Library Briefing
Library of the European Parliament 08/01/2013

Social welfare protection: the EU, USA and China

SUMMARY *Social welfare costs generally make up a large part of governments' total budgets in developed countries. Although the share is lower in China, amounts are rising rapidly.*

The most costly elements in many countries are healthcare and pensions. Both areas have required real increases in budgets for many years because of the ageing of populations: proportionately more people in retirement, using more costly advanced medical procedures and living longer. On the basis of demographic outlooks this trend will continue.

In a time of recession, other welfare costs such as unemployment benefits or guaranteed minimum resources are also cyclically higher, with greater stress in society affecting other budgets such as those covering invalidity.

At the same time, in the EU and the USA there is pressure to contain and even reduce costs, though the US benefits from an economically more favourable demographic profile.

China is not currently in the same situation. It has put in place the basic structure of its main welfare supports and is significantly increasing its spending. In particular, it is spreading benefits already enjoyed by public servants and, more recently urban employees, to give comprehensive coverage also to the 900 million rural dwellers (of 1 300 million total population). With universal healthcare and pension coverage the government aims to retain popular support and avoid instability.

In this briefing:

Context

The modern concept of the welfare state began in Europe, though today the great majority of countries in the world operate at least one social insurance or security scheme most often covering healthcare or pensions. Unemployment support is provided least frequently. Financing and qualification for benefits operate in many different ways.

Since the 1980s largely ageing populations in developed countries have meant pressure for real budget increases for healthcare and pensions. This pressure remains present in the austerity-hit **EU**, where social welfare protection already accounts for a large part of Member State (MS) governments' costs.

The **US**, with the world's largest economy, has its own distinct welfare system.

China has recently started to focus on welfare with significant budgetary increases, albeit from a relatively low base.

Social welfare protection

This covers **12** main areas: healthcare, old age, unemployment, sickness, maternity, invalidity, survivors, employment injuries and occupational diseases, family, guaranteed minimum resources and long-term care.

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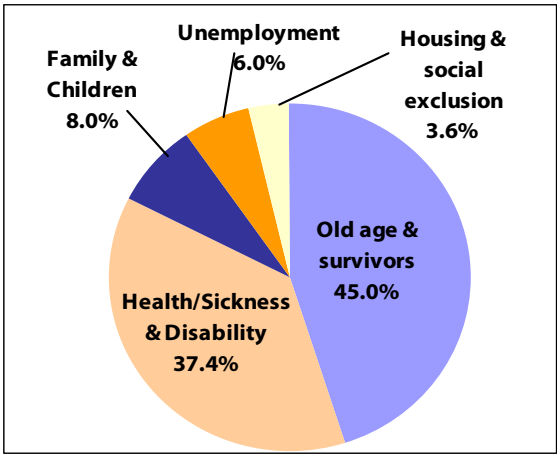
Pensions, healthcare and survivors' cash benefits payments are **long-term entitlements** that reflect demographic trends. Their increasing costs also reflect rising prices and technological progress in medicine. Unemployment compensation is an example of expenditure which fluctuates with the **economic cycle**.

Government support for the poor and otherwise disadvantaged members of society (e.g. some children, old and disabled persons) is usually done through provision of free and/or subsidised goods and services and is funded by taxpayers. The desired outcome is to improve the standard of living and where possible move the person off welfare.

EU

Main costs

EU social protection expenditure by type (2010)
See Annex for detailed analysis by MS.



Source: Eurostat

System structure

Though the EU has a direct influence on MS through internal-market policies, reflected in the setting of minimum standards for the likes of maternity and parental leave, it has few substantive social policy mechanisms. Each MS determines its own social policy.

In general since the 1970s, there have been regular crises and reforms with the aims of:

- Limiting expenditure, or restraining its growth, as its share of GDP continues to increase,
- Expanding social rights and entitlements, especially for family policy. Recently there have been more generous maternity leave conditions, parental leave, child allowances and expenditure on childcare centres, as well as improved family policies in respect of work / family life balance.

Although MS' systems are different they share a number of basic features such as supporting the disadvantaged, reducing inequalities in living standards and chances to advance within society and providing safety nets for the main risks to individuals, such as illness and unemployment.

The EU's Mutual Information System on Social Protection (MISSOC) gives detailed information about national systems, while the European system of integrated social protection statistics (ESSPROS) provides a comparison between MS of social benefits.

