

**An Analysis of the Welfare State in France and Sweden:
Convergence or Divergence?**

By

Peter Feher

A Thesis
Submitted to the Department of Sociology
in Partial Fulfillment of the Requirements for the Degree of

MASTER OF ARTS

Department of Sociology
University of Manitoba
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Abstract

A major debate in the welfare state literature is the extent to which modern welfare states are becoming more similar or different due to internal and external pressures. The present study examines the convergence/divergence debate as it relates to two well developed European welfare states, France and Sweden, over the last 25 years. Using secondary data sources such as OECD data and Social Security Programs Throughout the World (SSPTW), the study examines welfare state change over time in three key policy domains – family, health, and old age policy – from approximately 1977 to 2002. Two components of the welfare state, income security measures and social services, were compared across these policy domains. An examination of family policy revealed continued support for family allowance transfers and generous parental leaves in both France and Sweden. Health policy displayed no dramatic changes in sickness insurance benefits in both countries and no sharp declines in ambulatory and non- ambulatory health services. Old-age policy did display convergence within pensions where Sweden has become more similar to an earnings-related system like France, while elderly services exhibited no major changes. Overall, the social policy domains displayed continued divergence with the exception of the income-security component of pensions within old-age policy, which displayed a convergence. These findings offer important policy alternatives for welfare states like Canada who are currently debating the merits of privatization in health care. Policy makers could learn considerably from an examination of the welfare experience in Europe rather than relying solely on reforms and policy in the United States.

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Chapter One

The Welfare State: An Introduction

One of the most prevalent debates in the literature on the welfare state is the idea that over the last 25 years, due to a range of external and domestic pressures, the welfare state has been in crisis. This crisis has resulted in cuts to social programs and overall retrenchment of previous commitments to public welfare. A new strain of convergence theory suggests that, since welfare states are under similar pressures (such as declining rates of economic growth, increased unemployment, unfavorable demographic conditions, and increased competitive strain due to globalization), welfare states are moving towards a single model, one that provides minimum relief for only the most marginalized sections of the population. However, the notion that global macro-economic pressures or population aging are having a uniform effect across the industrialized world is hotly contested. Some research points to a diverse response to global economic pressures by industrialized nations in policy reform and even expansion, not retrenchment. It thus suggests that national welfare states have, for the most part, maintained their distinctiveness (Castles and Pierson, 1998; Olsen, 2002). This thesis will address this issue, focusing on two developed, but very different kinds of welfare states in France and Sweden. It will seek to examine the nature and degree of change, and possible directions toward convergence or divergence in these two nations. The time period for this thesis will be approximately 25 years from 1977 to 2002. If 1977 is not the beginning of the decline of the welfare state it is an approximate marker for the end of its expansion throughout the 1960s and 1970s. The oil crisis and economic stagnation of the mid-to-late 1970s heralded the end of what some authors call the Golden Age of Capitalism

which characterized the postwar economic boom until the mid 1970s (Esping-Andersen, 1996). The ascendancy of neo-liberalism as a political force also occurred around the late 1970s / early 1980s with the presidency of Ronald Reagan in the United States and the election of Margaret Thatcher in England (1979). Both leaders called for the reduction of the welfare state and expansion of the market. Furthermore, the past two decades coincides with most of the external and domestic pressures thought to be the sources of changes to the welfare state. Declining rates of economic growth, government debts and deficits, and demographic changes are thought to be the main domestic culprits behind welfare state retrenchment (Schwartz, 2001). Globalization is typically seen as the central external force, narrowing the range of economic policy options (control over national money supply and exchange rates) that have been until very recently the domain of the nation state.

Social policy researchers often disagree about what constitutes a welfare state. Broadly, the welfare state refers to an organized state system designed to ensure a decent living standard for its citizens (Tsukada, 2002). Yet, upon comparing the various programs of industrialized nations there is a clear disparity in how countries interpret “decent” within ‘decent living standard’. As this thesis will show, some welfare states interpret decent to mean meager unemployment insurance or minimal social assistance for only the most needy in society. Other nations support a more egalitarian view of capitalist society and have organized their welfare states not just for poverty alleviation, but for the elimination and prevention of poverty, greater gender equality, and societal redistribution of income (capital, resources). Some national programs are based upon antiquated notions of proper gender roles and only support the ‘man of the house’ with

generous benefits while ignoring working women. Thus, a more detailed definition is required before any county specific programs are examined.

The welfare state includes major income security measures and social services provided by the state. These can be divided into four categories: (1) income security programs including various forms of universal transfers, social insurance and social assistance (i.e., family allowances, old age pensions, unemployment benefits, social/public assistance, and other cash transfers); (2) social services such as child care, elderly care, health care, education, and labour-market training; (3) 'in-kind' goods such as food stamps, school meals, subsidized housing, and prescription drugs; and (4) social legislation or 'legal welfare' such as minimum wage, workplace health and safety, statutory vacation, and child protection laws (Olsen, 2002).¹

This study will focus primarily upon three central social policy domains within the first two categories above in France and Sweden. The three policy domains are (1) family policy, (2) health care policy, and (3) elderly care policy, examining central income security and social service measures in each area. Within each policy domain qualitative differences concerning eligibility rules, degree of program inclusiveness, how benefits are accessed, the length of benefits and waiting periods, and the generosity of income security measures or transfers (benefit levels and replacement rates) will be examined. The range and quality of services offered will also be analyzed to assess the degree and significance of changes to the welfare state in France and Sweden. It is hoped that this will allow the identification of any changes or policy trajectories that demonstrate tendencies towards convergence or divergence as it relates to the two countries examined.

Two Very Different Welfare States: France and Sweden

Most comparative social policy research has focused on extreme cases where welfare state differences are more obvious and striking (Gould, 1993). This is best demonstrated by comparing Sweden and the United States. Sweden is considered to have one of the most extensive, comprehensive, and generous welfare systems in the world, offering universal social protection to its citizens. The United States, in stark contrast, is best characterized as a social assistance welfare system for only the most economically needy in society. Other comparative research has focused on similar cases such as studies of the Nordic (Marklund, 1988), or Anglophone (Orloff, 1993) nations. Few studies of international social policy have focused on two highly developed welfare states such as France and Sweden. In terms of method, most comparative research has been highly influenced by quantitative studies which have included many national welfare states in their samples (e.g. Swank, 2002; Wilensky, 2002).

This thesis takes an intermediate approach by comparing two very different yet highly developed welfare states, France and Sweden. Each has developed from different traditions and has different political legacies and class structures. Both France and Sweden have introduced some of the first welfare provisions legislated by the modern state (Table 1.1). They both have a long history of support for a welfare state with the early implementation of social programs.

Table 1.1 Introduction of Four Major Social Programs in France and Sweden

Social Policy Domains	Program	France	Sweden
Family Policy	Family Allowance	1932 ^a 1938 ^a	1948
Health Care Policy	Sickness Insurance	1898 ^b	1891
Labour Market Policy	Unemployment Insurance	1905	1934
Pension/Elderly Care Policy	Old Age Pensions	1905 ^c 1910 ^d	1913 ^{c,d} 1946 ^e

Sources: Gregg M. Olsen (2002), *The Politics of the Welfare State: Canada, Sweden, and the United States* (Toronto, Canada: Oxford University Press); Social Security Programs Throughout the World (1997).

^a Employment-based programs

^b Originally based on sickness funds. These were a series of amendments in the 1960s and 1970s that increased coverage, widened the scope of medical/hospital services included, and increased the role of the state (Olsen, 2002).

^c Old age assistance

^d Old age insurance

^e Universal pension programs

Each nation's allotment to welfare is quite substantial in that social expenditures in 1995 in France and Sweden are both quite high (30.07 and 33.01 respectively) relative to the OECD average. The average social expenditure for all OECD member nations (excluding Greece) was 21.15 % of GDP in 1995 (OECD, 1999). Introduction of programs and social expenditure levels are helpful in providing a general picture of overall welfare effort. However, both are rather crude measures when comparing more detailed aspects of welfare states. Current research in comparative social policy has gone far in the examination of more detailed measures and international classification models. One such model is Esping-Andersen's three-fold welfare state regimes typology.

Table 1.2 Social Expenditures as a Percentage of GDP in France and Sweden 1980, 1987, and 1995

Programs/policy	France			Sweden		
	1980	1987	1995	1980	1987	1995
Old Age Benefit	7.79	8.82	10.36	6.83	7.44	8.17
Family Cash Benefit	2.24	2.28	2.23	1.79	1.97	2.13
Unemployment	1.31	2.21	1.79	.39	.84	2.30
Health	5.95	6.49	7.98	8.67	7.90	5.90
Total Social Expenditure	23.47	23.63	30.07	29.78	31.41	33.01

Source: The OECD Social Expenditure Database 1980-1996 (OECD, 1998).

Welfare State Regimes

Perhaps the most clearly articulated and comprehensive welfare state classification model has been the regime clusters identified in Esping-Andersen's seminal work *The Three Worlds of Welfare Capitalism* (Esping-Andersen, 1990). Esping-Andersen's model is based on the linkages between the family, the market and the state. In his view, a welfare state can be seen as developed to the degree that a broad range of social risks are covered or sheltered from the market (decommodified social rights), a large or entire population is included in programs (universal), and that the level of income replacement is high. One of the major theoretical contributions contained within the welfare state regime typology is the concept of decommodification, which refers to the possibility or degree to which individuals, or families, can uphold a socially acceptable standard of living outside or independently of market participation (Esping-Andersen, 1990). The level of decommodification is linked to a citizen's (not worker's) emancipation from the market. And welfare states that promotes higher decommodification levels reflect a more compassionate social order based on equality, not on economic fear. As well as examining the level of decommodification within the

welfare state, the way programs and services are delivered and accessed by citizens is a second factor in welfare state classification. The analysis of outcomes of welfare programs and services is the third factor used to classify welfare states in terms of their stratification implications for citizens (i.e. the degree of inequality produced by welfare programs). These factors are used to group the welfare states of industrialized countries into three distinct clusters or regimes:

- (1) the Social Democratic regime, which includes the Nordic/Scandinavian countries,
- (2) the Conservative regime, which includes continental, Western European nations, and
- (3) the Liberal regime, which includes the Anglo-nations.

Esping-Andersen sets out three ideal type welfare regimes or worlds. Two of these worlds will be examined in this thesis: the social democratic welfare state regime which includes Sweden and the conservative welfare state regime which includes France. Welfare states in the Social Democratic regime are characterized by universal provision, generous benefits and a comprehensive range of social services. Conservative welfare states are characterized by the maintenance or conservation of existing status and class structures. Here, social provisions are primarily linked to employment insurance schemes that vary across public and private employers.

The Social-democratic regime is the most highly developed welfare state regime. Within this category, Sweden most closely approximates the ideal type welfare state that has achieved the highest levels of decommodification. One of the main features of Sweden's welfare state is an emphasis upon generous, universally provided services and benefits as a right of citizenship. The Swedish welfare state has focused on poverty prevention rather than simply responding to the most needy and destitute citizens when

markets fail. These benefits are largely funded through general taxation and are supplemented with statutory employment-based social insurance programs. In Sweden, a layering effect occurs, where generous universal public provisions are provided to all citizens as a base. On top of this basic provision are added public, income-related social insurance programs for workers. Statutory private schemes constitute a 'third tier' of social protection in Sweden. Finally, the extensive range of high quality social services is also a key aspect of the welfare state in Sweden.

The Conservative regime category includes France, but it is Germany that most typifies the ideal type conservative welfare state. Here welfare benefits are extensive and funded through employer and employee contributions. Welfare provision occurs largely through the state and is provided in a manner that serves to maintain status differences within the population, rather than the distribution of wealth. Conservative regimes have often been heavily influenced by the Roman Catholic Church and other more 'traditional' structures such the male-dominated nuclear family. Yet, in France there are extensive publicly funded day care centers, private subsidies for both parents, and generous paid parental leaves which, minimally, provide the conditions under which a balance of work and child rearing can occur (Bergmann, 1996).

Esping-Andersen's approach is valuable because it examines qualitative elements like eligibility criteria, quality of benefits and services, targeted or universally provided programs.² It goes beyond the quantitative welfare state literature that focuses on expenditures by adding qualitative elements such as how benefits and services are accessed, the level of decommodification that different welfare systems produce and actual outcomes for the citizens in different nations. This classification model has

informed both quantitative and qualitative studies and has organized the myriad policy programs that are currently in place across industrialized nations. It is to the nature of change in the welfare state to which we now turn.

The Debate: Convergence vs. Continued Divergence

CONVERGENCE

A major debate in comparative welfare state literature focuses on the paths or direction of welfare state policy over the last two decades. The first position, which follows below, is a new version of convergence theory emphasizing the impact of economic and societal pressures (either endogenous or exogenous) on welfare states. The second position sees diversity and variation in welfare states through different cultural histories, political institutions and different constellations of power resources.

The first studies to examine the welfare state reflected a theoretical heritage based on a structural functionalist view of society and the state. Structural functionalists viewed society as a whole, comprised of various institutions, which performed specific tasks for the overall progressive advancement of society. From this perspective, as society moved from primitive to more advanced forms, various institutions like the welfare state developed to aid in the smooth functioning of an increasingly elaborate economy and state structure. As industrialization progress and the economy grew convergence theory argued that over time, various welfare states would become more similar and converge (Wilensky, 1975). Functionalism introduced the ideal of convergence (as societies progressed, their policies would become more similar) and important quantitative measures in examining welfare states.

Research from a functionalist perspective has focused on the size of the national economy as the main indicator of welfare state development.³ In theory, one would expect to find that nations with large economies would have the necessary resources to fund elaborate and comprehensive welfare programs. Yet in practice, this does not always hold. The largest economy in the world, the United States, with the highest GDP per capita, spends considerably less on welfare programs (measured by social expenditure, the proportion of GDP allotted to social programs and transfers) than many less wealthy nations. While this approach helps to group countries along a measurable quantitative dimension, it neglects many qualitative differences that cannot be understood by cross-national spending levels. At best it is a crude indicator of welfare effort. Indeed, expenditure levels have risen steadily from 1980 to 1996. However this increase can be attributed to increased health care costs and pension benefits due to demographic changes (Bonoli et al., 2000). Quantitative dimensions of welfare programs alone fail to include the various ways in which programs have developed in different countries and the different methods of financing and providing welfare benefits and services.

A new version of convergence theory links its deterministic heritage to globalization as a contemporary replacement for level of industrialization. In short, the role played by global competitive pressures for profit on capital and cost reduction in the private and public spheres are hastening the decline of nation state sovereignty (Martin and Schumann, 1996; Mishra, 1997). In its simplest form, this new version of convergence theory follows a deterministic logic according to which the global economy forces nation states to cut costs and promote profit by reducing taxes on trans-national corporations. In this context the welfare state is viewed as a drain on government budgets

and a disincentive for international investment. Thus, the welfare state ought to be dismantled in order for nations to compete in the global market. Convergence would then occur between welfare states not towards high standards reflecting high levels of industrialization and economic growth but rather in 'a race to the bottom' replete with program cuts, privatization of services and outright elimination of key components of the welfare state. Other studies of welfare state convergence suggest quite the opposite, that globalization has little to no effect on policy and that convergence pressures emanate from endogenous factors.

Domestic Pressures

Some versions of convergence theory suggest that, rather than global economic changes as the source of welfare retrenchment and government fiscal constraint, pressure on welfare states emanate from domestic demographic, economic and political factors. Indeed, Esping-Andersen argues that most of the conditions under which post-war welfare states were created are today invalid (Esping-Andersen, 1999). Family structure and labour market behavior of the 1950s certainly do not reflect current societal conditions and behaviors. An aging population of baby boomers, coupled with low and declining rates of fertility in industrialized nations is blamed for the welfare 'crunch' on income. Paul Pierson (1998) argues that the current 'crisis' of the welfare state is due to: lower productivity growth, a shift from manufacturing to service sector employment, and an aging population, with globalization having no adverse effect on the welfare state. The increased cost and strain on the welfare state is generated from domestic pressures and neo-liberal policies. The two main threats to the welfare state come from demographic changes (population aging) or choices made by political actors (neo-liberal market

fundamentalism in the public sector). Another factor within the labour market is the increased female labour force participation levels of the last 30 years. This sex difference has had debatable consequences for male unemployment and shifting family patterns.

External Pressures: Global Integration

The past quarter century has been characterized as a period in which several industrialized national economies have shifted focus to one global or world capitalist economy. This economic transition has coincided with changes to the welfare states of industrialized nations. The study investigates whether these two phenomena are related and if so, to what extent. The best way to settle the debate is to closely examine two well-developed, comprehensive welfare states to determine what has occurred over the last 20 years to social policy in those countries. Previous research on the debate surrounding the effects of globalization and the welfare state has produced two distinct perspectives whose positions vary to the extent to which social policy is impacted. These two perspectives present globalization as either: (1) having a direct and serious effect on welfare retrenchment or (2) having little, if any, impact on welfare states. Before we can examine the purported effects of globalization the concept itself must be clarified.

Like the term 'welfare state', globalization has been defined within various disciplines, has been adopted by economists, environmentalists, cultural linguists and political sociologists. It is currently a key buzzword in academia and popular media. For the purposes of this thesis globalization will refer to the economic sphere with an examination of recent changes in the areas of finance, production and trade, and how these changes affect welfare states. The globalization of finance, production and trade is

presented below in descending order and level of importance, reflecting the impact that globalization is thought to have on the welfare state.⁴

The globalization of finance

The mobility of financial capital, facilitated by advances in microprocessor speed and telecom infrastructure, have allowed capital to move anywhere in the world in seconds. How does this relate to the welfare state? Some have argued that the globalization of finance threatens nation state sovereignty itself 'Indeed, capital mobility is causing countries to rethink even the most fundamental aspects of the nation state' (Eichengreen, 2003). The movement towards open financial markets began in the early 1970's with the collapse of fixed exchange rates, which were a part of the Bretton Woods system. Coupled with this trend is the rise in volume of portfolio capital and an increase in speculative 'casino' capitalism (derivatives). Capital mobility can limit the effectiveness of national monetary and fiscal policies since governments are evaluated by financial markets and credit rating agencies like *Moody's Investor Services* and *Standard & Poors* (Sinclair, 1994). This allows capital to move quickly into foreign securities and currency markets and also permits rapid exit, or capital flight, as was witnessed in the 1997-98 Asian financial crisis, where in a matter of months Thai, Indonesian, and Korean financial systems collapsed in the wake of speculative currency attacks and soaring interest rates (Volcker, 2001). It is argued that capital mobility has greatly limited the possibility for Keynesian demand management policies and controls restricting government's ability to use its monetary and fiscal policy. For example, expansionary fiscal policies are undermined by the threat of capital flight from high interest rate environments (Hart and Prakash, 1997). Greater economic interdependence has produced

a situation of the 'competitive imperative' forcing national governments to pursue policies that encourage competitive advantage with reducing corporate tax and non-wage labour costs (Rhodes, 2000). Nowhere is the sheer volume of capital flows more pronounced than in foreign exchange markets. In 1989 the average daily net turnover was \$590 billion US compared to \$1,490 billion US in 1998 (Torres, 2001). These 'virtual' amounts so outpace actual trade in tangible goods and services that, by 1998, daily world turnover in foreign exchange markets was 78 times the daily volume of the export of goods and services (Torres, 2001). The rise in speculative portfolio capital also magnifies the luster of perceptions and expectations over reality, that in financial markets what influences the buying and selling of securities by actors is by and large their perceptions (Volcker, 2001).

