

*Europeanization and Social Solidarity: Restructuring of Pensions and Health*

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This paper investigates the ways in which European integration is contributing to changes in the development of public health and pension systems in the member states. Undoubtedly, EU treaties and secondary legislation covering pensions and public health do not specify much of a role for the Commission in terms of setting pensions, and they only vaguely delineate the particular objectives assigned to the Commission with regard to health. In general, the Commission and European Parliament have no explicit mandate to make policy decisions in these fields since political leaders have fought hard to protect these areas from far-reaching Europeanization. Moreover, both fields are embedded in the social welfare state and are financed by national taxes and social contributions. The European Commission and other EU institutions have little direct influence over the structure and policy processes of the social welfare state. Yet EU legislation and ECJ judgments increasingly create constraints on national systems and opportunities for EU institutions to steer a course of action and influence national legislation and policy in directions that are potentially at odds with the core principles of these national arrangements. These parallel developments – constraints on domestic policy regimes and opportunities for EU institutions – are shaping the future contours of pension systems and public health programs.

To be sure, there remains considerable institutional policy diversity across the 15 old member states and especially within the new European Union of 27 member states. Nevertheless, it is fair to say that European developments are pushing national reforms of pensions and public health in a very specific direction. For pensions, EU policies favor a multi-pillar model based on individual, employment-based pension entitlement. The central features of this emerging pension paradigm are: financially sustainable and adequate public pensions coupled with portable, funded occupational pension schemes that take full advantage of the internal market. In short, the trend encouraged by EU single market legislation is to undermine some of the solidaristic principles of national pension regimes, particularly those based on boundary control and familialism. This paper does not argue that European integration leads to a ‘race to the bottom’ for welfare states. Indeed, recent contributions to the welfare state literature show that social insurance spending in

Europe continues to grow, despite the pressures of market integration (Starke, Obinger, Castles 2008).

Similarly, European developments are pushing political leaders to revisit some aspects of their national health systems, especially the parts that address chronic diseases flowing out of patterns of consumption. The emerging features of the new public health highlight the growing prevalence of ‘lifestyle’ or non-communicable diseases such as cardio-vascular disease, cancer, diabetes, and stroke. Moreover, political leaders and professional associations are encouraged to focus on health disparities and address the overall social, economic, and cultural environment that is associated with lifestyle diseases and contributes to health disparities between financially secure and educated as opposed to underprivileged, disadvantaged social groups. In other words, EU policy is helping to shape a new, solidaristic public health paradigm where (often) none existed before.

The puzzle we address concerns the effects of EU influence on these two sets of policy institutions. In the case of pensions, the EU dilutes and reshapes some of the solidaristic features of national systems and reduces institutional diversity across national pension systems; in public health, the EU enhances its solidaristic dimensions. Why would the involvement of the EU have such contradictory effects? The literature on EU social policy does not offer a solution to this puzzle. The pessimistic view advanced by analysts such as Scharpf (2002; 2003) and Leibfried (2005) argues that EU policies create incentives for neo-liberal, supply-side social policies. In other words, EU policies, especially the internal market, constrain national policy-making autonomy and hinder many of the Keynesian strategies associated with the post-war welfare state. Ferrera (2005) makes a similar argument: European integration unleashes a "new spatial politics of welfare" where member states no longer control the boundaries of social provision. In a later article, Ferrera (2009) proposes a solution for mitigating the tensions between a closed system of entitlements and redistributive arrangements and regional integration. The EU should develop an EU social model that promotes European-wide safety-net and norms, which supplements or complements existing social welfare policies in the member states. Palier and Pochet (2005) also take an optimistic stance, arguing that EU policies constitute “a distinct European economic and social model” embedded in innovative forms of governance, including the Open Method of Coordination(OMC). Although they acknowledge the supply-side bias of EU economic and social policies, Palier and Pochet view the emerging forms of social policy

governance as a positive contribution to welfare state development. Even if demand-side policies are less attractive or even impossible, the EU's emerging multilevel social policy governance offers opportunities to strengthen social citizenship, solidarity and social inclusion.

Our explanation for the variable effects of EU policies on pensions and public health draws on Historical Institutionalism's core insight that "policy creates politics" (Thelen and Steinmo 1992; Thelen 1999; Immergut 1998). Pensions and public health differ in several important ways as distinct policy areas. For lack of a better label, we call this key dimension of variation "embeddedness,"<sup>1</sup> and what we mean by it is the following: the extent to which public policies as institutions (Pierson 2007) generate "increasing returns" in terms of actors' adaptation to and investment in that set of policies (Pierson 2000). To put it another way, embeddedness is likely to generate the types of "increasing returns" processes that lead to path dependence because actors adapt to the existence and functioning of an institution by incorporating the institution into their behavior and planning in that area. Actors join or create organized interest groups that protect and defend the essential structure and substance of that policy regime. In turn, the more embedded a set of policies is, the harder it is to change, and *vice versa*. Our argument takes this one step further by also arguing that embeddedness entails not only intensity of the type of involvement by actors but will also take into account the policy design. Thus it does not only matter how intensely actors value or prefer a particular policy, but it also matters what the structure of that policy is. This allows us to analyze how European policy initiatives collide with or reinforce existing social policies in the member states, and how these European pressures are helping to structure, de-structure (Ferrera's term) and re-structure domestic welfare state institutions.

Pension schemes have wide and deep roots in national legislation and funding programs while public health is the 'orphan' of the social welfare state. The EU can make a mark on public health because many member states have ignored this area of public policy and have been dismissive of the responsibility of governing agencies to promote good health. As political leaders and health authorities have neglected to build an operating and functioning public health system, the EU is able to provide a template and use a carrot and stick approach to move recalcitrant member states in a certain direction. It relies on 'soft law' consisting of recommendations and reports as well as specific regulations that mesh with single market

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<sup>1</sup> This is not the same as "goodness of fit." And it is not the same as veto players.

freedoms (Greer 2006). In the case of pensions, current policy choices are usually highly institutionalized because they are the product of decades (or a century) of political negotiation and renegotiation. All member states, both old and new, have extensive systems of retirement provision in which the public sector is heavily involved. The EU's template for retirement provisions emphasizes individual, portable, fiscally sustainable pensions that prevent social exclusion in old age. Both hard and soft law encourage the member states to move toward this template, but change has been slower and less dramatic than in the area of public health, largely because of the embeddedness of pension policies at the domestic level.

The first part of the paper places our arguments in the context of the literature on Europeanization and Historical Institutionalism. We then briefly discuss the variable forms of solidarity embedded in national pension systems and European Union efforts to reshape pension policy in the member states. The third part of the paper looks at health and examines the rise of the new public health paradigm and its consequences for national arrangements. The final section discusses the implications of our analysis for the study of Europeanization and the welfare state.

