

19 The link to the past and the post-communist welfare state

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- ▶ Childhood health and cognition have long-lasting effects on the prevalence of dire health and financial circumstances later in life
 - ▶ Such adverse health effects appear mitigated across various dimensions by the generosity of the welfare state, mostly related to extreme but reversible circumstances (serious – but not long-term or chronic – illnesses, financial hardship or hunger)
 - ▶ Superior cognitive skills are associated with better chances of making ends meet or avoiding hunger, whereas having experienced financial hardship seems unavoidable given the last 30–40 years of turmoil
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19.1 Introduction

Early life provides the foundation for many outcomes in adulthood. How strong is, however, the role of adverse childhood conditions in determining negative adult outcomes for Romanians? And given their current social insurance system, to what extent is this link mitigated by the western-type welfare policies implemented after the ‘dawn of democracy’ in 1989? Answering these questions will prove an interesting exercise, as Romania’s political and social trajectories during the last century have been quite unique. It is an eastern European country with strong Latin origins that emerged three decades ago from an overbearing communist regime. During ‘the regime’ (i.e., the better part of last century) the *Party* maintained a tight grip on power and control, while also promoting a widespread and quite generous universal social welfare system. The last years have seen the country transitioning to a western-like democracy with several periods of rapid and often chaotic reforms that brought significant social turmoil and economic disparities. So, how does all this matter for the old age Romanians’ link with their early life?

The relation between childhood conditions and health or socioeconomic status in later life has been well established (Currie, 2009). For instance, those who experience poor childhood health have significantly worse cognition, health and socioeconomic status as adults (Case et al., 2002; Currie, 2009). Early cognition and education appear as key drivers of socioeconomic success, with nourishing early environments and low exposure to adverse events (e.g. abuse, economic hardship) effectively shaping individual well-being (Heckman et al., 2013).

An interesting yet considerably less explored dimension relates to how early-life effects are mediated by national welfare systems and regional economic development. The issue is crucial from a policy standpoint because it provides policymakers and welfare architects with valuable insights into the behaviour of those most vulnerable: the old, the ill and the poor. Despite their key role, however, social welfare policies have not become – theoretically or empirically – a leitmotif of the research into disparities triggered by early life conditions. This has only recently changed through a series of SHARELIFE papers on the link between childhood circumstances and old age health, cognition, income, asset portfolio and risk attitudes (Christelis et al., 2011; Mazzona, 2014).

Numerous adult outcomes can be influenced by childhood health and cognition. This chapter focuses on the prevalence of adverse health and financial circumstances in old age. Once this link is proven, we investigate how it is affected by the welfare state generosity (or stinginess). The analysis is thus particularly relevant in light of the current social and political debate in Romania that has seen the public affected by extreme polarization around two main camps defined by their support for or against the welfare state.

In doing so, we will use Romania's first SHARE wave. Implemented in 2017, SHARE Wave 7 questionnaire included several childhood health, cognition and socioeconomic indicators. To capture the differential effects brought into play by the welfare state, we extend this dataset with several regional level indicators that capture the social insurance system coverage and economic development (e.g., county level social insurance benefits per capita, average individual welfare transfers, total economic surplus).

19.2 Why Romania?

Romania's welfare system is quite a special case: under the communist regime, virtually nobody was on welfare or received social assistance. Since the Iron Curtain fell, Romania became a welfare paradox with pensions and child benefits that rival wages but also the lowest unemployment and social assistance benefits in the European Union. Currently, nearly one in three Romanians (approximately 6.5 million people) receive some form of social benefit (NIS's 'Regional, economic & social benchmarks: Territorial statistics (2018)' – henceforth, NIS, 2018). Particularly interesting is how these benefits are distributed among the vulnerable groups. For instance, the 2016 national public spending on social insurance (health and social benefits) was approximately 19.40 billion EUR, with pensions, medical spending and welfare (or social

assistance) accounting for 59.92%, 28.74% and 11.34%, respectively, of this total amount (NIS, 2018). Zooming in on social benefits, we see these funds reaching more than 4.65 million retirees receiving decent public pensions but less than 0.25 million people on welfare (NIS, 2018). These groups represent 27.94% and 1.46% of the country's 15+ population, respectively, and unveil a striking discrepancy considering the 5.90% unemployment rate and 46.30% economic inactivity rate recorded during the same year.

