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# What the European and American welfare states have in common and where they differ: facts and fiction in comparisons of the European Social Model and the United States

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**Abstract** The classification of the American welfare state as 'residual' does not square with the empirical facts. The US system is dominated by public provisions for welfare among which social insurance programme, particularly Social Security and Medicare, clearly predominate, while public pensions are more universal, redistributive and generous than in some European countries. Key differences persist with respect to a stronger reliance on private provisions in pensions and health, a stronger emphasis on work-conditioned benefits and a greater importance of selective schemes. The term 'work-conditioned' welfare state captures some of these key features more adequately than the concept of the 'residual' welfare state. EU member states have not converged towards the US; private welfare spending increased without catching up, and the relative importance of selective benefits shrunk in most countries. There is some convergence on the level of policy discourse, where the idée directrice of European social policies has changed from social protection to activation, whereas the US is moving closer to Europe with respect to health care and the acceptance of state responsibilities.

**Keywords** European social model, Americanization, public and private welfare, policy learning, third way debate

## Introduction

Europeans like to pride themselves on having a unique social model that combines economic efficiency with social solidarity. Even those who are fully aware of the remarkable diversity of social models within the EU usually agree that European nations fundamentally differ from those in other regions of the world, particularly from the US, and particularly with respect to their social policies. Even though not entirely uncontested,[1] this notion is deeply engrained in a body of social science literature as well as in much of current political thought.

Many scholars agree with this view. In his book *EU enlargement versus social Europe?* published in 2003, Vaughan-Whitehead claimed: 'Despite the disparities between social protection systems, a number of basic features are shared by EU member states, such as universal social protection (at least to a certain extent), solidarity, combating social exclusion, and so on' (p. 111). He also added: 'Nothing similar to the European Social Model can be found in other parts the world. The model is quite distinctive, rooted in shared values that have not been replicated anywhere else so far. In particular, it differs from policies and developments in the US', 'and' – as he continued with a

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noteworthy twist of his argument – 'the United Kingdom' (p. 23).

The idea of a stark contrast between Europe and the US was perhaps expressed most bluntly in a phrase by an Irish sociologist who frequently served as an advisor to European trade unions when he stated: 'The simplest difference between the USA and Europe is that we have welfare states, they do not' (Wickham, 2002: 1).[2] In its Memorandum on *The new social Europe* the Party of European Socialists (2006: 7) expressed a partly similar idea stating: 'Indeed, the EU is a unique grouping of welfare states, based on our conviction that social inclusion and economic performance can go hand in hand. The European Social Model exists as a social reality and as a set of shared values. Europe's welfare states have much in common, distinguishing them from other world regions'.

The notion of strong differences between Europe and the US is by no means unique to Europeans, but shared by many American scholars. Examples include not only Lipset's theory of 'American exceptionalism' (Lipset, 1996; Lipset and Marks, 2000), but also welfare state researchers such as Skocpol (1992). In her historical study of the American welfare state entitled *Soldiers and mother*s she wrote: 'Despite the desire of many scholars to view its social policy history in universal evolutionary terms, the US has never come close to having a "modern welfare state" in the British, the Swedish, or any other positive Western sense of the phrase... No comprehensive American welfare state emerged from the New Deal and World War II. Nor was any such welfare state "completed" during the next "big bang" of US social policy innovations, the War on Poverty and the Great Society of the 1960s and early 1970s' (Skocpol, 1992: 5).[3]

Last but not least, the notion of a big difference between the welfare states in Europe and the US is rooted in the much-cited welfare state typology of Esping-Andersen (1990) in which the US is classified as a liberal or residual welfare state. In this type of welfare state means-tested assistance, modest universal transfers and modest social insurance plans are said to predominate, so that the welfare state caters essentially to the working class and the poor, while private insurance and occupational fringe benefits cater to the middle classes (Esping-Andersen, 1990: 26, 31). The typology implies that the American welfare state is a laggard, both in the sense of arriving late on the historical stage, and of providing only limited benefits of a less generous magnitude up to the present. Compared to European nations, which are said to adhere to the 'European social model', the US is thus characterized as an opposite polar type representing a different kind of social model.

Some American scholars have taken issue with this notion, arguing that the American welfare state is 'misunderstood' (Marmor et al., 1990), that it is different rather than incomplete (Glazer, 1988) and that there is a 'hidden welfare state' of tax benefits and mandatory private schemes in the US of which European scholars barely take notice (Howard, 1997). In his more recent book *About the welfare state nobody knows*, Howard (2007) highlighted the vast recent growth of American social programmes that European scholars tend to overlook in their search for counterparts of European schemes in the US. Gilbert (2002) even argued that, far from being a laggard, the American welfare state should actually be seen as the harbinger of the future, leading European countries on the way to an 'enabling state' that empowers people by making them self-reliant.[4]

This article takes a synthetic look at the similarities and differences of social policies in Europe and the US in three steps. Firstly, I will outline some key characteristics of the American welfare state. Secondly, I will analyze if recent developments signal convergence in the sense of an 'Americanization of European social policies' as claimed by Gilbert. In a third step, I conclude that even though relevant differences remain, the US and Europe have far more in common than the traditional distinction between 'residual' and 'institutional-redistributive' welfare states suggests. Disregarding differences in welfare state financing[5], we will focus on the expenditure side and also more on transfers than on services, which are more important for some new social risks but would deserve a special comparative analysis.

## The misperception of the American welfare state as 'residual'

### *Key characteristics: gross and net social spending*

The argument that the American welfare state is different rather than incomplete has in recent years

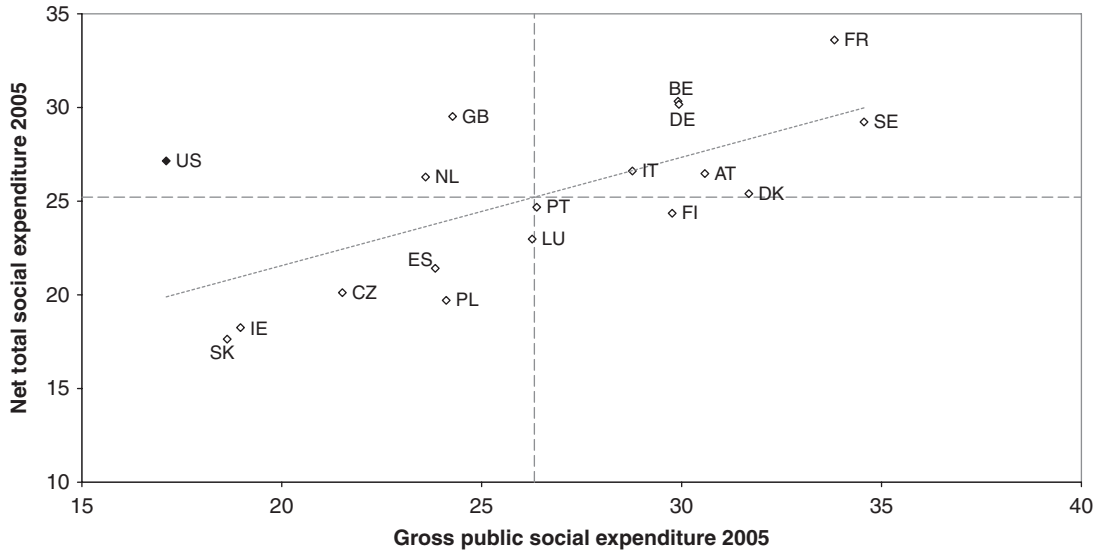


**Figure 1** Gross and net social expenditure for 2005 in percentage of GDP at factor cost
*Source*: Based on OECD (2008): Social Expenditure Data Base

been promoted most forcefully by the Organization for Economic Cooperation and Development (OECD) in Paris, where Adema and Ladaïque (2005) have made an admirable attempt to track more comprehensively what welfare states actually do by distinguishing between gross and net social spending. The former yardstick is traditionally used in welfare state comparisons based on social outlays, the latter takes four additional aspects into account, namely that: (1) welfare states frequently claw back what they spend by taxing benefits; (2) there are indirect tax benefits that support groups by granting them certain exemptions or privileges in taxation; (3) governments may mandate private employers to provide certain benefits; and (4) there are varying degrees of voluntary social activities, such as private charity.

Once the impact of taxes and publicly mandated schemes is taken into account, the US no longer falls far behind most European countries, but moves closer to the middle of the pack, becoming almost indistinguishable from such European countries as Spain, the Czech Republic, Poland or The Netherlands and ahead of Ireland and Slovakia. If voluntary private spending is included, the US even moves far above the European average of social spending and belongs to the group of the most lavish social spenders, topped only by five European countries (France, Belgium, Germany, Sweden and the United Kingdom – Figure 1). This, of course, has dual and ambivalent policy implications. On the one hand it suggests that the US does not represent a socially unbridled form of pure capitalism, but is rather similar to European countries that pride themselves on the social elements they add to the market economy. On the other hand, it also means that a limitation of welfare state responsibilities does not liberate society from social costs. Social risks that are not or no longer provided for by the state impinge either on firms – which have to provide occupational welfare – or on private households, which have to carry the costs from their private purse thus curbing their disposable income. Consequently, social costs accrue anyhow, but they are merely borne at another level, which usually implies that they are less equally distributed than in the case of public schemes with universal coverage (Alber, 2006; Alber and Gilbert, 2009).

Differences in the composition of social spending become further evident if we take a closer look at the two biggest spending social programmes,

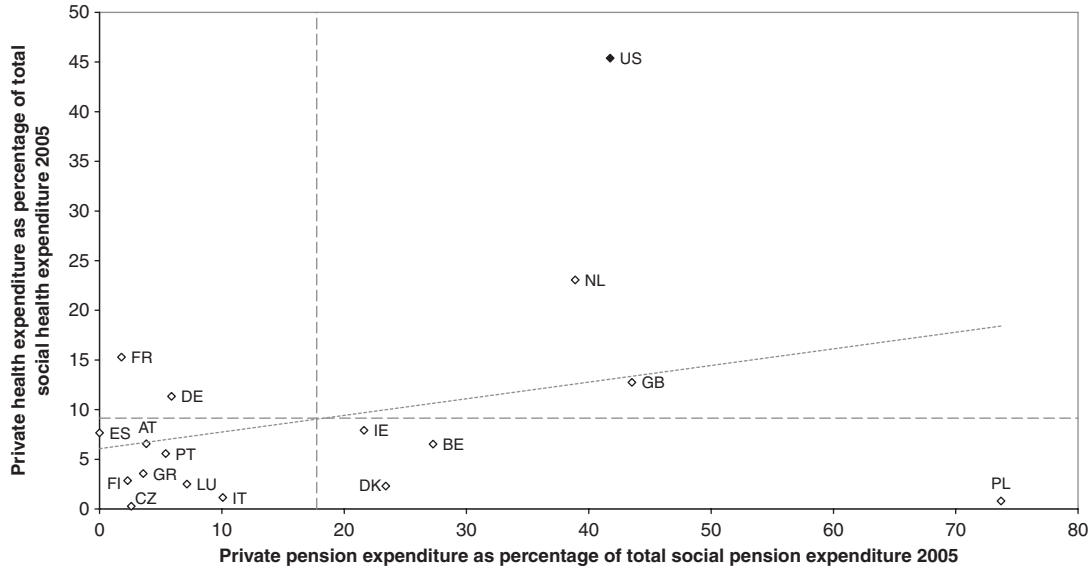


**Figure 2** Private share of social expenditure for pensions and health, 2005
*Source*: Own calculations based on OECD (2008); Social Expenditure

i.e. pension and health insurance schemes (Figure 2). The US is the only country that stands apart in both dimensions for its high share of private spending in 2005. With respect to pensions, most European countries limit the private share to less than 10%, and The Netherlands and the United Kingdom are the only European nations that come close to the American level of private spending. In health care spending, the private share in the US is more than twice as high as in The Netherlands, which stands out as the European frontrunner.