## **Theory**

By now there is a large literature on the "domestic impact of Europe" (Cowles, Caporaso and Risse 2001) and "Europeanization" (see, for example Falkner et al. 2005). Research in this tradition traces the impact of European integration on politics and policies in the member states. The purview of this literature is wide, encompassing every nook and cranny of public policy, from EMU to environmental policy to agricultural and fisheries policy. Despite the often fragmented nature of this literature, there is widespread agreement that domestic institutions "filter" the impact of European policies, even if researchers disagree about which domestic institutions matter most in mediating the effects of European integration (see most prominently Cowles, Caporaso and Risse 2001).

Pinning down the precise ways in which specific domestic institutions mediate the impact of Europe is, however, quite another issue, and the literature is disappointingly vague on this point. Broadly speaking, existing scholarship emphasizes the mediating impact of three types of domestic institutions: constitutional rules, norms and cognitive understandings, and political resources. We take a slightly different approach by drawing on the historical institutionalist literature and welfare regime scholarship as the basis for our concept of *embeddedness*.

Historical institutionalists argue that public policies should be analyzed as institutions because they have important *political* effects (Pierson 2000, Skocpol). Public policies shape political processes and behavior in two ways: by creating incentives for interest group activity and by shaping actor preferences and strategy. As Pierson (2007) puts it, public policies define (or at least influence) who the relevant political actors are in a given policy area, what these actors want, and how they organize. This argument has important implications for the study of the EU's impact on domestic policy and politics because domestic actors' preferences, strategies and resources shape domestic responses to European policy initiatives. If we want to know how member states respond to both hard and soft incentives coming from the EU, the obvious first place to look is political actors. What is the policy status quo and relevant actor constellation? Do European policies challenge or reinforce existing policies, and with them actor preferences, strategies and resources?

Ferrera (2005) argues that the member states respond defensively to EU initiatives that challenge their welfare state status quo. This is precisely because of the policy feedback effects of welfare state institutions. Over the past century, political parties devised, advocated and enacted social policies that met their programmatic goals and attracted votes; individuals responded by adapting their own "welfare maximizing" strategies to the existence of public social policies; interest groups formed around specific social policies (pensioners' groups, etc.); and organized business and labor adapted their membership and bargaining strategies to the constraints and opportunities offered by public social policies. Employers also incorporated the existence of public social policies into their production strategies (Mares 2001). To borrow from Pierson (1994), the welfare state has become a more or less permanent part of the political landscape, and political actors and individual voters have organized their vote-getting, organizing, and welfare-seeking strategies around these policies. This means that the structure of social policies is politically consequential because these details of policy design encourage certain behaviors and discourage others. Over time these individual and group choices add up to substantial investments in the status quo, or "increasing returns." If European Union policies collide with the incentive structure built into national social policies, the welfare state is thrown out of equilibrium, or as Ferrera calls it, "destructured." But how are we to conceptualize and explain this destructuring process?

We now return to the concept of "embeddedness" introduced at the beginning of this paper. We define embeddedness as the extent to which, and the ways in which, policy structures produce feedback or increasing returns. Thus the concept has two dimensions: intensity and structure. This means embeddedness can be strong or weak, and it can take different forms in terms of policy content. Pierson's work on path dependence tells us much about when to expect increasing returns, but he offers less guidance about how to deal with issues related to policy content. This is curious given his earlier work's focus on how specific kinds of policy structures generate specific kinds of feedback in terms of coordination effects. In other words, it matters not just how strong "returns" to policy are, but it matters what kind of "returns" these are. A brief look at the welfare regime literature will illustrate what we mean. Esping-Andersen's (1990) seminal contribution to the study of welfare states was to identify and explain the emergence and further development of distinct patterns of welfare statism. Without embarking on a lengthy discussion of this literature, we want simply to link our analysis to the welfare regimes approach by identifying four types of embeddedness based on the two dimensions, intensity and structure (table one). The chief indicator for intensity is, following Pierson, "returns." Here we simply refer to ways in which policies produce sunk costs and actor adaptation and coordination. These effects are obviously very high for mature pension schemes (Myles and Pierson 2001; Weaver 2007), and they are low in the area of public health. To capture the most salient dimension of policy structure à la Esping-Andersen, we use the notion of solidarity, breaking it down into two broad forms: group-based or individually-based solidarity.

**Table 1: Four Types of Embeddedness**

	<b>weak returns</b>	<b>strong returns</b>
<b>individual solidarity (liberal and social democratic WR)</b>	-Nordic public health -UK PH (under Labour) - most social policies in the NMS	-Swedish pensions -UK/ Irish pensions
<b>group solidarity (conservative WR)</b>	-French public health	-German pensions -French pensions

This conceptualization of embeddedness allows us to roughly predict how European Union policies shape member states' social policies. But we first need to know what kinds of "solidarities" the EU privileges. We argue that in the case of pensions, the EU is pushing an individually-based solidarity that is most compatible with the social democratic welfare regimes. EU policies are also compatible with the liberal regimes, except for the mismatch between the minimum ambitions espoused by EU policy and the often low thresholds of benefit adequacy in the liberal regimes. The picture is similar in public health. It is in the conservative welfare regimes where EU policies cause the most doubt. Thus our prediction for these welfare regimes is that strong increasing returns processes will slow down the transition to policies more in line with EU priorities.

The structure and substance of public health is radically different from pensions, largely because of the underdevelopment of health programs in many member states. In no member state are strong "increasing returns" processes evident, and the member states with existing public health policies only exhibit weak returns. Public health policies simply do not produce the wide range of positive feedback effects that pension policies do, because public health is regulatory and not redistributive in nature. Thus our prediction here is that the weak embeddedness of public health policies in the member states permits deliberate and ongoing policy change in line with EU priorities. The next two empirical sections illustrate our arguments.

### **Pension Systems and Solidarity**

Social science scholarship on welfare state variations typically focuses on the ways in which the structure of social protection differs along three dimensions: benefits, financing and

administration. For social insurance schemes like pensions, this means asking: What is the basis for benefit entitlement (citizen, worker, or dependent?), and how are benefits calculated (flat-rate or earnings-related)? How will benefits and services be financed (general tax revenues, employer/employee contributions, VAT)? Which group or agency will administer the scheme (unions, employers, mutual societies, private actors, or the state)?

Obviously there is a wide range of institutional variation in Europe, depending on how political actors designed the first social insurance schemes and how subsequent sets of actors modified them. In the field of pensions, this diversity is often overwhelming and exceedingly technical because of the extensive coverage and complexity of pension schemes and the large sums of money involved.<sup>2</sup> Even though Esping-Andersen (1985; 1990) has been explicit about the different kinds of solidarity embedded in national social policies, we still do not know enough about the relationship between solidarity and pension design. Analysts regularly invoke the concept of solidarity in discussing the effects of pension reforms, but this is usually not done systematically; scholars often refer, rather vaguely, to cost-saving pension reforms resulting in "declining solidarity" without ever really discussing the type of solidarity embedded in the pre-reform pension system and comparing it to the type of solidarity promoted by the reformed pension system. In contrast, Stjernø's (2005) analysis of the history of solidarity as an idea demonstrates the complexity of solidarity as a concept. But again, there is little discussion of the relationship between solidarity and policy design.