The globalization of production

Foreign Direct Investment (FDI) has increased over the last 25 years. The outsourcing of production by trans-national corporations to Newly Industrialized Countries (NICs) in Asia and South America lowers the demand for low skilled labour in industrialized nations (Wood, 1995). This, it is argued, increases unemployment of low skilled labour in industrialized nations. Productivity increases with technologization of the production process, thus beneficial for highly skilled knowledge workers of the future but to the detriment for the unskilled and semiskilled production worker. The globalization of production has a negative impact on social policy, it is argued, since there is the potential for a loss of tax revenue when corporations leave the home nation. The rise of the TNC has allowed evasion of taxes via transfer pricing and timing payments to or from foreign subsidiaries. Related to this is the fact that the transnational

corporation is becoming less reliant upon the domestic labour force. For example, in Sweden, 'this has left Swedish capital less sympathetic to labour's desire to maintain or expand Sweden's elaborate and comprehensive welfare state' (Olsen, 2002:190).

The globalization of trade

The dramatic increase in trade is one characteristic of the 'new' global economy. The multilateral trade agreement for the European Union (EU), it is argued, has weakened the nation state's ability to control economic policy (Carchedi, 1997). Requirements of the economic harmonization process stipulated in the Maastricht treaty for membership in the EU included that prospective member nations could not run deficits beyond 3% of GDP, that interest rates could not fluctuate beyond a 2% range for all countries, and that inflation could not exceed 1.5% (Olsen, 1999). These and other conditions for membership, it is argued, forced many nations to introduce austerity measures which increased unemployment. Also within the EU is the adoption of the Euro as the common currency, the culmination of years of preparation and planning by the European Economic and Monetary Union (EMU). The adoption of the Euro has eliminated currency devaluation by France as a measure of economic crisis management (the United Kingdom and Sweden are the only two EU member nations that did not adopt the Euro). However, devaluation of the kronor is substantively prohibited via adherence to the Maastricht treaty rules. In brief, the Swedish economy has always been very open to trade and heavily reliant on exports in the international market place. Devaluations of the Swedish kronor have in the past been beneficial for Sweden.⁵

A final point regarding the globalization of trade is its purported adverse affect on unskilled labour. A 10% decline in the demand for unskilled labour has been attributed to

trade with developing countries where labour is less costly (Wood, 1995). Wood views this decline as a long- term trend for labour markets in industrialized nations. However, within the European context, most trade is between European nations and the estimated share of total EU trade with non-member countries is less than 10 percent (Esping-Andersen, 1999).

CONTINUED DIVERGENCE

Culture

Upon first examining welfare states of different countries one is immediately struck by the different programs available, and the various national mixes of income security measures and social services. Seeking to account for this variation, cultural theories of the welfare state locate welfare variation in culture and national values (Lipset, 1986). For example explaining Sweden's highly developed welfare state one could point to a highly developed sense of community and solidarity, rather than a cultural emphasis on the primacy of the individual. The main weakness of cultural analysis is the minimization of power differentials within and between nations. Diverse cultural variations existing within nations are sacrificed in order to compare across national welfare states. However, policy scholars came to realize that any comprehensive welfare state analysis must take into account social as well as political contexts, and to theoretically account for the concept of power as it is made manifest in real policy programs.

State-centered/ Neo-Weberian Theories

Research from this perspective sees the state as considerably more autonomous than neo-convergence theories, with emphasis put upon state organization and structure.

Policies once institutionalized become solidified, gain popular support beyond the political parties which introduced them, and take on a momentum through time that become institutional legacies. Research from this perspective have examined domestic political climates (Steinmo, 1994), and are prominent in comparative analysis of developed welfare states. Another factor in understanding social policy formation is the importance of parliamentary structure and electoral organization. Bicameral and unicameral federal governments provide a more unified structure than a federally fragmented state or provincial type of organization where policy range and implementation could be diluted by special interest groups.

From a state-structural perspective, voter participation rates, indicators of voter apathy, and political involvement, are largely determined by structural features of national institutions. These factors point to a continued divergence unless state structures are undergoing dramatic change. One such factor is the prevalence of left leaning political parties who get elected. In Sweden, Social Democratic governments have been in power since the 1930s, with only two interruptions: from 1976-1982 and from 1991-1994 (Peterson, 1999). This political experience differs markedly from that of France. With its bi-cameral system consisting of the legislative and the executive branch, France has had many years of co-habitation during the past two decades with either a left president and a right legislative or vice-versa.

Class conflict/ Power Resources Theory

Class analyses of the welfare state have viewed the formation and development of the welfare state as a product of class struggle between labour and capital (Korpi, 1998). Class conflict theories reject the societal consensus espoused by functionalism, and the

state-centered approach. Marx critiques liberal democracy as being neither liberal nor democratic. Power resources theory supports the idea that, under certain conditions, the working class can use the state as a vehicle to counter the inequalities of the market. Welfare policy developed through conflict and decades of political and class struggle. Esping-Andersen's model of welfare state regimes includes these qualitative and historical dimensions within his classification typology. Power Resources and class conflict theory suggest continued divergence, or that, if change were to occur, it would emanate from a downward shift in labour strength thereby affecting the societal balance of power between capital and labour.

Between two extreme views, that globalization has a severe or a minimal impact on the welfare state, is a perspective suggesting that there are real global forces encroaching on welfare states but very different policy responses across nations which must be understood in the context of specific power resources within national welfare states. What is observed in the welfare state literature is variation and diverse policy responses to macro economic pressures depending upon widely varying national contexts (Castles and Pierson, 1998; Esping-Andersen, 1999; Geyer, 1998; Kosonen, 1998; Olsen, 1999, 2002). This thesis addresses this contentious issue and convergence theory in general by examining current welfare programs in Europe, specifically, comparing developed welfare states in France and Sweden to which we now turn.

Methodology

The purpose of the present study is to examine the nature of change within and between the welfare states of France and Sweden. While most research indicates that welfare states are undergoing some change, what is less clear is how, and in what direction, they

are changing. Although they have not been extensively compared in past social policy research, France and Sweden are particularly well suited for comparative research. Both Western European countries have highly developed welfare states and both are affluent industrialized nations with high living standards. However, the manner in which these two nations promote the welfare of their citizens varies considerably. As previously stated, Esping-Andersen classifies Sweden as the ideal type social-democratic welfare state. One of the main goals of the Swedish Welfare state is the elimination of both poverty and gender inequality among its citizenry via a redistribution of resources. The majority of income security welfare benefits and services are provided universally to all citizens as a legal right. France, in contrast, is classified within the conservative welfare state regime, and is somewhat more market-oriented than Sweden. The French welfare state is much more based upon public social insurance and, hence, directly tied to a record of employment. Unlike Sweden, France does not officially promote a more equal distribution of resources. Nor does it focus on poverty eradication.

To better understand the differences between France and Sweden it is necessary to examine central income security programs and social services within the three domains of the welfare state (Family Policy, Health Care Policy, and Old Age Policy). From this analysis it is hoped that a clearer picture will emerge as to the direction of welfare state change in these nations. Based upon the globalization and social policy literature three potential directions are hypothesized: (1) convergence is occurring between theoretically different types of welfare states; (2) divergence is occurring between theoretically different types of welfare states; (3) welfare states are moving in similar directions (positive, negative or no direction). Ten theoretical models of policy trajectories can be

identified (see Figures A through J). The first four figures are ideal examples of divergence. Figures A and B represent the situation where both countries start at the same point and, over time, one country increases or decreases while the other remains the same. Figure C represents the situation where both countries start at the same point and, over time, one country increases while the other country decreases. Figure D represents a situation of continued divergence; that is, both countries start at different points but do not change over time.

Figure A: Divergence Type a

Divergence

Country A stays same, while B increases

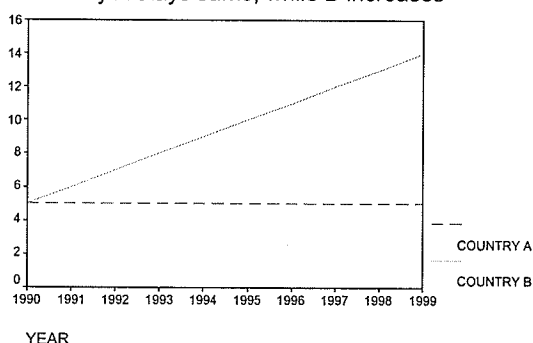


Figure B: Divergence type b

Divergence

Country A stays same, while B decreases

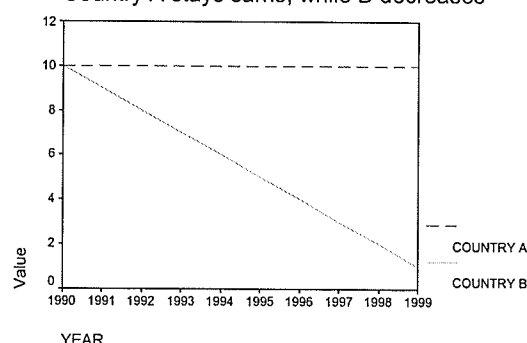


Figure C:

Divergence

Country A increases, while B decreases

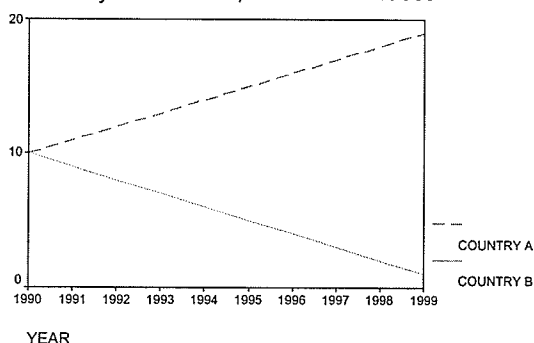
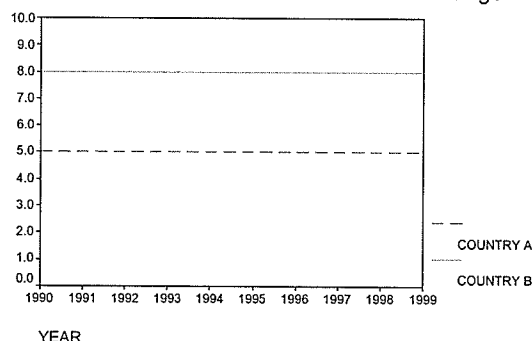


Figure D:

Continued Divergence

Different start for A and B and neither change



The next three figures are ideal examples of convergence. Figure E represents the situation where both countries start at different points but the country that starts at the

higher point decreases over time while the country that starts at the lower point increases over time. Figure F represents the situation where both countries start at different points but the country that starts at the higher point remains the same over time, while the country that starts at the lower point increases over time.⁶ Figure G represents the situation where both countries start at different points but the country that starts at the higher point decreases over time while the country that starts at the lower point remains the same over time. This is the classic example of a 'race to the bottom.'

Figure E:

Convergence

Country A decreases, while B increases

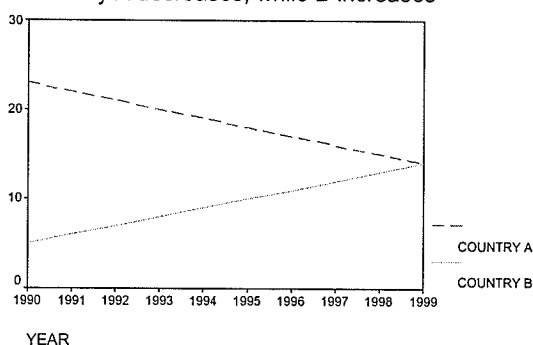


Figure F:

Convergence

Country A stays same, while B increases

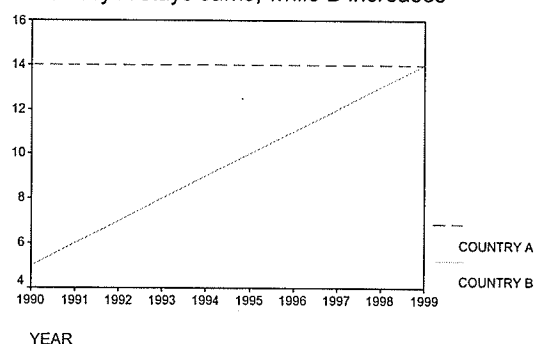
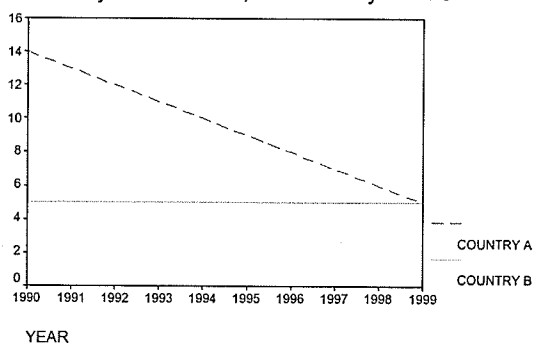


Figure G:

Convergence

Country A decreases, while B stays same



The three figures of E, F, and G represent situations where both countries move in similar directions. Figure H represents the situation where both countries start out at similar points and experience no change over time. We would therefore expect to find no significant change in either of the three policy domains. The final two figures represent the situation where both countries experience a decrease (Figure I) or increase (Figure J) over time.

Figure H:

Start out same/No change

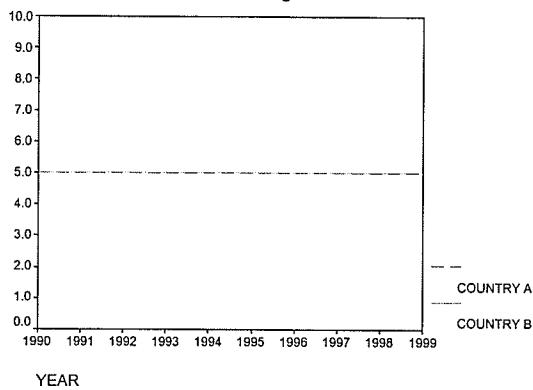


Figure I:

Start same/Decrease same

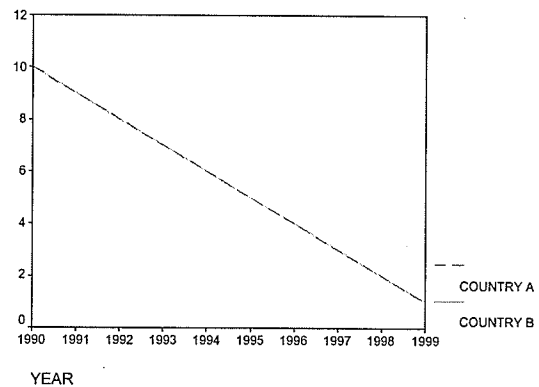
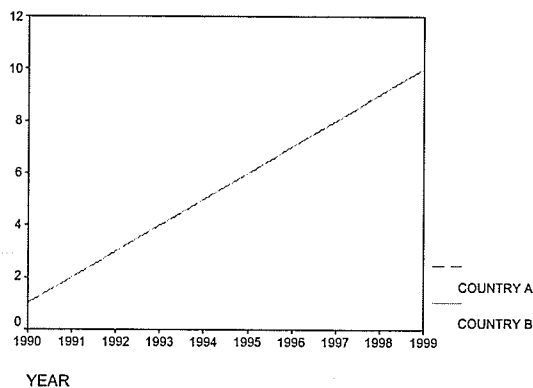


Figure J:

Start same/Increase same



Based upon the globalization and social policy literature two potential directions are hypothesized: (1) a 'race to the bottom' is occurring. This would consist of broad spending cuts and a reduction of services in all three policy domains; (2) continued policy divergence in which there is no significant change in policy (i.e. little contraction (retrenchment) or expansion within any of the three domains). In cases where comparable, quality data were available, data were graphically represented to demonstrate specific patterns within each policy domain. For example in ambulatory and non-ambulatory care within health data were graphed to show change over time. Many possible patterns of convergence or divergence are graphically represented (see above) and show the various ideal type patterns that would suggest a converging or diverging tendency for the particular measure under consideration.

This thesis will employ a qualitative comparative method to examine changes in the welfare states of France and Sweden during the last 25 years (1977 to 2002). This study will utilize data from the Organisation for Economic Co-operation and Development (OECD) and the United States' Social Security Administration document Social Security Programs Throughout the World (SSPTW) and secondary sources.

DATA

The welfare states of France and Sweden will be represented by three policy domains highlighting an income security component and a service component in each. An examination of these three key areas will allow for a better understanding of the extent to which these two welfare states are becoming more similar (converging) or are maintaining their distinctive national approaches. Social expenditure data for all three policy domains in France and Sweden were drawn from the OECD Social Expenditure

Database (OECD, 1998). Specific sources for each component of each of the three policy domains in Sweden and France are provided below.

Table 1.3 Policy Domains in France and Sweden by Income Security and Social Services Components

Policy Domain	Income Security	Social Services
Family Policy	Family allowance/Parental leave	Daycare
Health Care	Sickness Insurance	Ambulatory/non-ambulatory care
Old-age Policy	Pension/Old age benefit	Residential Care

Family Policy Data

Income Security Component: Family Allowance and Parental Leave

Data on family allowance and parental leave in France and Sweden will be provided by the serial publication *Social Security Programs Throughout the World (SSPTW)*. Editions of the SSPTW were obtained for the years 1977, 1983, 1991 and 2002 thus approximating a 25 year study period for this thesis. Access and Generosity will also be drawn from the SSPTW. For amount received within generosity all amounts in French francs, Euros and Swedish Kronor were converted into Canadian dollars and adjusted for inflation in 1995 dollars using the following formula:

$$ABAR = [(BAR \times ER)/CPI] \times 100$$

Where:

ABAR	=	Adjusted benefit amount received
BAR	=	Benefit amount received
ER	=	Exchange rate
CPI	=	Consumer Price Index

Foreign exchange rates were drawn from Statistics Canada CANSIM (2002) table:

Foreign Exchange Rates in Canadian Dollars number 176-0064. Inflation adjustments were calculated for every Canadian dollar conversion by dividing the dollar amounts by

the consumer price index from the International Monetary Fund Yearbook. The SSPTW was also utilized for comparing sickness insurance benefits and pension benefits in health policy and old age policy respectively. For example, the monthly family allowance in France in 1977 was 22% of 694.5 FRF or 152.8 FRF. Two calculations were performed, first to convert FRF into C\$ ($152.8 \times .216$) then to adjust for inflation.