The high levels of private spending are due to the fact that most American workers belong to employee benefit schemes tied to their workplace. Thus, in 2008, more than half of all civilian employees participated in an employer- or union-provided retirement programme, while also more than one half had employment-related health benefits (Table 1). In medium and large establishments coverage ratios are even close to two thirds. Compared to the situation in the 1980s, there is, however, a drastic decline in the percentage of covered employees, as well as a massive shift from defined benefit schemes to contribution defined occupational retirement plans, a trend that Hacker (2006) has described as the 'great risk shift'. In sum, we see that private schemes are of greater importance in the US, but in addition, there are also important differences in the composition of *public* social spending.

### *The exaggerated bifurcation into universal and residual programmes in the US*

According to the concept of the 'residual' welfare state, American public social policies are bifurcated into a rather limited social insurance branch for the middle classes whose less generous benefits leave ample leeway for the private insurance sector, and a rather big selective welfare branch with targeted benefits for the poor who belong to certain 'deserving' social categories – such as the blind, the disabled or the children of poor people – who pass rather ungenerous means tests. Serving the well-organized middle classes, the former are said to be fairly backlash prone, whereas the latter are supposedly more likely to become subject to curtailments. An inspection of the composition and growth of social spending in these categories helps to clarify to what extent this image is an appropriate characterization of the American welfare state.

**Table 1** Participation rates in employee benefits in the US, 1980 and 2008

| | *Health benefits* | | | *Dental benefits* | | | *Retirement plans (all types)* | | | *Defined benefit retirement plans* | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Total* | *Private sector* | *Public sector* | *Total* | *Private sector* | *Public sector* | *Total* | *Private sector* | *Public sector* | *Total* | *Private sector* | *Public sector* |
| **1980** | | **97*** | | | | | | | | | **83*** | |
| **1986** | | **95*** | **94*** | | | | | | | | **76*** | **93*** |
| **1994/95** | 61 | 58 | 79 | 37 | 34 | 58 | 57 | 51 | 91 | 36 | 28 | 86 |
| **2007** | | 52 | | | 36 | | | 51 | | | 20 | |
| | | **62*** | | | **49*** | | | **66*** | | | **32*** | |
| **2008** | 56 | 53 | 73 | | | | 56 | 51 | 86 | | | |
| | **67*** | **65*** | **74*** | | | | **72*** | **67*** | **88*** | | | |

*Source*: US Department of Labor (2008), Bureau of Labor Statistics: Employee Benefits in the US; eds. 1980, 1988, 1994/95, 2007, 2008. Consistent time-series are not available; the 1980 and 1986 surveys covered only medium and large firms in the private sector; data since 1994/95 refer to all establishments (bold and with asterisk symbol: only establishments with 100 workers or more). The difference between 'health insurance for participant' and 'non-contributory' schemes provided at no cost to employees is no longer made consistently in later years; the percentage of workers with non-contributory health benefits in 1980 was 72%; in 2007 24% of participating employees were in schemes not requiring an employee contribution; since a total of 52% participated, this would mean that 12.5% did not have to pay contributions, as compared to 72% in 1980.

*Reading examples*: The percentage of workers in medium or large private industry firms (100 workers or more) who participated in retirement schemes with defined benefits declined from 83% in 1980 to 32% in 2007. The percentage of workers covered for major medical benefits in private sector establishments of comparable size decreased from 97% in 1980 to 65% in 2008. Major medical benefits usually include hospital care, but frequently not dental care as illustrated by the data for 1994/95. Data on participation should not be confounded with the much higher data on access, because not all workers who have access decide to actually take up the benefit.

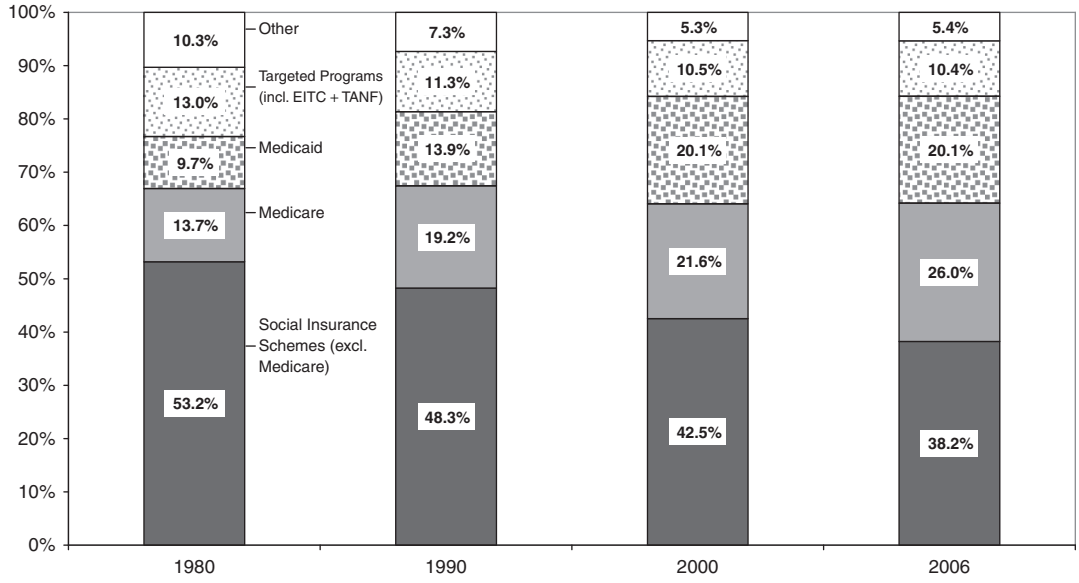


**Figure 3** The distribution of transfer payments by type in the US, 1980–2006
*Source*: Own Calculation based on Statistical Abstract of the United States 2009 (Tables 512 und 645)

Figure 3 shows what proportion of total transfer payments went to specific schemes. This reveals that the American welfare state is clearly dominated by social insurance schemes, which comprise above all two big schemes for elderly persons, i.e. Social Security and Medicare. Together with more minor programmes, such as unemployment insurance and workmen's compensation, these schemes devour about two thirds of social spending. Over time their share remained fairly stable, decreasing only slightly from roughly 67% in 1980 to about 64% in 2006. As the bulk of the American welfare state budget is thus spent on social insurance schemes incorporating the middle classes, the label 'residual' does not adequately represent the American system. Including the Medicaid scheme and, particularly due to its steep recent growth, the share of targeted schemes for the poorer part of the population, including the Earned Income Tax Credit (EITC or EIC), increased from roughly 23% in 1980 to over 30% in 2006. Even though they are targeted at the poor, both Medicaid and the EITC have enjoyed widespread political support that sustained their growth. Disregarding Medicaid, whose coverage has been successively widened, the share of selective schemes would have declined from 13% to slightly over 10%. The 'Other' category, which includes categorical schemes for specific groups such as veterans' benefits, decreased in relative importance.

The development of the single component programmes is better illustrated by their changing GDP shares (Figure 4). Disregarding Medicare, the various social insurance schemes have grown more slowly than the GDP over recent decades, while the Medicare and Medicaid schemes saw over-proportionate growth. Together they have now by far overtaken all other social insurance schemes combined, while the selective programmes, other than Medicaid, remained limited to roughly 1% of the GDP. Health-related expenditures have thus been the main drivers of change, regardless of whether they were more selectively targeted on the poor, as the Medicaid programme, or more universal in design, as the Medicare scheme, for the elderly population. Broadly based social insurance schemes – Social Security and Medicare – thus continue to represent the lion's share of the American welfare state, and in this respect the US is similar to European welfare states, which are also increasingly dominated by pension and health expenditure.

Attempts to contrast the 'European Social Model' with the US usually refer to three more fine-grained

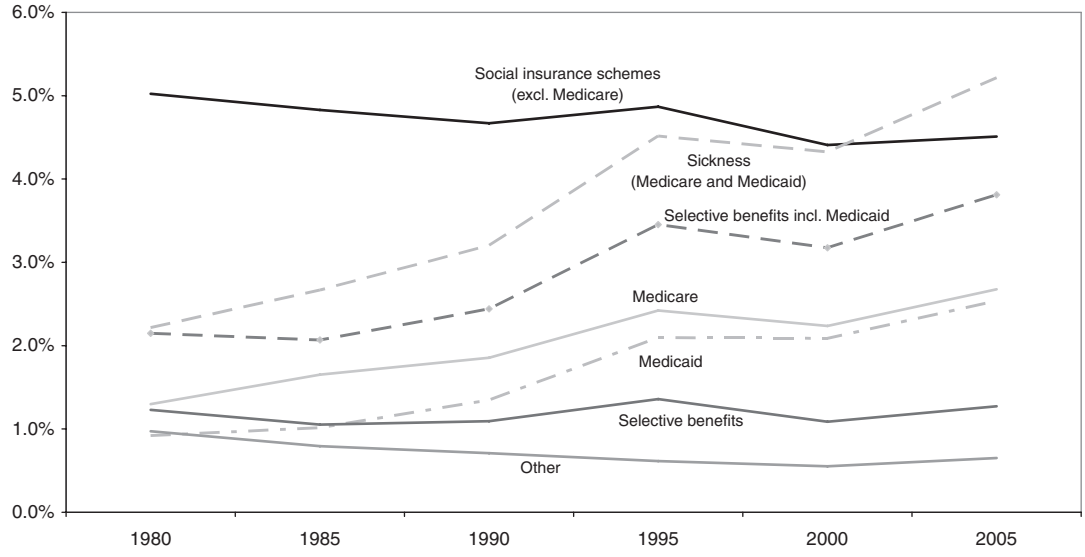


**Figure 4** GDP shares of various transfer programs in the US, 1980–2005
*Source*: Own Calculation based on Statistical Abstract of the United States 2009 (Tables 521 and 645)

characteristics, which frequently boil down to stereotypes in European perceptions of the US. The first two stereotypes hold that the American welfare state lacks two schemes that European welfare states typically have – a public health insurance programme and a minimum income scheme effectively safeguarding against poverty – while the third one claims that its biggest programme, public pensions, is supposedly less generous and of much more limited size than its European counterparts.[6]

