
Transitional Social Policy in the Czech Republic and Poland

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Abstract: Social policy has influenced both the popularity of economic reforms and the fate of reformist politicians throughout East Central Europe. With careful planning, social policies can be used to ameliorate the costs of economic reform. Yet some countries in East Central Europe have rated the social dimension of transformation more highly than others. In the Czech Republic, post-1989 governments made social policy an essential part of their transformation project, while Poland's "shock therapists" ignored or postponed dealing with the social dimension. As a result, the Czech Republic prevented social problems from causing a political backlash and began to construct or reconstruct the institutions of the welfare state. Lack of attention to social policy and poor state planning in Poland caused a misallocation of scarce resources and a disintegration of key elements of the social safety net. Loss of social security in Poland contributed to public displeasure with the course of reform and to the post-communist victory in parliamentary elections in 1993. Despite a continuing feud between neo-liberal and social-democratic approaches, the Czech Republic has created a basic framework for a reborn welfare state, while Poland has not progressed beyond reactive, stopgap measures.

Czech Sociological Review, 1995, Vol. 3 (No. 2: 179-196)

Transforming post-socialist economies confront vastly different social policy challenges from those of developed welfare states. Thinking of the special problems of transition in East Central Europe, Claus Offe [1993: 652] identifies a logical progression of three social policy stages that countries must traverse: "emergency measures, institution-building, and reform and adjustment within established social policy institutions." Emergency measures are *ad hoc* or discretionary procedures intended to cope with pressing transition-induced social problems such as rising unemployment. Once these are addressed, governments may construct new social policy institutions that fit the demands of the new economic system. Only after this process of institution-building is relatively advanced is it possible to speak of "'normal' social policies, including an ongoing process of institutional reform and adaptation" [Ibid.: 655]. I will argue that because the Czech Republic and Poland followed different overall strategies of socio-economic transformation in the immediate post-1989 period, the Czech Republic has entered the phase of institution-building and is well on the way to a "normal" social policy, while Poland has yet to advance beyond emergency measures. Differences in financial resources and initial conditions alone do not account for observed policy results.

Different social policy outcomes in the Czech Republic and Poland can be closely linked to strategic choices about the general course of reform. Post-1989 governments in the two countries adopted different strategies of radical economic reform: shock therapy in Poland and a social-liberal or social-market approach in the Czech Republic. These

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strategies were distinguished, in part, by their attitudes toward the social dimension of the transformation process. In shock therapy, as outlined and explained in the writings of Jeffrey Sachs and Leszek Balcerowicz, two of the most prominent architects of the “big bang,” the main object was to create markets and capitalism. These tasks, including price liberalization, macro-economic stabilization and privatization, had to be completed quickly, before strongly-organized interests could mobilize to block reforms that were in the interest of the country as a whole. Building or reconstructing social welfare institutions could wait for a further stage in the reform process. Jeffrey Sachs [1994: 5] writes explicitly that, “Although there are many submodels within Western Europe, with distinct versions of the modern welfare state, the Western European economies share a common core of capitalist institutions. It is that common core that should be the aim of the Eastern European reforms. The finer points of choosing between different submodels – the Scandinavian social welfare state, Thatcherism, the German social market – can be put off until later, once the core institutions are firmly in place.”

Radical neo-liberals in Czechoslovakia, including former Finance Minister Václav Klaus, probably agreed with this assessment. But in the first Czechoslovak governments from 1989-92, Klaus' view was not that of the majority. These first federal governments included former party members who, although probably not convinced Marxists, did have a vaguely social-democratic political outlook, and several 1968ers, advocates of “socialism with a human face,” who had been banished from Prague during “normalization,” but were still infused with the vision and ideals of a wildly popular economic reform program with a strong social-democratic content. Furthermore, President Václav Havel, while an indomitable opponent of communism, was no great friend of capitalism. He wrote scathing attacks on consumerism in the West and advocated moral, rather than economic, development. His political allies were more left-leaning on economic issues than Klaus' team, when they understood economics at all. The result of having Klaus at the Ministry of Finance and Petr Miller (a future member of the Czechoslovak Social Democratic Party) at the Ministry of Labour and Social Affairs was intense disputation, ending in a compromise embodied in Klaus and Vladimír Dlouhý's Radical Strategy of Economic Reform, passed by the government in April 1990. Klaus won on price liberalization, macroeconomic stabilization, and privatization, but the social democrats won on social policy. Klaus needed the votes of at least some of the social democrats to get his program through the government, so he accepted into his own program a social policy section drafted entirely by Petr Miller's Labour Ministry [Myant 1993: 177; interviews by the author with Petr Miller and Igor Tomeš]. The result of this social-liberal hybrid embodied in the “radical” strategy was the construction of the basic institutions and principles of a new welfare state concurrent with neo-liberal economic reform. Although there has been significant debate over the future of social policy in the Czech Republic, during the first five years of reform, the social-liberal strategy succeeded in ameliorating some of the most significant social costs of the transformation and began the process of founding new social policy institutions.

