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The welfare state: A glossary for public health

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Introduction

Although it has long been acknowledged that social policies and the nature and extent of welfare state provision are important determinants of health and health inequalities, as they mediate the extent, and impact, of socio-economic position on health, [1 2 3 4] it is not until recently that social epidemiologists have started to systematically examine how different national welfare state arrangements influence international variations in population health. [5 6 7 8 9 10 11 12 13 14 15] Such comparative social epidemiology increasingly utilises welfare state regime theory - which classifies welfare states into different types (or regimes), depending on the principles underpinning their provision, the relative role of the state as opposed to the market or the family, and the nature of social stratification. [16] Somewhat invariably, these 'regime' studies have all concluded that population health is enhanced, and inequalities in health reduced, by the relatively generous and universal welfare provision of the Social Democratic countries. [6 7 12 14]

However, despite the burgeoning nature of this research and the increasing attention it receives from policy makers (e.g. the European Union funded the EUROTHINE study, http://mgzlx4.erasmusmc.nl/eurothine/), nowhere in the public health literature are the key terms related to the welfare state explicitly defined. Many terms are used implicitly, with the assumption that those who wish to access and use the research are already in the know. Given the specific, and sometimes historical, nature of much of the terminology (e.g. decommodification, social transfers, etc.), we believe that this is actually highly unlikely and that subsequently, the current audience for such research is being artificially limited. Furthermore, until this conceptual gap is closed, it is unlikely that the public health community will be able to respond adequately to recent calls for more research into the relationships between welfare states and health. [15 17]

Therefore, in this glossary, we outline those welfare state related terms which are most frequently used, but so seldom defined, within social epidemiological studies. We hope that it will be a tool that enables more researchers, practitioners and policy makers to engage with and contribute to this exciting and fruitful area of public health research. Words which are in

italics are themselves defined in the glossary. The terms are not in alphabetical order as those that relate conceptually or historically to one another are presented consecutively. The glossary covers key terms and concepts relating to welfare state provision, the historical development of the welfare state, and cross-national variations in welfare states in the form of welfare regimes. Links between the concepts and public health are also made where appropriate.

Welfare state

The term *welfare state* was accepted in Scandinavia in the 1930s, but was only used more widely after World War II.[18] However, there is still no accepted standard definition of this concept.[19] Conventionally, it has been used in a narrow sense, as a means of referring to the various post-war state measures for the provision of key welfare services and *social transfers*. The *welfare state* is thereby used as a shorthand for the state's role in education, health, housing, poor relief, social insurance, in developed capitalist countries during the post-war period. [20] Public health services, such as health promotion, are also included within this definition.

Welfare state capitalism

This term reflects a view of the *welfare state* as a particular type of state and a specific form of society. In this way, the emergence of the post-war *welfare state* is regarded as a shift towards a new form (or forms – see *welfare state regimes*) of capitalist economy in which, following Keynesian economic theory, there is an emphasis on full (male) employment, *universalism,* and corporatist partnership.[21 22] The Keynesian economic theory has full employment as priority and sees government intervention in the economy as necessary for managing economic stability. *Welfare state capitalism* is most widely associated with Esping-Andersen's modern classic 'The Three Worlds of Welfare Capitalism' (1990), in which the *welfare state* is not just a set of *social transfers* and welfare services which are used to intervene in, and possibly correct, the structure of inequality.[16]. It is, in its own right a system of social stratification, because the way in which the *welfare state* distributes welfare services has consequences for the social and economical hierarchy in society. More specifically, the

welfare state actively (re-)organises social relations through the way in which it deliberately modifies market forces by guaranteeing citizens and families a minimum income (see *social citizenship* or *decommodification*) and by reducing the welfare responsibilities of the family (see *defamilisation*). Comparative social epidemiology which examines the influence of welfare state arrangements is often concerned with comparing the effects on population health of the social stratifications created by different types of *welfare states* (see *welfare state regimes*). [5 6 7 8 9 10 11 12 13 14 15]

Golden Age of welfare

The golden age of welfare refers to the classic *welfare state*, which was established across Europe shortly after the Second Word War and lasted until the *crisis of the welfare state* in the 1970s.[23 24 25] The *golden age* ended with the economic crisis of the 1970s (high inflation, slow economic growth, the end of full employment) during which there was a general loss of confidence in *welfare state capitalism* (initially in the USA and UK and then across continental Europe).[26 27 28] The classic *welfare state* was based on two main mechanisms. First, it was founded on a cradle-to-grave public *universalism*, both in terms of coverage of the population and the range of welfare services which were provided. Secondly, in following Keynesian economics to a greater (e.g. France) or lesser extent (e.g. UK), it attempted to maintain full (male) employment.[23] In this period, Europe saw significant improvements to public housing, health care, and the other main social determinants of health. Corresponding improvements in mortality and morbidity were experienced, although despite the achievements of *welfare states* in improving equality of opportunity, there is ample evidence that important health inequalities still exist.[29]