This section attempts to briefly sketch out what we think are the main ways that different aspects of pension design generate different kinds of solidarity.

1. universalism v. segmentalism
2. individual v. breadwinner entitlement
3. intergenerational v. intragenerational obligations

The notion of solidarity implies that the members of some defined group are bound by a set of mutual rights and obligations. Thus the first question in terms of pension design is: who will be included in the pension scheme? Universal coverage, as in the Scandinavian countries, means universal solidarity: all residents are entitled to benefits. No group can opt out, and no group has access to a better set of benefits on the basis of group membership. Segmentalist coverage means that different occupational groups are covered by different pension schemes,

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<sup>2</sup> See Esping-Andersen (1990) and Bonoli (2005) for two influential typologies. Baldwin (199x) uses the concept of "risk category" to distinguish between different kinds of social policy design.

often with varying levels of benefits and contribution rates. The continental or Bismarckian welfare states exemplify this approach to solidarity. For example, in Germany civil servants, farmers and miners have their own pension schemes. The free professions (lawyers, doctors, pharmacists, etc.) have access to separate pension arrangements. Blue and white collar workers in dependent employment (about 80% of the workforce) participate in the statutory pension scheme.

Second, significant differences in benefit entitlement persist among EU member states as well. ECJ interpretations of EC law prompted the reform of breadwinner-only access to statutory and occupational social security schemes in the 1970s and 1980s. And despite the massive entry of women into the labor force across the EU, many Bismarckian pension schemes retain extensive derived pension rights. This means that an individual worker accrues pension rights not just for him/herself, but also for his/her spouse or partner if he/she dies.<sup>3</sup>

Finally, the financing structure of pension schemes involve explicit assumptions about the rights and obligations of different generations. PAYG (pay as you go), defined benefit (DB) schemes imply an intergenerational contract whereas PAYGO notional defined contribution (NDC) schemes imply an intragenerational contract. Similarly, funded defined contribution (DC)<sup>4</sup> schemes are individually-based and thus involve no intergenerational obligations. Funded DB schemes involve a weak form of intergenerational solidarity because current contributions and current benefits are linked. Contributions rise or fall (unless the employer pays the full cost) depending on the costs of current benefits, so contributors and beneficiaries are mutually dependent in a way that does apply to DC or NDC schemes.

What does all of this mean in the real European world of pension provision? At one extreme are the Nordic, liberal (UK and Ireland) and new member state approaches to pension provision in which individual entitlement prevails, and derived rights are weak or non-existent. Within these individually-based systems there are substantial differences in reliance on DB/DC, flat-rate v. earnings-related pensions and the mode of financing. Nordic pension provision is based on the principles of universal, individual entitlement based on work and intragenerational solidarity; every generation pays for itself. The Anglo-Irish approach is characterized by weak

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<sup>3</sup> See Sainsbury (1996) on different types of benefit entitlement.

<sup>4</sup> In a DB scheme, benefits are fixed in advance (i.e. 70% of final salary) and contributions are adjusted as necessary to finance this benefit promise. In a DC scheme, contributions are fixed, and the pension benefit varies according to investment returns. An NDC scheme combines the DC logic with PAYGO. Contributions are recorded in individual notional accounts, and the pension varies with the pension system's internal rate of return.

universal solidarity (the state pension) embedded in a weak intergenerational contract, coupled with the strong segmentalism in the occupational pension system. In the Bismarckian countries, inter-generational segmentalism prevails: universal solidarity is weak or non-existent (weak minimum pension provision) and pension entitlement is often linked to parental status. Parents (almost always mothers) often accrue pension rights for child-rearing, and the childless sometimes pay higher contributions than parents (i.e. the Riester pension subsidies in Germany). And the PAYG, DB structure of pension provision implies a very strong intergenerational contract. Pension rights accrued today have to be paid for by the future contributions of today's children. This makes a DB, PAYG system sensitive to employment and fertility rates.

The point of this admittedly superficial overview is to demonstrate that there are multiple solidarities built into European pension systems.<sup>5</sup> While it is true that public provision still dominates in all but two or three countries (NL, UK, DK), it is certainly NOT true that public provision is characterized by some sort of one-size fits all solidarity that all member states more or less agree on. The reformed Swedish public pension system entails a very different sort of solidarity than the German one even if both systems rely on earnings-related benefits. Most Swedish policymakers would never dream of rewarding parents with subsidies for occupational pension provision, and it is a cornerstone of public policy that women should be economically independent. This principle is reflected in labor market policy, tax policy and pension policy. In contrast, German principles of solidarity entail that society should be supportive of parents (mothers) who stay at home to care for children, so pension credits for child-rearing are financed by the general budget.<sup>6</sup> The existence of multiple solidarities (intergenerational v. intragenerational; universal v. segmentalist; individual v. breadwinner/parents) means that member states are affected differently by the emerging EU approach to pensions policy.

### **OMC and Pensions**

By the late 1990s, EU legislation and jurisprudence had already extended the principles of equal pay and non-discrimination to statutory pensions as well as occupational pensions.<sup>7</sup> With the completion of EMU, however, the fiscal implications of public pension provision came under scrutiny for the first time, and EU institutions took the first steps toward prodding member

<sup>5</sup> See also Ferrera and Hemerijck's (2003) grouping of the MS into four "social Europes."

<sup>6</sup> The Swedish pension system also awards pension rights for child-rearing, but this arrangement is not nearly as generous as the German one.

<sup>7</sup> See, for example, Leibfried (2005).

states to reform their pension systems. In 2001 the European Council decided to apply the OMC to pensions in order to promote the pension system modernization as part of the overall strategy of reforming social protection to support the Lisbon Strategy (Eckardt 2005; Pochet and de la Porte 2001).<sup>8</sup>

As Annesley (2007) argues, Lisbon reignited debates about the role and status of a European social model (ESM). Pension policy is obviously a core element of the ESM because of the sheer scope of pension provision in the member states. For pensions, as well as other parts of social protection systems, the key issue was how to promote economic modernization and social sustainability at the same time? According to Annesley, the "emerging" European social model is a Adult Worker Model approach to social provision which is more social democratic than neoliberal. Consistent with previous EU policy and the Lisbon agenda's focus on activation, the OMC focuses on EU citizens as workers. In contrast to previous EU policy promoting paid employment, the Lisbon strategy explicitly supports the activation of groups that were often inactive in many member states, especially older workers, women and the disabled. Thus, the Lisbon strategy actively pushes all adults to enter paid employment. And social protection schemes should be reformed to support this goal.

Pension provision represents the core of the welfare state; public pensions typically are the largest item in member states' budgets (see graph below), averaging about 13% of GDP in the EU-25. Low fertility rates and increasingly longevity (add stats) mean big trouble for PAYG public pension schemes based on DB. One of the initial activities of the OMC process in pensions was to gather more systematic data about the nature of the "pensions crisis" in the member states in order to increase awareness of the future fiscal implications of expanding PAYG pension liabilities.