### *More specific comparisons with respect to three widely held European stereotypes*

The most widely held European stereotype concerning American social policies is re-iterated almost daily in the press and claims that the US does not have public health insurance so that there are huge gaps in health care coverage. This is certainly true in the sense that there is no universal sickness insurance scheme, but several qualifications are in place. The US health care system basically consists of four tiers: (1) Medicaid for the poor population below an income limit; (2) Medicare for the elderly; (3) employment-related health care plans for people in the labour force (with special plans for people in the armed forces); (4) a rather large group of people below retirement age without any insurance coverage.[7] It is noteworthy that despite the gaps in coverage, the US spends a similarly high GDP share on *public* health care programmes as high-spending European nations. The three leading sources on comparative health care spending – the OECD Social Expenditure Database (OECD, 2009a), the Classification of Functions of Government (COFOG) Database (Castles, 2009; Fraser and Norris, 2007) and the World Health Statistics published by the World Health Organization (2008) – differ with respect to details, but they all lead similarly to the result that public outlays on health care are *higher* in the US than in most EU member states.[8] Taken together, the two major American public health care programmes – Medicare for the elderly and Medicaid for the poor – now spend almost just as much as the statutory sickness insurance scheme of the European country with the oldest public health insurance scheme in the world, i.e. Germany (where the public insurance scheme dates from 1883). In 1990, Germany's sickness insurance scheme still spent almost twice as much as the two American public programmes (6.0% compared to 3.2% of the GDP), but in subsequent years the US closed up so that spending levels in the two countries were almost on par in 2006 (6.0% in Germany, 5.4% in the US).

Once again, this is a finding with ambivalent policy implications. On the one hand and contrary to the image of a residual welfare state, we see that the US spends more on public health care than most European countries. On the other hand, at a similar level of spending, the German sickness insurance scheme achieves wider coverage, insuring almost everybody in dependent employment as well as the pensioner population, and it also provides more comprehensive benefits, including hospital, ambulatory and dental care. If the more restricted Medicare and Medicaid schemes in the US now approximate the same level of spending, this is above all due to the higher *cost* of medical services in America (Peterson and Burton, 2007). In addition, extensions of coverage also played a role, however. The Medicaid programme was continuously opened to additional groups so that the number of children covered doubled from almost nine to almost 19 million between 1980 and 2000. Since the late 1990s, practically every second birth in the US has been paid by Medicaid (Howard, 2007: 98, Table 5.1, p. 97).

Yet the large and growing number of people who are uninsured must be considered the major weakness of the American health care system. The percentage of uninsured Americans increased from barely 12% in 1987 to above 15% in 2007.[9] Roughly 46 million Americans are presently without health insurance coverage (US Census Bureau, 2008). As a consequence of the segmented organization of the health care system there is also a marked income gradient in health insurance coverage: Only 8% of people in the high-income category ($75,000+) are uninsured, compared with 25% of people in the low-income category (with a household income below $25,000) (US Census Bureau, 2008: 22). This indicates that the Medicaid scheme falls short of covering the entire poor population. A report by Families USA (2004) highlighted that, contrary to popular belief, Medicaid does not provide coverage to most workers in low-wage jobs. As eligibility standards vary widely from state to state, a parent in a family of three working full time all year at the federal minimum wage would earn too much to qualify for Medicaid in half of the states.

It must be noted, however, that people without insurance are not necessarily permanently or chronically uninsured in the US. Given frequent moves into and out of unemployment in the flexible American labour market (Freeman, 2009), there is actually considerable turnover in the uninsured population. Estimates of the proportion of people who are permanently uninsured vary widely between one third and four fifths, depending on the method of the study. A panel study based on data for the periods 1987–1989 and 1990–1992 found that the typical uninsured spell lasted roughly eight months for the uninsured poor and roughly six months for the uninsured non-poor. It concluded that one third (32%) of the uninsured of the 1990 panel had uninsured spells that lasted longer than one year (McBride, 1997).

Cross-sectional surveys or studies working with recall data usually arrive at higher estimates. Based on the Census Bureau's Survey of Income and Program Participation (SIPP) in 2002 and 2003, the report by Families USA (2004) showed that the number of uninsured Americans is higher than the Census Bureau's data suggest once the focus is shifted from those without health insurance in the previous calendar year to those who were without insurance for all or part of a two-year period in 2002 and 2003. Approximately 82 million people – or 32.2% of those under the age of 65 – were without health insurance for all or part of these two years, and among these two-thirds (65.3%) were uninsured for six months or more (Families USA, 2004).[10]

In sum, public health care is not entirely absent in the US, and Europeans may overestimate the permanence of gaps in insurance coverage. However, the comparatively high level of public health care spending in the US does go together with a comparatively wide gap in health insurance coverage, despite the existence of various public and employment-related schemes, and in this sense there is an American paradox of high spending coupled with low coverage.[11]

A second widely shared stereotype holds that the US has only a very limited public pension scheme, as public programmes must leave sufficient leeway for private insurance companies catering to the needs of the middle classes. This image was firstly transmitted by Esping-Andersen (1990) and was later reiterated by scholars and journalists alike.[12] Crude comparisons of the GDP shares of public pensions seem to sustain this notion, as the old age pension expenditure ratio in the leading European countries – Austria (12.6%), Italy (11.6%) and Germany (11.2%) – is more than twice as high as the American

**Table 2** Pension levels in the US and Germany, 2006

| | *USA* | *Germany* |
|---|---|---|
| **Average monthly benefit for retired worker** | **$1,044** | **€805.61** (per person)[a] *($923.57)* |
| **Average for retired couple (worker and wife)** | **$1,726** | |
| **German net 'standard pension'** (if 45 years of insurance and life time average earnings) | | **€1067** (West – net) *($1223.36)* **€1176** (West – gross) *($1348.34)* |

*Sources:* US: Statistical Abstract of the US, 2009: Table 526.
Germany: Rentenversicherungsbericht, 2008: 18–19.
*Note*: Conversion rate German € in international dollars at PPP: 1.1465455
[a]2007: the average per each individual pension case is €718.20 *($823.45)*

one (5.3%), which has been stagnant in recent decades. A closer examination reveals, however, that the different GDP shares of pensions in Germany and the US are not the consequence of the more generous design of the German scheme, but above all of the different demographic and economic situation in the two countries. In 2007, the percentage of elderly people aged 65 or older was 20.1% in Germany, but only 12.6% in the US. On the other hand, the American GDP per capita, measured at purchasing power parities, was 137% of the German level in 2006. In other words, the GDP share of pensions in the US is calculated on the basis of a smaller numerator due to a much smaller number of people above retirement age and of a larger denominator. If all factors were equal, one would expect the German GDP share of pensions to be at only 63% of the present level on account of the smaller numerator and 37% smaller on account of the larger denominator. Both aspects combined would mean that the German GPD share of pensions would shrink from 11.2% to 5.1%, i.e. below the American level if the demographic burden and the level of economic affluence were identical.

If we look at the institutional regulations, the available comparative data collections show the earnings replacement schemes of the American social security scheme to be on the lower end, but within the range of the distribution of European countries (OECD, 2009b; Scruggs, 2005). Compared to the oldest programme in Europe, the German public pension scheme, it is in fact more universal in coverage, more redistributive in its benefit formula where replacement rates vary inversely with earnings,[13] and similarly generous with respect to the level of benefits – depending on the exact measure – as its German counterpart.[14] In order to give a more vivid impression of the magnitudes involved than the replacement rates usually found in comparative collections, Table 2 reports the absolute level of public pensions in Germany and the US. Measured at purchasing power parities in international dollars, the average pension in the US is 13% higher than the average pension (per person) in Germany. Even the so-called German 'standard pension', which a model retiree receives after having worked for 45 years at average earnings, is lower than the average retirement income for American couples. Most German retirees receive much less than this 'standard pension', however, because they have worked for shorter periods (men 41 years, women 29 years on average) or had earnings records below the average.[15]

A third stereotype holds that the US lacks an important element of social citizenship as it does not have a general social assistance scheme that would entitle everyone to a minimum level of subsistence. Examining this notion in a cross-national perspective, Saraceno (2009) recently showed that minimum income schemes cannot be considered a vital element of the European social model as they do not exist in all EU member states either. The existing American poor relief schemes do deviate in several respects from their European counterparts, however. Firstly, not all indigent people can make a claim to poor relief in the US, as benefits are usually reserved for certain 'deserving' categories such as mothers, or blind or disabled persons, whereas the able-bodied people at working age are expected to support themselves. Hence both classical 'welfare' programmes, the Aid for Families with Dependent Children (AFDC) scheme and the Temporary Assistance

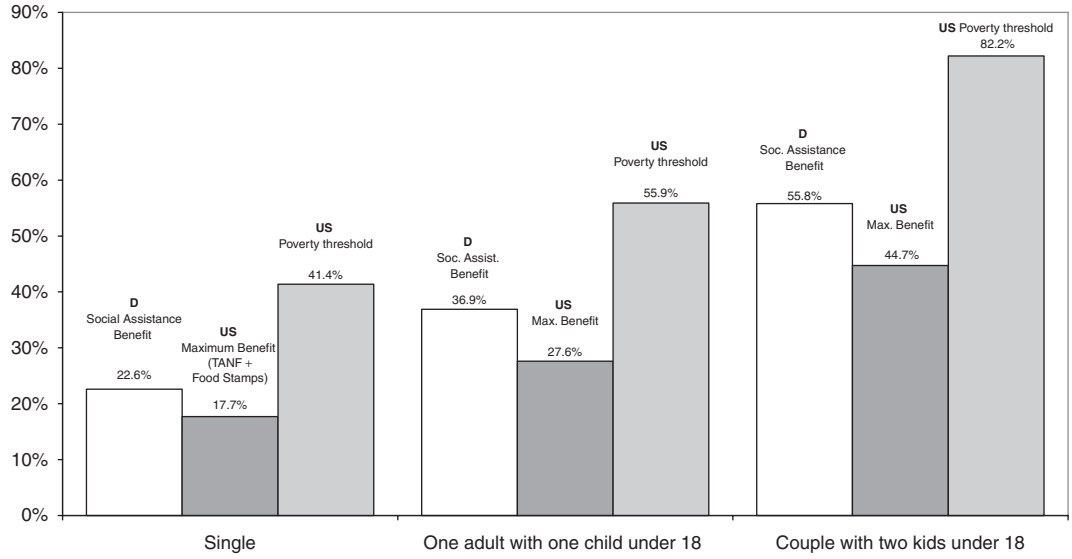


**Figure 5** The position of the American poverty threshold and of poor relief benefits in the US and in Germany in the national income distribution (expressed as a percentage of the median equivalent household income), 2003