Welfare state retrenchment

A political welfare backlash followed the *crisis of the welfare state* and the term *welfare state retrenchment* is used to refer to the subsequent *welfare state* reforms and cuts to social expenditure. The reforms were characterised by the privatisation and marketisation of welfare services (e.g. the purchaser/provider split in national health systems such as Sweden and the

UK);[30 31] entitlement restrictions and increased qualifying conditions (e.g. the population coverage of unemployment benefit in the UK decreased from 90% in 1980 to 77% in 1999, in Germany it decreased from 100% to 84% and in Norway, from 100% to 79%),,[32 33 34] and a shift towards targeting and means testing (for example, the setting of income limits for the receipt of family allowances in Italy and Spain); cuts or limited increases to the actual cash values of *social transfers* (e.g. in the UK, the replacement value of unemployment benefit decreased from 45% of average wages in 1980 to just 16% in 1999; in Germany it decreased from 68% to 37%, and in Norway from 70% to 62%);[32 33] modified funding arrangements (with a shift away from corporate insurance contributions and business taxation); and an increased emphasis on an active rather than a passive welfare system (e.g. by tying the receipt of benefits to training as is the case in Scandinavia).[34] Although initially limited to the UK and the USA, these processes are now commonplace across all *welfare state regimes*, although the nature and extent of *welfare state retrenchment* is limited by the structures of the prevailing *welfare state* system and is therefore to some extent path dependent.[35 36 37] Reforms of this nature are considered by some to have lessened the influence of the *welfare state* in moderating the relationship between market position and health, and has thereby led to increased health inequalities in some countries, most notably the UK.[4]

Welfare state regimes

According to Esping-Andersen (1990),[16] the *welfare states* of different countries can be classified, on the basis of *decommodification*, social stratification, and the private-public mix of welfare provision (the relative roles of the state, the family, the voluntary sector, and the market in welfare provision), into three different groups or *welfare state regimes*: Liberal, Conservative and Social Democratic (Box 1). Subsequent debates about the validity and composition of Esping-Andersen's original *welfare state regimes* typology has led to the production of competing classifications and the identification of other possible regime types: Radical, Southern, Confucian, and Eastern European (Box 1). [15 38] A significant body of work has examined how population health and health inequalities vary by *welfare state regime* with most concluding that health fares best in the Social Democratic *welfare states*. [5 6 7 8 9 10 11 12 13 14 15]

Decommodification

Decommodification was one of the major factors used in the composition of Esping-Andersen's typology of *welfare state regimes*.[16] Essentially, it is the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance.[16 35] Commodification on the other hand refers to the extent to which workers and their families are reliant upon the market sale of their labour. Labour became extensively commodified during the industrial revolution as workers became entirely dependent upon the market for their survival.[16 35] In the 20th century, *social citizenship* brought about a 'loosening' of the pure commodity status of labour. 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. However, it must be noted that under *welfare state capitalism*, whilst the pure commodification of labour is possible, its pure decommodification is not.[39] The issue under study is therefore the relative degrees of protection from dependence on the labour market provided by different *welfare states*. Recent public health research has found a positive relationship between levels of *decommodification*, income inequality and measures of population health such as infant mortality rates.[12 14]

Defamilisation

Defamilisation is often defined as the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationships, either through paid work or through social security provisions.[40] This concept acknowledges that often, the functional equivalent of market dependency for many women is family dependency.[35] The concept has been operationalised by commentators as either the extent to which *welfare states decommodify* the family [35 41] or the extent to which the *welfare state* enables women to survive as independent workers and decreases the economic importance of the family in women's lives. [15 42] To date, comparative social epidemiology has not utilised the concept to

examine gender differences in population health between countries. However, there is a growing trend towards research which looks at the influence of *welfare state* arrangements on women's social roles and the differences between the health of men and women. [43 44 45 46]

Social Citizenship

Citizenship is a status bestowed on those who are full members of a community and all who possess the status are equal with respect to the rights and duties with which that status is endowed.[25 47] Following Marshall (1963) there are three main components of citizenship: civil and political, which refer to individual freedoms and the right to participate in the exercise of political power, and *social citizenship*.[47] *Social citizenship* is the right to economic and social welfare in accordance with the standards prevailing in society.[47] Health, or the 'right to a standard of living adequate for health and well-being', is an important aspect of *social citizenship*.[48 49] In Europe, the *welfare state* has functioned as the embodiment of *social citizenship* as the *decommodification* it provides ensures that a certain standard of living (although these vary between countries – see *welfare state regimes*) is a right of citizenship rather than something solely acquired via individual market position (e.g. as a consumer). In this way, debates about *welfare state retrenchment* are also about the extent and validity of the rights of *social citizenship*.