Table 1.4 Exchange rates and CPIs for France and Sweden, 1977-2002

	1977	1983	1991	2002
France	.216 by 35.4	.162 by 67.6	.204 by 92.5	1.484 by 110.10
Sweden	.237 by 29.3	.160 by 52.0	.190 by 89.2	.162 by 107.10

Social Service Component: Daycare

Data on daycare services in France and Sweden will be provided by secondary sources and proportional expenditure will be provided by the OECD.

Income Security Components: Sickness Insurance and Pensions

Data on sickness insurance and pensions in France and Sweden will be provided by four editions of the SSPTW (1977, 1983, 1991, and 2002).

Social Service Component: Ambulatory and non-ambulatory care

Ambulatory and non-ambulatory care will be provided by the OECD's Health at a Glance 2002 for France and Sweden. Data on health services were analyzed in *SPSS 11.0 for Windows*. To better understand the differences between France and Sweden it is necessary to examine central income security programs and social services within the health care policy domain. From this analysis it is hoped that a clearer picture will emerge as to the direction of health care policy change in these nations.

Social Service Component: Residential Care

Data on residential care in France will be provided by the National Sickness Insurance Fund, and the Ministry of Labour and Social Affairs. Data for Sweden will be obtained from the National Board of Health and Welfare, and Statistiska Centralbyrån (SCB).

Measures/Indicators of Welfare

Income Security Measures

Income security measures for all three policy domains under scrutiny here (family, health care, and pensions/elderly care) in both France and Sweden will be divided into the following three dimensions: generosity, proportional expenditures, and access.

Generosity will be measured by the following three indicators: amount of benefit received, income replacement level, and benefit period. Proportional expenditures will be defined as the proportion of total social expenditures for each of the three policy domains and measured by the percentage of GDP allotted to a specific program. For example the total of family cash benefits by GDP. Access will be measured by the eligibility criteria for the specific income security benefit, the presence or absence of means-testing, and length of waiting periods.

Social Service Measures

While the income security measures (i.e. generosity, proportional expenditures, and access) will also be applied to the analysis of social services in France and Sweden where applicable, the social service measures vary according to the particular policy domain. Therefore indicators for social services will differ within each of the policy domains in

this section. The following indicators are to be interpreted as a preliminary set of indicators to assess the quality of social services.

a) Family Policy

As the social service component of family policy is day care, the indicator of services in France and Sweden will include: number of daycare centers, number of available spaces, percentage of children in daycare aged 0 to 24 months, 25 to 48 months, and 49 to 72 months, proportion of childcare workers to children measured in worker to child ratios, and amount of fees paid by parents for daycare.

b) Health Care Policy

The social service components of health care are ambulatory and non-ambulatory care. The three measures of ambulatory care used for this study were the number of doctor consultations per capita, the number of practicing physicians and pharmaceutical expenditure as a share of total health expenditure. All of the above measures were drawn from the OECD's Health at a Glance 2002. Measures for non-ambulatory or care in hospital included the number of certified practicing nurses, the number of hospital beds, the number of admissions, and the length of stay in hospitals.

d) Pension/Elderly Care Policy

The social service component of pension/elderly care is residential/home care. This will be measured by the number of elderly (65 and older) receiving residential/home care. The number of registered residential care providers and availability of meal and laundry services, and fees will measure elderly services.

Conclusion

The purpose of the present study is to examine the nature of change within and between the welfare states of France and Sweden during the past two decades. If convergence theory is correct results should indicate patterns of decline or broad program cuts in both social income security and social service measures within the period of study. Some income security programs' benefit periods might have been shortened, the prevalence of means testing may have spread to more social services and income security programs, or residential/home care quality may have declined. It is expected that the occurrence of change will differ between France and Sweden, yet similar patterns of decline may emerge from the data. If continued divergence is the case, then results should indicate variations and support for social services and income security programs in both countries. For example, the increase of actual amounts received for a typical maternity/parental leave, the lengthening of benefit periods for other income security programs, or the increase of the ratio of physicians per 100,000 people would point to betterment of welfare state provision in terms of income and services. The value of examining three key policy domains enhances understanding of potential patterns or policy trajectories that might be occurring. By examining change in the social policy domains of two highly developed welfare states potential policy implications may include identifying which policy domain is more vulnerable or robust within the current global political economy.

This thesis is organized into five chapters. Chapter one will outline the convergence / divergence debate within the welfare state literature, the choice of the welfare states of France and Sweden (representing the conservative and social democratic regime types respectively) as cases for study, and method. Chapters Two, Three and Four

will be organized by policy domain in the following sequence: Family policy, Health Care policy and Old Age policy. This sequence is chosen to reflect the stages of life at which various services and income security measures are accessed by a typical individual or family in France and Sweden. Chapter Five will provide a critical summation of the findings and how they relate to the convergence/ divergence debate of the welfare state and address possible areas of future study.

Chapter Two

Family Policy in France and Sweden

This chapter will compare family income security measures and childcare services in France and Sweden and attempt to identify significant developments and patterns of policy convergence or divergence. For many years, family policy in France and Sweden has been characterized by comprehensive service efforts and generous cash benefits. Both nations are considered leaders in terms of cash benefits and high quality, widely utilized daycare centers and child minding services. From the welfare state literature presented in chapter one, it is useful to locate each national family policy arrangement in relation to the broader welfare regimes.

Family policy in Sweden has been characterized as *pro-egalitarian* (Gauthier, 1996). This is in large part due to Sweden's commitment to promoting gender equality, high female labour force participation and broad family policy measures facilitating a balance between employment and childcare. Also, the government creates conditions that allow fathers to take a larger role in caring for their children.⁷ Sweden's social democratic classification is consistent upon examination of its family policy. France, however, (categorized within the conservative welfare state world) is considered a 'deviant' example of family policy when compared to other conservative nations like Germany. In fact, France is much closer to Sweden in terms of daycare services.⁸ However, researchers of comparative family policy have placed France in a *Pro-family / pro-natalist model* (Gauthier, 1996). Here, family policy is dominated by high levels of government support to maternity/parental leave and childcare for the purposes of encouraging fertility (especially the birth of a third child). Establishing policies with the

goal of enabling equality between men and women in raising children is far less evident in France than in Sweden.

The following section will present a general description of both welfare states (all policy domains) to situate family policy within the larger context of welfare systems in France and Sweden. This will be followed by a comparative analysis of income security, comprising family allowances and parental leaves. Three measures of income security for both family allowances and parental leaves will be utilized. *Proportional expenditure* will measure the percentage of GDP allotted to family allowances and parental leaves in both countries from 1980-95. *Generosity* will be measured by benefit amount received, income replacement level and benefit period for family allowances and parental leaves. *Access* to family allowances and parental leaves will be measured by eligibility criteria, means testing and length of waiting periods. Generosity and Access measures will be drawn from four editions of the SSPTW: 1977, 1983, 1991 and 2002. Measures for childcare services will include parental fees, number of childcare places, children enrolled, child to daycare worker ratios and include Proportional Expenditure and Access from income security measures. The period of study will approximate the past 25 years for Childcare services. Findings on the current state of services and income security measures are analyzed, concluding with an interpretation on what if any change has taken place over the study period.

The French Social insurance system, *la Sécurité sociale* or *la Sécu*, is highly complex and fragmented, with many compulsory insurance based schemes (Palier and Sykes, 2001). The largest of these schemes is the *régime général*, which includes employees in industry and trade and covers approximately 60% of the working

population. Beyond this general scheme there are literally hundreds of other social insurance schemes which cover the remaining 40% of workers (Palier and Sykes, 2001). The welfare state in France is organized like a large tree with many branches. The main 'trunk' of this tree, *la sécu*, supports the many branches or *régimes*. Each of the above schemes is tied to a fund or *Caisse*. In the case of family policy the main fund is the CNAF or *Caisse nationale des allocations familiales*. This fund administers most of the family income security benefits and childcare services and is the only social security fund in France that provides universal coverage (OECD, 2003).⁹

If social security in France can be described as branches on a tree, then social benefits and services in Sweden can be described like a layer-cake with a tiered structure. Most social programs consist of a universal, flat rate benefit, based on residence or citizenship as a first layer, then, a more generous employment based benefit on top (Bergqvist and Nyberg, 2002). Control of benefit funding resides with the central government and the municipalities. The first family policy measures centered around family allowances and subsidies and were legislated in the 1940s in Sweden, with loans provided for couples at marriage, housing subsidies for large families, financial supports for low income mothers and other provisions and benefits (Hass, 1996). In the late 1970s family policy shifted in Sweden to include greater gender equality, a greater emphasis upon the rights of children and the promotion of the full participation of women in the labour force. A unique feature of family policy in Sweden is the official policy of promoting gender equality through government policy. Maternal employment has been supported ever since female labour force participation rates started to rise in the 1970's.¹⁰ Welfare state policy has sought to balance civil and social rights of its citizens and family

policy is no exception. It is here we find policies designed to help women who are mothers combine work and family life, encourage fathers to assumed a greater role in parenting, as well as fostering and protecting a child's safety and well being (Olsen, 2002).

Income Security

Two main areas comprise income security within family policy, family cash benefits and paid parental leaves. The section that follows presents data on both of these benefits through the measures of Proportional Expenditure, Access and Generosity. Data on Proportional Expenditure is graphically represented for the period 1980-95, and measures the proportion of GDP in France and Sweden allotted to cash benefits and paid parental leaves.

Family Cash Benefits

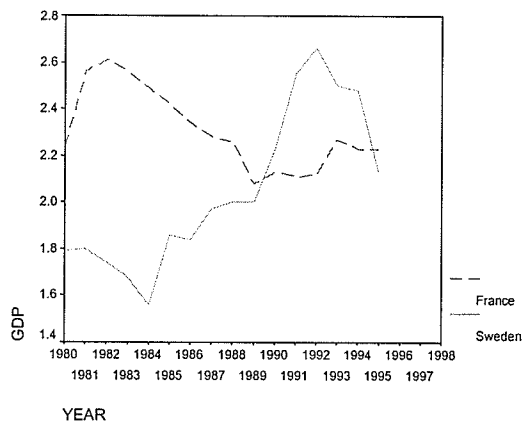
In terms of income security, France was one of the earliest providers of financial aid aimed toward children with the introduction of a mothers allowance in 1874 (Combes, 1993). This continued with one of the first family allowances legislated in 1938. Family allowances in France are considered the main instrument of family policy and in 1995 represented 2.23 % of GDP (OECD, 1998). In analyzing the structure of family cash benefits in France and Sweden there exists a marked variation in the number of programs offered, which in part reflects the social insurance structure of welfare in France, and the more universal, social-democratic structure in Sweden. At present, the number of separate categories for family cash benefits alone in France is 56, with 13 types of family allowances while in Sweden there are only three, a child allowance, a lone parent cash

benefit, and a maintenance allowance, with one type of family allowance outlined in the SSPTW (OECD, 1998; SSPTW: Europe, 2002).¹¹

Proportional Expenditure: Family cash benefits

Total expenditures for family cash benefits in France in 1995 were 2.23% of GDP (OECD, 1998). This was almost identical to the proportion in 1980, which was 2.24% GDP. Expenditures have ranged from the lowest proportion of 2.08% in 1989 to 2.61% in 1982. Total expenditures for family cash benefits in Sweden in 1995 were 2.13% GDP (OECD, 1998). Expenditures have ranged from the lowest proportion of 1.74% GDP in 1982 to 2.66% GDP in 1992. In general, family cash benefits in both countries have been above 2% of GDP since 1988. Here we see a converging trend in both countries with two intersecting points in 1990 and 1995.

Figure 1
Family Cash Benefits as a Percentage of GDP in France and Sweden, 1980-95



Access

The many family allowance benefits in France are accompanied by equally many qualifying conditions. These conditions include residency, family size, age of child and in some cases parental employment. Two of these qualifying conditions have remained

consistent over the study period, residency (at least 3 months) and family size (at least two children). Allowances that are granted to families with one child are detailed below. The number of cash benefits for families increased dramatically in France, from 5 in 1977 to 13 in 2002.

In 1977, there were five categories of cash benefits granted to families: family allowances, a parental allowance, a birth grant, a single-wage allowance and a mother-at-home allowance. The parental allowance and birth grant were provided to resident mothers. Family allowances were payable to families with two or more children under the age of 16 (20 for students, apprentices and invalids). This age requirement has held for 1983 and 1991. Qualifying conditions for family allowances included parental employment, where a parent must have worked at least 1,200 hours in the last year or 120 hours in the last month. This remained in place in 1983. Two allowances were paid to families with one child, the single-wage allowance and the mother-at-home allowance, which were income tested.

In 1983, the single-wage allowance and the mother-at-home allowance were replaced by the Family Supplement (FS) and the Guaranteed Minimum Family Income (GMFI) with the aim of providing cash benefits to small (1 to 2 children) and large (3 or more children) families respectively. The FS covered resident families with one or more children, was income tested, and applied to families with one child under age 3 or at least three children. These conditions were the same in 1991. In 2002, qualifying conditions were for three or more children older than age 3 up to age 21 and income tested.

In 1991, there were 8 programs of cash benefits for families with children. Family allowances, the FS and GMFI, the Young child allowance, Single Parent allowance,

Parental education allowance, Child care benefit, Family support allowance. In 2002, there were 13 programs of cash benefits for families with children. These benefits included Family Allowances, Young Child Allowance, FS, Accommodation Allowance, Single Parent Allowance, Family Support Allowance, Adoption Allowance, Child rearing allowance Home care allowance, Accredited child care benefit, Special allowance, Beginning of School Year Allowance, and a Parental Child Care Allowance.

In 2002, families who qualified for family allowances had to have at least two children under the age of 20 and earnings of less than 55% of the minimum wage in order to receive benefits. In 1983, family allowances were payable to families with two or more children, the family supplement was payable to resident families with one or more children, the parental allowance and birth grant applied to resident mothers and the guaranteed minimum family income was payable to resident families with 3 or more dependent children.

In Sweden, all residents with one or more children under the age of 16 are covered for family cash benefits. This has not changed during the study period. Qualifying conditions in 1977 and 1983 were for children under age 16 (19 for students). The student age limit was raised in 1991 (maintained in 2002) to age 20 (23 for students attending schools for children with learning difficulties).

Generosity

Family Allowances make up the main cash benefit for families in France. The following section will examine benefit amounts for family allowances and benefits for the Family Supplement (FS). Family allowances have been the only income security program for families in all 4 years of the study period thus making comparison possible.

The family supplement is the next most comparable program at 3 years (1983, 1991 and 2002). All family allowances from 1977 to 1991 were calculated using a percentage of a 'base wage'. This base wage has changed from C\$423.76 (694.50 FRF) in 1977 to C\$261.93 (1093 FRF) in 1983 and to C\$420.17 (1905.20 FRF) in 1991.¹² Family allowances were annually adjusted for cost-of-living changes for all three years of study except 2002. Listed below are amounts received for monthly family allowances from 1977 to 2002 and the family supplement from 1983 to 2002. All other cash allowances for families with children are listed in the appendix. All dollar amounts below refer to monthly benefits.

Amounts received per month for family allowances in 1977 were C\$93.24 (22% of 694.50 FRF) for the second child; C\$156.77 (37% of 694.50 FRF) for the 3rd and 4th child; and C\$139.85 (33% of 694.50 FRF) for the 5th and subsequent children. For older children between the ages of 10 and 15 years, amount received was C\$38.14 (9% of 694.50 FRF). For children over 15 years of age the amount was C\$67.80 (16% of 694.50 FRF) per month. In 1983, family allowance amounts were C\$60.24 (23% of 1093 FRF) for the second child; C\$110.00 (42% of 1093 FRF) for the 3rd; C\$98.25 (37.5% of 1093 FRF) for the 4th; and C\$92.98 (35.5% of 1093 FRF) for the 5th and subsequent children. For older children aged between 10 and 15 years, amount received was C\$23.57 (9% of 1093 FRF) and for children over 15 years the amount was C\$41.91 (16% of 1093 FRF). The latter two amounts for older children were calculated by using 9% and 16% of the base wage respectively. These percentages were the only figures that have remained constant for 1977, 1983 and 1991. In 1991, amounts received for family allowances were C\$134.45 for the second child; C\$306.92 for the 3rd child; 479.10 for the 4th child; and

C\$172.27 for the 5th child and other subsequent children. In 2002, amounts received were C\$146.73 per month for the 2nd child and C\$187.98 for the 3rd and each subsequent child. Older children between 11 and 16 years of age received C\$41.27 per month and children over 16 received C\$73.36 per month.

Amount received for family supplements (applicable for families with one child) have steadily increased between 1983 and 2002. In 1983, the family supplement was C\$109.04 (455 FRF) per month. In 1991 it was C\$175.11 (794 FRF) and in 2002 it was C\$191.00 (€141.68) per month.

The family allowance benefit amount in Sweden in 1977 was C\$131.44 (162.5 SEK) per month for the first and each other eligible child. In 1983, the benefit amount was C\$84.62 (275 SEK) per month for the first and each other eligible child with supplements for families with three or more children. Families with three children were eligible to receive 137.5 SEK a month, plus 275 SEK for each additional child (i.e. 4th child and beyond). In 1991, family allowance benefits were C\$159.75 (750 SEK) for the first child; C\$319.51 (1,500 SEK) for two children; C\$559.14 (2,625 SEK) for three children; C\$878.64 (4,125 SEK) for four children; and C\$1,278 (6,000 SEK) a month for five children; and for six children C\$255.61 per child. The Family allowance benefit in 2002 was C\$143.70 (950 SEK) per child.

