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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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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

This paper examines to what extent the classification of the American welfare state as "residual" squares with the empirical facts. Section I describes key features of American social policy developments. The U.S. system is clearly dominated by *public* provisions for welfare among which social insurance programs, especially Social Security and Medicare, represent the lion's share, and public pensions are more universal, redistributive, and generous than in some European countries. Noteworthy differences remain with respect to the stronger reliance on private provisions in pensions and health, the emphasis on work-conditioned benefits and a greater importance of selective schemes. The terms "work-conditioned welfare" or "corporate citizenship" adequately capture these key features by highlighting that employers are gatekeepers of social entitlements. Section II examines if key features of the American welfare state have recently become more prominent in Europe. A slight approximation to the American model is found with respect to a growing importance of private expenditure for pensions and health, but not with respect to a greater selectivity of benefits. On the level of policy discourse, the *idée directrice* of European social policies is changing from social protection to activation, as three traditionally American elements have come to prominence: an emphasis on individual responsibility, on the private supply of services and more consumer choice, and on the activation of people at working age. Yet there is no general convergence towards the American model, because the United States is approximating Europe with respect to health insurance while public attitudes are shifting in favour of extended state responsibilities. Hence there is a complex pattern of specific policy learning rather than convergence towards one model of social policy. In sum, similarities between social policies in Europe and America are found to be more noteworthy than the term "residual welfare state" for the U.S. suggests.

Contents

The misperception of the American welfare state as "residual"

Welfare state typologies usually classify the United States 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 image implied in this typology is 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 stingy magnitude up to the present. Compared to European nations which are said to adhere to the "European social model", the U.S. is thus characterized as an opposite polar type representing a different kind of social model.

Several scholars have taken issue with this notion arguing that the American welfare state is "not incomplete, but different" (Glazer 1988), that it is "misunderstood" (Marmor/Mashaw/Heady 1990), and that there is a "hidden welfare state" of tax benefits and mandatory private schemes in the United States of which European scholars barely take notice (Howard 1997). More recently, Neil Gilbert (2002) 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" which empowers people by making them self-reliant. 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 which would focus on social services and on "social inclusion through employment" (Esping-Andersen et al. 2002; see also Taylor-Gooby 2004). In the United States Christopher Howard (2007) set out to debunk myths about American social policy in a book entitled "About the Welfare State Nobody Knows" which highlighted the vast recent growth of American social programs which European scholars tend to overlook in their search for counterparts of European schemes in the United States.

This contribution takes a fresh and synthetic look at similarities and differences of social policies in Europe and the United States. It proceeds in three steps. First, I will outline some key characteristics of the American welfare state. In a second step, I will analyze if recent developments signal convergence in the sense of an "Americanization of European social policies" as claimed by Neil Gilbert. In a third step, I conclude that even though relevant differences remain, the United States and Europe have far more in

common than the traditional distinction between "residual" and "institutional-redistributive" welfare states suggests.[1]

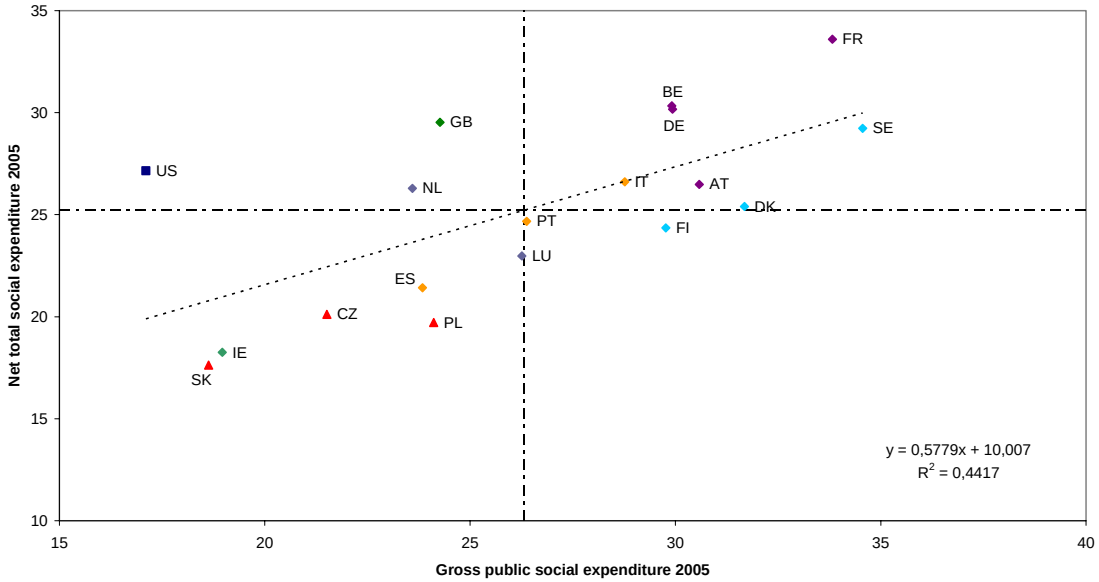
Key characteristics: Gross and net social spending

In recent years the argument that the American welfare state is not incomplete but different has been promoted most forcefully by the OECD in Paris, where Willem Adema and his collaborators have made an admirable attempt to track more comprehensively what welfare states actually do by distinguishing between gross and net social spending (Adema and Ladaïque 2005). The former yardstick is traditionally used in welfare state comparisons based on social outlays, the latter takes four additional aspects into account: (1) the fact that welfare states frequently claw back what they spend by taxing benefits; (2) the fact that there are indirect tax benefits which support groups by granting them certain exemptions or privileges in taxation; (3) the fact that governments may mandate private employers to provide certain benefits, and (4) the fact that 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 United States 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 far ahead of Ireland and Slovakia. If voluntary private spending is included, the United States 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 highlights that the U.S. does not represent a socially unbridled form of pure capitalism, but is rather similar to European countries which pride themselves for 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 which 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).