The mechanics of the OMC in pensions are well-known and need not be rehearsed here (see Eckardt 2005). The point of this brief section is to ask how the principles embedded in the Lisbon Strategy and the OMC pensions process affect national systems of pensions provision and the multiple solidarities embedded in them. First, if we return to Annesley's (2007) point that the Lisbon Strategy represents the promotion of the Adult Worker Model, it seems clear that

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<sup>8</sup> The process is now called the "EU Social Protection and Social Inclusion Process." According to the DG Employment/Social Affairs website, this process "coordinates and encourages Member State actions to combat poverty and social exclusion, and to reform their social protection systems on the basis of policy exchanges and mutual learning. As such, it underpins the achievement of the Union's strategic goal of sustained economic growth, more and better jobs, and greater social cohesion by 2010."

this principle potentially conflicts with the notions of solidarity embedded in the continental/Bismarckian pension schemes.

Second, the OMC's focus on the fiscal sustainability of pensions pushes in the direction of intragenerational solidarity, away from intergenerational solidarity. This has mainly to do with the financing problems associated with mature, PAYG DB schemes prevalent in the member states. As part of the OMC process, the member states have done the math, and the numbers are devastating for PAYG DB schemes. Barring a surge in either fertility, employment, or both, PAYG schemes will absorb unsustainable levels of public expenditure. Even the countries with what some consider to be a healthy multipillar mix (NL, DK, Sweden perhaps) are not completely immune to these same demographic constraints.

Third, the OMC's emphasis on paid employment and fiscal sustainability pushes in the direction of "actuarial fairness" in pension benefit formulae. Indeed, one of the most common features of pension reform across the EU is the strengthening of links between contributions and benefits. Most member states have increased the number of years required to qualify for a full pension and shifted the benefit reference period from a "best" number of years to career average earnings.

To be sure, the Lisbon Strategy and the OMC process in pensions cannot force any member state to reform pension provision in the direction of intragenerational solidarity, individual entitlement, and employment-based benefits. The OMC only offers incentives and a forum for mutual learning that provide the context for national-level debates and decisions concerning pension reform. But given that pension reform will occupy national political agendas for many years, it would be unwise to ignore the normative force and specific content of the OMC pension agenda.

### **The Occupational Pension Fund Directive**

One of the elements of the OMC pension process is the increased importance of supplementary and private pension provision to compensate for decreases in public provision. Only three member states have occupational pension sectors that cover at least 90% of the workforce: the Netherlands, Denmark and Sweden. Despite the very large size of the UK occupational pension sector, coverage is far below 90% (see European Commission 2006: 77-78). There is also considerable variation across the member states in the organization of

occupational pensions. In Denmark and Sweden occupational pensions are mainly organized according to life insurance principles. In the Netherlands and the UK, a pension fund arrangement is much more common. Life insurance contracts require full funding, whereas pension funds can be either partially or fully funded depending on national regulations. Book reserve schemes, common in Germany, are occupational pension schemes in which pension liabilities are entered on a firm's balance sheet. Table 2 shows the distribution of second pillar assets in Europe.

**Table 2: Second Pillar Pension Assets 2005 and 2006**

billions of euros

	2005	2006	2006		
			pension funds	group insurance	book reserves
<b>Austria</b>	21.92	23.32	12.56	1.30	9.46
<b>Belgium</b>	45.80	47.17	14.21	32.96	
<b>Denmark</b>	149.60	165.70	59.70	106.00	
<b>Finland</b>	9.91	10.33	5.53	4.80	
<b>France</b>	140.00	150.00			
<b>Germany</b>	401.50	413.55	93.32	46.76	273.47
<b>Hungary</b>	2.60	2.70	2.70		
<b>Ireland</b>	77.83	87.70	78.93	8.77	
<b>Italy</b>	50.05	51.48	43.29	3.64	4.55
<b>Netherlands</b>	722.38	780.00	690.00	90.00	
<b>Portugal</b>	7.78	8.69	8.69		
<b>Spain</b>	95.14	98.34	55.80	31.02	11.50
<b>Sweden</b>	155.80	160.47	12.46	133.08	14.94
<b>United Kingdom</b>	1496.00	1557.00	1423.00	134.00	
<b>EU TOTAL</b>	<b>3376.32</b>	<b>3551.32</b>	<b>2500.19</b>	<b>592.33</b>	<b>313.90</b>
<b>Iceland</b>	1.42	1.62	1.62		
<b>Norway</b>	93.19	98.00	23.00	75.00	
<b>Switzerland</b>	533.73	549.74	355.85	193.89	
<b>Europe Total</b>	<b>4004.65</b>	<b>4200.68</b>	<b>2880.66</b>	<b>861.22</b>	<b>313.90</b>

source: EFRP  
2008

Before 2003, there was no EU legislation covering pension funds whereas life insurance has been regulated for more than two decades. The completion of the internal market and the emergence of funded pension provision (as a component of pension reform) taking on new salience in the EU, the Commission initiated pension fund legislation in the 1990s. Haverland (2007) traces the decision-making process concerning the pension fund directive. The

Commission adopted the proposal in October 2000 (IORP; COM (2000) 507 final).<sup>9</sup> The proposal was made under the provisions of the single market. The directive continued the process of financial market liberalization because it would grant pension funds (IORPs, Institutions for Occupational Retirement Provision) the freedom to operate cross-border, something that other financial institutions already could do. The proposal included regulations concerning investment mix, financial oversight, and the definition of full funding (sufficient assets to cover current and future liabilities). Book reserve schemes were excluded from the directive, and there was no mention of biometric risks.

The directive was adopted in 2003 and the deadline for transposition was October 2005. Even though it was only recently adopted, the effects of the directive are becoming clear. First, directive creates incentives for member states to compete to be the domicile of choice for pension funds by implementing a more lenient regulatory regime. Belgium, Ireland and Luxembourg have already taken steps to increase their attractiveness as domiciles. The Netherlands joined this group later. Second, national transposition of the directive will consolidate and hasten the expansion of funded second pillar provision in member states that recently took steps to expand the second pillar.

Germany is a good example of the latter process. Book reserves (*direktzusage*) comprise about 60% of occupational pension assets (Wagner 2005). Germany's transposition legislation loosened rules for its two types of pension funds, *Pensionskassen* and *Pensionfonds* which account for € 367 billion in occupational pension assets, or about 20% of total occupational pension assets (Wagner 2005). *Pensionfonds* were created as part of the Riester reform in 2001. Unlike *pensionskassen*, they operate according to the prudent person principle. *Pensionskassen* are subject to quantitative investment restrictions (maximum 35% of assets in shares and 5% in hedge funds) because they guarantee a minimum rate of return.

German implementing legislation also included changes in the discount rate used to value liabilities (*Rechnungszins*) for *pensionfonds*. This will create incentives for pension schemes set up as book reserves to switch to *pensionfonds*. As noted, *pensionfonds* are not as restrictive as *pensionskassen* which means that they offer a potentially cheaper route than *pensionskassen* for employers who want to switch from book reserves to funding.