From the data on family allowances presented above some trends can be discerned in both France and Sweden. For example in examining benefits amounts in France for the second child from 1977 the percentage of the base wage increased slightly from 22% in 1977 to 23% in 1983. Actual amounts received from 1977 to 2002 for the second child increased from C\$93.24 in 1977 to C\$146.73 in 2002. The average amount received for

the study period for the second child in France was C\$108.66. In Sweden, the amount of benefit received for the first child was C\$131.44 in 1977 to 143.70 in 2002. The average amount received for the first child for the study period in Sweden was C\$129.88 per month. The difference between France and Sweden during the study period in real adjusted Canadian dollars was C\$21.22 per month. Family income security benefits as measured by family allowances have increased in both countries with families in Sweden receiving slightly more benefits than in France over the study period.

Maternity/ Parental leaves

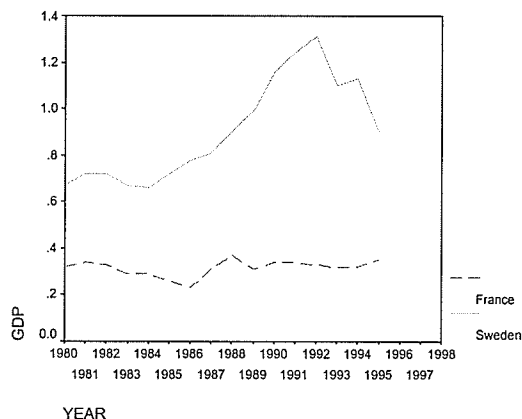
Paid maternity leave benefits have played a large role in the family policies of both France and Sweden. This section examines level of expenditure on maternity / parental leaves, access including eligibility criteria and waiting periods and generosity in France and Sweden.

Proportional Expenditure: parental leave

In 1995, Sweden paid 0.90% of GDP on parental leaves in 1980 0.67% GDP. Sweden peaked in 1992 at 1.31% GDP allotted to parental leaves. Average change from 1980-995 was slight for France but more pronounced for Sweden due to its large fluctuation. The average percentage of GDP spent on parental leaves in France was 0.3156 % (OECD, 2001b). The average percentage spent on parental leaves in Sweden between 1980 and 1995 was 1.21% GDP.¹³

Figure 2

Proportional expenditure for parental leaves in France and Sweden, 1980-95



In 1995, Sweden paid 0.9% of GDP on paid parental leaves (OECD, 2001b). The longest parental leave in the world is provided by Sweden at 64 weeks (Kuhnle, 2001). In the mid-1990s, maternity, parental and paternity leave combined, were up to 450 days of leave (64 weeks) of which 360 days (51 weeks) were provided with 80% wage compensation (Leira, 2000). In Sweden there is a return to work guarantee that any parent can return from a parental leave with no loss of employment-related benefits such as seniority maintenance, pension rights etc. (Jenson and Sineau, 2001). In terms of access, Sweden is much less restrictive than France however, not completely universal in that a parent must have been employed six months prior to birth or 12 months within the past 24 (Jenson and Sineau, 2001). One unique feature of family policy development in Sweden is the world leadership demonstrated in fatherhood or leaves taken by fathers. Between 1987 and 1992 the percentage of fathers who had taken up parental leave increased from 20% in 1987 to a world leading figure of 45% by 1992 (Leira, 2000).

In 1995, France paid .35% of GDP on maternity and parental leaves (OECD, 2001b). Both maternity and parental leaves contain 16 weeks maximum with 100% earnings

replacement rate and no waiting period. The *Assurance Maternité* applies to women who give birth to their first or second child. They receive 16 weeks of full paid leave (6 weeks before and 10 weeks after birth. For a third child the mother receives 26 weeks (8 weeks before and 22 after the expected date of childbirth, for twins 34 weeks (12 weeks before and 22 weeks after, for triplets 46 weeks (24 weeks before and 22 weeks after). In order to qualify for maternity leave a woman must have been registered to an insurance fund for 10 months and 200 hours of paid employment in the last 3 months before the beginning of pregnancy (SSPTW: Europe, 2002:80). Also in terms of access of the *allocation parentale d'éducation* (the paid parental leave) the parent must have two children, of these, one must be under three, and the parent must have been employed 2 of the last 5 years (Jenson and Sineau, 2001). This is much more restrictive than Sweden. Also unlike Sweden there are no such return to work guarantees; in fact there are negative consequences for pension rights (Jenson and Sineau, 2001). In France, the vast majority of women take parental leave. In 1995, 99% of recipients of parental leave were female and 97% of women received the parental child rearing allowance (Jenson and Sineau, 2001). However, as of 2002, a parental leave has been introduced providing fathers with a paid two week leave following the birth of a child. Finally, one of the stipulated aims of the 35 hour work week legislation in France is for the facilitation and balancing of family and working life (EC, 2002).

Access: Parental leave

In France, two qualifying conditions remained in place over the study period. These conditions for maternity leave eligibility included the recipient (a pregnant woman) to have entered into insurance 10 months before confinement, and 200 hours of paid

employment in the first 3 months of the last 12 months (or 6 months of contributions in 1983 and 1991).¹⁴ Only in 1991 were maternity benefits available to adoptive parents.

In Sweden, both parents were eligible to receive the parents' cash benefit. In 1977 and 1983 each parent was eligible for benefits if insured at least 6 months before confinement. This increased to 8 months before confinement in 1991 and remained in place in 2002. A waiting period of one day was in place in 1977 and 1983 due to benefits being paid from the second day of incapacity.

Generosity: maternity leave in France

In 1977, the maternity benefit provided an income replacement rate of 90% of earnings payable for 6 weeks before and 8 weeks after confinement, with the provision for 16 weeks in special cases. The maximum benefit amount per day was C\$66.08 (108.30 FRF). There was also a nursing benefit or milk coupon for nursing mothers, payable for 4 months. This was maintained in 1983 and 1991. In 1983, the income replacement rate remained at 90% for the 1st and 2nd child, payable for 6 weeks before and 10 weeks after confinement. For the 3rd and subsequent children maternity leave was granted for 8 weeks before and 18 weeks after confinement. In the case of medical complications during pregnancy a paid additional two weeks before confinement was available as well as an additional 2-12 weeks provision in the case of multiple births. The maximum benefit amount decreased slightly to C\$53.20 (222FRF) per day.

In 1991, the level of wage replacement decreased to 84% where for the 1st and 2nd child the maternity benefit was 84% of the basic daily wage, payable for 6 weeks before and 10 weeks after confinement. For the 3rd and subsequent children the benefit was payable for 8 weeks before and 18 weeks after confinement. In the case of complication

during pregnancy the additional 2 weeks before confinement and the 2 to 12 week extension for multiple births were maintained from 1983. The maximum daily benefit was C\$70.03 (317.52 FRF) with a minimum of C\$9.21 (41.77 FRF).

In 2002, the level of wage replacement increased to 100% of net earnings. This was payable for 6 weeks before and 10 weeks after the expected date of childbirth for the first and second child; for 8 weeks before and 18 weeks after for the third child; for 12 weeks before and 22 weeks after for twins and for 24 weeks before and 22 weeks after for triples. The two-week additional benefit for medical complications during pregnancy remained in 2002. The maximum daily benefit was C\$84.75 (€62.88). Payable adoption benefits, in 2002, corresponded to maternity benefits but only for the postnatal period (for example 10 weeks for the first child).

Generosity: parental leave in Sweden

The level of income replacement was 90% of income up to 7.5 times a base amount in 1977, 1983. Benefits were payable for up to 30 weeks in 1977. The minimum daily benefit was C\$20.22 (25 SEK) with the maximum amount being C\$160.16 (198 SEK). In 1983, benefits were payable for up to 38 weeks (26 connected with childbirth) and 13 weeks for either parent upon birth of child. The minimum daily benefit was C\$11.38 (37 SEK) and the maximum amount was C\$110.46 (359 SEK). In 1991, the level of income replacement at 90% was only available after 2 weeks. The parents' cash benefit replaced 80% of income for the first two weeks, 90% beyond two weeks and was payable for up to 51 weeks until the child reached age 4 (both parents combined). The maximum daily benefit in 1991 was C\$126.74 (595 SEK). In 2002, the income replacement level was 80% for 56 weeks at a minimum of C\$18.15 (120 SEK) per day and an additional 12

weeks at a minimum of C\$9.07 (60 SEK) per day. Benefits were payable for up to 64 weeks per child until age 8 (both parents combined).

From the data presented above some trends in parental leaves in both countries can be identified. Access to maternity and parental leaves did not see drastic tightening of eligibility rules in either country. In Sweden over the study period the level of income replacement has decreased from 90% to 80%; in France it has increased from 90% in 1977 to 100% by 2002. The maximum daily benefit for maternity leaves in France increased over the study period from C\$66.08 in 1977 to C\$84.75 in 2002 with the average amount being C\$68.52. In Sweden, the maximum daily benefits decreased from C\$160.16 in 1977 to C\$126.74 in 1991 with an average of C\$132.45 per day between 1977 and 1991. The length of parental leaves have increased in Sweden along with increased leaves for fathers. In France, maternity leave length increased slightly from 14 weeks in 1977 to 16 weeks by 2002 with no special provision for fathers until only very recently.

Daycare Services

Both France and Sweden are considered world leaders in daycare services, with abundant provision for preschool aged children (Anttonen and Sipilä, 1996).¹⁵ Fees for daycare services are paid by parents in both countries and are calculated on a sliding scale based on family income and number of children. Pre-school in France was incorporated into the education system early on, whereas in Sweden it is only recently that the Ministry of Education has included pre-school under its administrative control. Daycare, unlike family allowances, is less clearly defined with two separate administrative bodies sharing

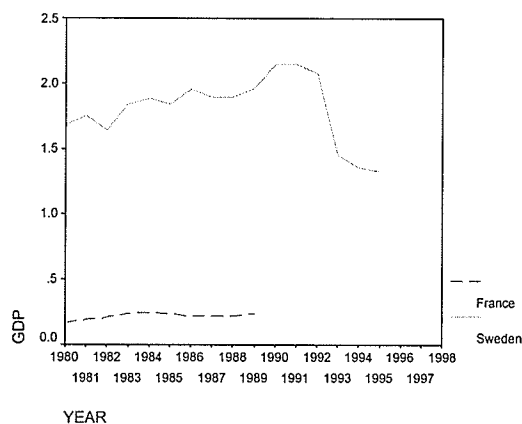
responsibilities. This jurisdictional overlap is between welfare and education. In general, education services for children over three are located within education and childcare services for the under 3s are a welfare issue. This is certainly the case in France where welfare and education do remain separate. Recently, in 1996, Sweden integrated responsibility for early years, compulsory schooling and childcare within its education system (Statham and Mooney, 2003).

Proportional Expenditure: Childcare

From 1980 to 1995 Sweden has consistently spent more on childcare than France (OECD, 2001b). Not included in this comparison however are the figures within the French education system for preschool which include most 3 to 6 year olds.

Figure 2

Formal Daycare in France and Sweden as a percentage of GDP, 1980-95



France

Compulsory school age for children in France is 6 years of age, however most children enter the education system through preschool at age 3. There are two systems of publicly funded services for children under six years- daycare and education. Preschools or *écoles maternelles* were incorporated into the national education system in the 1880s

and have continued to be a major component in the daycare/education of young children under six years of age (Morgan, 2002). Preschools in France are free, have standardized curricula, and are operated by the Ministry of Education. Preschools are also widely utilized and the main form of 'daycare' outside the actual daycare system. For example, in 1996, 36.1% of two year old children and 99.9% of three year olds were attending preschools (Martin et al., 1998). Thus, most daycare services in France are utilized by children under three years and are organized around several types of centers and home arrangements.

The traditional daycare centers or nursery in France is the *Crèche*. The first *Crèches* (nurseries or asylums) came into being after the first child labour laws were passed in 1841 (Combes, 1993). These early *Crèches* were primarily for the poorest of families, and were operated by charities and the Catholic Church. Beginning in the late 19th century the French republican state removed administrative and teaching control of education of young children by the Catholic Church by nationalizing preschools and secularizing *crèches* (Combes, 1993). The most common and traditional *crèche* is the *crèche collective*. They operate from 7 am to 7 pm, with the average number of child places being 44 (Martin et al., 1998). In 2000, there were 319,000 places in *crèches collectives*, with worker/child ratios of 1:5 for non-walkers and 1:8 for walkers (Mozère, 2003).

Family daycare or *crèches familiales* are schemes that organize childminders into the homes of parents and are employed by a local authority. Family daycare includes childminders in an organized scheme, *assistante maternelle agréée de crèche familiale*. A family *crèche* brings together 30 registered childminders under the supervision of a

puéricultrice, a specialized nurse or a social worker (Mozère, 2003). In 1994 there were 1,060 crèches familiales staffed by 31,700 registered childminders with 65,300 places (Martin et al., 1998). Crèches and family day care are regulated by the Ministry of Health, and inspections are carried out by the infant and maternal protection agency (Mozère, 2003).

Parental daycare centers or *crèches parentales* are parental daycare co-operatives. Between 10 and 15 children are 'serviced' in these centers. In 2000, there were 8,700 places in parental crèches (Mozère, 2003). *Halte-garderies* are drop in centers, and are frequently attached to a collective crèche (there were 60,100 places in late 1993 Martin et al., 1998, which increased to 68,100 places by 1999, DREES, 2000). *Assistantes maternelles* or unregistered childminders are allowed to care for no more than three children including their own in their private residence. Private registered childminders (*Assistante maternelle agréée*) are employed by parents, and in 2000 there were 376,000 (Mozère, 2003). The Income security benefit AFEAMA pays parents who employ a private childminder (see income security section).

Sweden

Compulsory school age for young children in Sweden is 7 years. Unlike France, Swedish childcare was not incorporated into the national education system until only recently in 1998 (Skolverket, 2003). There are five main components for the care of small children in Sweden. In Sweden in 1993, 33% of under 3s had access to available spaces in daycare (Jenson and Sineau, 2001). Recent reforms in Sweden have decentralized some administration of childcare services, but the structure of financing is still state controlled.

Daycare centres or *daghem* (literally day-home) form the main component of daycare for the under 3s. (Jenson and Sineau, 2001:221). Family day-care homes or *familjedaghem* are municipal child minders in their own home (similar to registered child minders in France). Pre-school or *förskola* is the main component of daycare for children above age 3. Open pre-school or *öpen förskola* are drop-in centers where parental attendance is encouraged. Leisure-time centers/ open leisure-time activity or *öppen fritidsversamhet* are for children aged 6 and up and parents are encouraged to attend.

Preschool teachers and qualified child minders are the two main categories of staff for pre-schools in Sweden. Preschool teachers make up 60% of the staff at preschools and are university trained. In family daycare services over 70% of day care mothers are trained to work with children, having either a children's nurse certificate or participated in a training program provided by the municipality. University-trained preschool teachers formed the largest category of daycare worker in 1998 (Bergqvist and Nyberg, 2002).

The percentage of under 3s (0-2 year of age) in daycare including childcare centres, preschools, and family daycare units in Sweden has increased during the 1980s with a slight decrease during the 1990s with 31% in 1980, 45% in 1985, 44% in 1990 and approximately 40% in 1996 (Bergqvist and Nyberg, 2002; Leira, 2000). Parental fees for childcare have increased from 10% in 1990 to approx. 18% by 1999 (Palme et al., 2002; Skolverket, 2002). Worker child ratios have increased due to decentralization from the state to the municipalities and an abolition of regulations (Szebehely, 1998). In the 1980s child/staff ratio in daycare centers was 4:1 in 1995 was nearly 6:1. This reflects the

overall trend of increasing children in daycare coupled with stagnant or decreased childcare employee numbers after 1991 (Szebehely, 1998:266).

This chapter has sought to shed light on key social programs in France and Sweden that make up family policy. Based on the analysis of income security measures and childcare services, family policy clearly remains a prominent component of the welfare state in these two countries.¹⁶ Indeed, new income security measures have been introduced in both countries and Sweden continues to expand and has recently introduced a second daddy month extending parental leave to 13 months (Daune-Richard and Mahon, 2001; Olsen, 2004). Family policies are embedded in the larger welfare regimes in France and Sweden. Sweden is consistent and fits into the social democratic category, yet France does not. France, although not officially promoting gender equality (as in Sweden), does have some of the best childcare arrangements in the world.

Childcare has progressed towards greater universality in Sweden during the 1990s (Bergqvist and Nyberg, 2002:294; Palme et al., 2003). By 1995, coverage for 0-6 year old children had also increased, indicating Sweden's commitment to childcare as a priority of the welfare state even during recession (Kuhnle, 2001). These findings are counter-intuitive within the context of economic crisis in Sweden and budgetary constraint in the 1990s (Olsen, 2004). However, Jenson and Sineau (2001) point to a growing convergence in European childcare arrangements, one that encourages flexibility and decentralization (nannies and private child-minders) and not state sponsored gender equality. Other trends have included job creation over increased state funding of services, or increase in transfers instead of more costly public spending on services or more emphasis on fiscal welfare (tax-breaks) than on services. During the 1990s, the

percentage of children in privately operated (publicly financed) childcare-centres increased 3 fold from 5% in 1990 to 15% by 1999 (Palme et al., 2002).

Overall, French family policy has been characterized along two paths or streams since 1945. The first tradition or stream focused on republican equality and included feminist conceptions of women's full labour force participation (Jenson and Sineau, 2001). The influence that these ideas had on policy was a greater incorporation of early childcare and education by the state. Political discourse that surrounded family policy at this time focused on the 'reconciliation of family and working life' (Jenson and Sineau, 2001). A second stream for family policy concerns itself with parental choice. More recently, talk of having a 'Libre Choix' in childcare has meant a proliferation of different kinds of childcare centers and methods including greater parental involvement, more subsidies to parents for childminders (Morgan, 2002). This rhetoric of 'choice' is used to justify the increase in private day care and create jobs in the caring industries where more childminders were crucial in creating jobs for young women (Jenson and Sineau, 2001). By 1995 16% of the CNAF expenditures were allocated to these two programs (Jenson and Sineau, 2001).

Childcare and employment policy have been closely linked in Sweden, where official policy has promoted and enabled greater gender equality in labour force participation of men and women (Jenson and Sineau, 2001). In contrast, childcare and employment policy in France has promoted incentives to employ childminders over traditional daycare centers (*crèches collectives*). Both the AGED and AFEAMA subsidies encourage parents to employ childminders over public daycare services thus creating jobs for childminders (Martin et al., 1998).