*Source*: Own Calculations based on: USA: Green Book (online:http://www.census.gov/hhes/www/povertythreshld.html) and PSID (disposable income weighted by square root of hh-size). DE: Bundesministerium für Gesundheit und Soziale Sicherung (social assistance standard rate plus housing subsidies and single payments) and GSOEP (disposable income weighted by square root of hh-size)

for Needy Families (TANF) scheme that replaced it were targeted at families with children. Secondly, benefits in kind, such as Food Stamps, and work-conditioned benefits, play a more prominent role than in Europe (Blank, 2009). Thirdly, American welfare benefits were never designed to push people above the official federal poverty line, but are merely meant to supplement other sources of income, while the generosity of benefits varies widely from state to state where the payment standards usually fall short of the need standards defining eligibility. It is true that the EU member states do not make the statistical poverty line – i.e. the at-risk-of-poverty threshold drawn at 60% of national median earnings – the basis of an entitlement to minimum subsistence either, as national benefits are well below this level (Saraceno, 2009), but the American poverty line (which varies with household size) is drawn at a much lower level corresponding to only about 40% of the median national equivalent income for singles. A comparison of the rates in the German social assistance scheme and the combined rates of the TANF and Food Stamps programmes illustrates the difference: welfare entitlements in the US remain not only far below the official poverty line, but are also stingier relative to the national median equivalent income than in Germany (Figure 5).[16]

The more limited character of poor relief in the US must be seen in combination with two other factors, however. Firstly, the US has a legislated minimum wage, and secondly, wages in the low-wage sector are supplemented by the EITC, which grew sizably over the past two decades. The development of the federal minimum wage, which may be modified by state legislation, is shown in Figure 6. As the rates are not indexed for inflation and remained unchanged for almost a decade, the real value of the minimum wage declined by one third between 1980 and 2006. The three subsequent years then saw annual increases, and in 2009 the federal minimum wage stood at $7.25 per hour.[17]

While the minimum wage decreased in real terms, the EITC aimed at making work pay was considerably

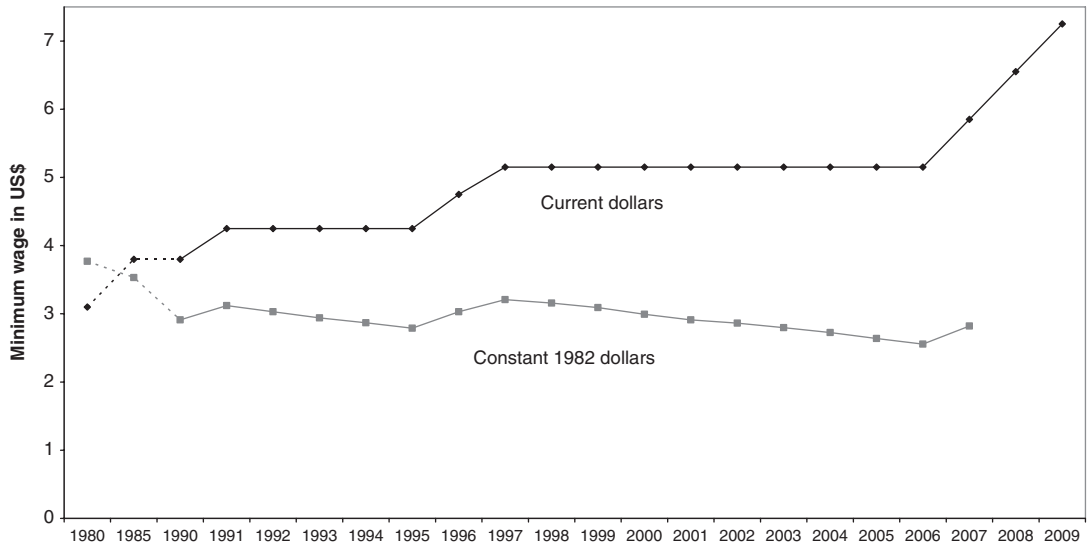


**Figure 6** The development of minimum wage rates in the US, 1980–2009
*Source*: Based on Statistical Abstract of the United States 2009 (Table 629: Federal Minimun Wage Rates. Table 702: Purchasing Power of the Dollar)

expanded in recent years, thus making it one of the fastest growing social programmes. The credit is a Federal government programme, which may be supplemented by similar schemes on the state level. Created in 1975, it is available to low-income tax payers. Originally limited to families with dependent children, its coverage was extended in 1993 to also include childless workers with a low income. Designed to strengthen work incentives, the scheme grants a refundable tax credit that is calculated as a percentage of earnings up to a certain limit. The credit thus increases with earned income until it reaches its maximum amount at a certain level of earnings. This income limit is called 'minimum income for maximum credit' or 'limit on creditable earnings'. For incomes beyond this limit the credit remains constant until a second income threshold is reached, beyond which the credit is reduced by a certain phaseout percentage (i.e. percentage of earnings above the threshold), until the 'break-even' point is reached, at which the credit is reduced to zero. All EITC income limits have been indexed to inflation since 1986. The income limit on creditable earnings at which the maximum credit is reached for a family with two children roughly corresponds to 30% of the average earnings in social security ($11,340 compared to $37,601), whilst the threshold at which the phaseout begins for such a family (in 2006 it was $14,810) corresponds to about 40%. The break-even point is slightly below the level of average earnings in social security (96% – see Figure 7). Varying with the number of children, the threshold is more than twice as high for families with two children as for childless workers.

In 2006, the maximum credit amounted to $378 per month ($4,536 a year). Twenty-three million families received a credit that amounted to $160 per month on average ($1,926 per year). Figure 8 shows the steep growth of the EITC, which enjoys high popularity among politicians and tax payers alike. The number of recipient families grew almost fourfold from around six million in the 1970s to above 23 million in recent years, while the total cost of the credit even increased by a factor of 35 and amounted to more than $44 billion in 2006. In sum, the American welfare state combines a variety of different tools to provide a minimum floor, which are difficult to compare with minimum income security schemes in Europe. Instead of one general social assistance scheme, there is a patchwork of several programmes, most of which are strongly work conditioned and aim at supporting people with low earnings from work.

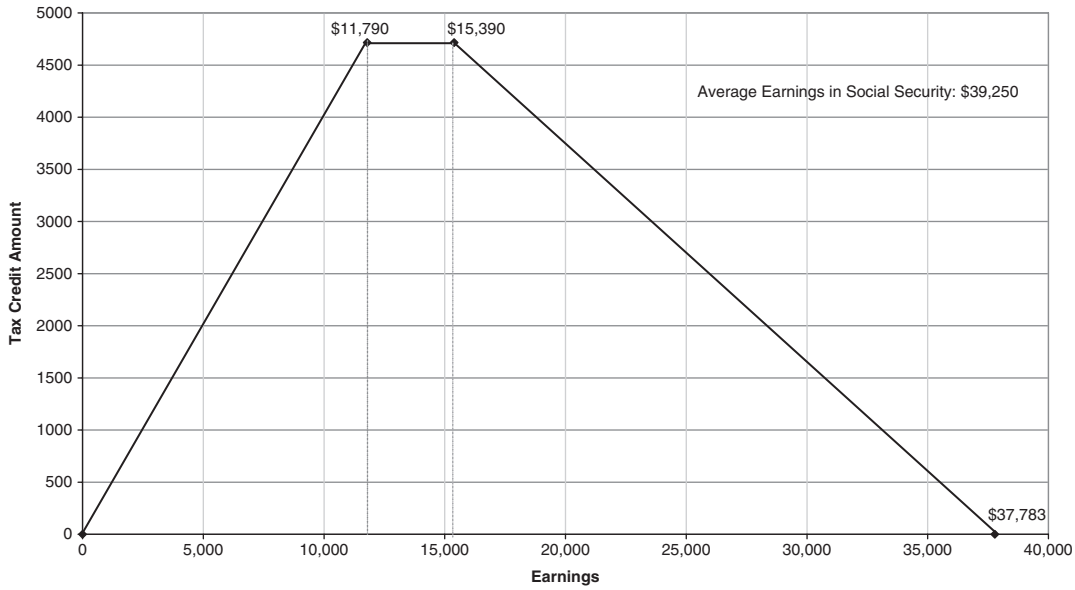


**Figure 7** The functioning of the Earned Income Tax Credit for a family with two children, 2007
*Source*: Based on Internal Revenue Service (IRS) and Tax Policy Center (Historial EITC Recipients)

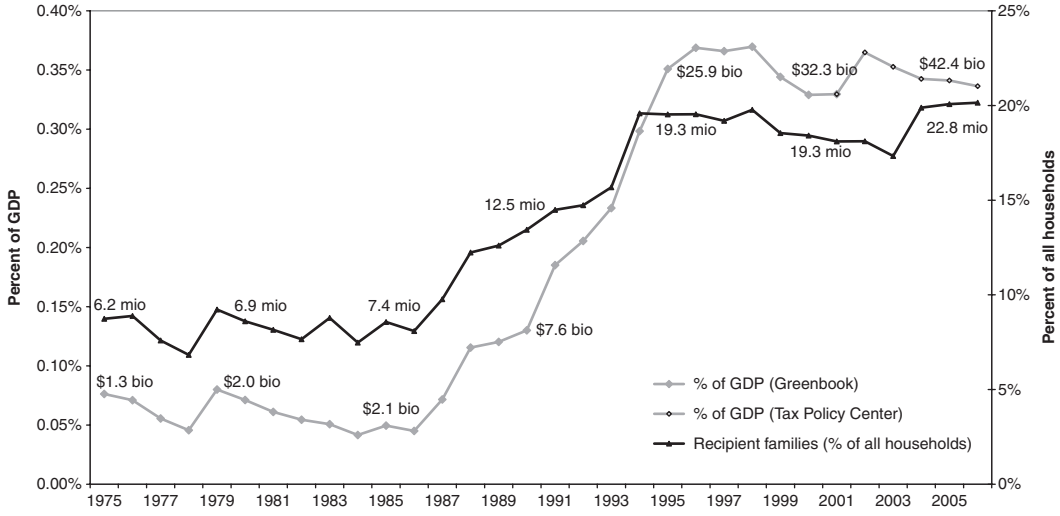


**Figure 8** Earned Income Tax Credit expenditure (as % of GDP) and recipient families (as % of all households), 1975–2006
*Source*: Calculations based on Statistical Abstract of the United States 2009 (Tables 53, 456, 645), Tax Policy Center. Historical EITC Recipients, Greenbook 2004 (Table 13–41), Historical Statistics of the United States (Table Ae29-37).