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<sup>9</sup> Procedure was co-decision.

The directive coincides with developments in international accounting standards that create incentives for firms to shift book reserves to pensionfunds. German DAX companies have already started to shift to funding, so the implementation of the directive provides them with another, perhaps more attractive option, for shifting to funded schemes. International accounting standards (IAS19) requires adjustments to the ways in which liabilities are included on a firm's balance sheet.<sup>10</sup> This makes book reserves unattractive because they are basically unfunded pension liabilities. Bosch, as well as many other German multinationals have shifted from book reserves to either pensionfunds, pensionskassen or contractual trust arrangements (Wagner 2005).

The size of the funded occupational sector in Germany has grown significantly since the Riester reform of 2001, and the occupational pension directive has contributed to this development (see table 2 above).

### **Occupational Pension Portability**

Efforts to adopt a directive on occupational pension portability have been unsuccessful. The proposed directive announced in October 2005 has been extremely controversial, especially in the Netherlands and Germany. The core of the proposal would permit workers to take accrued pension rights with them to a new job after a vesting period of two years. Another important aspect of the proposed directive is the requirement for pension providers to index the value of dormant pension rights.

The directive sparked the most opposition from the member states with the largest funded and unfunded occupational pension sectors: the Netherlands and Germany. The Dutch threatened to veto the directive (which they have never done before as EU members) because it would result in the transfer of pension assets out of the Netherlands. Given that pension contributions are exempt from tax, Dutch policymakers saw pension portability as the exit of untaxed assets. German occupational pension providers criticized the provision requiring pension schemes to guarantee portability by capitalizing assets held as book reserves when a worker changed jobs and pension scheme. German employers lobbied for the exclusion of book reserves and PAYG schemes (Wagner, Brooksbank and Evans-Pritchard 2005) because capitalizing accrued benefits would be too costly.

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<sup>10</sup> IAS 19 lays out the rules for the accounting and disclosure of employee benefits and requires that the cost of employee benefits be recorded for the period in which the employee accrues the benefit rather than when it is paid.

Dutch employers as well as the government opposed the proposal's provisions concerning the indexation of pension accrual (Widdershoven 2005). Current Dutch legislation does not require the indexation of pension accrual nor of dormant pension rights. In the wake of the 2000/2001 stock market downturn and heavy investment losses, the indexation of pension accrual, dormant rights, and pension payouts were made dependent on pension fund solvency (Anderson 2007). This is one of the prime policy instruments for keeping DB pensions in the Netherlands solvent.

## **Discussion**

Both the ongoing OMC process embedded in the Lisbon Strategy and European legislation concerning occupational pension funds are premised on a conception of solidarity that in many ways is at odds with prevailing notions of solidarity embedded in national systems of pension provision. Both the OMC and the pension fund directive push the member states in a multi-pillar direction by creating the normative and legal foundations for the recalibration of public provision, the expansion of funded occupational provision, and the strengthening of individual, employment-based pension entitlement. The type of solidarity that is most congruent with this emerging pension paradigm is intragenerational, and it is based on the individual's obligation to work. And a range of public policies and services support employment and the reconciliation of work and family. To be sure, the OMC process also promotes the principle of pension adequacy by encouraging member states to improve policies that guarantee a minimum income in old age.

To those familiar with the Nordic models of social protection, these norms will look familiar. One of the pillars of the Nordic model is the "work line," (*arbetslinjen*) or the idea that work always comes before welfare. Cash benefits were a last resort, to be drawn when retraining, rehabilitation and other measures were exhausted. Sweden, Denmark and Finland each experienced deep economic recessions in the 1980s and 1990s. Each country adopted a series of welfare state reforms that corrected deviations from the "work line." Pension reform was a centerpiece of these reform processes. Sweden transformed its PAYG defined benefit public scheme into a PAYG notional defined contribution scheme with obligatory funded individual accounts in 1998. In other words, Sweden shifted from intergenerational solidarity to intragenerational solidarity. Denmark did more or less the same thing, but a bit earlier. Denmark never legislated public earnings-related pensions in the 1950s as Sweden and many

other European countries did. Instead, the flat-rate state pension was the main source of income for low-wage workers, while many middle class wage earners were covered by occupational pensions. Coverage was less than 60% until the late 1980s, however, until blue collar unions and employers agreed on the extension of occupational pensions to these groups. By the early 1990s coverage had reached more than 90% of the labor force.

Thus the Danish, Swedish and Finnish public pension systems rest on principles of individual entitlement within a collective scheme based on intragenerational solidarity. The size of the funded occupational pension pillar differs across these three countries, but the underlying principle is fairly clear: portable defined contribution benefits.<sup>11</sup> This set of first and second pillar pension institutions is most compatible with the types of solidarity implied by the OMC pensions process and the direction of EU legislation concerning occupational pensions and pension portability. The norms of solidarity embedded in the Bismarckian/continental pension systems are very different because they rely much more on intergenerational rights and obligations as well as family-based rights and obligations. Moreover, the fragmentation of pensions along occupational lines in many Bismarckian countries has created multiple, competing solidarities which are hard to undo.

### **Public Health in Europe – Lack of Solidarity**

Public health is on quite a different scale than pensions. Its institutional features and financial obligations are modest and the number or variety of vested interests is limited. In terms of its ‘embeddedness’ it has thin roots, a small audience, and few engaged stakeholders. Public health as a policy regime generates limited returns for the stakeholders and the number of actors in general whose behavior is shaped by this field is small. Public health is more open ended and porous, and thus more receptive to outside pressures or initiatives. Because of this it is difficult to argue that the institutions of public health determine the course of action or decisions of future policy processes because the designation of public health itself undergoes reclassifications and new definitions.

While public health is a branch of the national health care system, the latter is obviously more akin to national pension arrangements. Health care refers to delivering health services and medical treatments and involves pharmaceutical industry, physicians, clinics, and hospitals. Health care is paid for by a mixture of private and public funds while insurance companies,

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<sup>11</sup> Some second pillar schemes in Sweden are still DB. Add details.

employers, employees, government agencies alongside the medical community and the patient are important actors. Public health differs from health care because it focuses on the health of the community as a whole. Public health is community health. The difference is best captured by the following statement: health care is vital to all of us some of the time, but public health is vital to all of us all of the time. Public health is called ‘public’ because the private sector and private funding constitute a small and insignificant part of the system.

Public health has evolved over time and has assumed new responsibilities and obligations because its days of glory and fame date from the late 19<sup>th</sup> century when scientists first gained greater understanding of infectious diseases and aimed to control the risk of contagion. Thanks to clean water and improved sanitation, many deadly infections became a thing of the past. Prevention of infectious diseases is also widely accomplished owing to childhood immunization, and vaccination has resulted in the eradication of smallpox, elimination of poliomyelitis in the OECD area as well as the control of measles, rubella, tetanus, and diphtheria. Thus, the ‘heyday’ of public health was in the years before 1950s (Awofeso 2004; Porter 1999).