Universalism

In short, *universalism* means that *social transfers* and welfare services (including health care services) are granted for everyone on the basis of *(social) citizenship*. This implies that despite prevailing socio-economic inequalities, every citizen is of equal worth within the *welfare state*.[10] *Universalism* is most typically associated with the Social Democratic *welfare states* since these countries promote an equality of the highest standards of welfare services and *social transfers*. However, some degree of *universalism* is also associated with those *welfare states* based on the Beveridge model (e.g. the National Health Service within the UK),[25] albeit in these cases it is often an equality of a basic minimum. Approaches counter to the principles of *universalism* are means-testing (in which entitlement is restricted on the basis of income), targeting (i.e. when benefit receipt is only available to the restricted groups,

often the most impoverished) or workfare (in which participation in employment or training is a condition of benefit entitlement).[34]

Social transfers

Social transfers are interchangeably referred to in the literature as income maintenance programmes, social security, or cash benefits. They are the aspect of the *welfare state* most associated with income redistribution e.g. housing related benefits, unemployment, pensions, and sickness and disability benefits. They are distinct from welfare services (health care, education, social services, etc). There are five main types of *social transfer*: social insurance benefits (which are contribution based and therefore earned entitlements), social assistance (often residual, means-tested benefits for those who do not qualify for social insurance benefits), categorical benefits (paid to specific groups as long as the criteria are met e.g. child benefit in the UK), occupational benefits (e.g. sickness and disability pensions or maternity payments which are often administered by employers or other social partners), and fiscal transfers (tax allowances and reliefs such as the Earned Income Tax Credit in the USA or the Working Tax Credit in the UK). [50] The relative value of *social transfers* as a replacement for wages (replacement rates, see *decommodification*) varies across *welfare states* (with more generous levels provided by the Social Democratic *welfare states*).[16] In some systems they are related to previous earnings (e.g. Norway, Germany) whereas in others they are provided at a standard flat-rate (e.g. UK). The relative levels of *social transfer* have important repercussions for income, and therefore health, inequalities within and between countries. [51]

Box 1: Welfare state regimes

Liberal/residual

In the *welfare states* of the liberal regime (UK, USA, Ireland, Canada, Australia), state provision of welfare is minimal, *social transfers* are modest and often attract strict entitlement criteria; and recipients are usually means-tested and stigmatised.[16] In this model, the dominance of the market is encouraged both passively, by guaranteeing only a minimum, and actively, by subsidising private welfare schemes.[16] The liberal *welfare state regime* thereby minimises the *decommodification* effects of the *welfare state* and a stark division exists between those, largely the poor, who rely on state aid and those who are able to afford private provision.

Conservative/Corporatist/Bismarckian

The conservative *welfare state regime* (Germany, France, Austria, Belgium, Italy and, to a lesser extent, the Netherlands) is distinguished by its 'status differentiating' welfare programs in which benefits are often earnings related, administered through the employer; and geared towards maintaining existing social patterns. The role of the family is also emphasised and the redistributive impact is minimal. However, the role of the market is marginalised.[16]

Social Democratic

The Social Democratic regime type (Nordic countries), is characterised by *universalism*, comparatively generous *social transfers*, a commitment to full employment and income protection; and a strongly interventionist state. The state is used to promote social equality through a redistributive social security system.[52] Unlike the other *welfare state regimes*, the Social Democratic regime type promotes an equality of the highest standards, not an equality of minimal needs and it provides highly *decommodifying* programs. [16]

Southern

It has been proposed that the Southern European *welfare states* (Italy, Greece, Portugal and Spain) comprise a distinctive, southern, *welfare state regime*.[53 54 55] The southern *welfare states* are described as 'rudimentary' because they are characterised by their fragmented system of welfare provision which consists of diverse income maintenance schemes that range from the meagre to the generous and welfare services, particularly, the health care system, that provide only limited and partial coverage.[54] Reliance on the family and voluntary sector is also a prominent feature.

