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Contents

Figures

Tables

23

States of health

Welfare regimes, health and healthcare

Clare Bambra, Nadine Reibling and Courtney L. McNamara

Introduction

This chapter discusses how health research has influenced the development of welfare state regime typologies, and how these typologies have themselves influenced health research. Three key developments are examined. First, the integration of healthcare services into the welfare state typologies literature; second, the importance of decommodification with regard to health and healthcare; and third, how welfare state regimes have been used by comparative social epidemiologists to examine and explain international differences in population health and health inequalities. The chapter starts with a definition of key terms. It concludes by reflecting on the implications of health research for the further development of welfare state regime typologies and comparative social policy.

Various key concepts are used within this chapter: decommodification, social epidemiology, population health, health inequalities and the social determinants of health. The key underlying concept in Esping-Andersen's *Three Worlds* typology (1990) was decommodification. Decommodification is "the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance" (Esping-Andersen, 1987: 86). The welfare state decommodified labour because certain services and a certain standard of living became a right of citizenship and reliance on the market for survival decreased (Esping-Andersen, 1990: 22) (see also Chapter 11, this volume). Health may itself be regarded as something which is variously commodified and decommodified (Bambra *et al.*, 2005). Social epidemiology is about the social causes of disease distribution within and between societies; it is "about why different societies – and within societies, why different societal groups – have better or worse health than others" (Krieger, 2011: vii). Population health refers to the health status of populations as opposed to individuals, the "extant and changing population distributions of health, disease, and death" (ibid.). Health inequality is a term used to describe systematic differences in health status between different social or demographic groups (such as inequalities by gender or ethnicity). Generally, it is used to refer to socio-economic class inequalities in health (measured via education, income or occupational class): inequalities in health are "systematic differences in health between different socio-economic groups within a society. As they are socially produced, they are potentially avoidable and widely considered unacceptable in a

civilised society" (Whitehead, 2007: 473). Health inequality is measured in absolute or relative terms (for more detail see Bambra, 2011a). In developed countries, welfare states are important macro-level determinants of health, as they mediate the health impact of socio-economic positions and the exposure of different population groups to the social determinants of health: access to essential goods and services (specifically water and sanitation, and food); housing and the living environment; transport; unemployment and social security; working conditions; and access to healthcare (Bambra, 2016).

Healthcare and welfare state regimes

Healthcare is an important social determinant of health and a significant component of a country's welfare state accounting for an average of 9 per cent of GDP in OECD countries (OECD, 2015). However, healthcare was long overlooked by regime typologists. For example, Esping-Andersen's influential *Three Worlds of Welfare Capitalism* (1990) typology was devised by focusing almost exclusively on the decommodification of cash transfers, and the role of welfare services (such as education, social care and healthcare) was largely ignored. This was also the case with the later typologies of Castles and Mitchell (1993), Ferrera (1996) or Korpi and Palme (1998) which all ignored the role of welfare services, including healthcare (see Table 23.1). Indeed, what was most remarkable about the 'welfare state regimes debate' was that while there were numerous critiques about Esping-Andersen's range, his methodology and the absence of gender in his typology (for overviews of the critiques see Bambra, 2005b, 2006a), a core procedure attracted less attention: the analytical focus on cash benefits (Bambra, 2005a, 2005b) and the creation of regimes that generalised about all forms of social policy provision from this base (Kasza, 2002). Welfare state regime theory had ignored the fact that welfare states are also about the actual delivery of services, such as healthcare, education or social care, and that, far from being internally consistent, countries vary in terms of the relative emphasis they place upon cash benefits and/or welfare state services. Indeed, welfare services may well account for the greatest differences both between and within countries' welfare state arrangements (Castles, 1998; Bambra, 2005b). Healthcare is by far the largest area of welfare state service delivery and it is a strong example of internal welfare state inconsistency in the provision of cash benefits and welfare services. Therefore, a number of scholars rooted in the comparative welfare state debate investigated the existence of healthcare regimes and demonstrated both the similarities and the differences of these types to existing welfare state typologies.