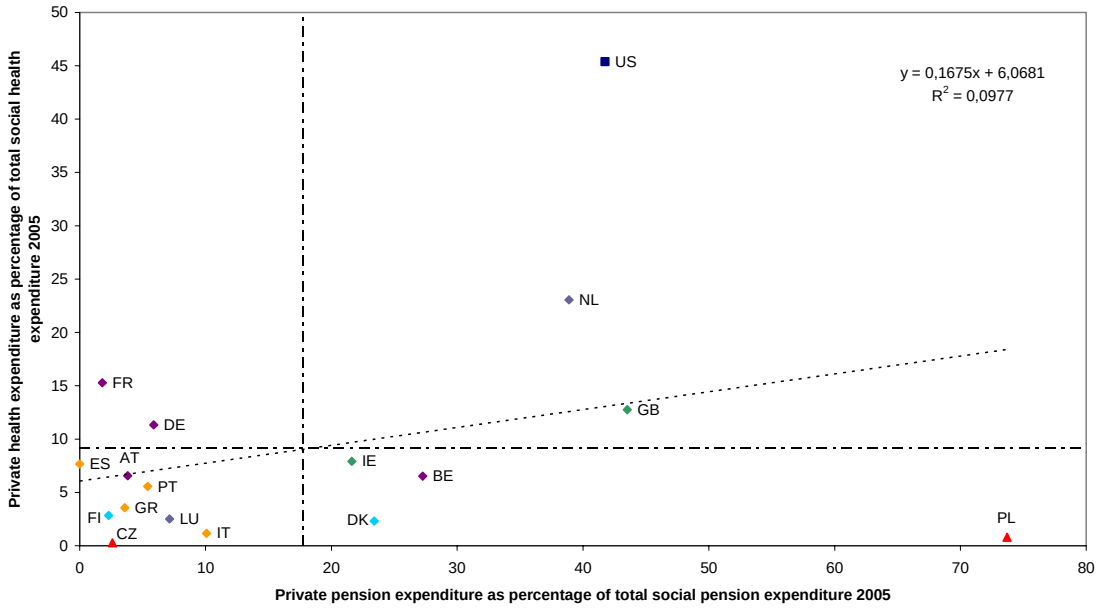
[1] As the focus here is on the benefit side of social transfer programs, different levels or structures of financing are not dealt with. The share of total tax revenues in GDP grew from 27.3 % to 28.0 % in the U.S and from 38.2 to 39.8 % in the EU-15 in the period 1990-2006, thus leading to a widening gap between Europe and America (OECD 2008).

Figure 1: Gross and net social expenditure 2005
In percentage of GDP at factor cost



Source: OECD (2009) Social expenditure database

Figure 2: Private share of social expenditure for pensions and health 2005



Own calculations based on OECD (2009) Social expenditure database

Differences in the composition of social spending become further evident if we take a closer look at the two biggest spending social programs, i.e. pension and health insurance schemes (Figure 2). The U.S. is the only country which 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 which come close to the American level of private spending. In health care spending, the private share in the U.S is more than twice as high as in the Netherlands which stands out as the European frontrunner with respect to privatized health spending.

Table 1: Participation rates in employee benefits in the U.S., 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 **62***			36 **49***			51 **66***			20 **32***	
2008	56 **67***	53 **65***	73 **74***				56 **72***	51 **67***	86 **88***			

Source: U.S. Department of Labor, Bureau of Labor Statistics: Employee Benefits in the United States; 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.

The high levels of private spending are due to the fact that most American workers belong to employee benefit schemes tied to their work-place. Thus, in 2008, more than half of all civilian employees participated in an employer- or union-provided retirement program, while also more than one half had employment-related health benefits (Table 1). In middle 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 shift to contribution defined occupational retirement plans, a trend which Hacker (2006) has described as the ”great risk shift”. In sum, the data on private benefits underline the idea that the American welfare is not so much “incomplete” as relying on different and diverse tools of social support (Howard 2007).

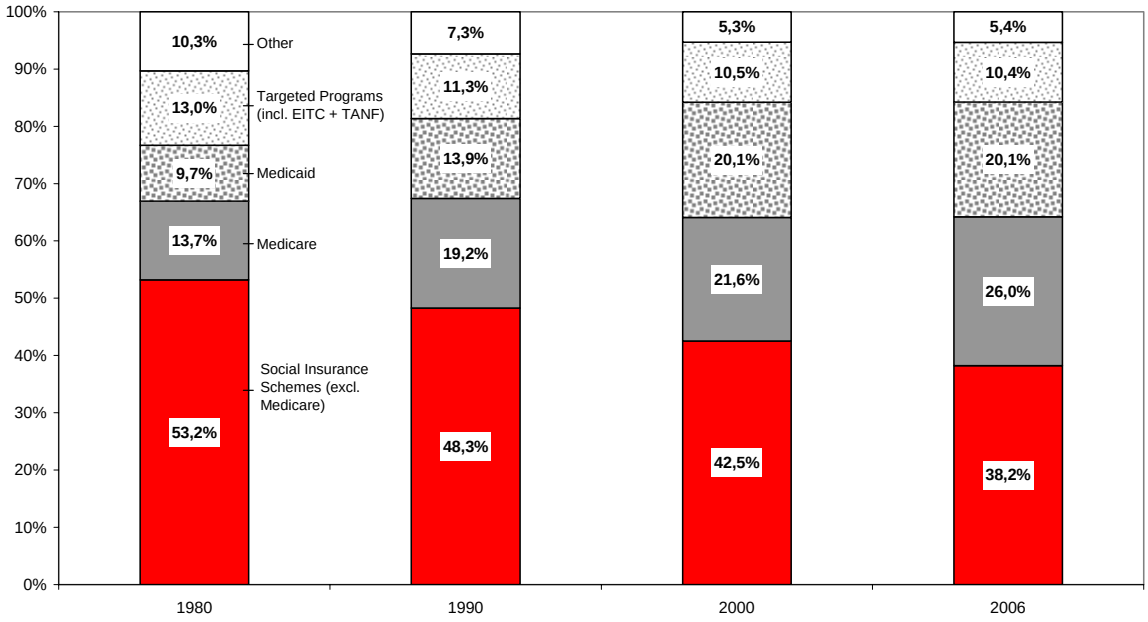
The exaggerated bifurcation into universal and residual programs in the U.S.