Radical/targeted

Castles and Mitchell (1993) argue that the UK, Australia and New Zealand constitute a *radical*, targeted form of *welfare state*, one in which the welfare goals of poverty amelioration and income equality are pursued through redistributive instruments rather than by high expenditure levels.[56] In the same vein, Korpi and Palme describe the existence of a targeted *welfare state regime* .[57]

Confucian

The Confucian *welfare state* (Japan, South Korea, Taiwan, Hong Kong and Singapore) is characterised by low levels of government intervention and investment in social welfare, underdeveloped public service provision, and the fundamental importance of the family and voluntary sector in providing social safety nets. This minimalist approach is combined with an emphasis on Confucian social ethics (obligation for immediate family members, thrift, diligence, and a strong education and work ethic).[58]

East European

According to Esping-Andersen (1999), these countries are clearly the most under defined and understudied region in terms of *welfare state* development.[35] The formerly Communist countries of East Europe have experienced extensive economic upheaval and have undertaken extensive social reforms throughout the 1990s.[59] These have seen the demise of the *universalism* of the Communist *welfare state* and a shift towards policies associated more with the liberal *welfare state regime* notably marketisation and decentralisation. In comparison with the other member states of the European Union, they have limited health service provision and overall population health is relatively poor. [60]

REFERENCES

1. Townsend P, Davidson N. The Black Report. In: Townsend P WM, and Davidson N. , editor. *Inequalities in Health: The Black Report and the Health Divide.* London: Penguin, 1992.
2. Bartley M., Blane D. Socioeconomic determinants of health: Health and the life course: Why safety nets matter. *BMJ* 1997;314:1194.
3. Whitehead M. The Health Divide. In: Townsend P WM, and Davidson N., editor. *Inequalities in Health: the Black Report and the Health Divide.* London: Penguin, 1992.
4. Acheson D. Independent Inquiry into Inequalities in Health (the Acheson Report). London: HMSO, 1998.
5. Martikainen P., Lahelma E., Marmot M., et al. A comparison of socioeconomic differences in physical functioning and perceived health among male and female employees in Britain, Finland and Japan. . *Social Science & Medicine* 2004;59:1287-1295.
6. Navarro V., Borrell C., Benach J., et al. The importance of the political and the social in explaining mortality differentials among the countries of the OECD, 1950-1998. *International Journal of Health Services Research* 2003;33:419-494.
7. Navarro V., Muntaner C., Borrell C., et al. Politics and health outcomes. *Lancet* 2006;368:1033-1037.
8. Navarro V., Shi L. The political context of social inequalities and health. *International Journal of Health Services Research* 2001;31:1-21.
9. Raphael D., Bryant T. The welfare state as a determinant of women's health: support for women's quality of life in Canada and four comparison nations. *Health Policy* 2004;68:63-79.
10. Dahl E., Fritzell J., Lahelma E., et al. Welfare state regimes and health inequalities. In: Siegrist J., Marmot M., editors. *Social inequalities in health*. Oxford Oxford University Press, 2006:193-222.
11. Chung H., Muntaner C. Welfare state matters: A typological multilevel analysis of wealthy countries. . *Health Policy* 2007;80:328-339.
12. Coburn D. Beyond the income inequality hypothesis: class, neo-liberalism, and health inequalities. *Social Science & Medicine* 2004;58:41-56.
13. Conley D., Springer K. Welfare state and infant mortality. *American Journal of Sociology* 2001;107:768-807.
14. Bambra C. Health status and the worlds of welfare. *Social Policy and Society* 2006;5:53-62.
15. Bambra C. Going Beyond The Three Worlds of Welfare Capitalism: Regime theory and public health research *Journal of Epidemiology and Community Health* in press.
16. Esping-Andersen G. *The three worlds of welfare capitalism*. London: Polity, 1990.
17. Muntaner C., Chung H. Welfare State Typologies and Global Health: An Emerging Challenge. *Journal of Epidemiology and Community Health* in press.
18. Kaufmann F. Towards a theory of the welfare state. . *European Review* 2000;8:291-312.
19. Powell P., Hewitt M. *Welfare State and Welfare Change*. Buckingham: Open University Press., 2002.
20. Ginsburg N. *Class, Capital and Social Policy* London: Macmillan, 1979.
21. Gould A. *Capitalist Welfare Systems: A Comparison of Japan, Britain and Sweden*. London: Longman, 1993.
22. George V., Page R. *Modern Thinkers on Welfare* London: Harvester Wheatsheaf, 1995.
23. Gladstone D., editor. *British Social Welfare: Past, Presence and Future.* London: UCL Press., 1995.
24. Sullivan M. *The Politics of Social Policy*. Hemel Hempstead: Harvester Wheatsheaf., 1992.
25. Hewitt M., Powell M. A different back to Beveridge? In: Brunsdon E., Dean H., Woods R., editors. *Social Policy Review 10*. London: Social Policy Association., 1998.
26. O'Connor J. *The Fiscal Crisis of the State* London St James, 1973.