Both France and Sweden have experience 5 trends in childcare services identified by Jenson and Sineau (2001:255). These trends are (1) less costly services, thus fitting within lower spending limits across Europe due to European monetary policy; (2) decentralization of service provision from central government to local municipalities /authorities; (3) increased diversification in program access and availability; (4) greater flexibility in use of childcare; and (5) the individualization of choice. There are indications that some convergence has occurred with less emphasis on services and more focus on transfers (especially in France) in France and Sweden but these are not seen as paradigmatic changes to private, or family sector provision of childcare (Jenson and Sineau, 2001). In short, family policy continues to form a key component to the welfare state of both France and Sweden.

Chapter Three

Health Care Policy in France and Sweden

This chapter will attempt to move beyond the limitations of the existing research by comparing two main components of social policy (i.e. income security and social services) as they relate to health care in two different yet well-developed welfare states. While most research indicates that welfare states are undergoing some change, what is less clear is how, and in what direction, they are changing. As previously stated the welfare states of France and Sweden are classified by Esping-Andersen's welfare worlds typology as conservative and social democratic regimes respectively. Researchers of international health systems have used various classification schemes to situate national health care arrangements (see, for example: Gordon, 1990; Olsen, 1994; Roemer, 1991). Overall, France is considered having a *sickness insurance model* of health care while Sweden is categorized as a *national health service model* (Olsen, 2002). These distinctions have remained the same over the study period with no dramatic restructuring in the administration of either health systems. France is still a social insurance system, with near universal coverage and Sweden is still a publicly funded universal system with some but relatively little private hospitals and clinics.

This chapter will examine changes in health care policy in France and Sweden over the past 25 years (1977 to 2002). Although they have not been extensively compared in past social policy research, France and Sweden are particularly well suited for comparative research. Both countries have highly developed health care systems and both are affluent industrialized nations with high living standards. However, the manner in which these two nations promote the health of their citizens varies considerably. Outlined

below is a general description of both health care systems, followed by data analysis on sickness insurance and service measures. Information on health services in France and Sweden was obtained from the *Organisation for Economic Co-Operation and Development (OECD) Health Data* (2001a). Information on sickness insurance in France and Sweden was obtained from the 1977, 1983, 1991 and 2002 volumes of the SSPTW published by the Social Security Administration of the United States.¹⁷ While other non-governmental and governmental organizations such as the World Health Organization (WHO), the United Nations, Eurostat, and *Institut National de la Statistique et des Etudes Economiques* (INSEE) are detailed and valuable sources of health information, their measures are not uniform and consequently make international comparisons difficult. It should also be noted that information on health services derived from *OECD Health Data* was often not available for all years in the study period.

Swedish Health Care System

The Health and Medical Services Act (1982) provides the legal and constitutional framework for health care in Sweden and stipulates that the entire population has the right to be provided with the same quality of care for all (Palme et al., 2002). Five basic principles guide health policy in Sweden and stipulate that (1) every citizen is entitled to good health care, (2) that the goal of health care is to equitably secure good health and provide good health care to all citizens, (3) that the delivery of health care shall meet the requirements for good care, (4) health care shall be based on the population's need for care and (5) every county is responsible for the provision of good care to its inhabitants. Health care in Sweden is often described as a conglomerate of 21 interlocking health care systems organized around 21 regional county governments and 289 municipalities (Kaati,

2002). County councils are elected every four years and are responsible for most forms of medical and health care (Olsen, 2002). Counties formulate and implement policies with considerable independence from the central government, including the right to levy taxes (Olsen, 2002).

The design of the present-day Swedish health care system began in 1962 via legislation that entitled every resident to health care and sickness cash benefits (Roemer, 1991). Prior to this legislation, Swedish residents had compulsory health insurance since 1955 and before that, voluntary but heavily subsidized health insurance. Since 1970, patients visiting an ambulatory facility are required to make a small co-payment (20 to 30 percent of the cost) for each visit. By the late 1970s, all individual social insurance contributions ended with contributions deriving from employers (75%) and government (25%). There are a number of funding mechanisms used in the Swedish health care system. Ambulatory care is financed through national insurance funds and low ceiling patient fees, whereas hospital services (including physician salaries) are financed through tax revenue from county income taxes and grants from the central government (Roemer, 1991). The majority of physicians in Sweden are salaried employees paid by the health insurance scheme. Some local governments contract with private physicians for service, but the impact is negligible (Roemer, 1991).

French Health Care System

The organization of the welfare state in France can be thought of as a large tree with many branches. The main 'trunk' of this tree, *la Sécu* or *la Sécurité sociale*, supports the many branches or *régimes*. Each of these regimes is tied to a fund or *Caisse*. One branch on the social security tree that makes up the French welfare state is the health sector with

its accompanying Sickness Insurance Fund (SIF) or *caisse*. Participation in an SIF is mandatory. The SIFs are based primarily on occupational class and secondarily on place of residence and are augmented by nonprofit insurers or mutual supplementary carriers and some general tax-based funding (Anderson, 1998). SIFs cover 99.5% of the population and account for 75% of health care expenditures. The largest of these funds is the National Sickness Insurance Fund for Wage-Earning Workers or *Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (CNAMTS)* and is responsible for the administration of health, maternity, invalidity, professional sickness, death, and on-the-job accident insurance (OECD, 2003). The CNAMTS covers over 80% of the population in France and includes industrial and commercial employees, government workers, and the self-employed (Costich, 2002).¹⁸ A smaller SIF covers farmers and agricultural employees and their families, which make up about 9% of the population; another SIF covers skilled craftspersons, small businesses, and professionals, which make up about 6 percent of the population (Costich, 2002). Specific SIFs are also available for certain government employees, physicians, students, military personnel, miners, clergy, and other occupational groups. In addition to the SIFs, approximately 84% of the population has supplementary coverage through Mutual Insurance Funds (MIFs) and Private Health Insurance (PHI), which cover the cost of cost-sharing arrangements and other out-of-pocket expenses (Costich, 2002). Thus the health care system in France can be summarized as a two-tier health insurance system with a basic mandatory public pillar, and supplementary insurance provided by private insurance and the *mutuelles*.

The principle of liberal medicine or *La Médecine Libérale* has a long tradition in France with the incorporation of the medical charter in 1927 which guaranteed four

principles: (1) free choice of the physician by the patient, (2) freedom of prescription by the physician, (3) agreement by both patient and physician on fee price level and (4) fee-for-service payment (Cruise, 2002). The provision of health care services in France is divided between ambulatory care which operates on the liberal medicine principal and is funded through social insurance contributions; and the hospital sector which is universally provided by the state (i.e., physicians are public employees) and is funded through general taxes. Private hospitals are both for-profit and not-for-profit, usually with fee-for service doctors. Public hospitals employ salaried doctors and are under direct regulation by the Ministry of Health (Cruise, 2002). Hospitalization, medicines, and paramedical services are reimbursed by the local sickness fund to the insured patient. Amounts that are applicable for reimbursement vary, for example, 60% is reimbursed for paramedical services, and 80% for hospitalization (United States, SSA 2002). The patient/consumer in France pays a set daily fee for a hospital room and board charges with no set duration limit. Patients who are exempt from paying any fees are disabled children, war victims, and work accident victims (United States, SSA 2002). In 1996 regional hospital agencies were established to improve funding contracts with public and private hospitals. These agencies now supervise the distribution of regional funding and monitor the purchasing of public hospitals.

Ambulatory care is provided by private practice doctors, paid on a fee-for-service basis. Physicians practicing in private clinics or doctor-owned proprietary hospitals are also paid on a fee-for-service basis (Cruise, 2002). Many of these fees, however, are covered under workers' medical benefits.¹⁹ Some services that are covered include dental care, general and specialist care, transportation, laboratory services, appliances (i.e.

dialysis), and pharmaceuticals. The insured person normally pays for these services and then is reimbursed by the local SIF (United States, SSA 2002). Amounts eligible for reimbursement vary depending on the type of service in France, for example, 35% to 65% of pharmaceutical expenses are reimbursed, and 70% of fees for medical services (general practitioner and specialist) are reimbursed (United States, SSA 2002).

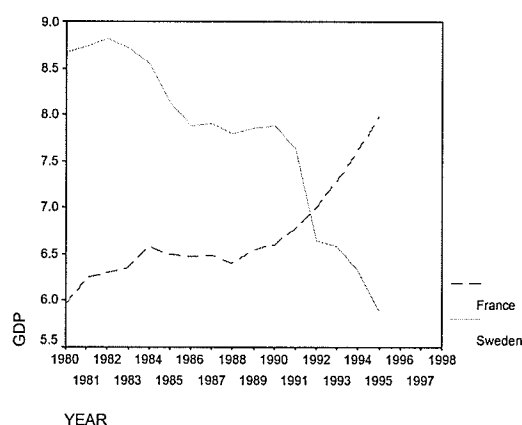
While the French health care system was recently ranked first in the world for overall health system performance by the WHO (2000), it is not without shortcomings. First, the right of patients to 'shop around' for their choice of doctor and for physicians to be able to charge fee-for-service has been criticized by French health care officials for its potential for abuse.²⁰ In fact, only since 1971 have any attempts been made by the national health insurance system to limit fees charged by physicians (Roemer, 1991). Up to that time doctors in France could charge any fee they wished. Today, there is a fee schedule stipulated in national health insurance regulations but exception exist to charge over and above these limits (Roemer, 1991). Second, the philosophy that guides the French health care system has been criticized for being too costly. In particular, costs in the social insurance general practitioner care are rampant with high pharmaceutical charges. Costs are more easily contained in the public hospital sector through a centralized administrative budget procedure adopted in 1983 (Wilsford, 1996).

Proportional Expenditure

In 2001, France and Sweden both ranked above the OECD average on health expenditures (spending 9.5% and 8.7% of GDP, respectively) and both countries have consistently ranked above the OECD average since 1970 (OECD, 2003). Public funding as a percentage of total health expenditure or Proportional Expenditure differed in both

countries at 76% for France and 85.2% for Sweden (OECD, 2003). Health care in both countries also differs markedly in their methods of financing health services and providing citizens with income benefits if they fall ill. While public funding is the major source of financing health care in both countries, in Sweden, 85% of health expenditures are derived from public funding while in France, the majority (73%) of public funding comes from the social security schemes (OECD, 2003).²¹

Figure 1
Public Health expenditure as a percentage of GDP in France and Sweden, 1980-95



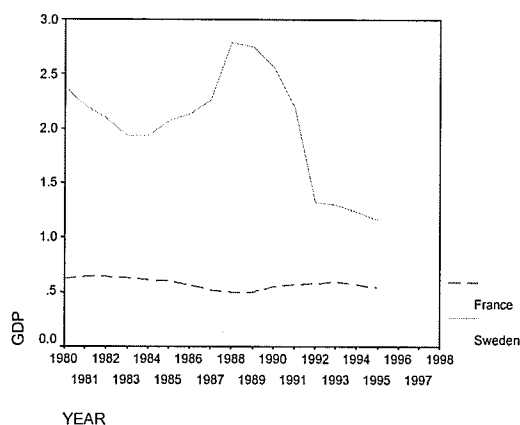
Sweden's decline can be attributable to cost control and severe economic recession in 1990. France's increase since 1989 can be attributed to fundamental aspects of its system of fee for service for physicians. After 1992 health expenditure patterns begin to diverge with Sweden continuing its decline while France increases steadily.

Income Security: Sickness Insurance

The following section will examine the differences in the sickness insurance schemes between 1977 and 2002 in both France and Sweden. To assess change over time, sickness insurance data from the 1977, 1983, 1991, and 2002 volumes of the SSPTW will be

compared. To assess differences between countries two measures will be used: access and generosity. Access includes the eligibility criteria for the specific income security benefit and the length of any waiting periods.²² Generosity includes the maximum amount received (measured in adjusted Canadian dollars), income replacement level, and benefit period. From figure 10.5, we see that Sweden has undergone much more variation in sickness benefit levels than France. Sweden has decreased towards the French level of benefits. France has remained constant throughout the study period while Sweden has decreased.

Figure 1
Sickness benefit as percentage of GDP in France and Sweden, 1980-95



Access

Sickness insurance has a long history in France with one of the first income supports for workers when they fall ill and are unable to work. This tradition has survived to this day. The general supervision of sickness insurance rests with the Ministry of Social Affairs and Employment (renamed the Ministry of Labor and Social Affairs). The national SIF is responsible for the coordination and financial equalization of regional

funds, the regional SIFs are responsible for the coordination of local funds, and the primary (local) SIFs are responsible for the registration of the insured, payment of cash benefits, and refunds of medical expenses (United States, SSA 2002).

People eligible to receive a sickness benefit for up to six months must have 200 hours of paid employment in the last 3 months. For extended eligibility (beyond 6 months), 800 hours of paid employed are required in the last year including 200 hours in the first 3 months (United States, SSA 2002). This has not changed from the eligibility criteria in 1977. After a 3-day unpaid waiting period, the benefit is payable up to one year but may be extended up to 3 years if chronic or prolonged illness and special qualifying conditions are met (United States, SSA 2002). This has not changed in any of the years under study.

Like France, Sweden has a long history of a separate social program that provides cash benefits and income security to those who are too ill to work. Both France and Sweden were two of the first countries to introduce such measures.²³ The general supervision of sickness insurance rests with the National Social Insurance Board, while regional and local social insurance offices administer the program (United States, SSA 2002). This has not changed since 1977. In 2002, the sickness benefit covered all gainfully occupied individuals earning C\$907.56 or 6,000.00 kronor a year or more. The nominal amount of 6,000.00 kronor remained unchanged in 1983 and 1991, where the actual amounts were C\$1846.15 and C\$1278.00 respectively. Only in 1977 was the annual earnings cut-off for sickness benefits 4,500.00 kronor or C\$3639.93. There was no minimum qualifying period in 1977 and 1983. However a waiting period of 15 days was

present in 2002 yet the employer pays the sickness benefit from days 2 to 14 at an income replacement rate of 80%.²⁴

Generosity

In France, the amount payable of 50% of covered earnings (increased to 66.67% after 30 days if three or more children) has remained the same over the study period. What has changed, however, is the minimum and maximum benefit. Specifically, in 1977, the maximum benefit was C\$36.70 (60.16 FRF) per day and C\$48.95 (80.22 FRF) per day if 3 or more children. In 1983, the minimum benefit was C\$7.43 (31 FRF) per day and C\$9.82 (41 FRF) per day if 3 or more children. The minimum benefit was C\$9.16 (41.55 FRF) per day in 1991, while the maximum was C\$41.68 (189 FRF) per day. If the sick person has three or more children, then the 50% of covered earnings is raised to 66.67% after 30 days, with a minimum of C\$12.28 (55.69 FRF) per day and a maximum of C\$55.58 (252 FRF) per day (United States, SSA 1991). In 2002, the maximum benefit increased to C\$52.83 (39.2 Euro) per day with no minimum, as well as for a sick person with three or more children to a maximum benefit of C\$70.45 (52.27 Euro) per day with no minimum benefit (United States, SSA 2002).

In Sweden, benefit levels were the same in 1977 and 1983 where the sickness benefit paid 90% of income up to 7.5 times the base amount. The ceiling for benefits has remained at 7.5 times the base amount for the study period. Benefits are paid for the duration of the illness (no time limit); this has not changed from 1977 to 2002. The maximum daily benefit in 1977 was C\$160.16 (198 SEK)²⁵ and the minimum daily

benefit was C\$6.47 (8 SEK). In 1983, the maximum and minimum daily benefit decreased to C\$110.46 (359 SEK) and C\$4.61 (15 SEK) respectively. In 1991, the maximum daily benefit increased to C\$126.74 (595 SEK) with no minimum daily benefit. Also the income replacement rate declined from 90% of income in 1983 to 65% of income for the first 3 days, 80% for the 4th through to the 90th day, and 90% from the 91st day of incapacity. In 2002, the maximum daily benefit was C\$94.23 (623 SEK) with no minimum daily benefit. The level of wage replacement has decreased slightly from 90% of income replaced by sickness benefit in 1977 and 1983 to 80% in 2002. The amount payable has decreased in Sweden from 90% of income loss in 1983 to 80% in 2002. The maximum adjusted daily benefit has decreased from a maximum amount of C\$160.16 (198 SEK) in 1977 to C\$94.23 (623 SEK) in 2002, even though the nominal increases during the study period are substantial.

From a comparison of the changes in both countries from 1977 to 2002, France and Sweden have basically maintained their generosity and access for sickness insurance with Sweden being more generous and having greater ease of access than France over the study period. First, the amount of sickness benefits received has increased in France and decreased in Sweden. In France, the maximum benefit amount has risen from approximately C\$37 in 1977 to C\$53 by 2002. In Sweden, the maximum amount was approximately C\$160 and by 2002 it was C\$94. Second, the income replacement level has been consistent in France (50% of insured earnings), while it has fluctuated in Sweden in 1991 and 2002. Third, the eligibility criterion in both countries has remained the same. Finally, while the length of waiting period in both countries has remained the same over time, it is shorter in Sweden (i.e. 1 day) than it is in France (i.e. 3 days). From

the data presented above, no dramatic changes have occurred in the sickness insurance policies of France and Sweden. Therefore continued divergence seems to best describe the trajectories of sickness insurance policy between the conservative welfare state of France and the social democratic welfare state of Sweden.

Services: Ambulatory and Hospital Care

The provision of health care in both countries can be divided into hospital services (including surgery, overnight stays, diagnostic testing, laboratory tests, the administering of drugs) and less medically serious care in ambulatory services outside the hospital (also hospital outpatient services) such as visits to general practitioner, or doctor consultations per capita, and specialist physicians, pharmaceuticals, eye and dental examinations. Data on health services were analyzed in *SPSS 11.0 for Windows*. Since we are interested in describing health services in France and Sweden over time on a number of continuous variables, a line graph was the most appropriate data analysis technique.

Ambulatory Care

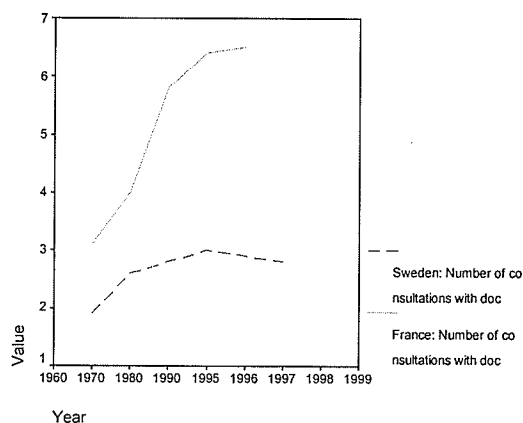
Three measures of ambulatory care will be used for the purposes of the present analysis. These include the number of doctor consultations per capita, the number of practicing physicians, and pharmaceutical expenditure as a share of total health expenditure, and will be used to describe any changes between 1980 and 1997. These are broad measures and by no means comprehensive in determining the extent to which actual health care policies in France and Sweden are becoming more similar or diverging.

i) Number of Doctor Consultations Per Capita

Consultations with doctors refer to the number of ambulatory contacts with physicians (both generalists and specialists) divided by the entire population.