According to the concept of the “residual” welfare state, American social policies are bifurcated into a rather limited social insurance branch for the middle classes on the one side whose stingy 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 a the blind, the disabled or the children of poor people – on the other who pass rather stingy 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.

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 programs such as unemployment insurance and workmen’s compensation these schemes devour about two thirds of social spending in the United States. 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 especially due to its steep recent growth, the share of targeted schemes for the poorer part of the population including the Earned Income Tax Credit increased from roughly 23 % in 1980 to over 30 % in 2006. Even though targeted at the poor, both Medicaid and the Earned Income Tax Credit have enjoyed widespread political support which sustained their growth. Disregarding Medi-

caid, 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.

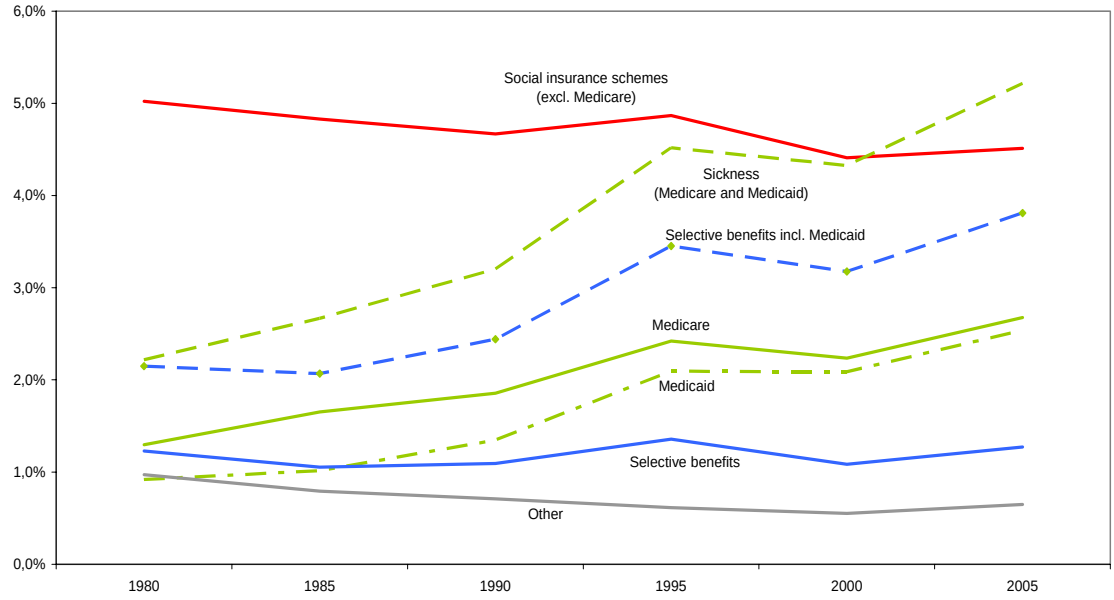
Figure 3: The distribution of transfer payments by type in the U.S., 1980-2006



Source: Own Calculations based on Statistical Abstract of the United States 2009 (Tables 512 und 645)

The development of the single component programs is better illustrated by their changing GDP shares (Figure 4). Disregarding Medicare, the various social insurance schemes have grown slower than GDP over the past 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 programs other than Medicaid remained limited to roughly 1 % of 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 program 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 United States is similar to European welfare states which are also increasingly dominated by pension and health expenditure.

Figure 4: GDP shares of various transfer programs in the U.S., 1980-2005



Source: Own calculation based on Statistical Abstract of the United States 2009 (Tables 521 and 645)

Attempts to contrast the "European Social Model" with the U.S. usually contain three more fine-grained stereotypes which can be confronted with the empirical facts. The first one holds that the American welfare state lacks two schemes that European welfare states typically have – a public health insurance program and a minimum income scheme effectively safeguarding against poverty – while its biggest program, public pensions, is supposedly more stingy and of much more limited size than its European counterparts.[2]

[2] For different accounts contrasting the European Social Model with the American model see Wickham (2002), Vaughan-Whitehead (2003, esp. chapters 1 and 3), Jouen and Papant (2005), Jepsen and Pascual (2005), Alber (2006), Castles (2009), Alber and Gilbert (2009). The idea of a stark contrast has perhaps found its bluntest expression in a phrase by a frequent advisor to the Commission stating: "The simplest difference between the USA and Europe is that we have welfare states, they do not." (Wickham 2002: 1). More detailed accounts focussing on minimum income schemes or health care are given by Saraceno (2009) and Blank (2009) for anti-poverty programs and by Hacker (2009) for health care.

More specific comparisons with respect to three widely held European stereotypes

The most widely held European stereotype concerning American social policies is that the U.S. does not have public health insurance. Even though it is true that a universal sickness insurance scheme is absent, as the major public programs, Medicaid and Medicare, are categorical schemes geared to specific groups, several qualifications are in place. In terms of expenditure, the U.S. spends a similarly high GDP share on public health care programs as high-spending European nations. The three leading sources on comparative health care spending – the OECD Social Expenditure Data Base (OECD 2009), the COFOG Classification of Functions of Government Data Base (Fraser and Norris 2007; Castles 2009), and the World Health Statistics published by the World Health Organization (2008) – differ with respect to details, but all lead similarly to the result that public outlays on health care are *higher* in the U.S. than in most EU member states.[3] Taken together, the two major American public health care programs – Medicare and Medicaid – 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 programs (6.0 % compared to 3.2 % of GDP), but in subsequent years the U.S. closed up so that spending levels in the two countries were almost on par in 2006 (6.0 % in Germany, 5.4 % in the U.S.).

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 U.S. 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 hospitals, and ambulatory and dental care. If the more restricted Medicare and Medicaid schemes in the U.S. now approximate the same level of spending, this is above all due to the higher *cost* of medical services in America. In addition, extensions of coverage also played a role, however. The Medicaid program was continuously opened to additional groups so that the number of children covered doubled from almost 9 to almost 19 million between 1980 and 2000. Since the late 1990s, practically every second birth in the U.S. has been paid by Medicaid (Howard 2007: 98; Table 5.1, p. 97).