Czech Social-Liberalism

One of the ironies of the Czech transformation is that its successes in the social policy arena have been shielded from public view by the neo-liberal rhetoric of Prime Minister Václav Klaus. Klaus often calls for a market economy “without adjectives,” rather than a social-market economy, and has become the most prominent advocate of Thatcherism in

East Central Europe. Nonetheless, the Czech Republic was much less Thatcherite in its social policy than Poland, where privatization of the health service followed quickly after 1989 and a *laissez-faire* attitude towards the social dimension of reform has generally prevailed. As one Czech sociologist gently put it, “the rather low impact of Right-wing ideologies on social policy matters” in the Czech Republic is remarkable, despite their strong role in shaping macroeconomic policy [Potùèek 1994a]. Since Klaus’ victory in the June 1992 elections in the Czech lands and the split of Czechoslovakia in 1993, he has attempted to shift social policy more in line with his brand of neo-liberal thinking, but has faced resistance from already-established institutions founded under a social-democratic policy regime. In many cases, Klaus has not fundamentally altered them.

The social-democratic or rather social-liberal vision that prevailed in the Czech Republic immediately after 1989 had both a short-term and a long-term component. In the short term, the policy planners intended to cushion the effects of the economic transformation through a range of transitional measures. Many of these were laid out in the “radical” strategy document prepared by Klaus and Dlouhý in early 1990. In the long run, a thorough reconstruction of the social welfare system was envisaged that “would motivate individuals and social groups into action, would lead to social independence and responsibility of the citizen and of whole social groups for their own social situation” [Miller et al. 1993: 7]. The goal was to create a welfare state based on liberal principles that would be compatible with a market economy and support political democracy.

Of the short-term measures, probably the central one was the concept of compensating citizens for cuts in consumer subsidies with direct cash payments. Food subsidies were slashed in mid-1990 and abolished completely in the first few months of 1991 [Koèárník 1992: 27], but the money that had previously been paid to food producers was now paid directly to food consumers, though only for a few years. Compensation amounted to 140 crowns per month per person, or around 5% of the average wage. Compensation payments for the loss of food subsidies amounted to over 6 billion crowns in 1991 and over 7 billion in 1992 (\$256 million) [*Czech...* 1994: 166] and were then gradually reduced from 1993 to 1995, being paid only to lower income families as part of an attempt to introduce greater targeting of social benefits [Heady and Smith 1994: 31]. While the government levied no tax on food from 1990-1992, in January 1993 the value-added tax (VAT) was introduced and food began to be taxed at the lower 5% rate. So through a combination of tax policy and direct cash payments, Czech citizens were protected to a significant extent from the vast increase in food prices caused by price liberalization in 1990 and 1991. Partly because of the lack of taxation, food prices grew much less dynamically from 1990-92 than prices for non-food goods, rising 74.2 percent over their 1989 levels, as compared to 104.4 percent for non-food goods, thus significantly limiting the level of inflation [*Czech...* 1994: 153].

Table 1. Consumer Price Index of Goods and Services, Czech Republic

	1989	1990	1991	1992
Total	100	109.9	172.2	191.3
Food goods	100	110.5	159.7	174.2
Services	100	106.9	148.6	186.6
Public catering	100	110.1	174.8	189.5
Non-food goods	100	110.5	187.5	204.4

Source: Czech Statistical Office [*Czech...* 1994: 160].

An additional transitional policy continued government subsidies of basic consumer costs, such as rent, heat, electricity, and transport. Although the total level of subsidies in the Czech Republic was cut from 15 percent to 5 percent of GDP [Koèárník 1992: 7], the remaining subsidies were almost entirely targeted towards alleviating the social costs of reform. Czech rail fares did not increase at all between 1990 and 1994, making the Czech passenger train system the cheapest in Europe. A Union Bank of Switzerland study in 1994 found that Prague had the cheapest municipal mass transit system and the lowest wages of all the European cities included. A ten kilometer ride in Prague in 1994 cost \$0.20, while a similar ride in Zürich cost \$2.24. Wages in Prague were, on average, ten percent lower than in Budapest. Food prices were lower than in Manila, Cairo, Bogota, or Jakarta. And in Prague, a Czech could still find a small apartment for as low as \$40 per month.

Rent control and rent subsidies were perhaps the most controversial element of the transitional social policy. For they concerned over a hundred thousand landlords who had apartment buildings “returned” to them through restitution as well as many others who had tenants in their privately-owned homes throughout the communist period. Since rent control clearly did not benefit everyone, and reflected a state-imposed restriction on owners of private property, Klaus was frequently attacked for not living up to his Thatcherite rhetoric on this issue. Klaus answered critics publicly in one of his regular weekly articles in *Lidové noviny*, a pro-government daily newspaper, entitled, “Why we still regulate rents” (25 April 1994). Klaus argued that instant deregulation of the housing market would cause enormous social problems and cost the state budget a great deal of money. Noting that rent de-regulation would also force a reallocation of money from tenants to home-owners, Klaus asked “whether we must perform this reallocation at the height of the transformation process, together with not small complications for many of our people, or whether we want to spread it out into a further time period.” It should be noted that Klaus had previously declared the transformation process complete in a speech in the West Bohemian city of Plzeò. Apparently that did not apply to the housing sector. Rent controls were eased between 1992 and 1995, allowing a dramatic increase in rents only after the massive 1991 price liberalization. But even when rents doubled, since the initial level was so low, the average low-income working class household spent only 16.9 percent of its income on rent in 1992 [*Czech...* 1994: 172]. The following table shows that government-controlled service prices, including rent, grew much less rapidly than prices of other goods, especially in 1991. Table 3 shows that government-controlled prices for rent, fuel, and health care grew much less rapidly in the Czech Republic than in Poland, relative to growth in the consumer price index.