Additionally, Romania exhibits a regional development gradient across its four historic regions (Transylvania, Moldavia-Dobrogea, Muntenia and Banat-Oltenia), largely due to their distinct historical, cultural and economic growth roots. Given the strong socialist philosophy of the communist regime, these territorial discrepancies were less prominent before 1989 but deepened substantially recently. The 'transition' period after 1989 observed imbalances and inequality soaring across the country and, although a number of policies were implemented to diminish poverty and the risk of social exclusion, large regional variations still exist (see NIS's 'Labour force in Romania: Employment and unemployment (2016)' – henceforth, NIS, 2016; NIS 2018). For instance, the 2016 unemployment rate averaged 5.9% nationally, but ranged between 4.7% in Transylvania and 7.6% in Banat-Oltenia (NIS, 2016) (see Table 19.1). This

Table 19.1: Welfare paradox of social benefits.

	Transylvania	Moldavia Dobrogea	Muntenia	Banat Oltenia	TOTAL
<i>Total population</i>	4,911,312	5,707,418	5,306,173	3,781,626	19,706,529
Number of pensioners	1,190,458	1,275,577	1,281,488	930,185	4,677,708
<i>Share of pensioners</i>	24.24%	22.35%	24.15%	24.60%	23.74%
Number of unemployed persons	101,000	127,000	178,000	124,000	530,000
<i>Unemployment rate</i>	4.70%	4.80%	7.00%	7.60%	5.90%
Number of welfare beneficiaries	53,507	91,914	49,028	50,365	244,814
<i>Share of welfare beneficiaries</i>	1.09%	1.61%	0.92%	1.33%	1.24%

Source: http://www.insse.ro/cms/sites/default/files/field/publicatii/labour_force_in_romania_employment_and_unemployment_2016.pdf.

situation translated into significant differences in welfare beneficiaries' figures, ranging between 0.92% (Muntenia) and 1.61% (Moldavia-Dobrogea). Strikingly, and supporting our previous discussion of the meagre welfare pillar of the Romanian social insurance system, less than half of those unemployed received any form of social assistance (NIS, 2016).

Overall, we expect any link between childhood conditions and current health and financial circumstances to be affected by the dual-dimension of this heterogeneity. The welfare system discrepancies should make a difference for those receiving transfers, mitigating a potential negative association. Economic development further changes the equation of available resources and opportunities, driving different groups of people in the category of social insurance beneficiaries. We subsequently investigate these issues.

19.3 Something old, something . . . current

As mentioned, Romania joined SHARE in 2017 with a questionnaire that included a rich set of questions meant to capture health and cognition in early life. We use four childhood indicators: (i) subjective childhood health status as reported by respondents today and captured by whether one recalls being in fair or poor health; (ii) objective childhood health captured by the number of chronic conditions that one was diagnosed with early in life, and (iii) two cognition indicators on having above-average academic skills in Maths and language relative to one's peers.

Figure 19.1 show a dramatic difference in self-reported health, with Transylvanians reporting bad health almost twice as often than those in Banat-Oltenia (8.23% vs. 4.76%). Those in Transylvania were also the most affected by chronic conditions, as shown by the 18.40% of respondents diagnosed with two or more chronic conditions, whereas the 'objectively healthiest' region in this respect is Muntenia (11.51%). Interestingly, the regional cognition gradient appears less prominent, with the best-performing region (Muntenia) having 45.08% and 51.55% of respondents scoring higher than average in Maths and languages, respectively; Moldavia-Dobrogea is at the lower end of the range in both categories, with only 38.03% and 42.62% of respondents scoring higher than average.

Regarding our outcome variables, we will focus on six adverse conditions in adulthood: (i) whether one has ever had periods of serious illness, (ii) whether one has ever had periods of long-term illness, (iii) whether one is currently diagnosed with two or more chronic conditions, (iv) whether one has ever experienced hunger, (v) whether one has ever experienced financial hardship, and (vi) whether the household can make ends meet.