[3] The COFOG data presented by Fraser and Norris have the U.S. ahead of *all* EU member states, the OECD SOCX data base has only Belgium, Sweden, France, and Germany ahead of the U.S., and according to WHO statistics only six European countries (Germany, Sweden, France, Denmark, Malta, and the United Kingdom) spend higher shares of GDP on public health programs than the U.S. (The WHO states the total health expenditure ratio and the proportion of public spending in this ratio thus allowing to calculate the public health expenditure ratio from its data.)

The major weakness of the American health care system is the large and growing number of people who remain uninsured. The percentage of uninsured Americans increased from barely 12 % in 1987 to above 15 % in 2007.[4] Roughly 46 million Americans are presently without health insurance coverage (U.S. Census Bureau 2008). The U.S. 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.[5] This segmented organization also implies that there is a marked income gradient in health insurance coverage: Only 8 % of people in the high-income category ($75,000 +), but 25 % of people in the low-income category (with household income below $ 25,000) are uninsured (U.S. Census Bureau 2008, p. 22). This is an indication that the Medicaid scheme falls short of achieving a comprehensive coverage of the poor population.

It must be noted, however, that people without insurance are not necessarily permanently or chronically uninsured in the United States. Given the frequent moves into and out of unemployment in the flexible American labour market (Freeman 2009), there is actually considerable turnover in the uninsured population. A panel study based on data for the periods 1987-89 and 1990-92 found that the typical uninsured spell lasted roughly 8 months for the uninsured poor and roughly 6 months for the uninsured non-poor. It concluded that 32 % of the uninsured of the 1990 panel had uninsured spells which lasted longer than one year (McBride 1997). A biennial health insurance survey conducted by the Commonwealth Fund in 2005-06 found a higher prevalence of chronically uninsured people. 28 % of U.S. adults aged 19 to 64 were either uninsured at the time of the survey or had experienced a time without coverage in the past 12 months (Collins et al. 2006: 2). Of the nearly 32 million adults who were uninsured at the time of the survey, 82 % said they had been uninsured for one year or more (Ibid.: 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 (Ibid.: 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 bankruptcy (Himmelstein et al. 2005: W5-67).

Based on the Census Bureau's Survey of Income and Program Participation (SIPP) in 2002 and 2003, a report by Families USA (2004) showed that the number of unin-

[4] For historical data since 1987 see Historical Health Tables, www.census.gov/hhes/www/hlthins/historic/hlthin05/hihistt1.html and U.S. Census Bureau 2008, Table 6.

[5] In 2007 27.8 % 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 (U.S. Census Bureau 2008: 21).

sured 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). The report stressed 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.

In sum, Europeans may overestimate the absence of public health care in the United States as well as the permanence of lacking insurance coverage, but the comparatively high level of public health care spending in the U.S. does go together with a comparatively wide gap in health insurance coverage despite the existence of various public and employment-related schemes.[6] Until recently the awareness of this problem was rather under-developed in the U.S. Thus, a Congressional Research Service Report which aimed at clarifying why the U.S. spends more money on health care than any other OECD country drew attention to such factors as higher prices due to the better pay for health professionals but did not discuss the American paradox of high spending coupled with low health care coverage (Peterson and Burton 2007).

A second widely shared stereotype holds that the U.S. has only a limited public pension scheme, as public programs must leave sufficient leeway for private insurance companies catering to the needs of the middle classes. This image was early transported by Esping-Andersen (1990) and was later re-iterated by scholars and journalists alike.[7] 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 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 U.S. 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 U.S. 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 U.S. 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.

6 OECD data showing the much wider coverage of European sickness insurance schemes are summarized in a useful comparative table by Hacker (2009).

7 For a typical example taking it for granted that old age security has always been less developed in the U.S. than in Germany see Schimank (2007: 56). For a recent comparison based on OECD statistics and the Comparative Welfare Entitlement Dataset by Scruggs (2005) see Starke, Castles and Obinger (2008).

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 7.0 % because of the demographic factor and would be reduced further to merely 5.1 % if the German GDP were as high as the American one.

If we look at the institutional regulations, the American social security scheme is in fact more universal in coverage, more redistributive in its benefit formula where replacement rates vary inversely with earnings[8], and at least as generous in its benefit levels as its German counterpart.[9] Table 2 illustrates this with respect to the level of benefits. Measured at purchasing power parities in international dollars, the average pension in the United States is 13 % higher than the average pension (per person) in Germany**.** Even the so-called German "standard pension" which a model retiree receives who has 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.[10]

A third widely held stereotype holds that the U.S. does not have a general social assistance scheme which would entitle citizens to a minimum income as in Europe. Discussing this stereotype Chiara Saraceno (2009) recently showed that such minimum income schemes 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. First, not all indigent people can make a claim to poor relief in the U.S., 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" programs, the AFDC scheme (Aid for Families with Dependent Children) and the TANF scheme (Temporary Assistance for Needy Families) which replaced it were targeted at families with children. Secondly, benefits in kind such as Food Stamps and work-conditioned benefits tend to 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

[8] The 2003 earnings replacement rates for people in different income brackets were as follows: 41,6 % for average earners (percentage of last earnings in case of life long 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 - U. S. House of Representatives, Committee on Ways and Means, 2004, p. 1-45, 1-48 und p. 1-50.

[9] The Comparative Welfare Entitlement Dataset (Scruggs 2005) states the net average replacement ratio (for life time average earners in 2000) as 67 % in the U.S. and 64 % in Germany, with 58 % in the U.S. and 74 % in Germany for singles, and 76 % (U.S.) vs. 58 % (G) for couples.

[10] Mean earnings for men were 103.8 % of the average, for women 78.4 %, and 89 % on aggregate for both (Bundesministerium für Arbeit und Soziales 2008, pp. 20 and Übersicht 6).

