems. This is equally the case for most of the directives issued in the fields of labour and working conditions, equality of treatment for women and men, health and safety at work and public health - although in some cases, candidate countries have negotiated or agreed to transitional arrangements with the European Union. Overall speaking, the accession negotiations have well prepared the candidate countries in the alignment of EU legislation - and on the other hand the candidate countries have made considerably progress in this field. Thus, with respect to the implementation of regulations, the most important effect which might emerge through enlargement in itself, is the fact of a greater number of its members: Administrative procedures tend to get more complex and lead to confusion, the more "players" are involved. One example will illustrate the need to simplify actual EU procedures - and this not because of enlargement - but even more in the light of enlargement: The procedure of 1408/71 in the health care system allows (conditioned) mobility of patients, yet it preserves the internal cohesion of nation systems. In turn, the Kohll and Decker procedure introduces a certain degree of freedom, which, basically is unlimited and might disrupt the internal cohesion of national systems (Vandenbroucke 2002). Consequences of this duality could consist in increasing inequalities in access to health care and problems in guaranteeing a certain quality standard of care of patients - both objectives, which are included (in a positive sense) as objectives in the first preparations of the introduction of the open method of co-ordination in the health sector and which might become one of the cornerstones to measure the success of enlargement in the health sector. Consequently, in the field of EU regulation implementation, enlargement might have a certain pressure for a more consistent and simplified legislation - a task which has been referred to and is currently discussed in the on-going Convention.

Free movement of workers: During the accession negotiations with the European Union, most of the candidate countries have been made familiar with the European internal market rules which have been transposed - or are

on its way to be transposed into their respective national legislation. Therefore, candidate countries are not unprepared - and they are not unexperienced as well: one should not forget that they are already facing market forces since the early 90ies, when borders of the "cold war" were opened up and people started to move: This was for example the case between Estonia and Finland, where a considerable number of Estonian health care professionals immigrated to Finland because of better employment and wage conditions. Many doctors and nurses however returned after 2-5 years abroad - most of them because they wished to work in their language and live in their home country again (Jesse, 2002).

However, this example - as well as many research studies in this field (Brückner 2000, Sinn et al. 2000, Bauer/Zimmermann 1999)¹⁹ - reveals clearly, that enlargement and the membership of countries with a far lower GDP/ per capita as the current member countries encounters a two-fold danger - and this especially in the social field: On the one hand, candidate countries might experience the threat of a "brain-drain", thus might loose an important proportion of their most skilled and educated population. This would then apply also for the health sector and their professionals - and in a second step would affect for example old-age security. On the other hand, current member states - and here especially those with a geographical proximity to the new member states - might face an inflow of migrants which will put a considerable pressure on their respective labour markets and indirectly their social security systems.

The political compromise which has been found vis-a-vis this "enlargement effect" is the following: For the free movement of workers from the new to the current member states, there will be a transitional period of five years, which will be subject to an automatic review after two years. During this transition period, current member states of the Union can either restrict or open their labour markets for citizens of new EU member states on a bilateral basis. Countries experiencing shortages on their labour markets will also be allowed to recruit citizens of new members states on a preferential basis. At the end of the general transition period of five years, the current member states can apply for an additional transitional period of two years in order to further protect their national labour market. Thus, counting the beginning of 2004 as the accession date, restrictions will last at the latest until 2009-11. By then, the situation might have changed: Demographic forecasts indicate that Western Europe will than experience shortages on their labour market, and would welcome migrants as a supplementary workforce. In turn, the labour force in the CEEs will also decline after the year 2010 - because by than, the smaller cohorts of people born after 1989-90 will be leaving secondary school, thus their employment opportunities will rise at home.

¹⁹According to (Bauer/ Zimmermann, 1999), Poland, Romania and Bulgaria show the highest projected emigration rates per year due to the considerable differences in GDP per capita and unemployment rates - Slovenia the lowest projected rate (ca. 2%).