One of the earliest contributions was the development of a healthcare decommodification index and a resulting healthcare typology (Bambra, 2005a). Healthcare decommodification is "the extent to which an individual's access to health care is dependent upon their market position and the extent to which a country's provision of health care is independent from the market" (Bambra, 2005a). This was measured using private health expenditure as a percentage of GDP; private hospital beds as a percentage of total bed stock; and the percentage of the population covered by the healthcare system. For comparability purposes, the resulting healthcare typology was constructed using Esping-Andersen's methodology (despite its noted limitations: see Bambra, 2006a) and using only the same 18 OECD countries. A threefold typology of low, medium and high healthcare decommodification resulted (Table 23.1). There were notable differences with the cash transfer based typologies, particularly with regard to the positioning of Canada, New Zealand and the UK which were low in terms of labour market decommodification but highly decommodifying in terms of healthcare. Healthcare provision in the Liberal welfare states of Canada, New Zealand and the UK is based on principles (universalism), provision processes (public sector) and funding

Author	*Measures*	*Welfare state regimes*				
Esping-Andersen (1990)	*18 countries* • Decommodification • Social stratification • Private–public mix	Liberal Australia Canada Ireland New Zealand UK USA	Conservative Finland France Germany Japan Italy Switzerland	Social Democratic Austria Belgium Netherlands Denmark Norway Sweden		
Castles and Mitchell (1993)	*14 countries* • Aggregate welfare expenditure • Benefit equality	Liberal Ireland Japan Switzerland US	Conservative Germany Italy Netherlands	Non-Right Hegemony Belgium Denmark Norway Sweden		Radical Australia New Zealand UK
Ferrera (1996)	*15 countries* • Coverage • Replacement rates • Poverty rates	Anglo-Saxon Ireland UK	Bismarck Austria Belgium France Germany Luxembourg Netherlands Switzerland	Scandinavian Denmark Finland Norway Sweden	Southern Greece Italy Portugal Spain	
Korpi and Palme (1998)	*18 countries* • Social expenditure as a % GDP • Luxembourg income study • Institutional characteristics	Basic Security Canada Denmark Ireland Netherlands New Zealand Switzerland UK USA	Corporatist Austria Belgium France Germany Italy Japan	Encompassing Finland Norway Sweden		Targeted Australia

Navarro and Shi (2001)	*18 countries* • Political tradition	Liberal-Anglo Saxon Canada Ireland UK USA	Christian Democrat Belgium Netherlands Germany France Italy Switzerland	Social Democratic Sweden Norway Denmark Finland Austria	Ex-Fascist Spain Greece Portugal	
Author	*Measures*	*Healthcare regimes*				
Bambra (2005a)	*18 countries* • Healthcare decommodification	Low Australia US	Medium Austria Belgium France Germany Ireland Italy Japan Netherlands Switzerland	High Canada Denmark Finland New Zealand Norway Sweden UK		
Bambra (2005b)	*18 countries* • Healthcare and labour market decommodification	Liberal Australia Japan USA	Conservative Austria Belgium Canada Denmark France Italy	Social Democratic Finland Norway Sweden	Conservative sub-group Germany Switzerland Netherlands	Liberal sub-group Ireland UK New Zealand
Wendt (2009)	*15 countries* • Healthcare expenditure • Healthcare financing • Healthcare provision • Institutional characteristics	Low budget-restricted access type Portugal Spain Finland	Health service provision-oriented type Austria Belgium France Germany Luxembourg	Universal coverage-controlled access type Denmark Italy Ireland Sweden UK	Not classified Greece	Not classified Netherlands