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 programs illustrates the difference: Welfare entitlements in the United States 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).[11]

Table 2: Pension levels in the United States and Germany, 2006

	USA	**Germany**
Average monthly benefit for retired worker **Average for retired couple (worker and wife)**	**$ 1.044** **$ 1.726**	**€ 805,61** (per person)[1] *($ 923.57)*
German net "standard pension" (if 45 years of insurance and life time average earnings)		**€ 1067** (West - net) *($ 1223.36)* **€ 1176** (West - gross) *($1348.34)*

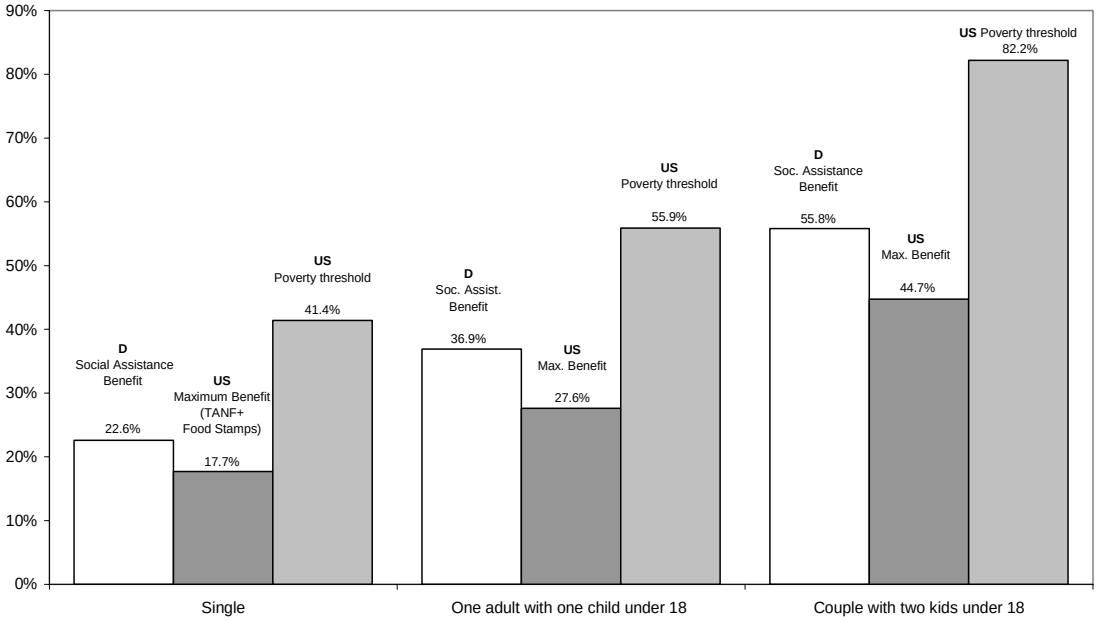
Sources: U.S.: Statistical Abstract of the United States 2009, Table 526
Germany: Rentenversicherungsbericht 2008, p. 18-19
Conversion rate German € in international dollars at PPP: 1.1465455

[1] 2007: the average per each individual pension case is € 718,20 *($ 823.45)*

The more limited character of poverty relief must be seen in combination with two other factors, however. First, the United States has a legislated minimum wage, and secondly, wages in the low-wage sector are supplemented by the Earned Income Tax Credit 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.

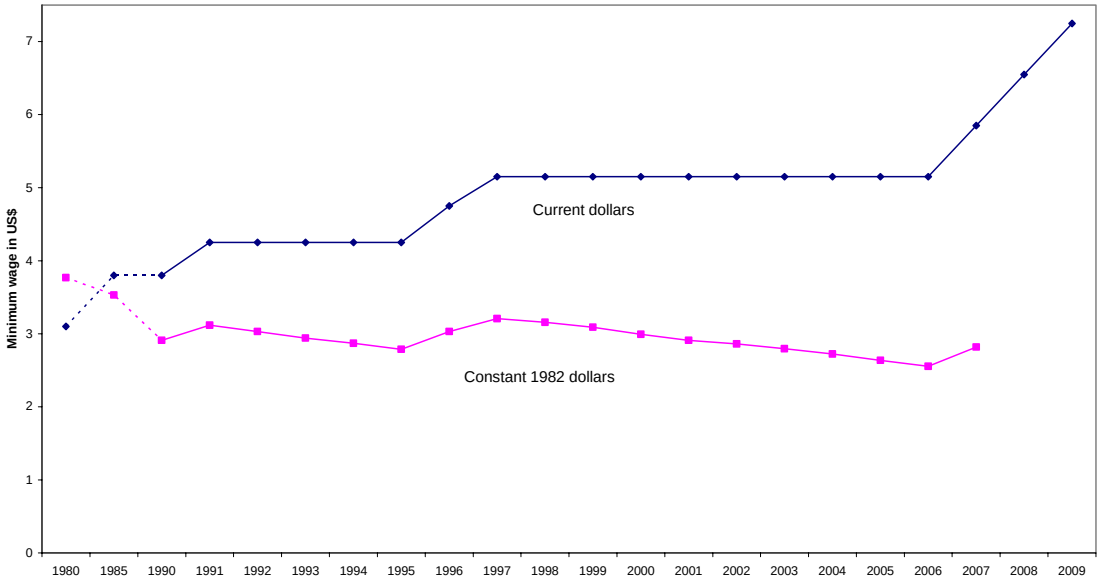
[11] It must be noted, however, that the two major American benefits need not be the only benefits, as they may be supplemented by other forms of assistance such as housing or heating subsidies.

Figure 5: The relationship of minimum subsistence benefits and of the U.S. poverty threshold to the national median equivalent household income, 2003