We might therefore conclude that taking this transitional arrangement into account, enlargement would not have any considerable effect in the short run on the mobility of workers - at least not from "East to West". However, in the long run, economists have recognised the potential danger of increased mobility leading to a loss of the tax base - or even to a "tax competition" between member states, as citizens may register their income where tax is the lowest. This again might have the effect that the capacity of certain member states to finance their social programmes will be reduced (Vandenbrouke 2002).²⁰

Free movement of patients: With respect to this freedom of the internal market - the freedom of services in the health care system as the most competitive one within the social systems - the most interesting question in light of enlargement might be: Will we create opportunities by offering new solutions to European patients with respect to the built-in solidarity of our systems, or will we simply export our problems to each other? As outlined in chapter 3 and chapter 5.2.2., the financing of the health care system is the "weak flank" in light of enlargement - thus the major problem we could export to each other. This applies to the candidate countries and their health systems - but it also true for the financing situation in health care in more and more current member states, especially if we take the reality of ageing into consideration. The balance between expenses and the quality of care - which is two sides of one medal - is a very sensible one in each current member state - and possibly a much more fragile one in the candidate countries. If this is the case, than the free movement of patients in an enlarged Europe might even create a higher "Leidensdruck" in the new members states to seek for new and "efficient solutions".²¹

Basic approaches to those "efficient solutions" are already known and partly practised in the current members states - if we think for example of cross-border care in Euregios, which are supported by the Interreg programmes of the European Union: They are aimed to support measures to promote co-operation in health, particularly the sharing of resources and facilities on a cross-border basis. Under the Euregio Rhine-Waal project, for

²⁰ This argument has been used as well when Spain, Portugal and Greece joined the EU - but did not occur in a significant manner in practice. However, this time borders might be longer and average income differences bigger, thus the effect might be lying in the greater size of opportunities.

²¹ From an economic point of view, efficient solutions to provide public goods are discussed for example at the theory of fiscal federalism: The economic theory of fiscal federalism is based on the theory of public goods and concentrates on the regional or geographical scope of such goods. On the basis of allocation (as there are: principle of fiscal equivalence, principle of subsidiarity, provision for regional spill-overs etc.), distribution, short-term and long-term stability, criteria are developed that help to decide whether certain public good should be provided at a more central or more local level.

example, situated in eastern parts of the Netherlands bordering Germany, patients living and insured in Germany have access to certain specialities at the University Hospital of Nijmegen, for which they would have otherwise to travel a much greater distance in Germany (High-level committee on Health, 2001).

Interreg projects will be open to the candidate countries once they are members of the European Union and there are already lots of examples where this practice can be easily adopted or further developed - between new Member states and between new and current Member states - and for the benefit of economies of scale. For example, there are currently negotiations between the border regions in Slovenia and Italy to enter into a cross-border collaboration. The initiative aims at co-ordinating the utilisation of inpatient and outpatient treatment facilities on both sides of the border - the exchange of medical teams, the co-ordination of duty services such as emergency services and other activities to co-ordinate the treatment of Slovenian and Italian patients (Kramberger, 2002). Another cross-border co-operation in the far north of Europe - between Latvia and Sweden - deals with an education programme for people working with mentally handicapped persons and is supported by the EC PHARE programme.

A further example for an "efficient solution" which might be of special interest for the smaller candidate countries, is the idea of establishing "centres of excellence" which has been recently presented by the Chairs of the high level committee on health: "The purpose of centres of excellence is to deal with the problems of uneven health care and outcome in rare and exceptional disorders and to deal with the uneven adoption of new technologies for such conditions. Centres of excellence may also serve as knowledge centres updating and/or contributing to the latest scientific results and implementing them on patients. They may be real institutions accepting patients from all over Europe or in cases of more than one centre for the condition in question from certain parts of Europe" (Chairs, 2002)

As most of the smaller candidate countries would not be able to provide such highly specialised and technology charged medical capacities on a permanent basis on national level, the idea to share especially the financial burden - but also the highly qualified personnel and expertise involved, might be an appropriate solution before the background of the actual scarce resources in those countries.

It might even be the case that the development of such "efficient solutions"- and thus in a way the implementation of a new quality of "variable geometry" into practice - will be more accelerated in the future and after enlargement because the number of smaller countries within the Union will increase: With Estonia, Latvia, Lithuania, Slovenia and - in a limited way Malta and Cyprus (islands without direct border), six out of ten of the candidate countries can be considered as small - and might be frontrunners

for new and closer co-operation forms in the social sector in Europe²² - as for example citizens of Luxemburg and the Netherlands has become in a certain way for the health policy of the EU 15 in the past.

Impact of the economic and budgetary policies of the EU: Budget policies and the principles of the Stability and Growth Pact have indirect impact on the financing of the national social security systems of the Member states: Sound and sustainable public finances are a *conditio sine qua non* for a sound and sustainable social policy - this especially in the light of our ageing societies. However, the focus on financial prudence always carries a certain danger for the social sector: In order to lighten budgetary burdens, national governments tend to shift costs to the private sector. This is already the case in many of the current member states - but might become especially the favoured strategy in the candidate countries once they are members and once they will start to prepare for membership of the monetary union. Consequently, as the private social sector is usually run by benefit-oriented market rules, values such as equal access and quality might become less important - or at least less financially feasible. Here once again - as to balance the trade-off between quality in social investments and the costs for social investments, "efficient" solutions might be the only way out (Vandenbroucke, 2002).