Consultations in physicians' offices, in primary-care clinics and in the outpatient wards of hospitals as well as home visits are included (OECD, 2001a). Both public and private consultations are included. The percentage change in doctor consultations from 1980 to 1997 between France and Sweden is quite dramatic. For example, whereas Sweden experienced a 7.7% increase in the number of doctor consultations, France experienced a 63% increase over this same period, which is well above the OECD average of 22.6% (OECD, 2001a).²⁶ Even though both countries began at different levels, this gap has widened over the study period and has certainly diverged over time. Both countries have moved in diverging directions represented in our theoretical model in Figure D, and Figure A where both countries began at different levels but diverged over time with Sweden increasing less dramatically than France.

Figure 2:
Number of doctor consultations per capita



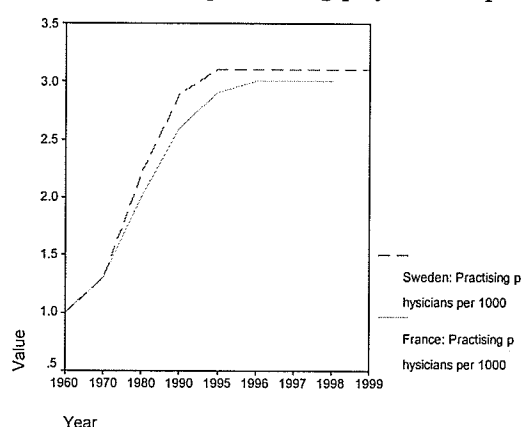
ii) Number of Practicing Physicians per 1000 Population

Practicing physicians are defined as the number of full-time equivalent physicians who are actively practicing medicine in public and private institutions (OECD, 2001a).

The percentage growth rate in the number of practicing physicians per 1,000 population

was identical in both countries at 2.9% between 1960 to 1999. Thus, we are seeing a pattern similar to our theoretical models in Figure J from chapter one where both countries start off at similar points and increase, then plateau together.

Figure 3:
Number of practicing physicians per 1000 population

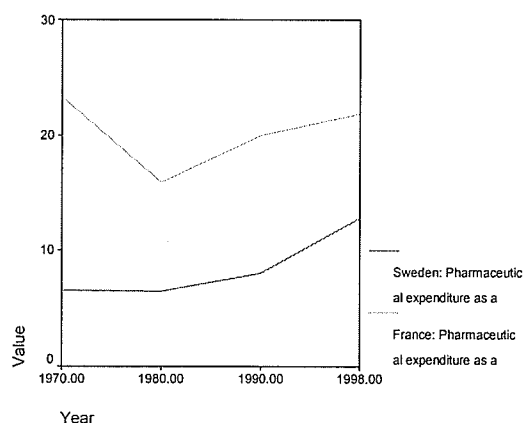


iii) Pharmaceutical Expenditure as a Share of Total Health Expenditure

Pharmaceutical expenditure includes expenditure on prescription medicines and self-medications, often referred to as over-the-counter products (OECD, 2001a). It also includes pharmacists' remuneration when the latter is separate from the price of medicines. Pharmaceuticals consumed in hospitals are excluded. The average percentage share of total health expenditure on pharmaceuticals has risen in both countries since 1980. However, France has consistently spent a greater share of its total health expenditure on pharmaceuticals (on average, 11.8% more) than Sweden. Thus, we are seeing a pattern of continued divergence similar to our theoretical model in Figure D

from chapter one, where the countries start off at different points and neither experience much change over time.

Figure 4:
Pharmaceutical expenditure as a share of total health expenditure



Care in Hospital

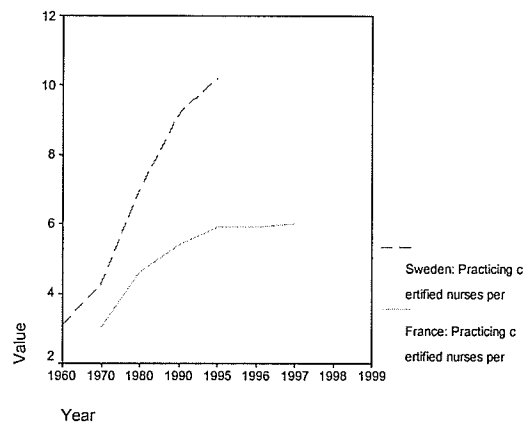
Four broad measures will be used to examine hospital care in France and Sweden. These include the number of practicing and certified nurses, the number of beds, number of admissions, and length of stay.

i) Practicing Certified Nurses per 1000 Population

Practicing nurses are defined as the number of actively practicing certified/registered nurses employed in public and private hospitals, clinics and other health facilities (OECD, 2001a). The percentage growth in the number of practicing and certified nurses between 1980 and 1995 is higher in Sweden than in France (2.5% versus 1.6%). More recently, in the 1990s, nurse numbers increased in all OECD countries except Canada,

Australia, Sweden and Poland. It should be noted that while the percentage growth in the number of nurses has increased to a greater extent in Sweden than in France, Sweden has consistently had a greater number of practicing and certified nurses than France between 1970 and 1995. The pattern displayed over time seems to be a combination of the theoretical models in Figure J and Figure B where both countries move in similar positive directions in the early years and then diverge in the early 1980s. Although they start out at different points, this small different increases displaying divergence.

Figure 5:
Number of practicing certified nurses per 1000 population

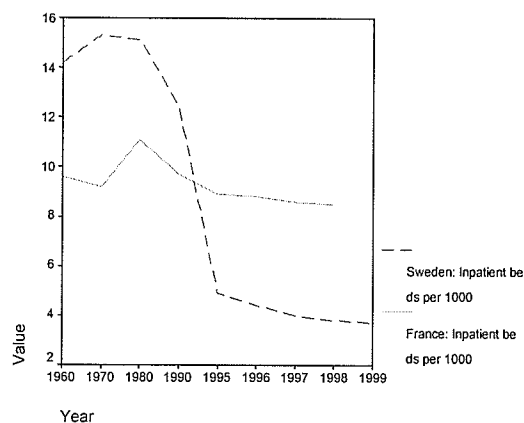


ii) Number of Beds

Both inpatient and acute-care beds will be examined for the purposes of the present analysis. Inpatient beds are defined as all available beds in public and private inpatient institutions, including nursing homes (OECD, 2001a). Acute-care beds are beds accommodating patients where the intent is to: manage obstetrics, perform surgery, perform diagnostic or therapeutic procedures, relieve symptoms of illness or injury (excluding palliative care) and reduce severity of illness or injury (OECD, 2001a). The percentage growth in the number of inpatient beds per 1000 population has decreased in

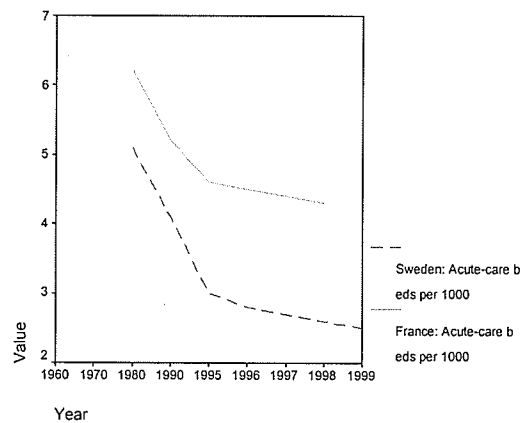
both France and Sweden from 1980 to 1998 with Sweden displaying a dramatic decrease from 1982 to 1995. The number of inpatient beds in France and Sweden converged in the mid 1990s but diverged dramatically with France beginning to plateau and Sweden continuing to decline, widening of the gap between the two countries after 1993. The pattern displayed is similar to our theoretical models in Figure G and Figure B, where Sweden converges towards France and continues to decline, while France levels off. Here we see both convergence then divergence over time.

Figure 6:
Number of inpatient beds per 1000 population



Looking at the percentage growth rate in the number of acute beds per 1000 population, we find a greater decrease in the growth rate for Sweden than France (-3.7 and -2.0% respectively) between 1980 and 1998. In fact, Sweden's negative growth rate percentage between 1980 and 1998 was the largest of all industrial nations and well above the OECD average of -1.7 (OECD, 2001a). The pattern displayed is again similar to our theoretical models in Figure D and Figure I where both countries decrease but because they start from different points, they continue to diverge over time.

Figure 7:
Number of acute-care beds per 1000 population

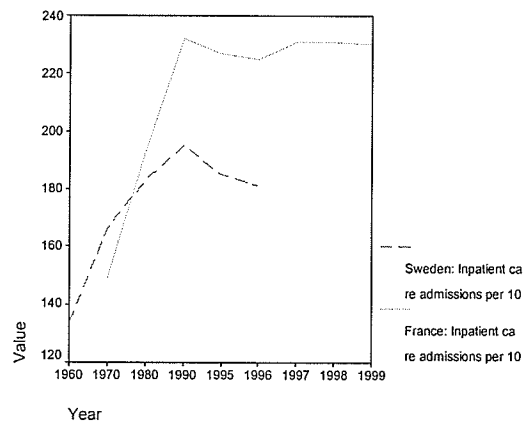


iii) Number of Admissions

Inpatient admissions measure the number of patients who were admitted and stayed overnight in inpatient institutions, including nursing homes. Same-day surgery is not included. Acute-care admissions measure the number of patients who were admitted to acute-care beds. Sweden experienced a positive growth rate of 0.3% between 1970 and 1998 for inpatient care admissions per 1000 population and a positive growth rate of 0.1% between 1970 and 1998 in acute-care admissions. France also experienced an increased growth rate of 1.7% in inpatient admissions and 0.9% in acute-care admissions. Because there is little initial difference between France and Sweden in the 1970s in the number of inpatient care admissions, the increase in the growth rate has had a divergent effect on the number of admissions in the late 1990s. For example, in 1970, there was a difference between France and Sweden of 17 inpatient admissions per 1000 population. By 1996, France had 44 more inpatient admissions than Sweden. The pattern displayed for inpatient care admissions fits the theoretical model in Figure J and Figure C where

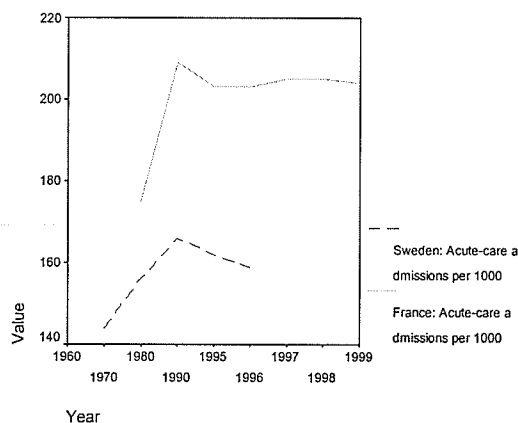
both countries increase, converge then diverge. Inpatient care admissions display both convergence then divergence over time in France and Sweden.

Figure 8:
Number of inpatient care admissions per 1000 population



The pattern displayed in acute-care admissions is not as pronounced as in inpatient care admissions. This is because there was a larger initial difference between France and Sweden in the 1980s in the number of acute care admissions. What we observe with acute-care admissions is close to our theoretical model of divergence in Figure C, with the exception that France has a short period of increase in admissions in the early years followed by a plateau in subsequent years.

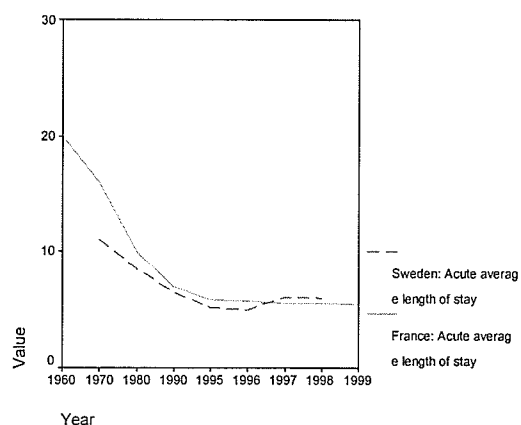
Figure 9:
Number of acute-care admissions per 1000 population



iv) Acute Average Length of Stay

Acute average length of stay (ALOS) refers to the average number of days (with an overnight stay) that patients spend in an acute-care inpatient institution and is calculated by dividing the total number of days stayed for all patients in acute-care inpatient institutions during a year by the number of admissions (OECD, 2001a). The growth rate in ALOS from 1980 to 1998 decreased for both France and Sweden (-3.1% and -1.9 respectively). The pattern observed is similar to the theoretical models in Figure G and Figure I where France decreases to converge with Sweden yet both countries exhibit very close descending patterns.

Figure 10:
Acute average length of stay (ALOS)



CONCLUDING REMARKS

The chapter has attempted to assess whether convergence or divergence is occurring in the health care systems of France and Sweden. From the analysis of sickness insurance

data and various indicators on health and medical services, the predominant pattern has been one of continued divergence for the two countries. The occurrence of change differed between France and Sweden, yet similar patterns of continued divergence predominated with variations in support for social services and income security programs in both countries. From the graph data on health services 4 measures displayed similar patterns. The number of practicing nurses per 1000 population (figure 5) and the number of doctor consultations per capita (figure 2) both have diverging slopes for France and Sweden. Conversely, the number of practicing physicians per 1000 population (figure 3) and acute average length of stay (figure 10) have nearly identical slopes for both countries. An explanation of why these patterns occur is beyond the scope of the present study. Further research could examine if these four patterns in health services occur in other OECD countries over the same time periods. Examining change in health care policy is just one domain toward identifying converging or diverging trajectories in welfare states.

Chapter Four

Old-Age Policy in France and Sweden

Old-age policy in many OECD countries is *the* current focus of reform. More than the previous two policy domains, old age policy reveals demographic and fiscal pressures that many governments are responding to. European governments began to evaluate this financial crisis in the 1990s with many changes sought to minimize the squeeze on fiscal policy and state pension budgets. In fact, both France and Sweden have recently adopted reforms that have changed their pension schemes. Sweden recently cancelled its long standing universally provided Folkspension, with the Guaranteed Pension, a modest, supplementary, pension provided only to those with low or no income (Olsen, 2002). While France, in the spring of 2003, adopted reforms that increased the number of work years required to gain a full pension for public sector employees amid opposition and strikes (*The Economist*, 16 Oct. 2003). These recent reforms can be viewed as a continuation of reforms adopted in the private sector in 1993 where the qualifying years for full pensions were extended from 37.5 to 40 years along with the time period of reference salary calculations from the best 10 years to the best 25 years (Bonoli et al., 2000). Researchers of social policy cite many reasons why governments are choosing to reform now, however demographic and fiscal pressures of ageing societies predominate.

Current old age welfare arrangements are considered unsustainable due to population ageing brought about by health and lifestyle gains in life expectancy and lower fertility among industrialized countries. These trends result in an age 'crunch' with the ratio of retirees to workers increasing in the decades ahead (Myles, 2002). Other pressures include trends towards earlier retirement in all OECD countries. Slower economic

growth, higher dependency ratios trends toward earlier retirement, growing generosity of pensions and the rising cost of benefits and services for the elderly (especially those elderly aged 80+) have forced governments to reform old age services and income programs (Olsen, 2004). These pressures have forced governments to examine their old age income and service programs.

France and Sweden differ in their methods of old age policy and are situated in different models in literature on old age social policy. Researchers of international old age pension policy group France and Sweden within different pension models. The *income security model* requires a worker pension replacement of at least 50%, that minimum pensions are not granted on the basis of citizenship and that there exist several occupationally distinct pension schemes (Palme, 1990). France is usually placed in this category while Sweden has traditionally been considered in the *institutional model* of pension benefits. Classification into the above model requires that the right to at least a basic pension is based on citizenship as opposed to need, that the minimum pension replacement is at last one-third, and that the worker replacement is at least 50 percent. The institutional model was consistent with Sweden's pension system until the late 1990s. However, since the elimination of the flat-rate Folkpension in 1998 Sweden's pension system can now be considered closer to the *institutional model* as in France.

This change marks a break with traditional universal benefits in Sweden. Also the earnings related pension program, or ATP has undergone restructuring with a change to a defined contribution scheme from a defined benefit system. Now pension benefits are upon lifetime earnings and economic growth and not the 15 best-paid annual earnings as in the previous scheme (Olsen, 2002). Unlike the former national pension, the guaranteed

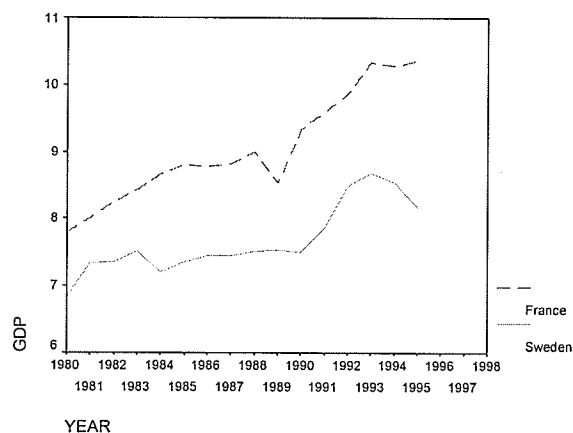
pension is paid to those with very low or no earnings-related pensions and effectively does away with the universal element of the Swedish pension system (Timonen, 2002).

Income Security

The following section will outline changes in overall expenditures on all old age cash benefits in France and Sweden and specific changes in the two pension systems in terms of access and generosity. Data on Proportional expenditure is graphically represented for the period 1980-95, and measures the proportion of GDP in France and Sweden allotted to old age cash benefits (including pensions). Data on pension programs access and benefit levels will be derived mainly from the four volumes of

Proportional Expenditure: Old Age cash benefits

Figure 1
Old Age Cash Benefits as a Percentage of GDP in France and Sweden, 1980-95



The proportional expenditure for old age cash benefits follow similar patterns after 1982 (see figure 1). France experienced a sharp drop between 1980 and 1981 while Sweden has experienced steady increase with slight decrease beginning in 1993. The

average spent on old age cash benefits in France was 9.05% of GDP and 7.67% for Sweden. Policy specific expenditures for old age benefits provide a starting point for analysis over time yet omit the qualitative variation within pension systems between France and Sweden with which we now turn.