Table 2. Consumer Price Index of Services (Czech Republic)

	1989	1990	1991	1992
<i>Total (All Goods and Services)</i>	100	109.9	172.2	191.3
<i>All Services, including:</i>	100	106.9	148.6	186.6
Administrative, notarial, court, local and other fees, insurance, etc.	100	100.3	102.9	114.1
Housing rent and municipal services	100	100.1	144.7	209.6
Education, culture, entertainment and sports	100	107.5	144.7	166.4
Transport and communications	100	107.6	150.9	173.9
Recreation, health care, social facilities, etc.	100	128.6	178.6	192.0

Source: Czech Statistical Office [*Czech...* 1994: 160].

Table 3. Relative Price Changes in the Czech Republic and Poland, 1989-1993 (1989=100)

Relative Price of:	1989	1990	1991	1992	1993
<i>Gross Rent and Water Charges</i>					
Czech Republic	100.0	93.5	95.4	124.5	134.5
Poland	100.0	120.2	158.1	176.5	174.2
<i>Fuel and Power</i>					
Czech Republic	100.0	91.7	98.4	117.8	108.7
Poland	100.0	182.4	304.8	413.9	449.7
<i>Health</i>					
Czech Republic	100.0	109.9	112.5	125.3	157.9
Poland	100.0	136.1	155.0	169.0	171.0
<i>Education</i>					
Czech Republic	100.0	92.4	78.2	95.0	96.1
Poland	100.0	97.4	129.4	136.3	132.9

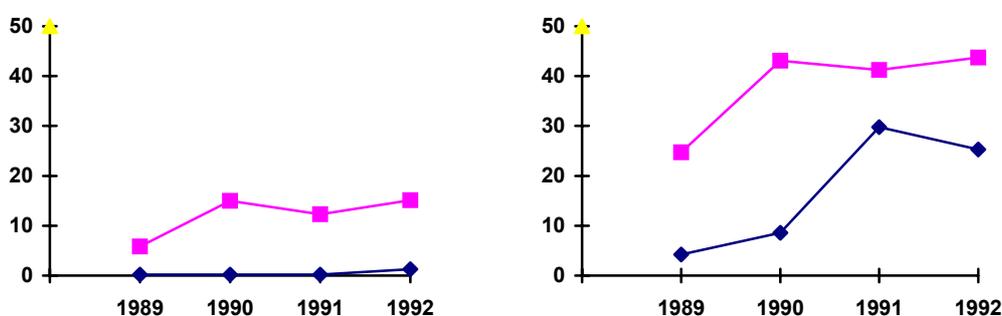
Source: Unicef ["Crisis..." 1994: 100]. Relative prices reflect changes in the price of certain items compared to the change in the total consumer price index, essentially inflation-adjusted price changes from a 1989 base level.

Long-Term Social Policy and Institution Building

Compensation payments, consumer subsidies, and rent control were mainly viewed as transitional measures, but the 1990 scenario for social reform also prepared the basis for a long-term reconstruction of the social safety net. Fundamental to this was a reformation of the "living minimum", implemented with the passage of federal law 463/1991 and subsequent republic legislation [Průša 1993: 33]. The living minimum was intended to define a guaranteed level of social income below which no citizen would be allowed to fall. Planned and implemented with technical assistance from the International Labour Organization and funding from the European Union, the living minimum provided a universal standard for minimum pensions, social benefits, unemployment benefits, and the minimum wage level. Czech governments are required to revise the living minimum yearly in line with changes in the consumer price index and average wages. At the end of

1991, when the living minimum law took effect, an estimated 125,000 households – 3 percent of the total number – were living below the minimum. This number rose to 158,000 in the first quarter of 1992 before falling to 120,000 later that year [Průša 1993: 35]. The proportion of households living below the official minimum remained around 3 percent throughout the transformation. Since the living minimum was not only calculated by the Ministry of Labor and Social Affairs, but actually implemented through the central and local networks of welfare and labor offices, very few Czech citizens experienced extreme poverty during the transformation, although the vast majority suffered a decline in income, and considered themselves to be living on or around the border of subsistence in 1992, subjectively defined [Potùèek 1993: 211].

Graph 1. Extreme poverty (left) and poverty (right) rates (in percent) in the Czech Republic (◆) and Poland (■)



Source: Unicef [“Crisis...” 1994: 2]. Unicef calculates the poverty line at 40 percent of the 1989 average wage (not the current average wage) for Poland and 35 percent of the 1989 average wage for the Czech Republic. This definition and data may overestimate poverty [Schwartz 1994]. For this reason, Unicef also calculates extreme poverty, which they define as 60 percent of the poverty line. Here the effects of the living minimum in the Czech Republic can be seen.

The following table shows that under Klaus, the living minimum fell 8-9 percent below its initial 1991 level, but has since been maintained in real terms. This is a good example of the extent of Klaus’ neo-liberalism in the social policy arena. State generosity was reduced slightly, but the program remained fundamentally unchanged.

Table 4. Increases in Living Minimum for a Four-Member Family, Czech Republic

Month/Year	Nominal Payment (Czech crowns)	Real Value Index (1991 level = 100)
11/1991	5600	100
3/1993	6400	91
2/1994	7060	92
1/1995	7840	92

Source: Mladá fronta Dnes, 9 December 1994, p. 2. Figures are for a four-member family with two parents and two children between 10-15 years of age.