Public health re-emerged as an important policy area in the early to mid-1980s when the World Health Organization began to warn that further improvements in life expectancy would be stymied if the prevalence rate of so-called diseases of comfort— cardiovascular diseases, certain kinds of cancers, diabetes, high blood pressure, strokes, and so forth – continued to increase. These causes of death were blamed on particular forms of lifestyle habits such as smoking, drinking, lack of physical activity, and calorie-dense diet and are typically prevalent in wealthy prosperous societies though India, which has a very high rate of malnutrition also records high rates of obesity (Chatterjee 2002). Already, in the 1970s lifestyle diseases were identified as a major cause of premature death and national authorities in the OECD areas responded by redirecting the health care systems to recognize the presence of chronic diseases and to introduce treatment plans. In the early 1990s, it became popular, following the advice of the WHO, to pour resources in educating and informing consumers of the health-related consequences of certain choices and habits, hoping that citizens would take to heart the advice of public authorities and refrain from binge drinking, smoking, drug usage, tanning etc. The goal was to convince people to behave differently and if that failed to rely on the health care system to address the negative consequences of the damaging lifestyle habits. In the long run, it was thought, positive health behavior would reduce the incidence of chronic diseases and decrease the mortality rate

associated with preventable diseases. Importantly, the individual was seen as a key to improved health statistics and public health policies tended to be geared towards altering individual behavior in order to improve the health of the community.

Many European countries did not buy into the WHO paradigm for various reasons. In some EU member states, the public health branch of the health care system was genuinely stunted and marginalized. In other member states, opinion leaders, the medical establishment, politicians, and professional associations firmly rejected the proposition that state agencies ought to convince people to alter their individual behavior so that they adopt more wholesome habits and consumer choices. A third group of countries possessed a public health domain and as a result supported the efforts of the EU to create a European-wide system of sharing information, educating citizens, and design programs to encourage good health. Nevertheless, this group of countries may not necessarily have supported an EU initiative if the program contradicted their own efforts.

For an outside observer, this patchwork of underdeveloped policy regimes and divergent approaches and attitudes complicates the search for easy categories in which member states fall. For sure, the traditional classification of conservative versus liberal versus social democratic welfare states is not very helpful in mapping out public health strategies and commitments. However, it is probably correct to say that conservative Christian democratic and liberal welfare states were ambivalent about an European public health framework in general. They did not like the idea of ordering people around by telling them to abstain from certain activities like smoking or drinking, they were reluctant to tie down the corporate sector with numerous regulations to prevent them from marketing unhealthy products to vulnerable groups, and they were hesitant to deploy public finances to underwrite different health campaigns. Their ambivalence stretched from the very first alerts about the rise of lifestyle diseases in the 1980s to the most recent and latest formulation of the WHO campaign to improve mortality and morbidity rates in advanced industrialized countries by undertaking collective or community measures and by emphasizing the overall environment in which the individual pursues unhealthy lifestyles (Petersen 1997).

Countries with no public health policy to speak of were Greece, Spain, Portugal, as well as Austria and Germany. The Mediterranean countries simply stuck to the traditional model of vaccination and treating chronic diseases. There were minimal efforts to induce individuals to reconsider heavy drinking, smoking, driving while intoxicated, personal safety, safety of the

unborn, risky sexual behavior, etc. Public health policies did not exist until recently while the medical community did not emphasize collective preventive health campaigns. Interestingly, the full impact of ‘diseases of comfort’ were only felt in the 1990s because the lower standard of living and higher ratio of physical or manual labor meant that these countries have a more physically active population with less access to highly processed foods and beverages. This may be another reason why public health did not fully register with the authorities.

**Table 3. Public Health Approaches: Classification**

Embeddedness	Solidarity	
	Weak	Strong
Weak	Greece, Italy, Spain Portugal CEE	Austria, Denmark, NL FRG
Strong	UK	Finland Sweden

In Austria and Germany, a small group of public health advocates confronted a skeptical public, a disinterested political class, and disengaged medical professionals because of the odd legacy bequeathed by Hitler and the Nazi regime. Embarking on aggressive lifestyle campaigns in the 1930s, the Nazi regime perverted public health by aligning it with eugenics and racialist policies, and after World War II, the medical field in both countries shunned public health. German academia neglected the study of public health with the result that German-language research in lifestyle ‘diseases’ such as nicotine, alcohol, and drug addiction were underemphasized and understudied (John 2001). Opponents of public health campaigns – the private sector for the most part – exploited the Nazi record to affirm the link between public health and totalitarianism. Repeatedly, feeble efforts by ministries of health or nongovernmental organizations to address tobacco consumption were labeled as inappropriate and inconsistent with liberal democratic principles (Cooper and Kurzer 2003; Grüning, Strünck, and Gilmore 2008; Proctor 1999). Voices on both the Austrian and German political left and the right dismissed concerns about the link between smoking, drinking, and unhealthy diets and trends in mortality and morbidity on the grounds that governments should not meddle with people’s private lives (Frankenberg 2004).

Denmark and the Netherlands (and the UK during the reign of the Conservative party) shared some of the biases of Germany and Austria since political and opinion leaders disliked

‘health nannyism’ (Albæk 2004; Duina and Kurzer 2004; Kurzer and Cooper 2003). There, political values tended to uphold the idea of individual choice and challenged the idea that governments should determine how people conduct their lives. Priority was assigned to consumer sovereignty with the result that detailed government intervention in private affairs of citizens was snubbed. They perceived the health campaigns of the US (against cigarettes, drunken driving, crack, obesity) as “American hyper health vigilance” (Duina and Kurzer 2004).

Possibly, corporatist policy making contributed to the weak presence of public health in continental Germanic welfare states. The public health paradigm of the 1980s sought to restrain people from making ‘bad choices’ and to promote a healthy and balanced lifestyle. Public authorities and non-governmental organizations in favor of steering people towards different lifestyle habits had to solicit the cooperation of the private sector because the food/beverage/cigarette sectors offered the consumer an abundance of choices and opportunities to pursue unhealthy lifestyles! By definition, an activist public health policy assumes the cooperation or acquiescence of the corporate sector since the latter is supposed to curb its corporate freedoms and avoid the temptation to push products to children, young adults, and other vulnerable groups. Thus, alcoholic beverages and calorie-dense processed foods are harmless at some level. But if pushed onto children who find it more difficult to understand nutritional balance of different food products or beverage, processed foods can have enormous health consequences. Therefore, a campaign on nutrition and diet must solicit the acquiescence of the private sector, which ought to desist from marketing its products to certain groups.

It may be that in polities reliant on corporatist policy arrangements it is harder for state agencies to insist that corporations act in a way consistent with the principal goals of public health. Usually, in these settings, representatives of the private sector participate in the deliberation of policies, although implementation is voluntary and self monitored with the result that actual enforcement may be weak (Read 1996).