There are big differences in the **private element of funding** in MS' social protection systems. In Spain, Poland, the Czech Republic, Estonia, Hungary and Luxembourg private social spending was less than 1% of GDP.

Details of benefits

Old age pensions are the most comprehensive, complex and costly of programmes. With increased ageing in society, there is concern as to the sustainability of systems, resulting in many attempts at reform and restructuring. One reform is to increase and harmonise male and female state retirement ages.
The European Commission wrote in 2009 that the government sector has the dominant proportion of pensions in most MS.

The basic principles for the funding and provision of **healthcare** vary between MS, but there are two main systems:

- A universal (national) health service available to all residents and funded out of general taxation.
- Access and entitlements to healthcare based on an individual's social insurance payment record.

The Netherlands spends the most in Europe on private health.

Long-term care for the rising number of significantly older people with chronic health conditions, sickness or injury and possibly unable to live independently, has gained in importance. The policy response is very varied in MS.

Workplace welfare

Sickness payments make up all or (usually) part of the loss of wages, when an employee is unable to work for medical reasons.

Maternity / paternity benefits have been made more flexible in recent years. They provide for the mother to be away from employment before and after birth for at least 14 weeks.

Invalidity benefits support those who, due to long-term sickness or disability, are unable to undertake paid employment. Payments in this area have grown significantly, reflecting, in part, the intent to reduce the unemployment numbers.

Accidents at work and **occupational diseases** provide for employer compensation support for the injured worker and dependants.

A nominated **survivor's** (usually a spouse or partner) benefit is paid from a pension plan/fund after the death of an employee. The benefits vary greatly between countries.

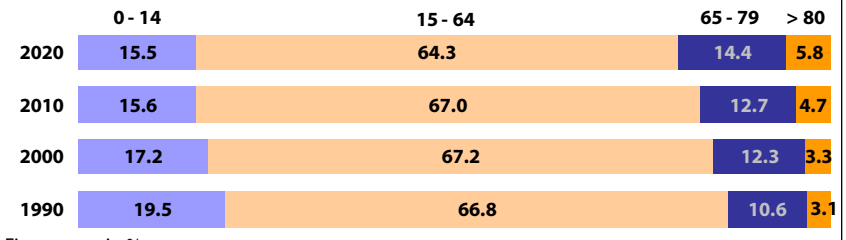
Support for **unemployed** people, who must often show evidence of job searching, is via:

- Unemployment insurance: based on a contribution history. This is normally for employees but increasingly also the self-employed. It is time limited and based on previous earnings.
- Unemployment assistance, existing in under half of MS, is given subject to criteria such as citizenship and a means test: determining a citizen's eligibility based on their financial well-being.

Family support is often a combination of policies, regulations and laws. It includes child allowance - sometimes means tested (i.e. income based) - to help with the cost of raising children. Some countries now give the benefit via tax credits against income.

All MS except Greece make provision to support individuals and their dependants when they are without income ("**guaranteed minimum resources**"). Access is means tested.

EU: 30 year demographic change and outlook



Figures are in %

Source: Eurostat, EUROPOP2010

Outlook

In healthcare there has been a continuing move from treating diseases to prevention, and to lower cost interventions at local levels, supporting people in or close to their homes. With the rapid evolution of low-cost technology (telecommunications, micro-sensors etc.) this is likely to continue.

Recent trends in MS' welfare systems include:

- "Flexicurity": promoting flexibility in labour markets while ensuring there are good benefits for the unemployed.
- Stronger targeting of benefits and means testing.
- Emphasis on reducing the number of people receiving social assistance and disability or unemployment benefits, and on increasing gainful employment.

Overall there is recognition of demographic change (population ageing) and the costs it brings. Along with austerity, this indicates a continuing squeeze on overall social welfare protection spending.

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USA

Main costs

2012 US social protection budget					
(US$ billions)	Federal	Transfers	State	Local	Total
Pensions	820	0	176	40	1 036
Health	846	-379	458	134	1 059
Welfare	452	-50	294	95	791
Source: USgovernmentspending.com					

Government spending in 2012 was budgeted at US$6.3 trillion, with the main social areas representing roughly 46%. This covers federal, state and local levels, and includes federal transfers to states.