Or - as future members of the monetary union facing the stability criteria - new member states might find themselves in the same situation as currently some very prominent old member states, asking to soften the stability criteria. In this respect, "social enlargement" - in the long run - might also initiate a discussion within the European Union to re-think about the balance between its financial and its social politics.

Impact of voting rules: The requirement of unanimity in the Council for important areas of social policy - and this especially in the realm of social co-ordination (Hanau/ Steinmeyer/ Wank, 2002) - entails the risk of paralysis of decision-making in the social field. This is already today the case with 15 Member states and will even be more virulent with a European Union of 25 Members. Thus, with respect to decision-making procedures within the social field, the most important effect which might emerge through enlargement in itself, is the fact of a greater number of its members: But even if the unanimity rule will be abandoned in favour of a qualified majority voting at the next Intergovernmental Conference, it is clear that a broad coalition of the candidate countries, possibly supported by one or two of the current Member States, could easily block decision-making. To counteract such a possible "East-West fractions" situation, it will be of utmost importance that candidate countries will receive appropriate financial support to continue their reforms of the social systems - and this beyond the

²² An interesting idea for the field of securing old-age pensions might be for example that smaller countries like the Baltic states could share the administration of their old-age security systems/ pension funds.

accession date of 2004.²³ However, 2004 - 2006 might become critical years - as the "Berlin financial framework" will only expire at the end of 2006 - and transitional payments as well as the "Institution Building Facility" does not seem to be especially dedicated to fields such as social inclusion, public health, a sustainable health and social protection system and health and safety at work. Candidate countries might even face a decrease in their net position from 2003 to 2004.²⁴

The open method of co-ordination in an enlarged single (social) market

Since the summit of Lissabon in March 2000, the open method of co-ordination is seen as a new instrument of the "Social Europe" and can be defined as follows: "The open method of co-ordination is a process whereby common objectives are fixed at the EU level. Progress in the Members States towards achieving these objectives is determined through indicators"(Busse 2002) and bench-marking systems and should enable EU member states to compare practices and learn from each other. This method respects local diversity and is flexible - and it aims to promote progress in the social sphere: in the field of social exclusion and poverty, employment, pension and health care. Whereas the institutional set-up to introduce this method to the latter sector is currently on its way - the institutional set-up for all other mentioned fields is already in place.

Candidate countries are in general well prepared to take part in the open method of co-ordination. If we look at the direct co-operation between the European Commission and the candidate countries, we can state that in particular in those fields where intensified co-operation among the EU member states has been developed during the last years, namely in the field of employment and of poverty and social exclusion, the co-operation between the candidate countries and the European Commission is quite advanced as well.

²³ See also (CEPR, 2002): "Most of the conditionality that has been imposed on candidates in the course of the accession process is concerned with the *acquis communautaire* of product quality standards and health and safety regulations. This is legitimate since such legislation is essential for the single market to operate effectively. But ensuring appropriate welfare standards in the CEECs is equally important. (...) ..following accession, newcomers cannot be treated differently from other members". The authors of this paper go even further: (page 17) "one way of discouraging the CEECs from using beggar-my-neighbour policies is to use the process of Eastern enlargement to ensure that on joining the EU, they have an appropriate level of social protection."

²⁴ See (Mayhew 2002): "When the first year of membership of these countries is considered, the risk of short-term financial instability appears to be considerable". The author mentions also another interesting point in this respect (p.3): "For the candidate countries, the issues of equality of treatment and no distinction between old and new members of the Union are at least as important as the level of transfers they will receive. With the need to win referenda on accession, they cannot afford to agree to a clearly unfair settlement with the Union."

Open co-ordination and employment

Since 1999 co-operation in the area of employment has started: the so-called Joint Assessment Papers – JAPS – include a review of the employment situation and identify priority areas of reform – these papers are drafted by national authorities and the Commission. The synthesis report on employment for the European Council in spring 2003 will include developments in the candidate countries for the first time.