Countries more receptive to public health policies are the Nordic countries, France, and the UK (under Labour), which occupies a position between the corporatist and the interventionist group. Although France had no established school for public health to train medical doctors, while the latter considered it beneath their dignity to play the role of policy advocate, the French state has a long commitment to meddling in consumer behavior and choices of French citizens. French intellectuals associated public health with typical state authoritarianism that trampled on

the liberties of the people. The Left viewed some of the preventive measures to promote healthier lifestyles (such as anti smoking measures and alcohol policies) as exclusionary and punitive towards the young and the poor. However, by the early 1990s, the socialist government took greater interest in public health in the wake of a stream of health statistics, pointing out that in spite of what many English-language publications touted as the healthy life style of the French people, French mortality trends painted a different picture. France recorded a fair proportion of excessive deaths (i.e. above and beyond the European average) due to accidents, cirrhosis of the liver, and certain types of cancers. Even in 2004, French men still had excess mortality rates in the age group 35-64 compared to other EU states (Vallin, D'Souza, Palloni 1990; WHO/Europe 2004).

Furthermore, income and education were correlated with sickness and death in that the poor were more likely to drink and smoke. French socialist politicians were slowly persuaded that people's eating habits, drinking patterns and high smoking rates warranted immediate attention and specialized policy initiatives (Nathanson 2004). The socialist leadership proclaimed that solidarity necessitated a revision of the behavior and choices of French citizens many of which seem to succumb to self inflicted accidents. The ascendance of the Gaullist president Jacques Chirac did not change the focus of French state policies and the French government came down hard on smoking and drinking (Nathanson 2007; Craplet 2005; Abramson. 2000). Thus, French politicians from the left and the right joined the Commission to elevate health as one of the priorities for Europe.

The UK has an established tradition of public health and some of its scientists were pioneers in establishing the link between smoking and lung cancer. But it was often difficult for state agencies to conceive of intervention as it was considered a violation of prevailing principles of ethical governance. The Conservative party was unwilling to confront the private sector by insisting on implementation of restrictions on advertising etc so that it could embrace a reduction of disease model (Berridge 2004; Read 1996).

The Labour party was more willing to confront health risk and private behavior because some of its leaders endorsed views espoused by Christian socialism on health and a good society (Brandt 2004). British socialism associated a good society with a healthy society. Socialists fretted about the tendency of the working poor (men mostly) to waste their lives by smoking and drinking. Prominent members of the Labour party campaigned incessantly in the 1950s to

impose restrictions on tobacco sales and launched an aggressive education program (Palladino 2001). In 1997, when Labour came to power, it took up the earlier vision and the Blair government strongly emphasized improvements in health.

The Nordic countries (except for Denmark) were probably the most committed to the idea of 'health of all.' The labor movements in these countries entrusted the state with extensive responsibilities over individual lives to guarantee progress towards a better society. From the beginning, the process of modernization relied on public policy measures to promote the good modern life, which included a life free of excessive drinking as well as employment, social insurance, public services, and redistribution. Aspects of public health were extensions of the social welfare state, which sought to regulate morality, lifestyle, education, and culture in its widest sense. Public health education and programs were supposed to guide people in using their resources to the maximum benefit of their happiness, and happiness was associated with the good life (Sulkunen et.al. 2000). Both the WHO and the Commission have been inspired by Swedish programs to address alcohol consumption and to protect underage consumers from excessive drinking, smoking, drug taking (Cisneros Örnberg 2008; Ugland 2003a; Ugland 2003b).

Thus, a snapshot of the situation in the 1980s indicates that most European leaders were indifferent to the emerging health dilemmas associated with increased prosperity, changing eating habits, sedentary work environments, and easy access to alcohol, cigarettes, and other addictive substances. Their lack of interests in smoking, alcohol, or nutrition ultimately hurt the young, the vulnerable, and the disadvantaged because they tend to possess less social capital and fewer financial resources to opt for healthier lifestyles or seek treatments for addictions or have access to sports clubs, gyms, spas, and other facilities to improve people's health profile. It also filled up a regulatory void since politicians were not very interesting in following the call of action issued by the World Health Organization to combat non-communicable diseases.

### **The European Commission and Health: the Rise of Solidarity**

The first attempts to introduce a popular dimension to EU legislation dated from the 1984 summit at Fontainebleau where President Mitterrand of France and Prime Minister Craxi of Italy commissioned a report designed to identify areas where the EU could develop new policy dimensions closer to the concerns of ordinary citizens. In retrospect, this decision was the starting point for the gradual expansion of EU activities in the field of consumer protection,

environment, and health. The EU's activities in these policy areas were given a large subsequent boost by the Amsterdam Treaty and Article 152, which extended EU competence to "promoting" in addition to "protecting" the health of EU citizens (Randall 2001). The former Constitutional treaty did not focus on health per se, but it granted the commission a stronger mandate to fight health threats such as tobacco and alcohol. The new Reform Treaty Article 152 draws attention to the protection of public health concerning tobacco and the abuse of alcohol though fighting health threats, first mentioned in the defunct Constitutional Treaty has been diluted.

Nevertheless, when the commission drafted its first public health regulations it derived the proposed measures from single market legislation. Most member states were indifferent to public health and not too keen to extend the commission's mandate in this area. Their frostiness meant that the commission had to tread carefully and hide behind the rhetoric of the single market to introduce measures with a distinct public health tinge. Public health was an alluring target because it benefited directly the citizens of Europe and filled up a gap and enhanced the visibility and powers of the commission. Doing good worked well for the commission itself!

In the beginning, in the late 1980s the commission drafted highly technical and narrow regulations and submitted them to the council of ministers arguing that these new rules would accelerate the free movement of goods. Although the first initiatives consisted of tobacco control regulations in order to reduce the smoking prevalence rate in the EU and thus decrease the incidence of tobacco-related disease, the commission presented the measures as removing obstacles to the free movement of cigarettes. It claimed that divergent health warnings, packaging requirements, excise taxes, and national advertising rules impeded the free movement of this common product.

Some member states, in particular the UK under the Conservative party leadership, Germany and Austria, Greece, Denmark, and the Netherlands questioned the legality of public health/single market rules, claiming that the measures were disproportionate in view of the end objectives. For example, if the end objective was the free movement of cigarettes, a comprehensive ban on both direct as well as indirect advertising seemed excessive and out of proportion with the intended objectives of legislation (Hervey 2001; Tridimas and Tridimas 2002).

As the commission encountered resistance, it looked for allies elsewhere and tapped the considerable institutional and network resources of the World Health Organization/Europe

office. A partnership with the WHO made sense since each organization served the same constituency and both shared the ideological commitment of improving the health of Europeans. However, close collaboration also revealed the true nature of many of the proposals drafted by the commission and reduced the vagueness of its recommendations by tying it to WHO campaigns. Thus, in the 1990s, the WHO and the European commission issued joint reports, held joint conferences, and shared information and data, which enhanced the credibility of Brussels' suggestions, but it also prevented EU officials from pretending that the new EU rules seek to improve the workings of the single market.