After the reformulation of the living minimum in 1991, the next great step in creating a new welfare state came in January 1993 with the initiation of a tax reform that instituted separate payroll taxes for pension and sickness insurance, unemployment benefits and active labor market policies, and health insurance. Health insurance payments were henceforth to be collected by an extra-budgetary General Health Insurance Fund, although later reforms allowed citizens to choose to direct their contributions to a variety of public and private health care funds. The separation of health insurance from the state budget, with a guaranteed source of payroll tax income, was a major step in changing the methods of health care finance, and one that has not yet occurred in Poland, where health care funding comes directly from the state budget and was thus vulnerable to budget cuts, falling 9.2 percent in 1991 in real terms [Golinowska 1994: 36].

Table 5. Dedicated Payroll Taxes in the Czech Republic and Poland, 1994 (in percent)

	Pension & Sickness Benefits	Unemployment Policies	Health Insurance Fund	Total
Czech Republic	32.00	3.00	13.50	48.50
Poland	45.00*	3.00	–	48.00
Employer contribution:				
Czech Republic	24.00	2.25	9.50	35.75
Poland	45.00	3.00	–	48.00
Employee contribution:				
Czech Republic	8.00	0.75	4.00	12.75
Poland	0.00	0.00	–	0.00

Sources: Czech Ministry of Labor and Social Affairs [*Social Protection...* 1994] and Institute of Labour and Social Studies [*Social Policy...* 1994] for Poland.

*) In Poland, the 45 percent contribution to FUS also covers family and maternity benefits that are funded out of the general budget in the Czech Republic. Therefore the numbers in this column are not strictly comparable.

Pension and sickness benefits were not fully separated from the state budget, a source of dispute between the government and trade unions, but a Czech Social Security Administration was founded with a network of district offices, under the direct authority of the Labor Ministry. Minister of Labor and Social Affairs, Jindřich Vodička, explained the government's unwillingness to create an independent fund, saying, "We do not want to surrender the possibility of the state not only to formulate, but also to directly pursue particular goals of social policy. (...) Besides that, a complete separation of social insurance from the state budget would require an automatic system of indexation" (interview in *Ekonom* 41: 1993). The government wished to maintain control over the goals and financing of social policy and prevent the system from becoming a drain on the state budget. By contrast in Poland, fully 20 percent of the state budget was paid as a subsidy to the deficit-ridden Social Insurance Fund (FUS) and the Retirement-Disability Fund for Farmers (FRUS) in 1992, adding significantly to Poland's fiscal crisis [Golinowska 1994: 31]. In the Czech Republic, the social insurance fund has collected more than enough money to cover outlays, with a 17.5 billion crown (\$625 million) surplus in 1993. The remaining

money was used to subsidize state budget expenditures on social assistance, much to the exasperation of the trade unions who want the money placed in a separate fund and used only for future pension and sickness benefits (*Hospodářské no-viny*, 21 April 1994).

Visible employee contributions to the Social Security Fund were intended to increase the transparency of the social welfare system and to introduce a sense of individual responsibility. In the communist past, individuals had taxes automatically deducted from their pay and did not know how much went for pension, health, or other benefits. Reformers believed that employee contributions would make citizens realize the full cost of the social safety net and therefore reduce demands on the paternalistic provision of the state. The tax reform emphasized the principle of insurance, rather than universal free provision from general funds for pensions and health. A stronger link was established between individual contributions and benefits, although basic health and pension insurance were made mandatory, with the state filling in for people unable to pay. Thereby a level of social solidarity was maintained and a minimum level of benefits insured. With the tax reforms of 1993, the Czech Republic entered the institution-building phase of its social policy transformation.

Klaus' victory in the June 1992 elections caused a shift away from the social-liberal principles that underlay earlier plans and attempts to reform the health and pension systems. While the changes were not immediate or dramatic, the focus and philosophy of Czech social policy clearly changed from 1992 to 1995, more or less in line with a new neo-liberal philosophy. The aims of the new social policy were to eliminate corporatist elements contained in previous social-liberal programs, to reduce state responsibility by relying only on minimum benefit levels, and to target social support only to those living within a narrow band just above the living minimum [Večerník 1994: 8]. Klaus and his team have to some extent successfully redefined and reoriented the development of the Czech welfare state, although in certain areas the new deal faced social resistance and had to be amended.

Supplementary Pension System: Neo-Liberalism in Practice

The new Czech supplementary pension system, introduced in 1995, best reflects the neo-liberal vision of social policy. In comparison to previous proposals, which had envisaged joint management of pension funds by trade unions and employers, the new Czech system relies on individual pension savings accounts to supplement the basic social security scheme described above. In defiance of International Labour Organization norms and general practice worldwide, employers were not required to make any contribution to their employees' supplementary pensions, leaving responsibility to the individual citizen and the state. Individuals make monthly payments into a capitalized pension savings account, and are rewarded with a matching payment from the state budget. Employers may contribute to their employees' pension accounts, but only on a voluntary basis, or as regulated by collective bargaining agreements and individual labor contracts. Obviously employers gain from this type of liberalism, while the benefits to employees remain to be seen. The individual and contractual nature of the new pension system angered the Czech trade unions, who had hoped to participate in the management of enterprise-based employee pension funds. After years of ineffective opposition within the tripartite Council for Economic and Social Accord, the Czech-Moravian Chamber of Trade Unions (ÈMKOS) called a 24-hour protest strike in December 1994 as a last-ditch attempt to stop the government pension program from going forward (*Mladá fronta Dnes*, 14 December