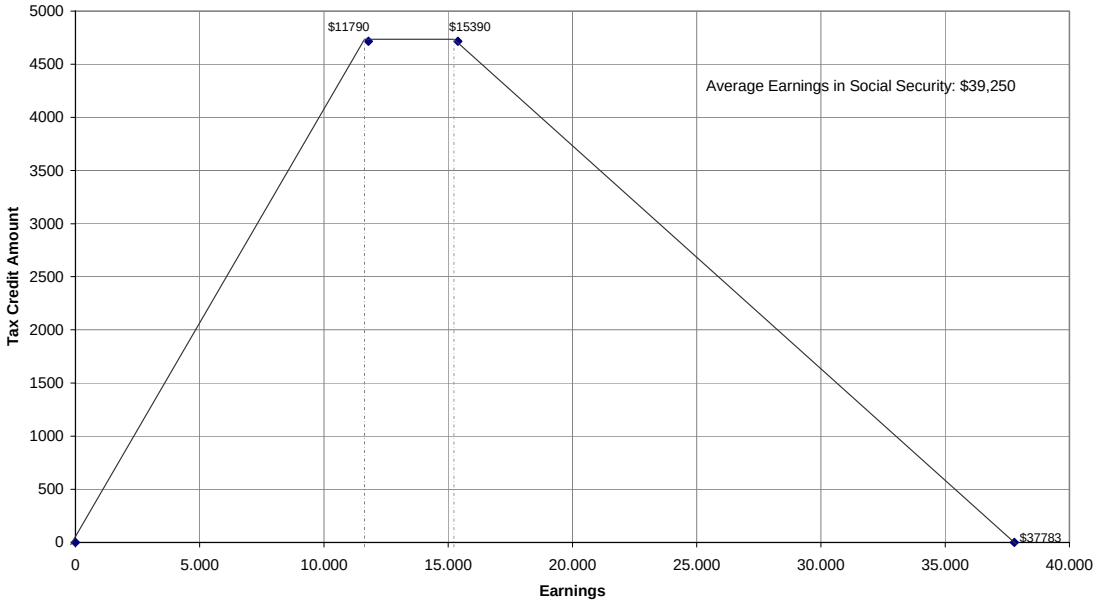
Own calculations based on: USA: Green Book (online:http://www.census.gov/hhes/www/poverty/threshld.html) and PSID (disposable income weighted by square root of hh-size). DE: Bundesministerium für Gesundheit und Soziale Sicherung (Sozialhilferegelsatz plus Wohnkostenzuschuss und einmalige Leistungen) and GSOEP (disposable income weighted by square root of hh-size).

Figure 6: The development of Minimum Wage Rates in the United States, 1980-2007



Based on Statistical Abstract of the United States 2009 (Table 629: Federal Minimum Wage Rates. Table 702: Purchasing Power of the Dollar)

Figure 7: The functioning of the Earned Income Tax Credit for a family with two children, 2007



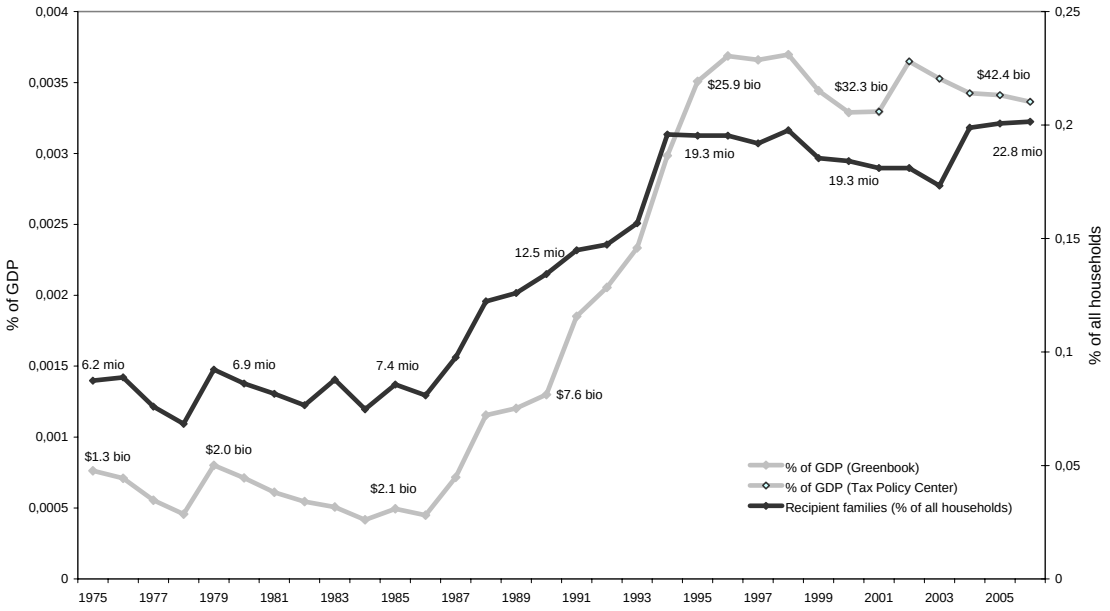
Based on Internal Revenue Service (IRS) and Tax Policy Center (Historical EITC Recipients)

While the minimum wage declined, the Earned Income Tax Credit (EITC or EIC) aimed at making work pay and was considerably expanded in recent years, thus making it one of the fastest growing social programs. The credit is a Federal government program 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 low income. Designed to strengthen work incentives, the scheme grants a refundable tax credit which 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. percent of earnings above the threshold), until a “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 the poverty threshold for unrelated individuals (2006: 110 %, i.e. $ 11.340 compared to $ 10.294). The threshold at which phaseout begins for such a family (2006: $ 14.810) corresponds to about 40 % of the average earnings in social security (which stood at $ 37.601). 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 ($ 4536 a year). 23 million families received a credit which amounted to $ 160 per month on average ($ 1926 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 6 million in the 1970s to above 23 million in recent years, while the total cost of the credit even increased by factor 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 patchwork of several programs most of which are strongly work-conditioned and aim at supporting people with low earnings from work.

Figure 8: Earned Income Tax Credit expenditure (as % of GDP) and recipient families (as % of all households), 1975-2006



Calculations from 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 Ae 29-37)

The major insights from this short description of the American welfare state may be summarized in three points: First, in many respects the American welfare state is different rather than incomplete, because it uses a host of different instruments including not only social insurance, but also minimum wage legislation, tax credits for the working poor, as well as sum other measures not described here such as loan guarantees and

other subsidies in housing, regulation of employment conditions, and tort law (Howard 2007). Second, 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 programs, especially Social Security and Medicare, predominate, it is more universal, redistributive, and generous in its public pension scheme than the German pension insurance system, it is growing over time also in recent decades, and moving closer to Europe with respect to extended public health care schemes. Third, noteworthy differences to Europe remain, most notably a stronger reliance on private schemes in pensions and health, a stronger emphasis on work-conditioned benefits, thus assigning important gatekeeper roles to employers, a greater importance of selective or targeted schemes which represent about one third of 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 which a typology based on a quantification 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 which Titmuss (1974) used to characterize continental European welfare states); the *opportunity-insurance state* (Marmor/Mashaw/Harvey 1990); the *enabling state* (Gilbert 2002); the *work-conditioned public support state* (Blank 2009). Since the element of work incentives is an implicit component of all of these proposals, I think that the term "work-conditioned" welfare state which Rebecca 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 also the minimum wage, the Earned Income Tax Credit, 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 on state bureaucracies administering the programs, 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 United States. In the following I will examine if European welfare states have moved closer to the American case with respect to the following features: the level of gross social spending; the proportion of private benefits, and the relative share of selective means-tested benefits. In addition, we 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 U.S.