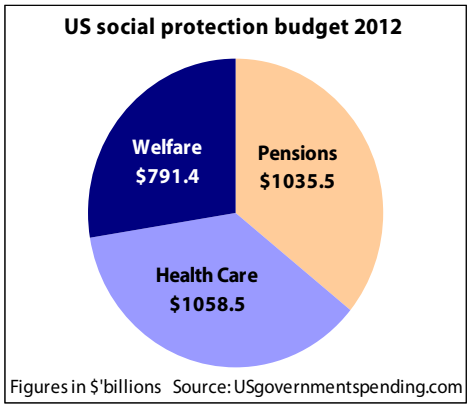
In 2010 the US spent an average of US$8 009 per citizen on **healthcare**. This includes government, households' out of pocket and employer spending.

The 2012 budget splits approximately:

- 46% on seniors (older people),
- 32% to vendor payments,
- 19% on medical service.

The 2012 **welfare** budget gives about:

- 32% for social exclusion,
- 24% for unemployment trust,
- 17% for family and children,
- 14% for unemployment and
- 9% for housing.



System structure

The US public has historically a somewhat unenthusiastic view of government intervention and welfare "entitlements". The middle classes have private sector insurance (over 10% of GDP in 2007) to compensate for rather limited social insurance, while the poor have rather extensive welfare coverage. There is an emphasis on work-conditioned benefits and selective schemes. Employers are the gatekeepers of social entitlements.

Pension system

About half of private-sector and most public employees are in pension plans funded by employers and employees through payroll taxes. Employers are given tax incentives to contribute.

One of the most important plans, which is run by the government's Social Security Administration, provides benefits for workers from 66 years old (65 prior to 2008 rising to 67 by 2027). However, it provides only a portion of a retiree's income needs. Hence, there are high levels of private pension contributions.

Many people, especially the self-employed or those without employers' contributions, save in tax-advantageous Individual Retirement Accounts (IRAs).

The United States provides a means tested benefit for the elderly, known as supplemental security income.

Healthcare

There are private and public healthcare insurers, but the private element predominates for under-65-year olds. Data for 2011:

- 58% had private employer-sponsored insurance,
- 23% were in public insurance programmes e.g. Medicaid (for the poor) and
- 18% (48 million) had no health cover.

Americans over 65 have Medicare cover.

When voluntary private spending is included, the US spends a similar proportion of GDP on public health care programmes as the higher-spending EU MS.

'Obamacare'

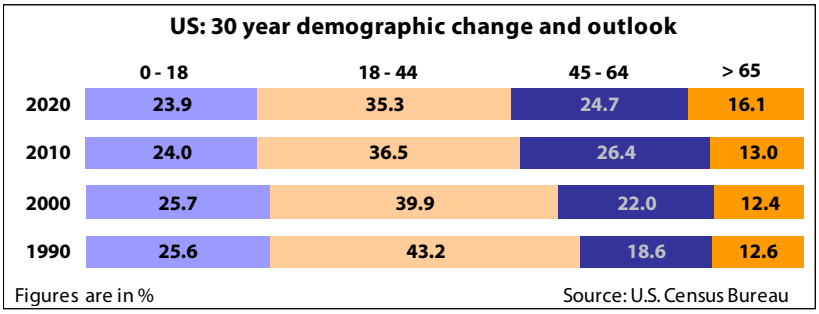
The 2010 Patient Protection and Affordable Care Act (ACA) is a significant regulatory change to the US healthcare system, aimed at reducing the number of uninsured people and reducing costs. It is gradually being

introduced, although there are a number of legal challenges. Its main features are:
- Near-universal coverage,
- Extension of Medicaid eligibility to every American with a household income below 133% of the poverty line,
- Requirement for insurers to cover evidence-based preventive services.

Welfare

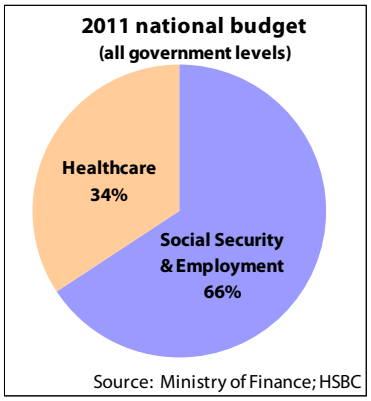
There is no unified welfare system because many important functions are the responsibility of states. It is mainly for the working class, the poor (e.g. Women, Infants, and Children programme), the unemployed and underemployed, as the middle classes have private or workplace schemes. Assistance is means tested and there are modest universal transfers and social insurance plans.

Outlook



Healthcare costs have been rising in real terms for many years through increased numbers of older people and improved and more medicine / procedures. This looks like continuing but costs need to be contained perhaps via ACA or health savings accounts, introduced under President Bush in 2003.