continued

Table 23.1 Continued

Author	*Measures*	*Healthcare regimes*				
Reibling (2010)	*16 countries* Access dimensions: • Legal regulations • Financial incentives • Supply	Mixed regulation states Finland Italy Portugal	Financial incentives states Austria Belgium France Sweden Switzerland	Strong gatekeep-ing/ low supply states Denmark Netherlands Poland Spain UK	Weak regulation/ high supply states Czech Republic Germany Greece	
Wendt (2014)	*32 countries (2001)* • Healthcare financing and private payment • Healthcare provider indices • Regulation	Type 1 Finland Iceland Portugal Spain Sweden	Type 2 Austria Belgium Canada France Germany Japan Luxembourg New Zealand	Type 3 Australia Czech Republic Denmark Estonia Hungary Ireland Italy Netherlands Poland Slovak Republic Slovenia UK	Type 4 Greece Israel Turkey	Not classified Korea Norway Switzerland USA
	32 countries (2007)	Type 1 Finland Iceland Portugal Spain Sweden	Type 2 Austria Belgium Canada France Germany Japan Luxembourg New Zealand	Type 3 Australia Czech Republic Denmark Estonia Hungary Ireland Italy Netherlands Poland Slovak Republic Slovenia UK	Type 4 Israel Turkey	Greece Korea Norway Switzerland USA

mechanisms (general taxation) that are in stark contrast with the rest of their market-orientated welfare state package.

This analysis was further refined by comparing the relative role of healthcare decommodification and labour market (cash transfers) decommodification (Bambra, 2005b). This work produced a fivefold classification (Table 23.1). Most notably, the composition of the high-scoring group confirmed the existence of a distinctive Scandinavian regime that provides consistently high levels of provision (Esping-Andersen, 1990). A group of key Conservative countries was also identified reflecting comments that the Conservative regime countries tend to place more emphasis upon cash benefits in their welfare mix (Castles, 1998). Finally, the division of the Liberal regime countries into two distinctive groups, one that is consistently low in decommodification and one that is more service orientated, gives credence to claims about a fourth – radical – world of welfare that is a subtype of the Liberal regime (Castles and Mitchell, 1993).

A further contribution was made by Wendt (2009), who used a more extensive set of indicators on healthcare expenditure, financing, provision and institutional characteristics to classify 15 countries based on a cluster analysis. Three healthcare types were identified: *a universal coverage-controlled access type* consisting of most National Health Service (NHS) countries, a *health service provision oriented type* of social insurance countries and a *low budget-restricted access type* comprising Finland, Spain and Portugal. The analysis also indicated that two countries, Greece and the Netherlands, did not match any of the three types. While there is some overlap to existing welfare regimes, particularly a common group of continental European countries, there are also similarities in the healthcare sector between Scandinavian, Southern European and Anglo-Saxon countries that cannot be found in other fields of welfare provision.

Linking healthcare again to the decommodification principle, Reibling (2010) presented a typology based on detailed institutional indicators on healthcare access with a strong similarity to Esping-Andersen's operationalisation of decommodification. Four healthcare access regimes evolved: a *strong gatekeeping/low supply type*, a *financial incentive type*, a *mixed regulation type*, and a *weak regulation/high supply type*. The four types demonstrate that the European countries show both different levels of access regulation and make different use of legal measures, financial incentives and limitations of supply to regulate access to services. This classification shows less similarity with existing welfare regimes, demonstrating that the regulation of access in the healthcare system shows little consistency with the regulation of income-replacement programmes.

Both welfare and healthcare regimes are not static entities (Bambra, 2006a). Therefore, Wendt (2014) compared 32 OECD healthcare systems between 2001 and 2007. The comparison indicated a strong persistence of healthcare types during this period. However, since then healthcare systems have undergone extensive reform (e.g. in the UK and New Zealand with marketisation reforms) (Leys and Player, 2011), extension of coverage in the USA and increased out-of-pocket expenditure in Southern Europe following the financial crisis (Gelormino *et al.*, 2011).

Welfare state regimes, health and health inequalities

In addition to extending welfare state regimes research by including the decommodification of healthcare, health researchers have applied the welfare state regimes concept to the study of international variations in the distribution of disease (Schrecker and Bambra, 2015). Welfare states, through their decommodifying effects, moderate the extent, and impact, of market-derived class and income inequalities within a country (Bambra, 2006b). Therefore, the decommodification provided by welfare states may be expected to have an indirect relationship with

health status (Raphael and Bryant, 2004). Countries with a highly decommodifying welfare state package will have less stark class and income inequalities (Esping-Andersen, 1990, 1999) and therefore better national health outcomes (Pickett and Wilkinson, 2015) than those countries that operate a less decommodifying system (Coburn, 2004; Bambra, 2006b).