Aggregate social spending

Table 3 shows that social expenditure kept growing not only in the United States 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 fifteen old member states of the EU saw a moderate downward trend in social spending between 1990 and 2006 (Denmark, Finland, Sweden, Spain, Luxembourg, Netherlands).[12] The pattern is somewhat different for the new member states, where seven out of twelve countries reduced social spending relative to GDP. On average the trend in social spending up to 2006 is moderately positive in the EU-15, 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 between old and new member states of the EU. Differences between the EU-15 and the United States have not narrowed, but widened over time.[13]

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

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

13 For similar results based on less recent data see Starke, Obinger and Castles 2008, and Castles 2009. Comparisons between the enlarged EU and the U.S. are impaired by the fact that the Eurostat definition of social expenditure differs from the OECD definition while the OECD data base has only data for four of the new EU member states (Czech Republic, Hungary, Poland, and Slovakia).

Table 3: The development of gross social expenditure rates (% of GDP)
(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	
EU-15	19,5	21,4	24,3	24,0	25,4	0,15	0,08	0,05
NMS		17,7	19,9	16,5	16,4		0,11	-0,08
EU-27	19,5	20,6	23,3	20,7	21,4	0,15	0,08	0,00
Stand. dev.								
EU-15	*5,08*	*4,76*	*3,63*	*4,95*	*3,79*			
EU-27 (EU-19)		*(4,63)*	*(3,82)*	*5,64*	*5,79*			
Coeff. of var.								
EU-15	*0,26*	*0,22*	*0,15*	*0,21*	*0,15*			
EU-27 (EU-19)		*(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

Sources: OECD 2009: Social expenditure database. The OECD keeps changing data on the web. This table is based on data found in May 2009. Eurostat 2009: ESSPROS. Trends: Own calculations based on: OECD 2009: Social expenditure database and Eurostat 2009: ESSPROS

More fine-grained indicators of the composition of social spending

The data collection of the OECD allows an over-all 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 United States where private spending on welfare kept increasing further. In 2005, private social spending in the United States amounted to roughly 10 % of GDP, whereas the United Kingdom and the Netherlands were the only European countries beside Belgium with private GDP shares above 3 %.[14]

Table 4: The share of voluntary private social expenditure 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: Adema/ Einerhand 1998, Adema 2001, Adema/ Ladaique 2005

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 the past 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 U.S. developments, the gap separating the U.S. from the (West) European

[14] 2005 data are available for 17 European countries, but time series are only available for the countries in the table.

average increased, because the U.S. continued to pursue the privatization of pensions much more vigorously than most European nations. In line with the notion of path dependency, countries which departed from higher levels of privatization at the beginning of the period also tended to have a steeper trend increase of the private share (r = 0.43). 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.

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)
United States	19,7	41,8	0,84
EU-15	9,9	13,9	0,16
NMS-4	2,4	6,8	0,34
EU-19[1]	8,7	12,7	0,19
Standard deviation EU-15 (EU-19)[1]	*9,4 (9,0)*	*14,1 (13,2)*	
Coeff. var. EU-15 (EU-19)[1]	*0,9 (1,0)*	*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[2]	-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 Social Expenditure database 2009

[1] EU-19 without Hungary
[2] 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)
United States	41,8	45,4	0,08
EU-15	4,5	7,8	0,11
NMS-4	0,4	0,9	0,09
EU-19	3,8	6,6	0,10
Standard deviation EU-15 (EU-19)	*3,8 (3,8)*[1]	*6,1 (6,1)*[1]	
Coeff. var. EU-15 (EU-19)	*0,9 (1,0)*[1]	*0,8 (0,9)*[1]	
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: Calculated from OECD Social Expenditure database 2009

[1] EU-15 without Sweden, EU-19 without Sweden and Slovak Republic

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 United States expanded its private share further, the gap separating Europe and America did not diminish. Whereas almost half of total health outlays in the U.S. is 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 ten per cent mark. In contrast to the pension systems there is no path dependency in

the sense that countries which departed from higher levels in the 1980s also had steeper increases of privatization (r = -.08). Only three European countries – Austria, Greece, and the Czech Republic – were exempted from the general trend toward more private provisions. Judged by the coefficient of variation, European countries became a bit more similar on somewhat higher levels of privatisation, 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 United States.

Scholars of different leanings such as Neil Gilbert (2002) and Bo Rothstein (1998) agree in the belief that Europe witnessed a move toward selective needs-tested programs since the early 1990s. Gilbert arrived at his diagnosis of a trend from "universal to selective" benefits by counting social provisions with income-limits as part of 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 to programs 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 as targeted –, Table 7 based on Eurostat-data[15] shows how the proportion of selective benefits changed over time.

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 U.S. Over time the share of selective benefits slightly *decreased* in Europe 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 U.S. has grown. Traditionally, only Ireland, the United Kingdom, and Malta had double digit shares of selective schemes coming close to the U.S., 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 United States.

[15] The American figures are not strictly comparable and based on the U.S. official statistics shown in figure 4.

Table 7: The share of selective benefits in social expenditure
(% 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
EU-15	9,4	9,4	-0,03
NMS	8,1	6,0	-0,20
EU-27	8,8	7,9	-0,11
Standard deviation EU-15 (EU-27)	*7,2 (6,5)*	*5,9 (5,5)*	
Coeff. of var. EU-15 (EU-27)	*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
SL (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

Own calculations based on: Eurostat 2009: ESSPROS, for the USA calculated from the Statistical Abstract of the USA 2009, Table 521

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, SL: Slovenia, USA: United States of America

In sum, we do find traces of an Americanization of European social policies with respect to a growing importance of private expenditure for social purposes, but not with respect to the importance of selective schemes. Of course, implementing change takes time, so that a more significant transformation may perhaps be found with respect to the policy discourse which will only affect change with a time lag that the available data do not yet capture.