The major insights from this short description of the American welfare state may be summarized in three points: Firstly, in many respects the American welfare state is different and complex rather than incomplete, because it uses a host of different instruments, including not only social insurance, but also minimum wage legislation and tax credits for the working poor, as well as some other measures not described here, such as loan guarantees and other subsidies in housing, the regulation of employment conditions, and tort law (Howard, 2007). Secondly, within the realm of social security the American welfare state is more similar to European welfare states than the term 'residual welfare state' suggests, because it is also dominated by *public* provisions for welfare, among which social insurance programmes, particularly Social Security and Medicare, predominate; because its public pension scheme is more universal, redistributive, and generous than the German pension insurance system, because social programmes have also been growing over time in recent decades; and because it is moving closer to Europe with respect to extended public health care schemes. Thirdly, noteworthy differences to Europe remain, most notably a stronger reliance on private schemes in pensions and health, a stronger emphasis on work-conditioned benefits, and a greater importance of selective or targeted schemes, which represent about one third of the total social spending in the American welfare state if Medicaid is included.

In short, this suggests that the term 'residual welfare state' is misleading, because it conceals important similarities in European and American social policies, as well as some American peculiarities that a typology based on a quantification in terms of more or less in identical dimensions cannot reflect. In order to characterize this model of social policies, various terms have been proposed in the literature, which all seem to capture relevant features better than the term 'residual welfare state' does. These concepts include: the *industrial achievement-performance model* (a term that Titmuss (1974) used to characterize continental European welfare states); the *opportunity-insurance state* (Marmor et al., 1990); the *enabling state* (Gilbert, 2002); and the *work-conditioned public support state* (Blank, 2009). Since the element of work incentives is an implicit component of all of these proposals, I believe that the term 'work-conditioned' welfare state that Blank has suggested is particularly telling, because it implicitly draws attention to one important element: since many benefits are tied to work – apart from the contribution-based insurance schemes, the minimum wage, the Earned Income Tax Credit and the heavily subsidized employee benefits – employers function as key gatekeepers of social entitlements. In this sense, the American welfare state is less based on social citizenship and state bureaucracies administering the programmes, but on what Dobbin (2002) has called 'corporatized social citizenship'. In this system the work contract with private employers is used as the basis of social protection, and this also means that the loss of a job is punished twice, because not only earnings from work but also social rights are forgone.

'Americanization' would then mean that some of the peculiar features of the American welfare state become adopted or strengthened in other countries as well, so that they converge with the US. In the following we will examine if European welfare states have moved closer to the American case with respect to the following features, which can serve as litmus tests for our analyses: the level of gross social spending; the proportion of private benefits; the relative share of selective means-tested benefits; and the emphasis on work-conditioned benefits. In addition, I will examine if the American welfare state has become more radically American itself with respect to these features.

## Recent social policy changes in Europe and the US

### *Aggregate social spending*

Table 3 shows that social expenditure kept growing not only in the US, but also in most European OECD member states after 1980. On average, social spending was higher in 2005 than in 1980 or in 1990. Only six of the 15 old member states of the EU saw a moderate downward trend in social spending between 1990 and 2006 (Denmark, Finland, Sweden, Spain, Luxembourg and The Netherlands).[18] The pattern is somewhat different for the new member states, where seven out of 12 countries reduced social spending relative to their GDP. On average, the trend in social spending up to 2006 is moderately positive in the EU15, moderately negative in the 12 new member states and zero on average. In sum, we neither see general welfare state shrinkage nor a converging race to the bottom, but a widening gap

**Table 3** The development of gross social expenditure rates (% of GDP)[a] (shaded = declining)

| | *Levels OECD* | | | *Levels Eurostat* | | *Trends (b coeff.)* | | |
|---|---|---|---|---|---|---|---|---|
| *Country* | *1980* | *1990* | *2005* | *1990 (or earliest data)* | *2006* | *OECD 1980–2005* | *OECD 1990–2005* | *Eurost. 1990–2006* |
| USA | 13.1 | 13.4 | 15.9 | | | 0.12 | 0.11 | |
| EU15 | 19.5 | 21.4 | 24.3 | 24.0 | 25.4 | 0.15 | 0.08 | 0.05 |
| NMS[b] | | 17.7 | 19.9 | 16.5 | 16.4 | | 0.11 | –0.08 |
| EU27 | 19.5 | 20.6 | 23.3 | 20.7 | 21.4 | 0.15 | 0.08 | 0.00 |
| *Stand. dev.* | | | | | | | | |
| EU15 | *5.08* | *4.76* | *3.63* | *4.95* | *3.79* | | | |
| EU27(EU19) | | *(4.63)* | *(3.82)* | *5.64* | *5.79* | | | |
| *Coeff. of var.* | | | | | | | | |
| EU15 | *0.26* | *0.22* | *0.15* | *0.21* | *0.15* | | | |
| EU27(EU19) | | *(0.22)* | *(0.16)* | *0.27* | *0.27* | | | |
| Denmark | 24.8 | 25.1 | 26.9 | 27.4 | 28.3 | 0.14 | 0.00 | –0.02 |
| Finland | 18.0 | 24.2 | 26.1 | 23.8 | 25.4 | 0.30 | –0.42 | –0.36 |
| Sweden | 27.1 | 30.2 | 29.4 | 36.9 (*1993*) | 30.0 | 0.08 | –0.30 | –0.37 |
| Austria | 22.5 | 23.9 | 27.2 | 25.3 | 27.6 | 0.20 | 0.19 | 0.15 |
| Belgium | 23.5 | 24.9 | 26.4 | 25.9 (*1995*) | 28.7 | 0.06 | 0.04 | 0.27 |
| France | 20.8 | 25.1 | 29.2 | 25.9 | 29.2 | 0.31 | 0.19 | 0.14 |
| Germany | 22.7 | 22.3 | 26.7 | 24.9 (*1991*) | 27.6 | 0.20 | 0.20 | 0.19 |
| Greece | 10.2 | 16.5 | 20.5 | 19.2 (*1995*) | 23.6 | 0.31 | 0.32 | 0.41 |
| Italy | 18.0 | 19.9 | 25.0 | 23.0 | 25.7 | 0.21 | 0.35 | 0.11 |
| Portugal | 10.2 | 12.9 | 23.1 | 19.1 | 23.8 | 0.57 | 0.67 | 0.58 |
| Spain | 15.5 | 19.9 | 21.2 | 19.3 | 20.4 | 0.21 | –0.04 | –0.07 |
| Luxembourg | 20.6 | 19.1 | 23.2 | 20.6 | 20.0 | 0.07 | 0.26 | –0.03 |
| Netherlands | 24.8 | 25.6 | 20.9 | 29.6 | 27.5 | –0.27 | –0.43 | –0.29 |
| Ireland | 16.7 | 14.9 | 16.7 | 18.0 (*1995*) | 16.9 | –0.17 | –0.01 | 0.05 |
| United Kingdom | 16.7 | 17.0 | 21.3 | 21.4 | 25.9 | 0.09 | 0.13 | 0.06 |
| Czech Republic | | 16.0 | 19.5 | 16.9 (*1995*) | 18.1 | | 0.24 | 0.15 |
| Hungary | | 21.1 | 22.5 | 20.3 (*1999*) | 21.8 | | 0.34 | 0.34 |
| Poland | | 14.9 | 21.0 | 19.1 (*2000*) | 18.8 | | 0.03 | –0.16 |
| Slovenia | | | | 23.2 (*1996*) | 22.2 | | | –0.13 |
| Slovak Republic | | 18.6 | 16.6 | 17.9 (*1995*) | 15.3 | | –0.19 | –0.28 |
| Estonia | | | | 13.8 (*2000*) | 12.2 | | | –0.19 |
| Latvia | | | | 15.0 (*1997*) | 11.9 | | | –0.51 |
| Lithuania | | | | 13.1 (*1996*) | 12.8 | | | –0.16 |
| Bulgaria | | | | 15.5 (*2005*) | 14.5 | | | –1.00 |
| Romania | | | | 12.9 (*2000*) | 13.7 | | | 0.22 |
| Cyprus | | | | 14.6 (*2000*) | 18.1 | | | 0.68 |
| Malta | | | | 15.8 (*1995*) | 17.9 | | | 0.13 |

[a]*Sources:* OECD (2008a): Social Expenditure Database. The OECD keeps changing data on the web. This table is based on data found in May 2009. Eurostat (2009): European System of Social Protection Statistics (ESSPROS). Trends: own calculations based on OECD (2008a): Social Expenditure Database and Eurostat (2009): ESSPROS.
[b]NMS = New Member States after the Eastern enlargement of the EU.

between old and new member states of the EU. Differences between the EU15 and the US have not narrowed, but widened over time.[19]

As discussed earlier, the gross social expenditure ratio is only a crude measure of welfare state activities that cannot capture important differences in the composition of social spending. Hence we should examine if European countries have become more similar to the US with respect to specific characteristics, such as the level of private spending for social purposes or the relative weight of selective targeted schemes.

**Table 4** The share of voluntary private social expenditure in 1993 and 2005 (as % of GDP at factor cost)

| Country | *1993 except for Italy (1997) and France (2001)* | *2005* | *Increase* |
|---|---|---|---|
| USA | 7.8 | 9.8 | 2.0 |
| GB | 3.2 | 6.0 | 2.8 |
| NL | 3.4 | 6.2 | 2.8 |
| DE | 1.5 | 1.8 | 0.4 |
| IT | 0.1 | 0.6 | 0.5 |
| FR | 2.1 | 2.9 | 0.8 |
| DK | 0.4 | 1.5 | 1.1 |
| SE | 1.0 | 1.8 | 0.8 |

*Source:* Based on Adema, 2001; Adema and Einerhand, 1998; Adema and Ladaïque, 2005.