1994). Despite a reasonable turnout, however, the trade unions failed to communicate clearly to the population the main reasons for their opposition and the government program was implemented in 1995 over their objections. The unions' failure to take advantage of a potentially popular issue (most Czechs opposed an increase in the retirement age, an important element of the pension reform) reflects their overall weakness and inability to mobilize support. This institutional malaise facilitated Klaus' construction of a neo-liberal pension policy regime. It is too early to assess the benefits of the supplementary pension system. Klaus' government believes capitalized pension funds will encourage economic growth by channeling public savings into the stock and bond markets, benefitting both pensioners and the economy as a whole. A long-term plan is to reduce the size of the basic state pension to approximately 35 percent of the average wage, thereby increasing reliance on the "second pillar" of individual pension accounts.

Health System in Transformation

The transformation of the health care system began immediately after the Velvet Revolution of 1989, at first led by a small group of activists within the Civic Forum committee of health personnel, which published a set of principles for health care reform in January 1990. These activists formed the core of the Ministry of Health Working Group for Reform that published a proposal for health care reform in May 1990 for public discussion. After a process of debate and consultation with health care professionals and associations, and within the government, the Czech government passed a set of "Principles of a New System of Health Care" at the end of 1990 that guided reform efforts over the next two years [Potùèek 1994b]. Essentially, the Czech government proposed to maintain state-guaranteed universal access to a relatively high standard of care, while decentralizing control over health care providers. Citizens would be free to use the provider of their choice, whether public or private; and providers would be paid a standard fee for all services from a central health insurance fund. Contributions to the insurance fund would come from employees and employers, or from the state, in the case of non-working people.

The 1990 principles reflected the social-liberal views of the Civic Forum health committee and Czech Minister of Health, Martin Bojar. The social element of their philosophy was reflected in their plans to maintain state-guaranteed access to a standard level of health care. It was liberal insofar as it planned for competition among health care providers and allowed citizens to freely choose their doctors and hospitals. The social-liberals were opposed by a group of neo-liberals led by the chairman of the parliamentary committee for social policy and health care, Petr Lom, who later became Klaus' first appointee to lead the Ministry of Health. Neo-liberals supported rapid privatization of health care facilities, rather than a de-centralization that placed many facilities in municipal ownership. They also believed in higher pay for doctors, and increased opportunity to pay higher prices for a higher level of service [Potùèek 1994b: 16].¹

¹) The Czech Prime Minister at the time was Petr Pithart, a friend of Havel's, and while Klaus did not control the government, he had a strong base of support in parliament. After Klaus won the presidency of Civic Forum in October 1990 against Havel's candidate, Martin Palouš, he controlled Civic Forum's parliamentary club, while the government became a *de facto* minority government. Klaus' group within Civic Forum evolved into the Civic Democratic Party (ODS), while Havel's group became the Civic Movement (OH) and lost the 1992 elections.

From 1990 to 1992, health care reform followed the social-liberal principles. In 1990 and 1991, the Regional and District Institutes of National Health were abolished and replaced by Local Associations of Health Services, a somewhat chaotic process that vastly increased the number of health care providers and enlarged the space for independent decision-making. In 1991 and 1992, parliament passed a great deal of major legislation, including acts on health insurance and the General Health Insurance Fund, and an act on non-governmental health facilities that created the legal basis for private health care providers. The General Health Insurance Fund was established at the end of 1991 with the task of planning and implementing a new system of health care finance. The Fund published a list of allowable fees for all types of medical procedures in May 1992 [Potùèek 1993: 220].

Neo-liberals in parliament were dismayed at the monopoly of health care finance by the General Insurance Fund, and drafted a law on Sectional, Professional, Corporate, and Other Health Insurance Funds that passed into law in 1992. This law liberalized the health insurance market, but in doing so undermined the whole social-liberal system of health care financing. When the General Health Insurance Fund began to accept payroll tax contributions in 1993, a variety of other funds competed with it for contributions. These funds were typically marketed toward healthy, younger individuals, and offered higher payments to health care providers. This competition threatened to leave the General Fund with only the older, sicker, and poorer individuals, a high deficit and lower fee payments, so the state introduced a complicated system of redistribution among the funds, in proportion to the number of older members [Výborná 1994: 12].

While the Czech Republic maintained universal access to health care throughout the transition period, the new health care system is riven with problems. The current fee-for-service system of insurance allows health care providers a degree of flexibility in their charges, creating tremendous cost inflation that now threatens to bankrupt the insurance funds or force higher payroll taxes. Accounting systems are in disarray and doctors' salaries remain very low [Výborná 1994: 14-15]. In the summer of 1995, the death of a man in Moravia erupted into a mass media scandal and heightened public awareness of the problems of health care finance. The man's family claimed that he had been denied care at a local hospital because his private insurance company had been severely indebted to the hospital in question and had just recently had its contract cancelled. The possibility that care might be denied for financial reasons disturbed the Czech population and attested to the failure of an ill-planned, ill-conceived neo-liberal reform in this area. As part of his effort to introduce a minimal welfare state, Klaus wants to change the basic principle of equal care for all by introducing the possibility of making extra payments for extra services, limiting the free choice of providers, and allowing insurance companies to combine with providers in health maintenance organizations. However a clear neo-liberal approach to health care has not yet emerged, and equal universal coverage still exists in the Czech Republic.