International research on the relationship between welfare states and population health has used different welfare state typologies (e.g. Bambra (2006b) and Coburn (2004) used Esping-Andersen's *Three Worlds*, Navarro *et al.* (2003, 2006) used the Navarro and Shi political traditions typology (2001), while Eikemo *et al.* (2008a) used Ferrera's (1996) typology (Table 23.1). Many of the studies to date have examined infant mortality rates (IMR) and have shown that they vary significantly by welfare regime type, with rates lowest in the Social Democratic countries and highest in the Liberal and Southern regimes. In a longitudinal cross-national study of income inequalities and welfare provision between countries, Coburn (2004) concluded that those countries which were the least neoliberal in their economic and social policy orientation (i.e. the Scandinavian welfare states) had significantly lower IMR, lower overall mortality rates and less mortality at younger ages. This study also suggested that welfare state regime might be the link between GDP/capita and mortality. Conley and Springer (2001) examined IMR in Esping-Andersen's three welfare regimes from 1960 to 1992. They found significant differences by regime type, but that these differences decreased over time with a certain degree of convergence in terms of IMR. Their analysis also identified that public expenditure on healthcare had an important association with IMR, particularly in the Conservative welfare state regimes. Similarly, Bambra (2006b) found significant differences in IMR between the three worlds of welfare. This study also found a moderate correlation between decommodification levels and IMR.

Navarro and colleagues (2003, 2006) examined differences between four different welfare state regimes (the Navarro and Shi (2001) typology); they found that those countries which have had long periods of government by redistributive political parties (most notably the Scandinavian countries) have experienced lower IMR and, to a lesser extent, increased life expectancy at birth. These findings were reinforced by Chung and Muntaner's (2006) multilevel longitudinal analysis of welfare state regimes in which they found that around 20 per cent of the difference in infant mortality rate among countries, and 10 per cent for low birth weight, could be explained by the type of welfare state. Social Democratic countries had significantly lower IMR and low birth weight rates, compared to all other welfare state regimes.

Outside of IMR, other health outcomes have also been explored, including life expectancy (Navarro *et al.*, 2006; Karim *et al.*, 2010; Popham *et al.*, 2013) and self-reported health (Eikemo *et al.*, 2008a). Many of these studies have also concluded that population health is enhanced by the relatively generous and universal welfare provision of the Social Democratic Scandinavian countries, especially in contrast to the Liberal welfare states. Others, however, have found that population health is better in other regimes (Brennenstuhl *et al.*, 2012; Bergqvist *et al.*, 2013). Popham and colleagues (2013), for instance, use an adapted version of Ferrera's regime typology to examine average life expectancy in 37 countries. The authors find that while life expectancy is higher in the Nordic countries for men, for women it is higher in East Asian countries. A study by Karim *et al.* (2010) (Table 23.2) also found that the Social Democratic welfare states had the lowest IMR but not the highest life expectancy (Table 23.2). To summarise, there is suggestive evidence which supports the idea that population health is better in Social Democratic countries. This indication, however, comes largely from studies measuring population health in terms of mortality rather than morbidity where there is much more variation found by studies (Brennenstuhl *et al.*, 2012; Bergqvist *et al.*, 2013).