The changing policy discourse: Three aspects of Americanization in Europe and two aspects of Europeanization in the U.S.

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 U.S. than in Europe have recently come to prominence also 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 United States (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. In sum, the responsibility of the state was to be curtailed while individual responsibility was to be extended (Kuper 1994*)*. Together with the impact of the World Bank and the IMF, the 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 2001 and Barcelona 2002 put a transitory emphasis on the virtues of social inclusion and the European social model, 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 which 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 which 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 Neil 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 people at working age who were put under heavier pressure to actively seek work.

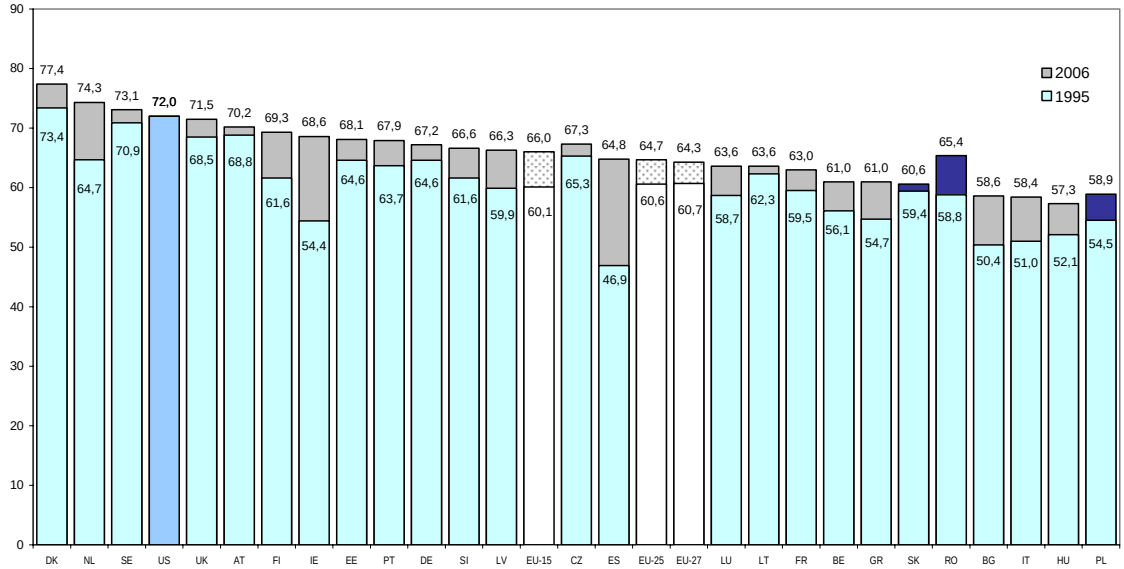
It may be exaggerated to declare the new emphasis on the activation of people at working age as a process of "re-commodification" in European welfare states, as Neil

Gilbert (2002) does. But in sum these new elements do signify a profound transformation of European social democracy which is of historic proportions. The European Labour movement has made its peace with the capitalist market economy and parliamentary democracy in three major steps. 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, the acceptance of parliamentary democracy and a strategy of piecemeal democratic reform. The second step was taken in the 1950s when the idea of public investment control and of nationalizing key industries was given up and the market economy was accepted as a growth machine and as an efficient form of allocating investments. The third step was taken now around the turn of the century, when the idea of limiting the sphere of market influence by extended public services and benefits which would partly "de-commodify" citizens through giving them access to means of livelihood outside the market was abandoned in favour of the new goal to empower as many people as possible to participate in markets. Making people fit for the market has now become the motto of "New Labour" and of a transformed social democracy, as inclusion into work is declared to be the ultimate form of empowerment (Giddens 2001). In some respects European countries have thus become more similar to the work-conditioned welfare state of the U.S.[16]

The new orientation has not been confined to the policy discourse, but has trickled down into re-shaping social reality. Practically all European countries have 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 United States in this respect. The fact that Scandinavian countries have particularly high employment rates, shows, however, that the idea of activation is not only enshrined in the American but also in the Scandinavian version of the welfare state (Alber 2008; Eichhorst and Hemerijck 2009).

[16] The transformation from old to new labour is particularly visible in the development of Esping-Andersen's writings (from Esping-Andersen 1990 to Esping-Andersen 1999 and Esping-Andersen et al. 2002. His new typologies still follow the "good, bad, ugly" scheme to which Philip Manow (2002) 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 now improve from "bad" (due to residual de-commodification) to "ugly" (high female employment, but only in the private sector), whereas the Continental European countries move from their "ugly" position in the original de-commodification typology to "bad" with respect to the insufficient insertion of everybody including women into the labor market leading to a low degree of de-familialization.

Figure 9: The change in employment rates, 1995*-2006



Source: Employment in Europe 2007, Key Employment Indicators. OECD Employment Outlook 2008 (USA)
* In the case of new member states nearest available data. USA data for 1994.

The United States have further strengthened some of the key aspects of the American social policy model by increasing the private share in pensions and health, by expanding "the hidden welfare state" of tax credits, by shifting from defined benefit plans for pensions to tax deductible individual savings accounts, and by extending their targeted programs (Hacker 2006). However, the U.S. 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 programs – Medicare and Medicaid – were successively widened, and also for the change in American attitudes on public policies even before the present financial crisis began. Health care may be the central field where American social policies converge towards Europe. Taken together Medicare and Medicaid have more than doubled their GDP share from 2.2 % in 1980 to 5.4 % in 2006. The Obama 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 (Hacker 2009; Executive Office of the President 2009).

There is also some change in American political attitudes. 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 favour" or "favour" "the U.S. government guaranteeing health insurance for all citizens, even if it means raising taxes." (The Pew Research Center 2007, p. 70). The majority of those favouring an increase in the minimum wage varied between 80 and 87 % between

1998 and 2007 (Ibid.) 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" (Pew, p. 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 % endorse and only 28 % deny 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.

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 United States. It was shown that the United States 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 United States. 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, Neil 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 represents even the best of all possible worlds.

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