Conflict Over Social Support

Beside pension and health care insurance, a key element of any welfare state is a system of direct state payments of social benefits to individuals and families. In the Czech Republic, some of these benefits were historically universal in coverage, like the child benefit that was paid to all mothers of children under three years of age. Some were also targeted to particularly needy social groups, such as invalids or parents of handicapped

children. One of the main goals of the Klaus government's welfare reforms has been to eliminate universal benefits and instead to offer state support only to families with incomes in a relatively narrow band above the living minimum. Klaus' attempt to introduce targeting of parent and child benefits in 1995 met with a great deal of resistance and public debate, forcing the government to withdraw its initial proposal from parliament. Opponents of targeting, including the trade unions, argued that means-testing required far higher administrative costs and had little social benefit. An independent analysis by British tax experts showed that the government's original targeting proposal would significantly reduce the number of families living at less than 1.25 times the living minimum, but mostly at the expense of families not much higher up the income distribution. Especially families earning at or around the benefit cut-off level "may be in the position where increasing hours of work will result in the loss of the child or parents' allowance" [Heady and Smith 1994]. The Klaus government eventually forced a compromise through parliament that staggered loss of benefits for people living at one to two times the living minimum. However, targeting seems to have upset a Czech population comfortable with the type of social solidarity implied by universal benefits and deeply rooted in national traditions. Conflict over targeting of social support corresponded with a substantial increase in support for the Czech Social Democratic Party, raising the question of how successful the neo-liberals will be in recasting the Czech welfare state in the long term.

Poland: The Ignored Social Dimension

In Poland, there was no overall vision of transitional social policy. Unlike the pro-active measures taken in the Czech Republic, Polish social policy has reacted to the fiscal crisis of the state more than it has conformed to any particular short or long-term strategy [Ksiezopolski 1993: 192]. What social policies did emerge were mostly emergency measures, some of them so ill-planned or ill-conceived that they frustrated development of long-term solutions. This was most notably the case with unemployment benefits and pension reform, both of which relied on a dangerous relaxation of eligibility criteria. Cash benefits to the unemployed and pensioners expanded dramatically, crowding out investments in health and education that are necessary for future growth. Although Poland undoubtedly entered the transformation period poorer and more indebted than the Czech Republic, poverty alone does not explain the failures of Polish social policy. Poor government planning and administration of benefit systems were important factors and are direct results of a shock therapy strategy of rapid economic transformation that tended to ignore the social dimension, or believe its reform could be safely postponed. Delaying social safety net reform and emphasis on *ad hoc* emergency measures damaged the ability of the state to deliver social services and further immiserated the population during the transition.

A surprising and contradictory personality in the Polish social transition was Jacek Kuroń, the first post-1989 Minister of Labour and Social Policy. In his short memoirs of his time in the Labour Ministry (entitled *Moja Zupa* [My Soup] [Kuroń 1991]), after the "Kurońówka" soup that became a symbol of poverty relief under shock therapy, Kuroń admits that post-1989 social policy had many shortcomings. He explains that Solidarity was simply unprepared to take power when it unexpectedly won the June 1989 elections. The book essentially describes how a Minister came to power with a group of underground printers, editors, and trade unionists and was overwhelmed by events. While this may have been true, the shock therapy economic program was carefully planned, dis-

cussed and elaborated in numerous committees, with support from Western governments and international institutions. Kuroń himself founded a committee of economists to plan radical macro-economic reforms in 1988. Social policy, however, bounced from emergency measure to emergency measure, reflecting its low priority in government concerns [Graham 1994: 193]. No convincing overall vision of social policy was produced, just stopgap relief measures represented by Kuroń's soup.

Health Care Disintegration

Although the pattern of incoherent reform and disintegration of the social safety net is visible across the board in Poland, it has been perhaps most dramatic in the health care system. Health care in Poland fell prey to the country's fiscal crisis in 1991, when real expenditures dropped over 9 percent, while the cost of medicine and equipment increased dramatically. Health care investment dropped 16 percent between 1990 and 1992 in real terms and wages in the health sector fell to 9 percent below the average wage level, while the number of people employed in health care also fell about 5 percent [Golinowska 1994: 37-42]. A new system of health care finance, based on an insurance model, was debated during the first years of reform, but was never implemented, partly because the World Bank recommended that Poles could not afford an extra health insurance payroll tax [Millard 1994: 6]. Without dedicated revenue sources, the health system lost funding and a two-tier system began to emerge, often without state regulation or intent: private, fee-for-service, health care for those who could afford it, and an increasingly restricted range of free state services for everyone else.² Part of this trend occurred through an expansion of private health care providers that accepted only cash payments, but also through developments in the state system where fees began to be charged for certain procedures, for citizens living outside the local health district, or by "private" doctors who had appropriated (or "rented") state facilities in a process analagous to the "spontaneous" privatization of state-owned industrial enterprises. For instance, one region of Poland leased its only urology clinic to a private practitioner at exceedingly low rates, making certain essential services unavailable within the free state system [Millard 1994: 9; Ksiezopolski 1993: 184].³