## *More fine-grained indicators of the composition of social spending*

The data collection of the OECD allows an overall examination of the private share in social spending, as well as more specific analyses for the fields of pensions and health care. Based on the OECD distinction between gross and net social spending, Table 4 shows the percentage of GDP (at factor cost) spent privately and voluntarily for social purposes for those countries for which there are time series data. Even though private social spending has recently grown in all European countries, The Netherlands and the United Kingdom are the only European countries that moved closer to the US, where private spending on welfare kept increasing further. In 2005, private social spending in the US amounted to roughly 10% of the GDP, whereas the United Kingdom and the Netherlands were the only European countries with private GDP shares above 3% (beside Belgium, which is not listed in the table because of missing time-series data).[20]

More refined data showing the proportion of social spending for selected purposes are available for pension and health in the OECD data collection. Following the OECD data, most European countries have increased the private share in pension outlays over recent decades (Table 5). Only five countries – Finland, Austria, Portugal, Spain and Luxembourg – were exempt from this general trend. As the measures of dispersion show, nation-specific differences within Europe did not diminish, but even increased. Although some European countries, such as The Netherlands and the United Kingdom, paralleled US developments, the gap separating the US from the (West) European average increased, because the US continued to pursue the privatization of pensions much more vigorously than most European nations. In line with the notion of path dependency, countries that departed from higher

**Table 5** The private share of pension expenditure. Mandatory + voluntary private social expenditure for pensions as percentage of total (public + private) social expenditure for pensions (shaded = growing)

| *Country (earliest year if not 1980)* | *1980 or earliest year* | *2005* | *Trends 1980–2006 (b coefficients)* |
|---|---|---|---|
| US | 19.7 | 41.8 | 0.84 |
| EU15 | 9.9 | 13.9 | 0.16 |
| NMS – 4 | 2.4 | 6.8 | 0.34 |
| EU19[a] | 8.7 | 12.7 | 0.19 |
| *Standard deviation* | | | |
| EU15 (EU19)[b] | *9.4* | *14.1* | |
| | *(9.0)* | *(13.2)* | |
| *Coeff. var.* | *0.9* | *1.0* | |
| EU15 (EU19)[c] | *(1.0)* | *(1.0)* | |
| Denmark | 15.7 | 23.4 | 0.33 |
| Finland (1993) | 4.3 | 2.3 | –0.15 |
| Sweden | 12.5 | 17.2 | 0.24 |
| Austria | 5.7 | 3.8 | –0.02 |
| Belgium | 4.8 | 27.3 | 0.95 |
| France | 2.6 | 1.8 | 0.03 |
| Germany | 4.8 | 5.9 | 0.05 |
| Greece (1983) | 0.0 | 3.6 | 0.22 |
| Italy | 10.0 | 10.1 | 0.02 |
| Portugal | 5.9 | 2.3[d] | –0.19 |
| Spain | 0.0 | 0.0 | –0.02 |
| Luxembourg (2001) | 9.3 | 7.1 | –0.60 |
| Netherlands | 19.7 | 38.9 | 0.77 |
| Ireland | 18.2 | 21.6 | 0.36 |
| United Kingdom | 35.4 | 43.5 | 0.35 |
| Czech Republic (1996) | 0.0 | 2.6 | 0.23 |
| Hungary | | | |
| Poland (1990) | 4.1 | 10.4 | 0.36 |
| Slovak Republic (1995) | 3.1 | 7.5 | 0.43 |

Own calculations based on OECD (2008) Social *Source*: Expenditure Database.
[a]EU19 without Hungary.
[b]EU19 without Hungary.
[c]EU19 without Hungary.
[d]2004.

**Table 6** The private share of health expenditure. Mandatory + voluntary private social expenditure for health as percentage of total (public + private) social expenditure for health (shaded = growing)

| *Country (earliest year if not 1980)* | *1980 or earliest year* | *2005* | *Trends 1980–2006 (b coefficients)* |
|---|---|---|---|
| US | 41.8 | 45.4 | 0.08 |
| EU15 | 4.5 | 7.8 | 0.11 |
| NMS – 4 | 0.4 | 0.9 | 0.09 |
| EU19 | 3.8 | 6.6 | 0.10 |
| *Standard deviation* | *3.8* [a] | *6.1* [a] | |
| EU15 (EU19) *Coeff. var.* | *0.9* | *0.8* | |
| EU15 (EU19) | *(1.0)* [a] | *(0.9)* [a] | |
| Denmark | 1.3 | 2.3 | 0.05 |
| Finland | 1.7 | 2.9 | 0.07 |
| Sweden | | | |
| Austria | 10.0 | 6.6 | –0.22 |
| Belgium (2003) | 6.4 | 6.5 | 0.07 |
| France | 6.6 | 15.3 | 0.33 |
| Germany | 6.9 | 11.3 | 0.16 |
| Greece (2000) | 4.5 | 3.6 | –0.26 |
| Italy (1990) | 0.8 | 1.2 | 0.01 |
| Portugal | 0.0 | 5.6 | 0.23 |
| Spain | 3.9 | 7.7 | 0.11 |
| Luxembourg (1999) | 1.5 | 2.5 | 0.24 |
| Netherlands | 13.2 | 23.1 | 0.35 |
| Ireland | 4.5 | 7.9 | 0.08 |
| United Kingdom | 1.5 | 12.8 | 0.27 |
| Czech Republic (2002) | 0.3 | 0.3 | 0.00 |
| Hungary (1999) | 0.1 | 1.5 | 0.25 |
| Poland (2002) | 0.7 | 0.8 | 0.02 |
| Slovak Republic | | | |

*Source*: Own calculations based on: OECD (2008) Social Expenditure Database.
[a]EU15 without Sweden, EU19 without Sweden and Slovak Republic.

levels of privatization at the beginning of the period also tended to have a steeper trend increase of the private share ($r$ = 0.43 if the trend coefficient is regressed upon the starting level). Hence we see a fairly general trend of a 'risk shift' in favour of private provisions as described by Hacker (2006) for the USA, but within Europe we find continuing diversity rather than convergence.[21]

Measured by the private share in total outlays for health, the health care systems were subject to a similar, but less pronounced, trend of privatization (Table 6). In West European countries the average private share increased from 4.5% to 7.8%, but as the US expanded its private share further, the gap separating Europe and America did not diminish. Whereas almost half of total health outlays in the US are ranked as private by the OECD, The Netherlands is the only European country with a share exceeding 20%, and only three more countries – France, Germany and the United Kingdom – surpass the 10% mark.[22] In contrast to the pension systems there is no path dependency in the sense that countries that departed from higher levels in the 1980s also had steeper increases of privatization ($r$ = –0.08). Only three European countries – Austria, Greece and the Czech Republic – were exempt from the general trend towards more private provisions. Judged by the coefficient of variation, European countries became a bit more similar on somewhat higher levels of privatization, but as the standard deviation increased, it would be exaggerated to interpret this as convincing evidence of convergence towards the model of greater private responsibility represented by the US.

The fourth litmus test refers to the degree of selectivity in welfare state schemes. Scholars of different leanings, such as Gilbert (2002) and Rothstein (1998), agree in the belief that Europe has witnessed a move toward selective needs-tested programmes since the early 1990s. Gilbert arrived at his diagnosis of a trend from 'universal to selective' benefits by counting any social provisions with income limits as part of the targeted benefits. As long as income limits do not fall below average earnings, but exclude only those on the very top, the term 'targeted' or 'selective' benefits would in my opinion better be reserved for programmes that are targeted on the poor and involve means tests in the sense of an administrative investigation into the living conditions of the households that the recipients of public benefits live in. Following this concept (which does not count compulsory insurance schemes with income limits above average earnings as targeted), Table 7, based on Eurostat data, shows how the proportion of selective benefits changed over time.[23]

The average share of selective benefits is below 8% in the enlarged EU and thus well below the American level, even if Medicaid is excluded from the calculation of selective benefits in the US. Over time, the share of selective benefits slightly *decreased* in Europe

**Table 7** The share of selective benefits in social expenditure[a] (% of total public social expenditure, shaded = growing)

| *Country (earliest year if not 1990)* | *1990 or earliest year* | *2005/06* | *Trends 1980–2005/06 (b coefficients)* |
|---|---|---|---|
| USA | 25.2 (11.3 without Medicaid) | 30.4 (10.4 without Medicaid) | 0.00 |
| EU15 | 9.4 | 9.4 | –0.03 |
| NMS | 8.1 | 6.0 | –0.20 |
| EU27 | 8.8 | 7.9 | –0.11 |
| *standard deviation* | *7.2 (6.5)* | *5.9 (5.5)* | |
| EU15 (EU27) *Coeff. of var.* | *0.8 (0.7)* | *0.6 (0.7)* | |
| DK | 2.6 | 3.0 | 0.02 |
| FI | 11.5 | 9.8 | –0.10 |
| SE | 6.3 | 2.9 | –0.36 |
| AT | 3.9 | 6.7 | 0.20 |
| BE | 2.7 | 3.7 | 0.07 |
| FR | 11.0 | 11.9 | 0.07 |
| DE | 8.6 | 12.2 | 0.07 |
| GR | 6.2 | 7.6 | 0.17 |
| IT | 4.7 | 4.6 | 0.00 |
| PT | 6.2 | 11.5 | 0.32 |
| ES | 13.6 | 13.1 | –0.09 |
| LU | 6.3 | 3.0 | –0.28 |
| NL | 9.6 | 11.9 | 0.23 |
| IE | 31.0 | 24.3 | –0.67 |
| GB | 16.5 | 15.5 | –0.17 |
| CZ (1995) | 8.9 | 5.2 | –0.25 |
| HU (1999) | 7.3 | 4.6 | –0.36 |
| PL (2000) | 5.0 | 5.2 | 0.20 |
| SK (1995) | 15.3 | 5.4 | –0.88 |
| SI (1996) | 8.8 | 9.7 | 0.14 |
| EE (2000) | 2.5 | 0.8 | –0.33 |
| LT (1996) | 4.4 | 2.1 | –0.15 |
| LV (1997) | 2.1 | 1.5 | –0.06 |
| BG (2005) | 6.6 | 6.1 | –0.52 |
| RO (2000) | 8.1 | 5.1 | –0.06 |
| CY (2000) | 5.9 | 8.9 | 0.48 |
| MT (1995) | 22.5 | 17.9 | –0.55 |

*Source*: Own calculations based on: Eurostat (2009): ESSPROS, for the USA calculated from the Statistical Abstract of the USA (2009: Table 521).