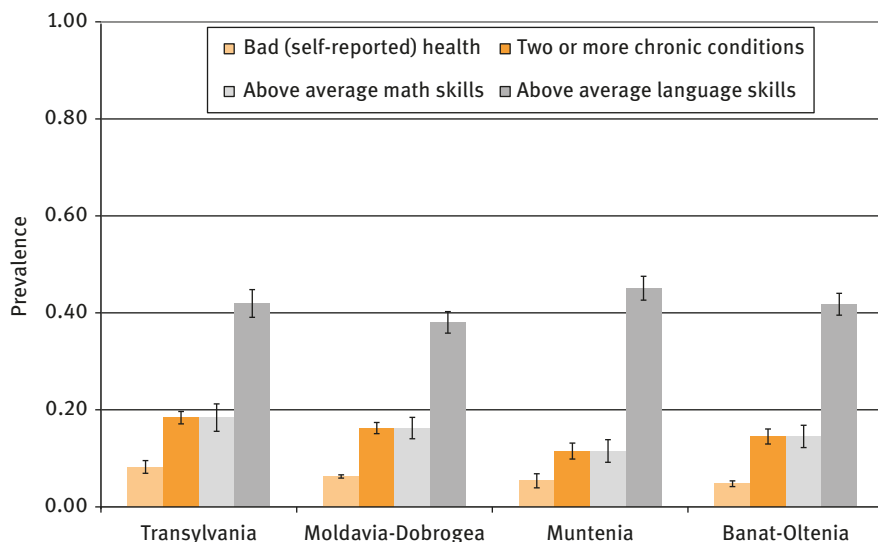


Figure 19.1: Childhood conditions prevalence.

Source: SHARE Wave 7 release 0.

Plotting the mean of every outcome variable by each childhood condition we study shows generally a clear direct association between them (results available on request). Here, we aim to estimate the magnitude of this relation and investigate the extent to which this association is mitigated by the welfare system and economic development. As a result, we include three county-level context variables: (i) per capita monthly amount of social insurance benefits (in health models), (ii) average monthly amount (in 00's) of individual welfare benefits (in financial models), and (iii) per capita total economic surplus (as economic indicator).

For each adult/childhood variable combination, we use a probit model to associate the outcome of interest with the early life health and cognition variables. As mentioned, we also include county-level measures of welfare generosity and economic development, and we interact childhood indicators with such measures to allow for as much differential effects across regions as possible. Our specifications also include respondents' age, gender, education and marital status, as well as two indicators of their childhood socioeconomic status: (i) the number of rooms in the house where respondents lived when they were 10 (adjusted for family size) and (ii) the number of books that their family possessed at that time. Thus, we can estimate childhood effects net of all these factors, which makes them less likely to be spurious.

The results in Table 19.2 show that bad self-reported health in early life is associated with being diagnosed with 2+ chronic conditions in adulthood, as well as with ever having experienced serious or long-term illnesses by 14.4 percentage points (pp), 11.3 pp and 15.4 pp, respectively. The same holds true for the childhood number of chronic conditions that negatively affect all our three measures of adult health, by 8.1 pp, 3.0 pp and 10.2 pp, respectively.

Given these strong direct relations to the past, is there any role for the welfare state in changing these patterns? The answer is yes, with welfare state generosity having beneficial effects for all three adult health outcomes when linked to self-reported childhood health. Such effects are strong enough to wipe out most of the negative childhood links except for those most extreme: early life chronic conditions remain strongly related to having long-term illness periods throughout one's life, above and beyond any public transfers meant to help address them (by 20.1%). Finally, and somewhat unsurprisingly, early cognitive abilities do not affect adult health, whereas economic development matters only for more extreme health circumstances such as long-term or chronic illnesses.

Turning to the relationship between childhood conditions and adult financial circumstances, we find that both our subjective and objective measures of bad childhood health play a key role in making it more likely that one experienced periods of hunger or financial hardship in later life. Bad self-reported health is associated with 3.1 (8.8) pp higher chances of having experienced financial hardship (hunger). Similarly, the effect of chronic conditions in early age is strong for all financial indicators, with the associations ranging from approximately 1.0 to 6.3 pp. Welfare generosity, as captured by social assistance transfers, is once more pretty strong in all models involving financial hardship or hunger. Interestingly, it also slightly mitigates (by 0.2%) the link between dire (objective) health and hunger. This contrasts public transfers making a difference for the current ability of households to make ends meet, which remains negatively associated by 3.1 pp with chronic illnesses experienced more than three decades earlier.