China



Main costs

The 2011 social security and employment budget represented 10.4% of total government expenditure, and the medical and healthcare share was 5.3%. The 2012 budget foresees continued increased spending on social welfare programmes.

System structure

Over the past 30 years the authorities have been moving responsibility for welfare to a combination of government, communities, enterprises and individuals. However since 2002 the authorities have been taking greater interest in social welfare and healthcare issues as a means of reducing the risk of political instability because of social challenges.

The **Urban Neighbourhood Committees** are important volunteer-based, resident representative local organisations. They are responsible for a wide range of civil affairs administration including welfare services.

In October 2010 the People's Congress passed the China Social Security Law, which requires the government to provide for:
- Old-age social security (pensions),
- Healthcare,
- Work-related disability,
- Unemployment and
- Maternity.

Pension system

China is building the largest pension system in the world, although the idea of saving for old age is something new to its citizens.

There are three, very different, nationwide pension plans, available to all citizens, employed or unemployed:

- Civil and public service employees, with around 40 million participants, wholly financed by the government. Pensions are based on final salary,
- Urban workers: obligatory and including China's some 200 million migrant workers. Urban workers (hukou) are also insured for working injury, diseases, widowhood and are entitled to housing and children's education.
- Rural: launched in 2008/9 and voluntary, full coverage is expected by 2020. It also

covers household support and social relief. All residents over 60 years old are eligible even without having contributed, though they receive a very low payment.

The three groups possibly contributing to pension savings are the government, the employer and the employee, although rates vary significantly. Retirement is at 60 years old for men and between 50 and 60 years old for women, with far better conditions and take up for urban workers over rural.

Healthcare

Health spending	
	Growth (per annum)
2006	32%
2007	48%
2008	54%
2009	21%
2010	30%
Source: China Health Ministry	

Total expenditure in 2011 was 5.1% of GDP. Expenditure per person in 2010 was US$224 (US$120 from government, US$82 from households and US$22 from others).

Some 90% of the population were covered by the basic healthcare insurance system at the end of 2010:

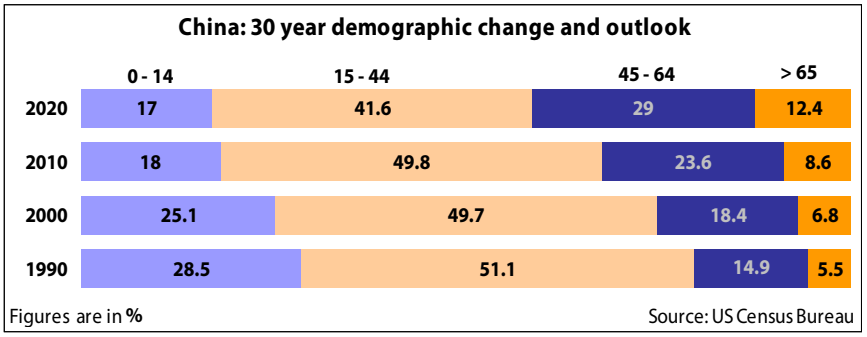
- 430 million urban and
- 830 million (out of approximately 900 million) rural citizens. However, only 20% of Chinese hospitals were in rural areas, with many having insufficient resources.

Social assistance programmes targeting the low-income groups have been expanded substantially. The poverty alleviation programmes and the Minimum Living Standard Guarantee Programme (Dibao) are the main ones.

The National Social Security Fund (NSSF) was established in 2000 to develop a national long-term strategic reserve fund for future social security expenses.

Outlook

The country's population in 2010 was 1.34 billion (900 million rural) with 178 million citizens aged over 60 – expected to rise to



200 million by 2015, whilst the working-age population will shrink from 2016 on. This could put pressure on the sustainability of the pension plan, especially as rural pensions need to be raised substantially in real terms.

Government action on healthcare is likely to continue improving the lot of the rural population.