Pensions

Both France and Sweden introduced social programs for old age pensions at similar times early in the 20th century. France introduced old age pensions in 1910 only three years before Sweden in 1913 (Olsen, 2002). Old age pensions in France are based on a Pay-as-you-go model where the present working age population pays for retirees now. This model is more stable with similar sized age cohorts moving through the pension system while sufficient numbers of workers finance the process. Problems of financial sustainability arise with large cohorts of retirees (baby boomers) coming into retirement at the same time of insufficient numbers of workers. The *CNAVTS* (*caisse nationale d'assurance vieillesse des travailleurs salariés*) administers the mandatory pension contributions of most employees and manages the targeted old age assistance programs. This caisse/fund, while France's largest public pension fund, covers less than half of pension benefits. The pension system in France is comprised of many pay- as- you- go schemes. As in family policy and health care, the pension system is highly segmented with hundreds of schemes however these are broadly divided into public sector pensions and pensions for private and self-employed workers. Employees in the private sector have two tiers with a general scheme and a supplementary level (Darnaut, 1999). In some cases there is a third level (*régimes surcomplémentaires*). A social assistance type

minimum public pension (*minimum vieillesse*) is provided to citizens aged 65 and over without adequate income (Darnaut, 2002).

The pension system in Sweden has gone through a structural overhaul that has affected the character of its pension policy. Specifically Sweden has done away with its basic universally provided old age pension, and has introduced pension accounts that individualize pension 'investment options' for Swedish citizens. These accounts by their very name and policy design point to a more market oriented direction for pension benefits in Sweden.

France has had many old age pension programs over the study period. Starting with 5 pension programs in 1977, France had 9 in 2002. During the period 1977 to 1991 France maintained six pension programs. The main program or Old Age Pension consisted of cash benefits for workers over the age of 60 years. The reduced pension, Spouse's and child supplements were called dependents allowance in 1977 (from 1983 to 2002 the dependent allowance was split into the spouse's supplement and child supplement. In 2002, the nine programs for old age pensions were the old age pension; minimum pension, maximum pension, constant-attendance allowance, Spouse's supplement, Child's supplement, old-age allowance, old-age supplement, means tested allowance.

Access

In Sweden, until recently there existed a universal pension and various employment related pensions. Two main types of pension programs existed in 1977, 1983 and 1991: the Universal Old-Age Pension and the Earnings Related Pension or ATP.²⁷ The most significant change came in 2000 with the implementation of the new pension system. The

Guarantee Pension replaced the Universal Old-Age Pension and a Premium Pension was introduced which established mandatory private pension savings accounts. This amounts to 2.5% of total contributions (18.5%). In 2002, there were three main pension programs: the Guarantee Pension, the Earnings Related Pension and the Premium Pension. These reforms have indeed changed the overall character of the Swedish pension system and have caused researchers of comparative social policy to rethink Sweden's place in an international pension typology.

In Sweden, coverage for the universal pension applied to all resident citizens in 1977. The earnings related pension covered all employees and the self-employed earning over a 'base amount'. The base amount has changed in every year of the study period from C\$8654.95 (10,700 SEK) per year in 1977 to C\$5853.78 (38,700 SEK) in 2002. For both pensions, retirement was not a requirement for receiving either pension; thus older workers were able to collect pensions while employed. This was maintained in 1983. Qualifying conditions included age, 65 years, for the universal pension and contributions for the earnings related pensions. For the Earnings Related Pension for 1977, 1983 and 1991 the main eligibility criteria were three years of coverage (employment) and age (65 years). In 2002, there were two sets of eligibility criteria which reflected the old and new systems for the Earnings Related Pension. For persons born in 1937 and earlier the old system applied. For this age cohort, the criteria were the same as the previous pension system (available to employees and self-employed residents earning over the base amount of C\$5853.78 (38,700 SEK) in 2002. The new system in 2002 applied to persons born in 1954 and later and included the two criteria for the Earnings Related Pension. These included a flexible retirement age from age 61 based on all lifetime earnings

reported to the scheme from age 16, and an income test where eligible pensioners must have had working years with earnings in excess of 24% of the base amount (C\$1404.91(9,288 SEK)), but earnings above 7.5 times the base amount (C\$43,903.35 (290,250 SEK)) were excluded from pension benefits. For the cohort born between 1938 and 1953 there existed an unspecified mix of qualifying conditions from both pension systems (old and new).

In France, there were six pension programs between 1977 and 1991. In 2002, there were nine. Like Sweden, retirement from the workforce is not a necessary condition to receive benefits in France. Thus pension benefits may be received while still employed. The old age pension is the main pension program in France. The main qualifying condition is age (60 years), and employment which has not changed during the study period. The Reduced Pension, the Dependent's Supplement, the Old-Age Allowance or 'Solidarity' Pension and the Means-Tested Allowance are the remaining 5 pension programs. The Dependent's Allowance was renamed the Spouse's Supplement and the Child's Supplement but they substantively are identical in providing supplements to old age pension for spouses and children of the pension recipient. Also In 1977 the main qualifying conditions were age 60, employment and 37.5 years of coverage (insured years of employment).

Generosity

The Old-Age Pension comprises the main cash benefit for French residents aged 60 years and older. This section will compare benefit amounts for France using three old-age cash benefit programs: Old-Age Pensions, the Old-Age Allowance or 'Solidarity' Pension and the Means-Tested Allowance. These three programs were chosen based on

comparability for all 4 years of study. For Sweden two old age cash benefit programs will be compared: the Earnings Related Pension and the Universal Old-Age Pension (changed to the Guaranteed Pension in 2000). Amounts received for Sweden pension benefits were converted into yearly amounts from monthly data presented in the four volumes of the SSPTW. Presented below are amounts received for pension benefits per year from 1977 to 2002 in France and Sweden.²⁸ All Pension data were drawn from the volumes of *Social Security Programs Throughout the World*.

Old-Age Pension benefits in 1977 in France were 25% of a worker's average earnings in 10 of the highest paid years of employment. This was raised to 50% if the employed person performed 'arduous work', or if the worker was unable to perform in an occupation without injury to their health. In 1983, and 1991 the benefit was raised to 50% of average earnings in 10 of the highest paid years of employment after 1947. In 2002, depending on the age or the duration of insurance coverage, the benefit amount varied between 25% to 50% of the average salary for the best 25 years of employment (adjusted since 1947). A minimum and maximum pension benefit was introduced in 1991, and remained in place in 2002. The minimum pension benefit in 1991 was C\$7563.88 (34,297.00 FRF) per year and the maximum benefit was C\$15005.58 (68,040.00 FRF). Both of these levels increased in 2002 with the minimum benefit level raised to C\$8501.82 (€6307.62) and the maximum benefit amount to C\$19,021.08 (€14,112.00) per year.

Old-Age Allowance or solidarity pension benefits in 1977 were C\$2867.80 (4700 FRF) per year. In 1983, the Old-Age Allowance became applicable to low income pensioners but the benefit amount was raised to C\$3642.60 (15,200 FRF) per year for a

single pensioner and C\$6326.63 (26,400 FRF) per year for a married couple. Again these amounts were raised in 1991 with C\$4526.60 (20,525 FRF) to low income pensioners if single and C\$7430.00 (33,690 FRF) for married couples. In 2002, the Old-Age allowance was granted in order to increase pensions up to a minimum amount of C\$3784.43 (€2807.72) a year for low income pensioners 65 years of age or older, single and who earn no more than C\$9432.00 (€6997.74) a year or C\$16,520.80 (€12,257.01) per year for a couple.

The Means-Tested Allowance increased steadily in all four years of the study period. In 1977, it was C\$2623.73 (4300 FRF) per year payable to low-income aged workers, if they are ineligible for pension. In 1983, this amount was raised slightly to C\$2708.00 (11,300 FRF) per year. In 1991, the Allowance was C\$3362.14 (15,245 FRF); and in 2002, the benefit amount was C\$3784.43 (€2807.72) per year for low income pensioners.

In Sweden the main universal pension (the Universal Old-Age Pension) was in effect in 1977, 1983 and 1991, and 2002 for persons born in 1937 and earlier. The Guarantee Pension comprised the new pension system and applies to persons born in 1954 and later. In 1977, Sweden's Universal Old -Age Pension benefit amount was C\$8221.40 (10,164 SEK) a year. This represented 95% of the base amount, which in 1977 was C\$8654.95 (10,700 SEK). For an elderly couple the benefit amount was raised to C\$13,414.36 (16,584 SEK) per year or 155% of the base amount. There was an increment of 0.6% of the pension benefit per month of deferral until age 70 which was maintained in 1983. All benefits were automatically adjusted for price changes in the cost of living as the base amount was adjusted over the study period.²⁹ In 1983, the benefit amount was C\$5760.00 (18,720 SEK) a year or 95% of the base amount which was C\$6061.54 (19,700 SEK).

For elderly couples the yearly amount received was 155% of the base amount and provided C\$9396.92 (30,540 SEK). In 1991, the amount received was C\$6584.40 (30,912 SEK) a year or 96% of the base amount which was C\$6858.74 (32,200 SEK). For elderly couples the benefit amount received increased to 157% of the base amount or C\$10,766.10 (50,544 SEK) a year. There was slight increase in the increment of 0.7% of the pension benefit per month of deferral until age 70 from 1983 and 1977.

In 2002, there was a transition mechanism in place where people receiving pensions from the old system would continue receiving benefits. Thus, within the new system the Universal Old age Pension maintained the same level of benefit amount as in 1991 at 96% of the base amount which was C\$5732.78 (37,900 SEK). This amounted to C\$5503.46 (36,384 SEK) of amount received. However, this figure was multiplied by the accrued number of fortieths or thirtieths to a single pensioner. The benefit amount for a married pensioner decreased to 78.5% of the base amount or C\$4500.23 (29,751.50 SEK).

The Earnings Related Pension was in place in Sweden for all four years of the study period. However, in 2002 there were two types of benefit amounts (old and new) which corresponded to the old and new pension systems. In 1977, the amount received was 60% of the difference between the average annual covered earnings and the base amount (C\$8654.95 (10,700 SEK), based on coverage since 1960. This was maintained in 1983 with the base amount decreasing to C\$6061.54 (19,700 SEK). The increment of 0.6% of pension per month of deferral until age 70 that applied to the Universal Pension benefit also applied to the Earnings Related Pension in 1977 and 1983. In 1991, the amount received was 60% of the base amount which was C\$6858.74 (32,200 SEK) multiplied by

the insured person's average annual number of pension points in 15 years with the most points.³⁰ The increment of pension benefits per month of deferral up to age 70 increased slightly to 0.7% in 1991, from 0.6% in 1983. In 2002, benefit amounts for the Earnings Related Pension (old system) were 60% of the base amount which was C\$5853.78 (38,700 SEK) multiplied by the insured person's average annual number of pension points in 15 years with the most points. The increment of pension benefits per month of deferral remained the same at 0.7% up to age 70. The new system for the Earnings Related Pension consisted of a system of national accounts. Benefits were derived from a pension formula which consisted of an annual index of average wages reported to the scheme plus an average life expectancy annuity factor and a 'norm' for the expected increase of average wages in future years. The norm for increases in the average wage was set at 1.6% and is used for annual adjustments of pensions for current payments as well as for calculating the first year pension amounts. The data provided in the SSPTW was insufficient to calculate an example of benefit amounts for the Earnings Related Pension (new system).

From the data presented above some trends can be discerned in both France and Sweden. The amount spent on old-age cash benefits was greater in France, reflecting a similar bias toward cash benefits over services as seen in chapter two. Sweden compensates for this lower spending on cash benefits by higher spending on services as seen in the next section. Qualifying and eligibility criteria in both countries (with the exception of the new pension system in Sweden) remained stable in both countries over the study period. In France, the Means-Tested Allowance increased throughout the study period and averaged C\$3119.57 between 1977 and 2002. In Sweden, the average benefit

amount for the Universal Old-Age Pension was C\$6855.26 per year between 1977 and 1991. During this period the percentage of the base amount used for the benefit calculation changed little from 95% in 1977 and 1983 to 96% in 1991. Overall, pensions remained the same for Sweden until recently, the main factor being the difference of new and old systems.

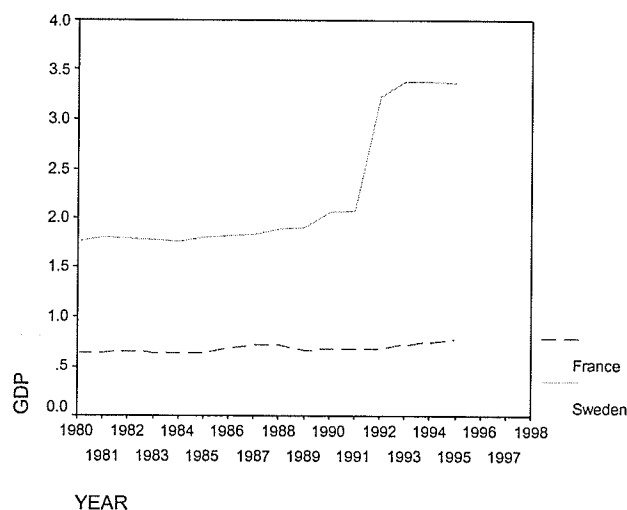
Services: Elderly Care

Similar to childcare services in chapter two, comparative data for social services for the elderly are scarce. Services for the elderly, unlike pension programs, are less clearly defined with two separate administrative bodies sharing responsibilities. This jurisdictional overlap is between health care sector and welfare. Little comparative statistical data was available for elderly services for both France and Sweden. What follows is a comparative analysis of secondary data from country specific studies on welfare services for the elderly.

Proportional Expenditures: Elderly Services

Figure 2

Proportional expenditure on services for the elderly and the disabled in France and Sweden, 1980-95



From the table above it is clear that Sweden has spent more on services for the elderly than France (2.23% vs. 0.68% of GDP respectively). France has never gone above 1% of GDP for services for the elderly.³¹ High spending on services is a defining characteristic of the welfare state in Sweden generally.

Sweden

Beginning in the early 1950s, old-age care shifted from institutions to more home help services. This marked the ascent of home help until the late 1970s at which time nearly 25% of retired elderly received home help services during a year, more than in any other country (Szebehely, 1998). Home help and institutional care have decreased in Sweden between 1980 and 1995. Since the end of the 1970s the number of places in institutions for the elderly has declined, and have been replaced by sheltered housing or 'service apartments' (Szebehely, 1998). Over the study period, elderly care has become more targeted to those in greatest need. During the 1990s, old age care was characterized by an increase in both the informal types of care provided mostly by relatives (usually women) and by private services purchased in the growing 'help' market (Palme, 2002). These trends have had the effect that senior citizens with financial resources have replaced municipal home help with market help to a greater extent while those less well off have had to rely more on informal care from family members (Palme, 2002). In Sweden during the 1990s, the percentage of the elderly (74-84 years) receiving municipal home help services decreased from 46% in 1990 to 33% in 1999. This was accompanied by an increase in privately purchased help and informal family arrangements (Palme, 2002). There has been a decline in both home help and institutional care settings between 1980 and 1995. The proportion of the population in Sweden aged 80 and over in

institutional care was 24% in 1980 and 16% in 1995.³² The proportion of 80+ elderly in service apartments was 2% in 1980 and 8% in 1995; and those elderly receiving home help in ordinary housing declined from 36% in 1980 to 21% in 1995. In 1985, there were 7 beds per 1000 populations in homes for the elderly in Sweden (Roemer, 1991: 209).

France

Formal welfare services for the elderly in France began in 1962 with the Laroque report which advocated services that would maintain elderly people in their own homes (Martin et al., 1998). Since then four types of formal care services for the elderly have developed. The largest form of professional help is the Home Help Service or *aide-menagère*. In 1990, there were 80,000 service workers under this category. In 1994, 490,000 elderly received an average of 12 hours of help per month. Payments for Home Help Services were out-of-pocket, by retirement funds (in particular the social security pension fund, which pays for 44% of total service hours), or by the *aide sociale* fund where individual income is insufficient. This covered 29% of total hours in 1994. Care Assistants or *auxiliaries de vie* help the frail elderly and handicapped people in daily life. In 1992, there were 4,000 Care Assistants who helped 13,000 people or families, 60% of whom were elderly. District Nurses or *gardes à domicile* work for non-profit organizations. Payment for services provided by District Nurses are mainly out-of-pocket payments by the elderly which are reimbursed through tax credits, a cash allowance for domiciliary help (the ACTP program), and other cash allowances. In 1992, the CNAV pension fund, created a district nurse service allowance which increased the take-up for the service from 14,300 in 1992 to 23,000 in 1995.

In 1989, there were 450,000 places in residential care facilities and 121,000 places in residential centers (Bungener, 1993). Residential care centers are comprised of individual dwellings that are located in a setting providing group services such as meal preparation and medical supervision.

Within publicly regulated formal care (institutional care) in 1994, there were 506,000 elderly people living in institutions; 170,000 were in private retirement homes; 154,000 were in sheltered accommodations; 93,000 were in retirements homes within public hospitals; and 68,000 elderly people were living in long-stay units of public hospitals.

From the data presented above services for the elderly in France and Sweden have decline over the study period. In the case of Sweden, it is noted that although public expenditure for old-age care has continued to increase at the same time that services have declined. This is in no small part due to population ageing and that Sweden has the world's highest proportion of 80 plus inhabitants (Szebehely, 1998). The proportion of the population aged 65 and over in 1999 was: 17.8 % in Sweden (highest among the OECD nations), 16.3 in 1980, 17.8 in 1990 and 15.9% in France, 13.9 in 1980, 14.1 in 1990 (OECD, 2001a). Also of note are future plan by the Swedish National Association of Local Authorities to restrict eligibility criteria for home help and to exclude services such as cleaning with the intent of focusing resources to those most in need (Szebehely, 1998). In France, the growth of an elderly caring industry is seen not as a means of increasing services to the elderly but as creating more 'carer' jobs. The trend for care workers in France is that the care worker has ceased to be an employee of a public

institution with good job protection but rather has become a short-term contract worker (Szebehely, 1998).