Besides the fiscal crisis that resulted in a de facto commercialization of health services, the Polish state lost any ability to guarantee health care access through a process of decentralization that empowered *województwo* (district) health offices, over the central Ministry of Health. The majority of Poland's health budget is paid in lump sums to the 49 dis-

²) Balicki [1994: 157] writes, "In the situation of disequilibrium between the obligations of the state and the possibility of their realization, there have arisen different informal methods of regulating access, often unopen, together with the privileging of certain groups of patients... This situation is particularly disadvantageous for economically weaker groups, for whom access to a number of services has lately been limited, despite the still existing provision in the constitution guaranteeing free care." The author, an employee of the Ministry of Health, blames the "weakness of the Ministry of Health and Social Care as leader of the transformation, the lack of an overall vision of change, the pressure of current matters and insufficient intellectual attention to long-term activities." [Ibid.: 156].

³) Golinowska and Ochocki [1994: 11] conclude that, "The process of commercialization in this sphere does not proceed in a regulated manner, which causes the increase in payments for social services to act in a blind manner, destroying the principles of social solidarity in such spheres of human life as sickness and the raising of future generations".

trict offices that set policy and allocate budgets in the regions. District health officers are appointed by the *wojewód* (district governor), who is in turn appointed by the Chief of the Council of Ministers, a cabinet-level position that is in fact stronger than the Minister of Health. While the Ministry of Health handles the central budget, the Chief of the Council of Ministers and the *wojewód* are in charge of personnel decisions in the state health service, as well as in many policy and budget decisions. This system of financing makes it extremely difficult to create and enforce a national health policy. Since individual districts and even towns are on different systems of financing, many state health care providers only give free care to residents of their district. A resident of Wrocław who has a car accident in Poznań may not be eligible for free care there, for instance [Millard 1994: 5-7; Halik 1993]. Probably the greatest irony of the health care disintegration in Poland is that the World Bank has lately criticized the reduction of health expenditures in Poland, while several years earlier, it encouraged decentralization and opposed the introduction of a general health insurance system, such as the Czech Republic used to maintain a high level of universal health care.

Pension Explosion and Fiscal Imbalance

While health care and education funding plummeted in real terms in 1991, government spending on pensions exploded, creating a fiscal crisis that crowded out more investment-oriented and better-targeted forms of social spending. Rapid expansion of pension payments was a direct result of over-generous and ill-conceived initial attempts to sooth the social costs of the transformation by extending pension and unemployment benefits. Jacek Kuroń, the first Solidarity Minister of Labour and Social Policy, was responsible for many of these initial policy mistakes. His good intentions, honest social conscience, and generous benefits made him the most popular politician in Poland, but technically, his programs have been a disaster. Workers over a certain age who lost their jobs due to privatization or restructuring became eligible for early retirement. As a result, the number of people collecting pensions mushroomed, the average retirement age for men decreased to 57 (the official retirement age is 65), and many of these people continued to work, often in the “grey” or unofficial sector. Similarly, unemployment benefits were initially set at levels high enough to discourage people from seeking work.

Table 6. Rapid Increase of Pensioners in Poland (in thousands)

	1989	1990	1991	1992
Retirement Age Population	4,799	4,903	4,979	5,062
Percent Growth	1.9	2.2	1.6	1.7
Number of Retirees and Pensioners	6,827	7,104	7,944	8,495
Percent Growth	2.4	4.0	11.8	6.9
Economically-Active Persons per one Retiree or Pensioner	2.6	2.3	2.0	1.8

Source: Golinowska [1994: 33-35].

The swift increase in the number of persons collecting benefits, coupled with a reduction in the number of people contributing to the social insurance funds (FUS and FRUS), caused them to run a tremendous deficit that had to be filled from the state budget. While in 1988, only 4.7 percent of the state budget went for social insurance subsidies (to the nominally independent social insurance funds), in 1992 that level reached 20 percent and

continued to grow. The government eventually managed to reduce the level of pension indexation from 100 percent to 91 percent of average wage growth, but generous eligibility criteria, once adopted, destroyed the fiscal balance of the system and political resistance to reducing pensions prevented any meaningful reforms throughout 1995.

Table 7. Pension Payments in Comparative Perspective

	Czech Republic	Poland	Hungary
Minimum Retirement Age			
Men	60	65	60
Women	53-57	60	55
Minimum Contributory Years for Eligibility			
Men	25	25	25
Women	25	20	25
% of Wage Replaced by Pension According to Law			
Net	54%	55%	67%
Nominal	50%	55%	63%
Average Pension as Percent of Average Wage (Percent of Average Wage Actually Replaced)*	49%	74%	49%
Pensions in Percent of GDP	10.2%	14.8%	10.6%
Social Security in Percent of GDP	21%	19.9%	27.6%

Source: Vittas and Michelitsch [1995].

*) The authors conclude that, "In Poland, the high replacement rate is attributed to the large upward adjustment of pensions effected in 1991 and the subsequent indexation of pensions to average wages" [Ibid.: 8]. Notice that pensions crowd out other social security spending in Poland.