Open co-ordination and social inclusion

Since 2002 – co-operation in the area social inclusion between the European Commission and the candidate countries has started as well. A number of workshop between national governments and representatives of the Commission have been held from April 2002 onwards this year. Following these meetings, so-called Joint Inclusion memorandums are currently drafted for a number of countries. The objective is to sign such a memorandum with each of the candidate countries before accession. The statistical offices in the respective countries are in contact with Eurostat and are working on collecting data for the 18 indicators developed. Once the candidate countries will become members, they will fully participate in the five-year action programme of the EU to encourage co-operation between Member states to combat social exclusion, which has been launched at the beginning of 2002. This action programme is aimed to support and monitor the achieving of the objectives agreed for the open method of co-ordination.

Open co-ordination and pension

Regarding pensions and the open method of co-ordination, the Council agreed in December 2001 on 11 common objectives and a working method which involves producing national strategy reports on the future of pension system by September 2002. These common objectives refer to the adequacy of pensions, the financial sustainability of pension systems and their modernisation in response to changing societal needs. For instance, the first common objective states that Member states should ensure that older people are not placed at risk of poverty and can enjoy a decent standard of living; that they share in the economic well-being of their country and can accordingly participate actively in public, social and cultural life. Before the background of some of the country reports of this study, this objective might become one of the crucial points, once the candidate countries will fully join the open method of co-ordination in this field. It is foreseen, that - depending on the further development of comparable data bases in the pension field - candidate countries will be integrated into the synthesis report in 2003.

Open co-ordination and health care

The European Commission has just recently launched a new initiative on this topic. However, Member states and their relevant institutions in this field are still quite reluctant to participate in the open-co-ordination in health care. Many researchers and concerned stakeholders state that data and

"information on health care presently available in the Member States is not sufficient for the open method of co-ordination" (Schneider 2002). This applies especially to the possible objectives which are currently discussed: "achieving a high population health status", "designing and functioning of health systems according to justified population health needs and expectations", "access to needs-based and effective health technologies" and "assuring a fair and sustainable financing" and which should than be used to compare the different systems. In the light of enlargement, this discussion becomes an even more difficult focus: Most of the Candidate Countries have just recently started to adapt their existing health statistics to the European standards and most data - which are already difficult to access in some old Member States - are not available. In addition to this more technical problem - some of the recent PHARE Twinning projects as in Hungary are focusing on this aspect - another more political aspect has to be taken into consideration: Given the financial problems within most of the candidate countries health systems, the danger to compromise only on the lowest possible standards and objectives has become more apparent in light of enlargement.

In Conclusion: Candidate countries already today take part in the open method of co-ordination. Although this is mainly accession-driven, Candidate countries have definitely one advantage: They participate already at a stage, where re-structuring of their social systems is still in process - which is from an economical point of view more efficient. While in old Members states, the possibility to access new data and to implement monitoring systems - which will have an indirect impact on the functioning of the social systems itself - is sometimes limited and hindered by the different involved stakeholders and pressure groups of the systems - and thus often more expensive to change as well, the candidate countries have the historical chance to establish a system of co-ordination and implement quality indicators in their respective systems all at once. They could even become the frontrunners of an enlarged Europe with respect to the technical requirements.

However, one might also take into consideration that the enlargement of the EU to 25 member states will certainly make the process of monitoring and evaluation in the open method of co-ordination more complex, opening up the risk that this may lead not only to output inefficiency, but also to actor frustration.²⁵ This trend is further amplified by the inevitable temporal and personal overlaps between the various ongoing processes themselves (Ferrera/ Hermerijck/ Rhodes, 2000). Therefore, the practical handling of such a process with 25 governments will require simplification of the process - including the revision of its frequency.

²⁵ This refers to the "deepening-for widening" argument.

With respect to the more political requirements of the open method in light of enlargement, one potential weakness of this method has to be discussed as well: The open method of co-ordination is an intergovernmental collaboration which is highly dependent on the respective political constellation of social ministers of the Member states. Thus, as it is not part of the formal *acquis*, things can change and other political constellations, especially in the new Member states, which might favour other fields of politics after accession, could endanger the quality of outcomes of the open co-ordination - or even the validity of the soft *acquis* as a whole. Therefore, given the ambition to establish a coherent and simplified new Treaty within the on-going Convention, one might argue to include the open method of co-ordination as one of the formal instruments of the Union - in light and because of enlargement.

Soft and open co-ordination seems to be a promising institutional mechanism for advancing on all the "grey areas" of a common Social Europe: if it can be made to operate at its best - the whole process may create an optimal mix between "Europeanization" and nationalisation in an enlarged Social Europe.

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