As mentioned, cognitive skills in early life are a key driver of adult socioeconomic status. We confirm this hypothesis, with the ability to make ends meet being strongly associated with higher than average test scores in both Maths (8.8%) and languages (9.0%), a positive and robust result. Interestingly, only superior Maths scores seem to lower the chances of experiencing hunger, even after taking into account social assistance (by 2.2%). This finding is unsurprising though, given the strong link between Maths skills and future earnings (Tyler, 2004). Finally, we find no effect of better cognition on ever having experienced financial hardship, possibly the result of Romania's political and

Table 19.2: Childhood conditions and adult outcomes.

Childhood indicator	Bad (self-reported) health	Two or more chronic conditions	Above averagemath skills	Above average language skills
Panel A.1. Ever had periods of serious illness				
Childhood Ind	0.113***	0.030***	0.253***	-0.023
Welfare Ind	0.117**	0.035	-0.017	-0.012
Child.*Welfare	-0.105	-0.251***	-0.142**	-0.129**
Econ Dev	-0.001	-0.001	-0.007	-0.036
			-0.001	-0.001
Panel A.2. Ever had periods of long-term illness				
Childhood Ind	-0.194	0.102***	0.201**	0.013
Welfare Ind	0.154***	-0.142*	0.005	-0.001
Child.*Welfare	-0.290***	-0.114	-0.282***	-0.207*
Econ Dev	0.373	-0.011***	0.007	-0.162
	-0.011***		-0.011***	-0.011***
Panel A.3. Diagnosed with two or more chronic conditions				
Childhood Ind	-0.145	0.081***	-0.043	-0.008
Welfare Ind	0.144***	-0.115	0.150	-0.013
Child.*Welfare	-0.133**	0.131	-0.064	-0.033
Econ Dev	0.318	-0.011***	-0.169	-0.220*
	-0.013***		-0.013***	-0.013***
Panel B.1. Ever experienced financial hardship				
Childhood Ind	0.061	0.063***	0.062***	-0.019
Welfare Ind	0.088**	0.007***	0.008**	0.004
Child.*Welfare	0.027***	0.000	0.008***	0.011***
Econ Dev	-0.017***	-0.017***	0.001	-0.003
			-0.017***	-0.017***

(continued)

Table 19.2 (continued)

Childhood indicator	Bad (self-reported) health	Two or more chronic conditions	Above averagemath skills	Above average language skills
Panel B.2. Ever experienced hunger				
Childhood Ind	0.031**	0.010*	0.012**	-0.024**
Welfare Ind	0.038**	0.010*	0.004***	-0.006
Child.*Welfare	0.002**	0.004***	0.000	0.001
Econ Dev	-0.007	-0.002**	0.002*	0.001
	-0.001	-0.001	-0.001	-0.001
Panel B.3. Household can make ends meet				
Childhood Ind	-0.032	-0.030*	-0.031*	0.091***
Welfare Ind	-0.044	-0.030*	0.088***	0.090***
Child.*Welfare	-0.001	0.000	0.000	-0.001
Econ Dev	0.006	-0.001	-0.001	0.000
	0.010**	0.010**	0.010**	0.010**

Note: The sample has 2,045 observations depending on specification, except for B.3 specifications that include 1,362 observations. Childhood Ind is one of the four early life indicators we study; Welfare Ind is the county-level indicator of welfare generosity; Child.*Welfare is the interaction of the aforementioned variables; and Econ Dev is the county-level economic development indicator. *** = 1%; ** = 5%; * = 10%

Source: SHARE Wave 7 release 0.

economic ‘transition’ climate in the last three decades, dominated by recession, economic and social uncertainty and chaotic reforms. All our respondents have been exposed to this rough ‘transition’ period; seeing welfare transfers and economic development taking centre stage in determining their chances of having experienced financial hardship is thus not surprising. One peculiar point to note is the positive sign of the welfare indicator in all significant models related to financial hardship and hunger. This could indicate that, although social assistance payments might be relatively less generous than other types of welfare transfers (e.g. public pensions), they are large enough to positively affect the chances of someone reporting dire financial circumstances.

These results make a strong case for early life welfare interventions. Boosting care affordability, promoting preventative health strategies, enforcing higher standards for healthcare providers, establishing programmes that prevent school dropout, striving for higher literacy levels and fostering remedial education for those who fall behind are only a few such policies with tremendous future individual, economic and societal benefits.

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