Chapter Five

Conclusion

This thesis has sought to shed light on the state of welfare in two European countries by focusing on three important domains of welfare policy with a particular emphasis upon Family policy, Health policy and Old Age policy over the past 25 years. It was demonstrated that no drastic welfare retrenchment has occurred in France or Sweden in the face of the recessionary trends of the late 70s and early 1980s, the rise of neo-liberal politics and the ascendancy of global capital and the rise of the transnational corporation. Findings from the present thesis have not supported a 'race to the bottom' convergence posited by some researchers as a response to accelerated competitiveness due to globalization. However, neither are welfare states expanding as they did in the decades following WWII during the 'golden age' of capital expansion and high levels of economic growth. From the analysis of three policy domains what has happened is a mix of policy contraction and expansion in some domains. The main finding of this thesis is variation; variation within policy domains and variation in policy reform.

The limiting of health spending in both France and Sweden combined with the expansion of family benefits and parental leaves are both examples of this mixed process. Pension systems, for example, are becoming less comprehensive through changes in age requirements (increasing retirement age) and the cancellation of universal forms of support pensions (for example, Sweden's Folkpension). However, it is important to remember that the means available to countries to resist or implement national programs can vary. For example, unionization rates in Sweden are still among the highest in the world, permitting continuing leverage in wage bargaining and political decision making.

France, at the other extreme, has one of the lowest unionization rates in the world.

However, the small and few unions that France does have, have powerful influence in the welfare state since the unions manage most of the welfare funds, and have broad public support demonstrated by many strikes and public protests.

Researchers of social policy have also found this mixed process in recent studies of European welfare states. Some researchers of family policy point to a future possible convergence within the European Union to harmonized family policy (Gauthier, 1996). However, until binding reforms are secured within the EU parliament distinct approaches to family policy are likely to persist (Gauthier, 1996). Trends in other policy domains have moved in opposite directions. For example, services for children have expanded with more public provision and paid care, while elderly services have seen cuts and an increase in unpaid care (Szebehely, 1998). In the area of family policy childcare has increasingly become a political issue as women's labour force participation has increased within a labour market that pays men more than women. By allowing more women to work, within the existing labour market that pays men more than women it is more profitable for capital to employ more women and save on wage costs.

Palier and Sykes (2001) have identified three perspectives that outline the potential and real impacts of globalization on the welfare state. The first scenario states that globalization is having a significant negative impact on welfare states via the increased dominance of the market. This perspective is closest to the neo-liberal argument outlined in a convergence 'race to the bottom' scenario. Here, market forces are considered too strong to be resisted and the policy options of national governments are dictated by international capital and the constant fear of investor flight from high taxes and high

wage costs. The second perspective questions the very existence of globalization, or suggests that, if it is real, globalization is having relatively little impact on the welfare state. Authors from this perspective routinely note that trade flows were up to or even more concentrated in the early part of the 20th century prior to the First world-war. They also suggest that demographic change has shifted welfare state responses, not globalization. The third scenario states that globalization is having an effect upon welfare states but that these effects are mediated through institutional structures and policy responses (Palier and Sykes, 2001). It is this third perspective that best fits the findings of the present thesis. Different welfare states are affected differently by globalization. Culture, political parties, parliamentary structures, level of worker militancy or unionization rates, can support or undermine the welfare state. In Canada, universally provided health care is one national policy that *identifies* Canada and Canadians as different from the United States; so too in France and Sweden. The welfare state is a defining characteristic of Sweden's cradle to grave social support, and *la Sécu* in France.

Policy change in France over the study period can be characterized by an increase in universalism. Specifically, the *Juppé Plan* in 1995, introduced a universal health insurance scheme making health a right of citizenship. More significantly, the plan made the first steps in shifting the financing of health and family benefits from contribution financing to a tax-financed system through the introduction of a number of general taxes (Daly, 2001). As mention earlier, the introduction of the RMI was one of the first universal, non contributory social programs in France to deal with social exclusion. Some authors argue that these changes are only the beginning of a shift away from a

Bismarckian system of welfare state provision to a more Beveridgean 'citizenship' approach (Bonoli and Palier, 1998). This shift can be viewed as positive with the increased access and coverage to health care as a right of citizenship and not record of employment. However, changes in administration and control over the system could pave the way for program cuts in the future. Control over the French welfare state formerly resided with the social partners and the trade unions. French unions derived most of their legitimacy in the eyes of the public through their administration of social security. This is no longer the case with universal tax based provision for family benefits and recent health care reforms. Now that control and financing resides with the state, the possibility of future cuts has become a reality with the potential of a second wave of welfare restructuring that would go beyond administration and control (Bonoli and Palier, 1998). Therefore any welfare reform must be seen in its capacity to create 'institutional opportunities' for more radical reforms in the future. In the case of Sweden, increased decentralization has widened the gap between national standards of welfare programs and the service delivery by the municipalities. For example social assistance has become increasingly dissimilar across municipalities (Olsen, 2002). As noted earlier, the cancellation of Sweden's folkspension has constituted a significant historical break with Sweden's principles of equality and vertical income distribution.

The conclusion that the welfare states of France and Sweden emerged relatively unscathed from recent policy reforms needs to be qualified. Researchers of social policy are quick to point out that while benefits and programs may have not been cut, structural reforms that change control of the system could permit more radical cuts in the future (Bonoli and Palier, 1998). For example, in Sweden, welfare state change was limited in

scope; being driven by the determination of the Swedish government to retain the main features of an institutional welfare system in the context of economic crisis during the early 1990s (Timonen, 2002). One of the benefits of examining policy changes over a 25 year period is that what appear to be minor structural changes could pave the way for more radical restructuring and cuts in the future. Change may also occur in the opposite direction with temporary cuts to welfare programs, later being restored. For example, in Sweden in Family policy reduced income replacement rates for parental leaves and welfare cuts during the early 1990s were restored in 1997.

The reverse may also be true. Over a longer time period we see welfare cuts being reversed and later expanded. This was the case in the early 1990s when Sweden, responding to a severe economic recession, engaged in cuts to welfare after the kronor currency devaluation in 1992 but five years later restored those cuts after the economy began to recover (Bonoli et al., 2000). Or the decreased income replacement rates in parental leaves in the early 1990s dipping to 75% from 90% then increasing a few years later to 90%. There has been no attempt to radically overhaul social policy in Sweden or dismantle the Swedish welfare state. And this seems unlikely given the dominant values, the unified nature of the state and the continuing strength of the Swedish labour movement (Olsen, 2002).

Limitations to the current study include its overall generalizability. Only France and Sweden were examined during the past 25 years in three policy domains. Extending the study period to include a longer time frame, more countries and more policy domains while not within the scope of the present thesis, could prove fertile ground for future studies of comparative social policy. This type of research could be conducted with more

countries and including policy domains. For example, two countries could be selected from each of the three welfare worlds (the United States, the United Kingdom; Finland and Sweden; and France and Germany) and studied for changes in income security and services across five policy domains of family, health, labour market, workers compensation, and old age policies. Data availability was also a mitigating factor in some policy areas like social services generally. Future studies could include interviews with policy actors, and more methodological triangulation with qualitative and quantitative data collection.

In general, over the past 25 years industrialized countries have experienced larger cuts in income security measures and retrenchment of services in weaker welfare regimes like the UK and USA, while stronger, more established welfare states have withstood the waves of external and internal pressures on welfare states. Change *has* occurred in all countries, but the degree to which welfare capacities have been damaged has varied significantly. An architectural analogy can be useful here in that an edifice with a stronger foundation is more resilient to shocks and harder to deconstruct or dismantle while buildings with weaker foundations can be more easily toppled. Mature welfare states have larger support (ie. welfare is not a poor people's issue used by only the most marginal segments of society), and strong union involvement in countries such as France and Sweden cement opposition to dramatic cuts. Weaker, less developed welfare states are subjected to more pressure for retrenchment while more developed welfare states are more resistant to retrenchment due to culture, large numbers public employees relative to workers in the private sector, strong unions, popular electorate constituencies, and also the view that the welfare state contributes to economic growth, job security and overall

economic wellbeing. In Sweden, parliamentary structures, fewer veto points, stronger centralized federal control, less leverage for interest groups, progressive taxation and an industrial labour policy (Solidaristic wage policy) have made the welfare state an integral component of both the economy and the nation as a whole.³³ Also, popular support for current policies and welfare systems can be seen by the population as a constitutive part of national identity and national pride.

It is hoped that this thesis has raised questions for the three policy domains examined and for other domains. Labour market policy and worker compensation policy are two domains that could add to future research. Directions for further research could include employment trends and active and passive labour market policies. Many of the three policy domains in this thesis are related to employment. For example, parental leaves are closely linked to the labour market and active retraining programs are key components to national employment patterns. The implementation of the minimum income in France (RMI) for the unemployed and uninsured financed via taxation revenue also points to important policy reforms over the last 25 years. Further studies could include tax credits and other tax incentives that do impact choices made by citizens for pension and childcare and elderly care arrangements. Two recent initiatives by the European Union might prove promising for improving data quality for social services, especially in the areas of international childcare and services for the elderly.³⁴

The present study has attempted to contribute to the comparative welfare state literature and offer some policy alternatives to other nations such as Canada. Much too often media reports cite U.S. policy in health care as a path Canada should adopt. In light of the present privatization debate in Canadian health care, private clinics and hospitals

do operate in both France and Sweden but are different and more accessible than those in the United States. Canadian policy makers could learn much from an examination of the welfare experience in Europe and not rely solely on reforms and policy in the USA.

Endnotes

¹ Tax allowances and credits, which perform many of the same functions of income security measures (cash transfers) and services, constitute components of fiscal welfare or the 'hidden' welfare state and will not be included in this study. See Olsen (Olsen, 2002) for a detailed summary of national welfare systems.

² Other welfare state typologies emphasize race and/or gender. There are many welfare state typologies (Lewis, 1998), but for the purposes of this study we are more interested with class and class interaction within the global economy.

³ For a detailed analysis of modern convergence theory, see Wilensky (2002).

⁴ The welfare state, overall, is thought to be negatively impacted by global capital mobility more than production and least by trade (Olsen, 2002). Specific sectors of the population may be more negatively affected directly by either trade or FDI (see, for example: Wood, 1995).

⁵ National currency devaluation has the positive economic effect of cheapening exports of the home nation on the global market. In open economies, like Sweden, which are heavily reliant on exports, a devaluation results in capital injection from other nations with non-devalued currencies (see Carchedi, 1997).

⁶ In an era of cost containment, this situation is very unlikely. An example would be the United States moving towards the Swedish social democratic welfare model.

⁷ Legislation in Sweden on parental leave instead of maternity leave is just one example of the many egalitarian measures within family policy (Gauthier, 1996).

⁸ France and Belgium followed close behind Sweden and Denmark in public expansion of childcare services. France even surpasses Sweden in providing daycare to 99% of children aged 3-5 years due to comprehensive and full-day preschools (see Esping-Andersen, 1999; and Mahon, 2002).

⁹ In addition to purely family social risks, the CNAF is also responsible for the RMI (*Revenu minimum d'insertion*) which is an anti poverty labour market program (OECD, 2003).

¹⁰ In Sweden, mothers' support in the labour force, including paid maternity leaves of long duration, is enabled through individual taxation policies and attractive parenting policies for fathers (Hofferth and Deich, 1994).

¹¹ In Sweden, there are specific family allowances not listed in the SSPTW, these include: a maintenance allowance which is provided to a custodial parent in the event of failure to pay child support by the non custodial parent; a care allowance for disabled children; child pensions for children with a deceased parent; housing benefits for low-income families with children and an allowance for multi-child families (*flerbarnstillägg*) (Daune-Richard and Mahon, 2001:169).

¹² Base Wages for France were converted into constant 1995 Canadian dollars. Benefit amounts for family allowances were calculated from the percentages specified in the SSPTW for 1977, 1983 and 1991. No base wage was specified in 2002 as amounts were simply listed in that edition of the SSPTW.

¹³ Sweden is only one of two OECD countries (Finland is the other) where the total costs of maternity and parental leave schemes exceed 1% of GDP (OECD, 2001b).

¹⁴ In 2002, the qualifying conditions were basically the same in that to received the maternity benefit ten months of registration were required and 200 hours of paid employment in the last 3 months before the start of pregnancy and not during the last year as in 1977 through to 1991.

¹⁵ A disadvantage in examining national data on daycare services is the neglect of regional disparities. For example, in France the national average for 2 year old children in preschool was 32% with ranges of 60% in *Bretagne* and 15% in *Ile-de-France* (Martin et al., 1998). In Sweden, urban centers like Malmö, Gottenburg, and Stockholm are better served than more northern rural areas (Olsen, 2002).

¹⁶ Some programs have been cut, such as school meals in Sweden cut in 1989, but generally family policy has weathered recession and calls for cost containment in both countries.

¹⁷ The rationale for choosing the time period 1977 to 2002 was based on the availability of the SSPTW, and OECD expenditure data from 1980.

¹⁸ By 1978, all French citizens had to be covered in one of 3 major SIFs. A decade later, the unemployed were assigned to the general fund with local government subsidizing the cost of membership (Cruise, 2002).

¹⁹ Although workers' medical benefits are formally an income security measure, it is logical to include these cash benefits within health services since the goal is to reimburse the patient/consumer for expenses incurred in hospital or ambulatory care.

²⁰ The discovery by a regional sickness fund of a patient who had visited five psychiatrists in a single day, submitted receipts for each consultation and drug prescriptions, and received full reimbursement highlights the problem of monitoring and abuse in ambulatory care in the French health care system (Wilsford, 1996).

²¹ In France and Sweden, the prevalence of private funding also differs with 24% of health expenditure coming from private sources in France vs. 15% of health expenditure derived from private funding in Sweden in 2000.

²² An unpaid benefit period (measured in days) will be considered and analyzed as a waiting period.

²³ Sweden first introduced sickness insurance in 1891 and France in 1898 (Olsen, 2002).

²⁴ Throughout the 1990s, sickness benefit regulations were repeatedly adjusted. In 1992, regulations were introduced making employers responsible for the first 14 days of illness. In 1997, this period was extended to 28 days, and lowered again to 14 days in 1998. One unpaid day before any compensation is paid remains in place (Olsen, 2002).

²⁵ The first number is the real benefit amount in Canadian dollars. The second number in parentheses is the nominal amount in the foreign currency (i.e. SEK, FRF, or Euros). Yearly exchange rates for the Kronor, Franc and Euro were obtained from Statistics Canada. Consumer prices were obtained from the International Monetary Fund and used to adjust for inflation for 1977, 1983, 1991 and 2002.

²⁶ While one may assume that an increase in the number of doctors would lead to more consultations, there was only a weak positive correlation ($r = 0.44$) between the growth in the number of physicians per capita and the growth in the number of consultations per capita during this period (OECD, 2001a).

²⁷ Sweden also provided supplements to its Universal Old-Age Pension in 1977, 1983, and 1991. In 1983 and 1991, a Partial Pension was in place aimed at part-time workers. Additional pension programs were the STP or Occupational Pension for Blue-collar Workers; ITP for White-collar workers; and separate programs for employees in central and local government (Palme and Svensson, 2003).

²⁸ All amounts received were represented by a percentage of the base amount or in adjusted Canadian dollars (C\$) followed by the nominal amount in French francs (FRF) or Euros (€) for France and Swedish kronor (SEK) for Sweden.

²⁹ Only in 1977 was the base amount adjusted for inflation on a monthly basis. From 1983 onwards, inflation adjustments were established for the base amount by the government annually. This applied to both the Universal and Earnings Related Pensions.

³⁰ For the Earnings Related Pension amount received the number of pension points in one year equals the difference between a worker's covered earnings and the year's base amount divided by the base amount. In 1991, the limit of pension points per year was 6.5 points (United States, 1991). This increased to 7.5 points per year in 2002 (old system).

³¹ Data on elderly services included the disabled. The OECD social expenditure database had no data for elderly services alone (OECD, 1998).

³² Demographic changes do not account for this decline since the proportion of Swedes aged 80+ have risen steadily over the study period (from approximately 260,000 in 1980 to over 405,000 in 1995 (Szebehely, 1998)).

³³ Veto points refer to the extent to which state structures hinder or enable social policy development and implementation. Fragmented state structures are weaker, providing more points of veto where one component of the state system can effectively block social policy proposals put forth by another component (Olsen, 2002).

³⁴ Recent Eurostat working papers seem promising in these two service areas (EC, 2002; 2003).

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Appendix

Current income security measures for families in France

- 1) Family Allowance (*Allocation Familiale*) a universal allowance to families with two or more children with no means-testing. This benefit is paid for children up to age 20 and earnings of less than 55% of the minimum wage.
- 2) Young child allowance (*Allocation Pour Jeune Enfants*) is paid from the 5th month of pregnancy until the child reaches 3 years of age, and is income tested.
- 3) Family support allowance (*Allocation de Soutien Familial ASF*) acts as a child support assurance, is payable to a parent raising a child without the help of the other parent, or to a third person caring for the child up to age 20.
- 4) Family supplement (*Complément Familial*) acts as an income tested, large family allowance and is applicable for three or more children between the ages of 3 and 21 years.
- 5) Accommodation allowance (*Allocation de logement familiale*) is an income tested housing allowance for a parent paying rent with at least one child under age 21.
- 6) Housing allowance (*Aide Personnalisée au Logement*) is a rent subsidy.
- 7) Beginning of school year allowance (*Allocation de Rentrée Scolaire*), previously called the education allowance to parents, is a back-to-school allowance awarded for children between ages 6 and 18. This benefit is paid yearly for each child and is income tested.
- 8) Single-parent allowance (*Allocation de Parent Isolé*) is awarded for a limited period to a single woman who is pregnant or caring for children. This benefit guarantees a minimum income for the recipient, plus a supplement for each child.
- 9) Special Allowance (*Allocation d'éducation spéciale*) is granted to a parent caring for a handicapped child up to age 20 (after which an allowance for handicapped adults replaces the AES).
- 10) Adoption allowance (*Allocation d'adoption*) is payable for 21 months to a family adopting a child, and is income tested.
- 11) Parental education allowance / child-rearing allowance (*Allocation parentale d'éducation*) is paid to a parent staying at home to raise two or more children. Prior to 1995, the criteria was three children. The parent must have worked 2 years out of the past 10 preceding the birth of the second child.

- 12) Home child-care allowance (*Allocation de garde d'enfant à domicile*) is paid to working parents who employ a childminder. Benefit levels are 50% of the employer's and employee's social security contribution. This amount can increase to 75% of contributions subject to means testing.
- 13) Accredited child care benefit (*Aide à la famille pour l'emploi d'une Assistante Maternelle Agrée*) is awarded for children under age 6 if parents are working and pay for child care by an accredited carer.
- 14) Parental childcare allowance (New, 2002) is awarded for a maximum period of 12 months to a parent who has fully or partially ceased employment to care for a seriously sick, injured, or handicapped child.