In the SLD-PSL government, pensions became the source of a controversy between Finance Minister, Grzegorz Kołodko, and Labour Minister, Leszek Miller. Kołodko wanted to index pensions to price rather than wage growth and introduce private pension insurance. Miller, on the other hand, wanted to maintain the current system in slightly altered form, while introducing a system of supplementary private pensions for more affluent citizens. In fact, a system of private pension insurance rose up spontaneously, without any specific legislation or tax incentives, simply because the basic pension was inadequate for wealthier Poles and because some companies wanted to offer pension benefits to attract employees (*The Financial Voice* 9: 37, 1994). Similar to pensions, generous unemployment benefits in Poland created a significant drain on the state budget, while crowding out investments in active labor market policies such as retraining and job creation.

Social Assistance

The 1989 Law on Social Assistance intended, like the living minimum in the Czech Republic, to create a social safety net to protect people who fell below the poverty line, either temporarily or permanently. However, problems emerged with the financing and administration of the Polish safety net and it is impossible to say that the safety net has effectively guarded against poverty. In the Polish system, some benefits are funded by the central government through earmarked contributions to the local budget, but administered by the local *gmina* governments, who have social assistance centers staffed with social workers. Other benefits are funded by the *gmina* itself from local taxes ["Poland: Income..." 1993: 33-35]. Although central and local government expenditures on social

assistance rose steadily throughout the transition, they could not keep pace with the rate of growth of social problems. Since the payments are administered locally, budget shortfalls produced a patchy distribution of benefits, with some families getting the full benefits and others receiving only a fraction of what they are eligible for under the law [Graham 1994: 242]. In 1995, all families earning less than 855.8 new z³oty per month were eligible for social assistance (in line with the minimum pension), although the Solidarity trade union proposed that the social minimum should be 589.4 z³oty, or 60 percent of the socially-defined poverty line. Despite generous calculation of the living minimum, 420,000 families, or approximately one-third of the poor, were not receiving full benefits. In some cases, they received only 50 z³oty (\$20) per person per month (*Gazeta Wyborcza*, 31 May 1995). The World Bank concluded that, "Whilst voivodships have some monitoring functions, it is not clear whether the Ministry of Labour and Social Policy or any other national body has any responsibility for looking at the ways in which the commissioned tasks are carried out, or the consistency of decisions" ["Poland: Income..." 1993: 65]. Caught between generous official benefits, rather less generous actual payments, and an inefficient delivery system, the Polish social safety net had serious holes during the entire transformation period, undoubtedly leading to discontent with reform, both among the poor and among others who lived in proximity to poor families and sympathized with a plight that was often caused by unemployment [Grootaert 1995]. Feelings of social solidarity are quite high in Poland, making it difficult for people to accept that perhaps one-fourth of the population is living in poverty. Disintegration of the social safety net shattered expectations of security and social solidarity that were fostered under socialism and before. Many Poles simply felt abandoned by the new democratic state.

Conclusion

While the Czech Republic implemented a strong package of social policies that helped smooth the transition to a market economy, Poland's social safety net fragmented and fell apart. Initial conditions clearly played a role in this, since Poland was and is a poorer country, had a history of greater problems with poverty [Milanoviæ 1991], and faced more difficult macro-economic challenges in 1989. Nonetheless, the failure of transitional social policy in Poland resulted not only from worse initial conditions, as some authors argue [Balcerowicz 1994], but from Solidarity's lack of policy direction in this area and the low priority of social policy in shock therapy strategy. Policy planning occurred in other policy areas, where the government made major achievements despite scarce resources.

Evidence presented here points to the fact that in Poland, resources were misallocated, creating great contrasts between over-generous pension benefits on the one hand and a disintegrating health care system on the other. Initial choices, like the 1991 decision to increase pension benefits and eligibility, have proven politically difficult (indeed impossible) to reverse, suggesting that better planning in the early stages would have prevented significant long-term problems.

Czech experience underlines the importance of planning and overall strategy in shaping transitional social policy. The social-liberal model of economic transformation in the Czech Republic sought to conduct a transformation in the social sphere concurrent with radical macro-economic reforms. New social policy institutions, such as the General Health Insurance Fund, and new financing and delivery systems were developed at the same time as market institutions, so that emergency relief measures did not crowd out the

development of long-term solutions. Because it began work at an early stage, the Czech Republic is the only country in East Central Europe that has created an effective social safety net [Götting 1994; "Crisis..." 1994]⁴ – albeit a residual one that provides only bare minimum standards, compared to the more elaborate Western, and especially Scandinavian, systems.

One further condition that seems to have helped the Czech Republic pursue a successful social policy is the greater centralization and efficiency of its state administration. Poland decentralized most social welfare functions in 1990, placing them under the authority of local self-governments, rather than in the local branch of state administration. While this may have been good for Polish democracy, it had tragic results for social service provision in some regions. Better organization and planning of the social safety net probably would have alleviated Poland's social crisis, despite scarce resources.

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⁴) Götting [1994: 195] writes, "All things considered, the Czech Republic today seems to be in the best position to set up a 'social safety net' that meets the concerns of both efficiency and 'social justice'. Favourable economic starting conditions combined with the pragmatic course taken towards capitalism have helped to ensure social peace." Unicef ["Crisis..." 1994: 17] writes, "The Czech Republic has been the most successful 'shock-therapist' to date, despite a 20 per cent output decline and rising poverty rates... Well-planned and consistently implemented social protection policies and – above all – much more favourable 'initial conditions' contributed to a comparatively more satisfactory performance and greater political stability."

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