In terms of health inequalities, until the late 1990s, the few comparative studies that had been conducted had concluded that the Social Democratic Scandinavian welfare states (particularly

Table 23.2 Infant mortality rates and life expectancy at birth for 30 countries and 6 welfare state regimes (2003)*

Welfare state regime and country	*Infant mortality rate (deaths per 1,000 live births)*	*Life expectancy at birth (in years)*
Scandinavian	3.98	78.52
Denmark	4.90	77.10
Finland	3.73	77.92
Norway	3.87	79.09
Sweden	3.42	79.97
Liberal	5.53	78.49
Australia	4.83	80.13
Canada	4.88	79.83
Ireland	5.34	77.35
New Zealand	6.07	78.32
United Kingdom	5.28	78.16
United States	6.75	77.14
Conservative	4.40	78.65
Austria	4.33	78.17
Belgium	4.57	78.29
France	4.37	79.28
Germany	4.23	78.42
Luxembourg	4.65	77.66
Netherlands	4.26	78.74
Switzerland	4.36	79.99
Southern	5.65	78.47
Greece	6.12	78.89
Italy	6.19	79.40
Portugal	5.73	76.35
Spain	4.54	79.23
Eastern	6.83	74.19
Hungary	8.58	72.17
Czech Republic	5.37	75.18
Poland	8.95	73.91
Slovenia	4.42	75.51
East Asian	5.29	78.70
Japan	3.30	80.93
Korea	7.31	75.36
Hong Kong	5.63	79.93
Singapore	3.57	80.42
Taiwan	6.65	76.87

Note
* This table is reproduced from Karim *et al.* (2010) with permission from Elsevier.

Norway and Sweden) had the smallest socio-economic health inequalities (Black *et al.*, 1980). This was in keeping with the theoretical perspective that labour market-generated socio-economic class inequalities in health would be smaller in the more highly decommodifying and egalitarian Social Democratic Scandinavian countries. However, the findings of more recent studies have been less homogeneous (Dahl *et al.*, 2006; Bambra, 2011a; 2011b; Brennenstuhl *et al.*,

2012; Bergqvist *et al.*, 2013). For example, Mackenbach and colleagues' (1997) large-scale comparative study of health inequalities in Europe found that in the 1980s, relative educational, income and occupational class inequalities in morbidity (self-reported health) were present in all the European countries studied (Mackenbach *et al.*, 1997). The Scandinavian countries did not have smaller relative educational inequalities in self-reported health than the other European countries, but they did have smaller relative income inequalities in self-reported health for men (but not women). Mortality was lower for non-manual occupations in all the countries studied but there were few differences in the sizes of relative inequalities by country (Mackenbach *et al.*, 1997). However, the Social Democratic Scandinavian countries did exhibit smaller absolute differences in mortality by occupational class. These findings were confirmed by a follow-up European-wide study of relative health inequalities conducted in the 2000s (Mackenbach *et al.*, 2008).[1]

A number of comparative studies have used welfare state regimes to examine cross-national differences in the magnitude of socio-economic inequalities in morbidity (Bambra, 2011c; Bergqvist *et al.*, 2013). Overall, they have all found that socio-economic inequalities in health are present in all types of welfare states. However, the comparative performance of different types of welfare state regimes varies by the measure of inequality used. This is best demonstrated across four studies, all of which used data from the European Social Survey, the Ferrera (1996) typology, and examined inequalities in long-standing limiting illness and self-rated health. In terms of educational inequalities, Bambra and colleagues (2010) found that inequalities were smaller in the Bismarckian and Southern regimes than in the Scandinavian regime. Eikemo and colleagues (2008b) also looked at educational inequalities and found that the magnitude of both relative and absolute educational inequalities were largest within the Southern welfare state regime and smallest within the Bismarckian regime. In this study, the Scandinavian regime was less favourably placed than the Anglo-Saxon regime. Looking at income-related inequalities, by contrast, Eikemo and colleagues (2008c) found that the Anglo-Saxon regime had the largest inequalities, the Bismarckian the smallest, while the Social Democratic and Southern regimes held an intermediate position. Finally, examining inequalities in employment status, Bambra and Eikemo (2009) found the largest inqualities in the Anglo-Saxon, Bismarckian and Scandinavian regimes.