[a]Country abbreviations: AT: Austria, BE: Belgium, BG: Bulgaria, CY: Cyprus, CZ: Czech Republic, DK: Denmark, DE: Germany, EE: Estonia, ES: Spain, FI: Finland, FR: France, GB: Great Britain, GR: Greece, HU: Hungary, IE: Ireland, IT: Italy, LT: Lithuania, LU: Luxembourg, LV: Latvia, NL: Netherlands, MT: Malta, PL: Poland, PT: Portugal, RO: Romania, SE: Sweden, SK: Slovakia, SI: Slovenia, USA: United States of America.

on average, and the number of countries with a shrinking importance of targeted benefits as indicated by the negative trend coefficients is higher (15) than the number of countries with increases (11). In this sense, Europe has not moved closer to the American model, and the gap separating the EU average from the US has grown. Traditionally, only Ireland, the United Kingdom and Malta had double digit shares of selective schemes coming close to the US, but none of them approximated the American model further in recent years. With the exception of Poland, Slovenia and Cyprus, the new member states of the EU belong to the countries with shrinking proportions of targeted schemes. In sum, there is no convincing evidence that would sustain the notion that EU member states are moving away from the ideal of universal welfare states towards selective benefits. As the shrinking measures of dispersion indicate, European countries have become more similar in this respect and tended to converge on slightly lower levels of selectivity, thus widening the gap that differentiates them from the US.

In sum, we do find traces of the Americanization of European social policies with respect to the growing importance of private expenditure for social purposes, but not with respect to the importance of selective schemes. Moreover, the gap separating the European mean from the US has not narrowed but widened. One might argue, of course, that implementing change takes time, and that a more significant transformation may be found with respect to the policy discourse that will only translate into actual change with some time lag, which the available data do not yet capture.

## *The changing policy discourse: three aspects of Americanization in Europe and two aspects of Europeanization in the US*

Up to the point covered by the most recent data, the actual transformation of European welfare states has remained rather limited, but a more profound change did take place on the level of social policy discourse. Three elements that used to be identified with the American model and have always played a stronger role in the US than in Europe have recently also come to prominence on this side of the Atlantic: a new emphasis on individual responsibility, a new interest in the private supply of services and more consumer choice, and a new emphasis on the activation of people at working age.

Up to the early 1990s, the idea that the welfare state might be the problem rather than the solution found little echo among policy makers outside the Thatcherite European political right, which had adopted the American idea that welfare benefits may involve perverse incentives inviting people to live at the expense of others. This changed in the early 1990s when the European Commission issued a set of Green and White Papers that highlighted the adverse effects of social benefits and called for a redirection of economic and social policy in the EU. The Commission made it clear that non-wage labour costs, such as income taxes and social insurance contributions, should be reduced, that traditional policies had become unsustainable and that public expenditure should be channelled from social consumption to productive investment. Frequently referring to the US (and Japan) as a model, the Commission called for a more active assumption of responsibility by each individual, for the introduction of pay-per-use systems and for a transfer of services from the state to the market. The gist of these statements was that the responsibility of the state should be curtailed, while individual responsibility should be extended (Kuper, 1994). Together with the impact of the World Bank and the International Monetary Fund (IMF), the new views of the Commission shaped the pre-accession policy discourse in the post-socialist transformation countries to a large extent. While the European Council meetings in Laeken in 2001 and in Barcelona in 2002 put a transitory emphasis on the virtues of the European social model and of social inclusion, the 2005 Review of the Lisbon Agenda put the emphasis once again on employment, growth and competitiveness.

The new emphasis on individual responsibility combined with a second discourse on the proper balance between the public and private supply of services was fuelled by a growing demand for more consumer choice. The expansion of higher education contributed to a growing number of people who called experts' judgments into question and developed a preference for differentiated services rather than standardized universalistic solutions (Rothstein, 1998). Traditional notions of solidarity were thus increasingly fused with a quest for new public/private mixes that would offer clients chances of voice *and* exit.

Partly in response to such changing citizen demands, national governments, as well as the European Commission, set the privatization of public services on the agenda of European politics. In Sweden, the bourgeois parties that were in power in the early 1990s called for a 'freedom of choice revolution' that would empower the dependent clients of state services by transforming them into self-confident modern customers (Rothstein, 1998). In the case of child birth, for example, there has been a sea change in favour of parents' choice, which Rothstein (1998: 190) summarizes as the change from giving birth on the hospital's terms to giving birth on the parents' terms. While in Sweden an Agency for Administrative Development was set up to evaluate the various freedom of choice models, other countries followed suit in developing models for a 'new public management' that would give citizens a greater say in their dealing with public bureaucracies (see also Giddens, 1998).

A third element in the changing policy discourse that could be considered a form of Americanization is the new emphasis on activation and *work incentives* to which Gilbert (2002) has convincingly drawn attention. In Britain, for example, the Labour government issued a Green Paper on Welfare Reform in 1998 which declared that 'the Government's aim is to rebuild the welfare state around work' (Gilbert, 2002: 65). France introduced a new minimum income scheme – Revenu Minimum d'Insertion – in 1988 and required the participants to sign a contract of rehabilitation worked out with the local administration. In Denmark the social assistance reform of 1997 introduced an element of workfare by requiring all beneficiaries to participate in formulating individual action plans and by introducing a 20% benefit reduction in case an offer of activation was refused. In The Netherlands 'work, work, work' became the motto of the purple coalition government under Prime Minister Kok in the mid 1990s. Its 1996 Social Assistance Act restricted access to welfare benefits, activated those on the rolls and altered the level of benefits (Gilbert, 2002: 74). An article published in World Politics in 2001 could still wonder 'why welfare reform happened in Denmark and the Netherlands but not in Germany' (Cox, 2001), but in 2002 the German coalition government, headed by the social democrats, followed the Dutch example by adopting the so-called Hartz reform, which ended welfare as we knew it in Germany by partly fusing the social assistance scheme with the unemployment compensation scheme and by abolishing the entitlement to social assistance for able-bodied

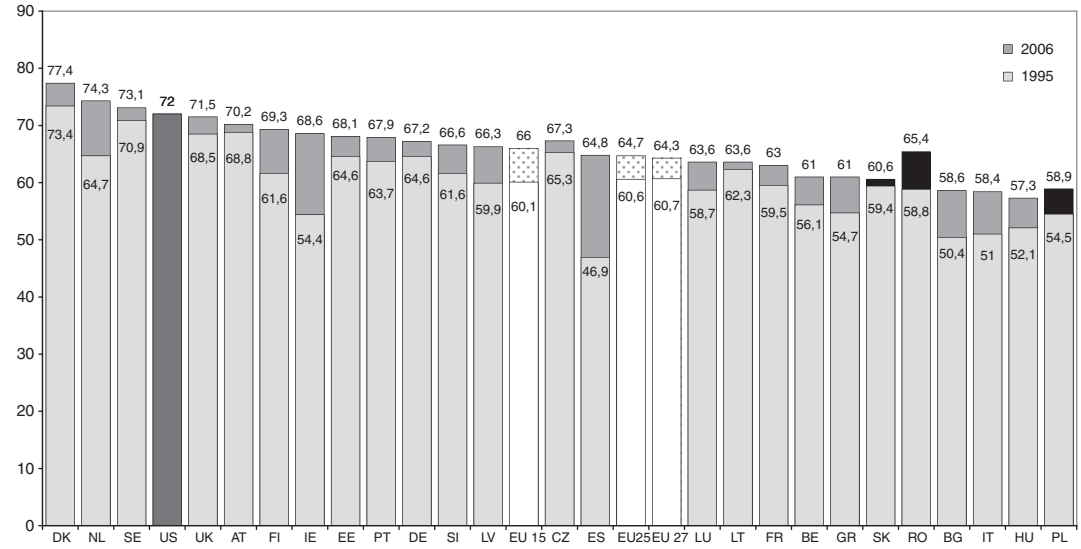


**Figure 9** The change in employment rates, 1995*–2006
*Source:* Employment in Europe 2007, Key Employment indicators. OECD Employment Outlook 2008 (U.S.).
*U.S. data for 1994/2006; in the case of CZ, SK, RO, BG, HU, PL, EE, LV, LT nearest available data; dark colours for SK, RO, PL, indicate decreasing employment rate.

people at working age who were put under heavier pressure to actively seek work.

It may be exaggerated to declare the new emphasis on the activation of people at working age as a process of 're-commodification' in European welfare states, as Gilbert (2002) does, or as an indication of a change to a 'Schumpeterian workfare regime' as suggested by Jessop (1995). However, taken together and seen in historical perspective, these new elements do suggest that European social democracy has reached a new stage in its changing relationship to the market economy. Historically, the (Continental) European Labour movement has made its peace with the capitalist market economy and parliamentary democracy in three major steps, which sequentially moved the notion of a 'third way' to a fuller endorsement of the market economy and in this sense to the right. The first step occurred in the course of the revisionism debate around the turn of the 19th century, which led to the renouncing of revolution, to the acceptance of parliamentary democracy and to a third way strategy aiming at *democratic socialism* through piecemeal reform. The second step was taken after the Second World War when the idea of public investment control and of nationalizing key industries was given up, and the market economy was accepted as an efficient form of allocating investments in product markets and as an ultimate growth machine, which should be complemented, however, by social compensation schemes for vulnerable groups in the labour market. The third way was now conceptualized as *social market economy*. The third step was recently taken around the turn of the millennium, when the propagators of a new 'third way' moved away from the idea of limiting the sphere of market influence through extended public services and social transfers – which would partly 'de-commodify' citizens by giving them access to means of livelihood outside the market – in favour of the new goal of empowering as many people as possible to participate in markets. As inclusion into work is now declared to be the ultimate form of empowerment, *activation policies* making people fit for the market have become the motto of 'New Labour' and of a transformed social democracy (Giddens, 1998, 2001). In some respects, European countries have thus

become more similar to the work-conditioned welfare state of the US.[24]

The new orientation has not been confined to the policy discourse, but has trickled down into an active re-shaping of social reality. Practically all European countries have now subscribed to the adult worker model championed by the European Commission and sizeably increased employment rates in recent years. Moving closer to the goal of full employment was not only seen as an avenue to social inclusion, but also as a functional imperative given the increasing demographic burden on pension systems and the need to promote the viability and sustainability of public pensions. Figure 9 shows that, with the exception of four countries, all European countries have recently increased employment and been moving closer to the US in this respect (for nation-specific employment patterns, see Alber, 2008; Eichhorst and Hemerijck, 2009).

The figure shows Scandinavian countries to have particularly high employment rates, and this indicates that the idea of activation is not only enshrined in the American, but also in the Scandinavian version of the welfare state. Since the labour movement is strong when unemployment is low, full employment has, in fact, always been a prime policy goal of European social democrats. More detailed comparisons of activation policies illustrate that much depends on their exact form of implementation, and that Scandinavian countries combining activating pressures with developed placement services and generous transfers pursue an 'enabling' policy variety, which should be distinguished from the more 'workfare' oriented policies in Britain or America or from Christian democratic activation schemes (Clasen and Clegg, 2003; Dingeldey, 2007; Huo et al., 2008).