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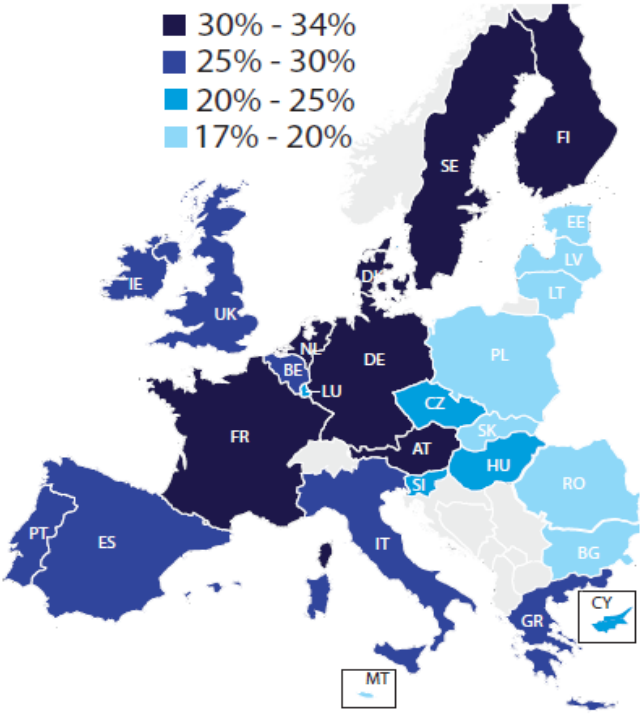
Annex: Additional EU data

GDP spent on social welfare protection by MS (2010)



Source: Eurostat

2010 EU social protection expenditure

	Spend % of GDP	Benefits - % of total social benefits				
		Old age & survivors	Health/ sickness& disability	Family & Children	Un-employ-ment	Housing & social exclusion
FR	33.8	44.9	35	8.3	6.9	5.0
DK	33.3	37.7	37.4	12.4	7.5	5.0
NL	32.1	39.2	43.4	4.1	5.2	8.1
DE	30.7	40.2	40.4	10.9	5.8	2.7
FI	30.6	39.2	37.3	11.1	8.2	4.2
AT	30.4	49.6	32.8	10.4	5.7	1.5
SE	30.4	42.1	39.1	10.4	4.5	3.9
BE	29.9	39.6	35.7	7.7	13.3	3.6
IT	29.9	60.6	31.5	4.6	2.9	0.3
IE	29.6	23.4	48.0	12.9	12.4	3.3
EU	29.4	45.0	37.4	8.0	6.0	3.6
EL	29.1	50.1	33.9	6.4	6.1	3.6
UK	28.0	42.3	41.8	6.9	2.7	6.4
PT	27.0	51.7	35.6	5.7	5.7	1.3
ES	25.7	42.4	35.7	6.0	14.1	1.8
SI	24.8	46.3	39.6	8.9	2.8	2.4
HU	23.1	46.4	33.7	13.0	4.0	2.9
LU	22.7	36.2	36.9	17.8	5.6	3.6
CY	21.6	45.7	26.9	10.0	5.0	12.4
CZ	20.1	47.2	40.1	6.8	4.2	1.7
MT	19.8	54.9	33.6	6.3	2.8	2.5
LT	19.1	44.0	35.8	11.9	4.4	3.9
PL	18.9	60.9	31.6	4.2	2.2	1.1
SK	18.6	43.0	39.5	9.8	5.1	2.6
BG	18.1	51.5	32.2	11.4	3.4	1.5
EE	18.1	44.2	37.7	12.7	4.2	1.1
LV	17.8	53.5	28.4	8.5	7.4	2.2
RO	17.6	50.7	34.7	9.6	3.2	1.7

Source: Eurostat

EU population age structure by MS

in %	0-19		20-64		65 or older	
	1990	2010	1990	2010	1990	2010
EU	27	21	60	61	14	17
BE	25	23	60	60	15	17
BG	28	19	59	63	13	18
CZ	30	20	58	65	13	15
DK	24	24	60	59	16	16
DE	22	19	63	61	15	21
EE	29	21	59	62	12	17
IE	37	28	52	61	11	11
EL	27	19	59	62	14	19
ES	29	20	58	63	13	17
FR	28	24	58	59	14	17
IT	26	19	61	61	15	20
CY	34	24	56	63	11	13
LV	28	20	60	63	12	17
LT	30	22	59	62	11	16
LU	23	24	63.4	62	13	14
HU	28	21	59	63	13	17
MT	31	22	59	63	10	15
NL	26	24	62	61	13	15
AT	24	21	61	62	15	18
PL	33	22	57	65	10	14
PT	29	21	58	62	13	18
RO	32	21	58	64	10	15
SI	28	19	61	64	11	17
SK	34	22	56	66	10	12
FI	25	23	61	60	13	17
SE	25	23	58	59	18	18
UK	26	24	58	60	16	16

Source: Eurostat
UK: 2009; FR excludes overseas depts.

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