Findings on health inequalities also vary by population subgroup with comparative studies of the most vulnerable social groups – the old (Avendano *et al.*, 2009), the sick (van der Wel *et al.*, 2010), children (Zambon *et al.*, 2006) and lone mothers (Van de Velde *et al.*, 2014) – finding that there are much smaller socio-economic inequalities in the Social Democratic Scandinavian welfare states – particularly Norway and Sweden. The least educated have also been found to benefit from generous welfare state protection (Dahl and van der Wel, 2013). Further, the use of relative or absolute measures of health has caused controversy, since while relative inequalities may not be the smallest in the Social Democratic welfare states, in absolute terms everyone does better: absolute mortality levels among disadvantaged groups are lower in welfare states with more generous, universal, social protection systems (Lundberg and Lahelma, 2001).

In contrast to their comparatively strong performance then in terms of overall mortality, data from most – but not all – of the recent comparative studies of health inequalities suggest that the Scandinavian welfare states do not have the smallest health inequalities. Given the higher levels of social expenditure in the Scandinavian welfare states, the smaller income inequalities and the commitment to equality underpinning the Social Democratic welfare model in Scandinavia, it is something of a 'puzzle' as to why the Scandinavian countries do not have the smallest health inequalities (Bambra, 2011b). Attempted explanations for the puzzle are varied, focusing on different issues within the broader debates about the causes of health inequalities – behaviouralism, materialism and so forth (ibid.). However, most notably, issues of measurement have been flagged up, and this is where the use of welfare state regimes as a methodological device has been heavily criticised.

The existence of the 'public health puzzle' – of why health inequalities are not the smallest in the Scandinavian countries – has been challenged on the basis that it is merely the result of the data and methods used. Certainly, the application of different indicators of social inequality (e.g. income, occupation and education) and the use of different datasets has produced divergent results. Different cross-national patterns also emerge in terms of the different ways in which specific indicators of inequality are calculated. For example, studies of educational inequalities can compare those with average years of education to those with one standard deviation below the national average, or the difference between those with no education or only primary education compared to those with tertiary education (Bambra, 2011b). There are also more general issues in terms of making cross-national comparisons of health inequalities, as it is not clear whether the bottom groups are the same in each country and whether their composition changes over time. The use of relative or absolute measures of health inequalities is also an important issue, as it has been shown that relative measures of inequalities are negatively associated with total population health: countries with lower overall mortality tend to experience larger inequalities in mortality (Eikemo *et al.*, 2009). The other crucial measurement problem is the use of 'welfare state regimes', a concept which assumes a homogeneous approach to welfare provision within and between the countries of any particular regime type when in fact there can be a great deal of variation within countries and within regimes – as the case of healthcare demonstrates (Abrahamson, 1999; Kasza, 2002; Bambra, 2006b) (see also Chapters 11 and 35, this volume). The analysis of specific social policies (Lundberg *et al.*, 2008; Kasza, 2002) and institutional arrangements (Beckfield *et al.*, 2015; Beckfield and Bambra, 2016) has therefore been advocated as an alternative way of conducting comparative health research (Stanistreet *et al.*, 2005).

Conclusion

Application of the welfare state regimes concept to health research has had both positive and negative impacts. Positively, it has resulted in the integration of healthcare decommodification into welfare state regime construction, and the regimes concept has been a productive way of exploring and to some extent explaining international variations in the population health of developed countries. However, on the negative side, the healthcare decommodification index has challenged the internal consistency of welfare state regimes, showing that there are differing service and transfer mixes. Similarly, the use of welfare state regimes to compare and explain differences in the magnitude of health inequalities between developed countries has also resulted in a questioning of the validity of the welfare state regimes approach to comparative research. The implications for welfare state typologies are thus threefold. First, to maintain value within comparative research, the welfare state regimes concept needs to be able to integrate all aspects of welfare provision. Second, the limitations of the concept need to be acknowledged by those using it to construct complicated explanations of population outcomes. Finally, the welfare state regimes concept, by identifying broad similarities between countries, makes possible more precise natural policy experiments between most similar cases. This will ultimately help advance our understanding of the interaction between welfare policies and health outcomes.

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Note

1 It should be noted that although Mackenbach *et al.*'s studies (1998, 2008) did not explicitly use welfare state regimes, the geographic areas which they did use broadly matched Ferrera's (1996) welfare regimes typology.

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