If the European policy discourse has in some respects moved closer to American debates about incentive structures, the American social policy discourse has also changed recently. On the one side, the US has further strengthened some of the key aspects of the American social policy model by increasing the private share in pensions and health, expanding 'the hidden welfare state' of tax credits, shifting from defined benefit plans for pensions to tax deductible individual savings accounts and extending their targeted programmes (Hacker, 2006). However, the US did not become more radically American throughout, but has in some respects even approximated Europe in recent years. This is true for the development of health insurance where both major public health care programmes – Medicare and Medicaid – were successively widened, and also for the change in American attitudes on public policies even before the present financial crisis began. Under the Obama administration, health care may become the central field where American social policies converge somewhat towards Europe. As shown above, Medicare and Medicaid have more than doubled their joint GDP share since 1980. The new administration is now determined to make another attempt at health care reform with coverage for all Americans, and various policy advisors have drafted plans for a reform that would avoid the errors of Clinton's failed initiative (Executive Office of the President, 2009; Hacker, 2009). At the time of writing, the exact nature and the likely success of the reform is still uncertain, however.

Beyond the recent turmoil about health reform, there were also some signs of a long-term change in American political attitudes even before the financial crisis set in. Based on surveys successively asking identical questions, the Pew Research Center for the People and the Press has recently published a report on *Trends in political values and core attitudes: 1987-2007*. This report shows that a solid two thirds majority of Americans 'strongly favor' or 'favor' 'the US government guaranteeing health insurance for all citizens, even if it means raising taxes' (The Pew Research Center, 2007: 70). The majority of those favouring an increase in the minimum wage varied between 80% and 87% between 1998 and 2007 (The Pew Research Center, 2007). A two thirds majority now agrees with the statement 'It is the responsibility of the government to take care of people who can't take care of themselves' (The Pew Research Center, 2007: 12). The gap between those agreeing and those disagreeing with this statement reached a nadir of 16 percentage points at the height of the debate about 'Ending welfare as we know it' in 1994, but has since grown to 41 percentage points in 2007, as 69% now endorsed and only 28% denied the government's responsibility. In the policy discourse, then, we see some convergence on the two sides of the Atlantic, even before the onset of the financial crisis made for a more pragmatic approach geared to more policy learning from countries facing similar problems. Such policy learning would probably be facilitated if we began to perceive the US and Europe to be similarly 'united in diversity' as the member states of the enlarged EU.

## Conclusion

Our comparison of American and European social policies shed doubt on the usefulness of the concept of a residual welfare state as applied to the US. It was shown that the US and Europe have more in common than the traditional distinction between 'residual' and 'institutional-redistributive' welfare states and the talk about widely discrepant social models suggest. Yet there are also persisting differences, which include the higher reliance on work-conditioned benefits, on selective targeted schemes, and on private welfare measures in the US. While selective benefits have not gained prominence in Europe, but remained rather marginal, private schemes have become more important, and 'activation' has become a key word in European social policies. In this sense, Gilbert (2002) was correct when he diagnosed a move from social protection to the idea of an enabling state. The idea of activating social policies forms, however, as much part of the Scandinavian as of the American social policy tradition, so that a stronger emphasis on work incentives and full employment need not necessarily indicate an 'Americanization' of European social policies and much will depend on the concrete implementation of specific policy programmes. Thus far, the basic transformation of European social policies has been on the level of ideas rather than on the level of institutional structures. While the basic structures of European welfare states have remained largely intact and were even combined with increased social spending in many cases, the idée directrice of European social policies and the political elites shaping them has changed from social protection to activation. A fairly persistent institutional structure has thus been combined with a new culture or spirit. Perhaps a combination of European welfare state structures and the American idea of individual responsibility might even amount to the best of all possible worlds.

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*Notes*

1 Castles (2009) stresses the similarities in the family of English-speaking nations. Wilensky (2002) insists on the many similarities in the group of rich democracies and Baldwin (2009) points out many frequently overlooked similarities between Europe and the US.
2 For a similar view from French policy consultants see Jouen and Papant (2005: 2) who state that: 'in the US, the middle classes brought in democracy and it has since remained liberal and centred on individual rights. In Europe, on the other hand, democracy was established by the workers, who provided it with a strong dimension of solidarity'.
3 See also Norris and Inglehart (2004: 108) who highlight the differences in religiousness and attempt to relate these to the discrepant degrees of economic insecurity experienced in Europe and America.
4 In his more recent work, Esping-Andersen partly subscribed to this idea, as he no longer considered 'de-commodification' but 'de-familialization' as the key problem of our times, and advocated shifting to a new welfare state that would focus on social services and on 'social inclusion through employment' (Esping-Andersen et al., 2002). Taylor-Gooby (2004) similarly drew attention to new risks to which welfare states now need to adapt.
5 In the period 1990–2006 the share of total tax revenues in GDP grew from 27.3% to 28.0% in the US and from 38.2% to 39.8% in the EU15, thus leading to a widening gap between Europe and America (OECD, 2008b).
6 For different accounts contrasting the European Social Model with the American model, see Alber (2006), Alber and Gilbert (2009), Birg (2005), Castles (2009), Jepsen and Serrano Pascual (2005), Jouen and Papant (2005), Norris and Inglehart (2004), Vaughan-Whitehead (2003, particularly chapters 1 and 3), Wickham (2002). Comparative descriptions of specific programmes are given by Blank (2009) and Saraceno (2009) for anti-poverty programmes, by Hacker (2009) and Peterson and Burton (2007) for health care and by OECD (2009b) for pensions.
7 In 2007, 27.8% of Americans were covered by a government health care plan, including Medicare (13.8%), Medicaid (13.2%) and Military health care (3.7%). Roughly two thirds (67.5%) were covered by private plans, including directly purchased ones, and 59.3% participated in an employment-related health insurance plan. 15.3% (45.7 million) were not covered by any scheme. These figures do not add up to 100, because the estimates by type of coverage are not mutually exclusive, as people can be covered by more than one type of health insurance during the year (US Census Bureau, 2008: 21).
8 The COFOG data presented by Fraser and Norris (2007) have the US ahead of *all* EU member states, the

OECD SOCX database has only Belgium, Sweden, France and Germany ahead of the US, and according to WHO statistics only six European countries (Germany, Sweden, France, Denmark, Malta and the United Kingdom) spend higher shares of their GDP on public health programmes than the US (the WHO states the total health expenditure ratio and the proportion of public spending in this ratio, thus allowing one to calculate the public health expenditure ratio from its data).

9 For historical data since 1987, see Historical Health Tables (n.d.) and US Census Bureau (2008: Table 6).

10 A Commonwealth Fund report based on recall data from respondents in the biennial health insurance survey conducted in 2005–2006 found that 28% of US adults aged 19–64 were either uninsured at the time of the survey or had experienced a time without coverage in the past 12 months; four fifths (82%) of the nearly 32 million uninsured adults said they had been uninsured for one year or more (Collins et al., 2006: 2, 4). More than 40% of the uninsured said they had problems paying or were unable to pay medical bills in the past year, and even among those insured all year, 16% reported such problems (Collins et al., 2006: Table 2, p. 20). A 2001 survey of personal bankruptcy filers in five federal courts found that more than half (54.5%) cited a medical cause for their bankruptcy (Himmelstein et al., 2005: W5–67).

11 For a summary of comparative data on coverage, see Hacker (2009).

12 Typical examples in Germany include Birg (2005) and Schimank (2007). The demographer Birg (2005: 117) claimed that American public pensions reach only one third of the German level. For a recent comparison of replacement rates in pension schemes see OECD (2009b), and the Comparative Welfare Entitlement Dataset by Scruggs (2005).

13 The 2003 earnings replacement rates for people in different income brackets were as follows: 41.6% for average earners (percentage of last earnings in the case of lifelong average earnings); 56.1% for low incomes (with 45% of average earnings); 29.8% for high income/maximum earnings (maximum earnings correspond to about 3.3 times the average earnings in social security (US House of Representatives, Committee on Ways and Means, 2004: p. 1-45, 1-48 und p. 1-50).

14 The Comparative Welfare Entitlements Dataset (Scruggs, 2005) states the net average replacement ratio (for life time average earners in 2000) as 67% in the US and 64% in Germany, with 58% in the US and 74% in Germany for singles, and 76% (US) versus 58% (D) for couples. In the OECD comparisons, the American gross replacement level for average earners (38.7%) is higher than in seven European countries and similar to Germany (43.0%), while the net replacement rate (44.8% for men) is lower than in most European countries, except Ireland and the United Kingdom (OECD, 2009b: 117, 121).

15 Mean earnings for men and women combined were 89% of the average (78.4% for women and 103.8% for men – Bundesministerium für Arbeit und Soziales, 2008: 20 and Übersicht 6).

16 It should be noted that the two major American benefits need not be the only benefits, as they may be supplemented by other forms of assistance, such as housing or heating subsidies.

17 The proportion of workers receiving the minimum wage seems to be rather low; among those paid by the hour in 2007 the 1.7 million workers with wages at or below the minimum wage represented 2.3% (BLS, 2007).

18 The trend coefficients are the bs of a linear regression over time.

19 For similar results see Castles (2009) and Starke et al. (2008). Comparisons between the enlarged EU and the US are impaired by the fact that the Eurostat definition of social expenditure differs from the OECD definition, while the OECD database has only data for four of the new EU member states (Czech Republic, Hungary, Poland and Slovakia).

20 2005 data are available for 17 European countries, but time series are only available for the countries in the table.

21 Of course, similar shares of private pension expenditure may conceal important differences in the design of private schemes. For useful comparisons of private pension programmes see Anderson (2008) and Meyer et al. (2007), as well as the very concise and telling summary of different private pension designs in chapters 6 and 9 of Thaler and Sunstein (2009).

22 The OECD data on private health expenditure do not include user charges. Hence there is an important caveat in these comparisons that leads to an underestimation of the actual extent of privatization in European countries.

23 The American figures are not strictly comparable and are based on the US official statistics shown in Figure 3, as the (rather cursory) Eurostat definition of targeted schemes may differ from the American definition.

24 The transformation from old to new labour is particularly visible in the development of Esping-Andersen's writings (from Esping-Andersen (1990, 1996, 1999) and Esping-Andersen et al. (2002)). His new typologies still follow the 'good, bad, ugly' scheme to which Manow (2002, 2008) has drawn attention, but only the Scandinavian countries classify constantly as 'good' in the de-commodification dimension, as well as in his new de-familialization dimension. The liberal former British Colonies have now improved from 'bad' (due to residual de-commodification) to 'ugly' (high female employment, but only in the private sector), whereas the Continental European countries have moved from their 'ugly' position in the original de-commodification typology to 'bad' with respect to the insufficient insertion of everybody, including women, into the labour market leading to a low degree of de-familialization.

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