While the commission presented its tobacco control program for Europe, the WHO had launched the *European Health for All* in 1986, which targeted health promotion by establishing a positive political environment. The idea behind the new program was that lifestyles must be framed within the collective incentives part of a person's day to day environment. Rather than viewing lifestyle choices as an individual matter, it called upon European leaders to examine the interaction between individuals and their environments and to employ political tools to address distortions in the environment. Good health, in short, was not simply a matter of convincing people to live balanced and wholesome lifestyles but rather the complex outcome of the interplay between social, political, and economic processes. The WHO urged member governments to move away from individualized perspective of health to a broader ecology of health.

The commission took up the WHO agenda by the early 1990s. After a slow start in the 1980s in part because it lacked a clear mandate it refocused its energies on launching different initiatives to combat smoking, excessive drinking, and unhealthy diets after 1993. It passed a dozen different tobacco control measures to discourage smoking. It also recognized alcohol as something more than an agricultural commodity and economic product, and proposed various European-wide measures to ban the sale of alcopops, which are sweetened fruit-flavored wine coolers from the market. It has convened multiple meetings to discuss nutrition and health, culminating in the 2007 White Paper: "*A Strategy for Europe on Nutrition, Overweight and Obesity related health issues.*" This report constituted a call for action to combat weight gain, particularly among children, and to prevent future sharp increases in cardiovascular disease, hypertension, type two diabetes, strokes, certain cancers, muscular-skeletal disorders and even a range of mental health conditions due to poor diets and lack of physical activity. The report built off an earlier publication, "*Eurodiet: Nutrition & Diet for Healthy Lifestyles in Europe,*" which

first proposed the need to supply uniform nutrition labels, to spend resources on the promotion of physical exercise and education, and to strengthen the protection of youthful consumers from the marketing tactics of food and beverage and cigarette companies.

Though many of the measures reflected the idea that Europe should also look after the concerns of European citizens, the approach taken to public health injected a measure of ‘solidarity’ into the public health discourse and policies of the EU member states. Instead of blaming individuals for ignoring public information campaigns and health messages, the goal espoused by the commission was to identify the underprivileged and disadvantaged and provide a more sustainable or balanced environment to enable them to pursue better health choices. The new public health, held up by the WHO as the path to a better future, increasingly argued for linking the social determinants of the individual and her/his health status. Apparently, poor people suffer poor health, for the settings of everyday life frequently shape health behavior. Smoking, drinking, and obesity are increasingly associated with socio economic status and education. The commission has used reports issued by the WHO to convey to the member states that they should pass new rules to protect vulnerable groups in society from risky lifestyle habits. WHO-Europe published *Declaration on Young People and Alcohol* in 2001, and the European council passed simultaneously a recommendation on the drinking of alcohol by young people, in particular children and adolescents (2001/458/EC). The recommendation produced new guidelines urging governments to prevent the alcoholic beverage industry from selling fruit-flavored alcoholic drinks (alcopops) to young people. Their reasoning is that the onus of protecting health should not fall on young people (or their parents) but on the regulatory environment that should impose labels on light alcoholic beverages, prohibit advertising of fruity alcoholic drinks to underaged consumers, and perhaps consider banning the sale of this sort of beverage since it only appeals to young people. In general, certain units in the commission have become much more aware of the dangers of underaged drinking and binge drinking, and the central focus on the debate has slightly shifted away from economics to health (Anderson and Baumberg 2006). In a similar vein, its ‘healthy diet’ campaign reiterates over and over again that the groups most at risk are those who are susceptible to marketing ploys because they lack the social capital and educational resources to understand the nature of advertising. Children are bombarded with food advertisements and they are also the least likely to understand the objectives of television advertising.

Thus, DG Health and Consumer Protection has made efforts to address health determinants in order to reduce the burden of disease and promote the health of the general population. On its website, it lists access to health services; and general socio- economic, cultural and environmental conditions as mediating variables for understanding exposures to health risks.

Other governments preceded the commission and both French and British governments have been more vocal about linking youth and poverty to unhealthy lifestyle choices. The Labour government published in 1998 a White Paper, *Smoking Kills*, which deflected accusations of “nanny statism” and mentioned first the possibility of enacting a smoking ban in the workplace, catering, industry, and other public spaces (BBC 2004; The Economist 2004). In France, mortality rates exceeding that of the EU average brings home that the French lifestyle contains some unhealthy elements and the previous center-right government has enacted smoking bans in public spaces and tackled drunk driving as well as binge drinking. As a result, the government of President Sarkozy, in spring 2009, passed a new bill that would raise France's minimum drinking age for wine and beer to 18 from 16 (Gauthier-Villars 2009).

Countries with strong cultural reservations such as the Netherlands and Denmark ditched their objections and joined the debate on poverty and health. The intervention of the EU, and its partnership with the WHO turned public health, which in many countries possessed a mixed reputation due to its perceived ‘nannyism’ into a strategy to rectify growing inequalities in society. It is precisely because public health had underdeveloped institutional features with embryonic policy programs that the policy regime produced little feedback or increasing returns. As it was neglected by national authorities, the EU has been able to lean on key officials to embrace the new model of public health. The direction in which the EU is pressuring recalcitrant member governments results in a solidaristic approach to public health because the premises of the latter holds the community at large responsible for the life trajectory of all citizens. It is important to point out that the American debate goes into a different direction, for it puts the onus of responsible lifestyle on the individual.

### **Discussion and Conclusion**

Interestingly, in both of the pension and public health stories, the Nordic countries play an important role. In pensions they were pioneers though their reforms resulted in diluting the solidaristic features of postwar public pension arrangements. In health, the Nordic model has

retained strong solidaristic aspects because the state assumes responsibility by regulating the environment so that people are deterred from making ‘unhealthy’ choices. The WHO first and then later the European Commission have adopted this approach. It has meant that presently greater awareness exists that poor health tends to cluster among the poor for socio economic, cultural, and geographic reasons.

The purpose of our paper is not so much to explore why the Nordic countries appear to be trend setters, but rather to examine whether the Europeanization of policy regimes driven by the officials in Brussels enhances or dilutes key aspects of domestic arrangements. The central feature we focused on is ‘solidarity.’ We claim that the solidaristic features of postwar pension arrangements are challenged by the advances made by the EU in pushing national authorities into a certain direction while solidaristic aspects of public health are strengthened by the pressures exerted by the commission. Our conclusion is that while the EU is pushing in a fairly specific direction, the result is not always a retreat from solidarity. EU policies can help to construct solidarity where little or none existed before, and thus they can restructure solidarity at the domestic level.

Our second objective was to understand why the EU exercises this contradictory impact. Here we highlighted the ‘embeddedness’ of policy regimes by focusing on the intensity and structure of two different arrangements. Attempts to reform pension entitlements and conditions produce wide and intense scrutiny and objections from numerous organized interests. Efforts to revive a viable public health policy in light of new developments in mortality and morbidity provoke less resistance because this policy regime is underdeveloped in many countries and involves a limited range of competing interests. This key difference, we argue, accounts for the variable impact of EU policy initiatives on domestic social policies.

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