27. Mishra R. *The Welfare State in Crisis: Social Thought and Social Change* London: Harvester Wheatsheaf, 1984.
28. Offe C. *Contradictions of the Welfare State* London: Hutchinson, 1984.
29. Kaplan G. Health inequalities and the welfare state: perspectives from social epidemiology. . *Norsk Epidemiologi* 2007; 17:9-20.
30. Rehnberg C. Sweden. In: Ham C., editor. *The Politics of Healthcare Reform: Learning from International Experience*. Buckingham: Open University, 1997.
31. Kingdom J. The United Kingdom In: Wall A., editor. *Healthcare Systems in Liberal Democracies*. London: Routledge, 1996.
32. Scruggs L., Allan J. Welfare state decommodification in eighteen OECD countries: a replication and revision. *Journal of European Social Policy* 2006;16:55-72.
33. Bambra C. Cash versus services: 'worlds of welfare' and the decommodification of cash benefits and health care services *Journal of Social Policy* 2005;34:195-213.
34. Rhodes M. The Welfare State: Internal Challenges, External Constraint. In: Rhodes M., Vincent A., editors. *Developments in Western European Politics*. London: Macmillan, 1997.
35. Esping-Andersen G. *Social foundations of post-industrial economies*. Oxford: Oxford University Press, 1999.
36. Pierson P. *Dismantling the Welfare State: Reagan, Thatcher and the Politics of Retrenchment*. Cambridge: Cambridge University Press, 1994.
37. Pierson P. The New Politics of the welfare state. *World Politics* 1996;48:143-179.
38. Arts W, Gelissen J. Three worlds of welfare or more? *Journal of European Social Policy* 2002;12:137-158.
39. O'Connor JS. Gendering Welfare State Regimes. *Current Sociology* 1996;44:1-130.
40. Lister R. *Citizenship: Feminist Perspectives*. London, 1997.
41. Korpi W. Faces of inequality: gender, class and patterns of inequalities in different types of welfare states. *Social Politics* 2000;7:127-191.
42. Bambra C. The worlds of welfare: Illusory and gender blind? *Social Policy and Society* 2004;3:201-212.
43. Lahelma E., Arber S. Health inequalities among men and women in contrasting welfare states: Britain and three Nordic countries compared. *European Journal of Public Health* 1994;4:213-226.
44. Stanistreet D., Bambra C., A. S-S. Is patriarchy the source of male mortality? *Journal of Epidemiology and Community Health* 2005;59:873-876.
45. Stanistreet D., Swami V., Pope D., et al. Women's empowerment and violent death among women and men in Europe: An ecological study *Journal of Men's Health and Gender* in press.
46. Rahkonen O, Arber S, Lahelma E, et al. Understanding income inequalities in health among men and women in Britain and Finland. *International Journal of Health Sciences* 2000;30:27-47.
47. Marshall TH. *Sociology at the Crossroads*. London Hutchinson, 1963.
48. United Nations. *Universal Declaration of Human Rights: General Assembly Resolution 217A (III), U.N. Doc A/810 at 71.* New York: United Nations, 1948.
49. Bambra C., Fox D., Scott-Samuel A. Towards a politics of health. *Health Promotion International* 2005;20:187-193.
50. Fitzpatrick T. Cash transfers. In: Baldock J., Manning N., Vickerstaff S., editors. *Social Policy*. Oxford: Oxford University Press, 2003:329-361.
51. Wilkinson R. *Unhealthy societies*. London: Routledge, 1996.
52. Kautto K., Fritzell J., Hvinden B., et al., editors. *Nordic Welfare States in the European Context.* . London: Routledge., 2004.
53. Bonoli J. Classifying welfare states: A two-dimension approach. *Journal of Social Policy* 1997;26:351-372.
54. Leibfreid S. Towards a European welfare state. In: Ferge Z, Kolberg JE, editors. *Social policy in a changing Europe*. Frankfurt: Campus-Verlag, 1992:245-279.
55. Ferrera M. The southern model of welfare in social Europe. *Journal of European Social Policy* 1996;6:17-37.
56. Castles F., Mitchell D. Worlds of welfare and Families of Nations. In: Castles F., editor. *Families of Nations: Patterns of Public Policy in Western Democracies*. Dartmouth: Aldershot, 1993.

57. Korpi W., Palme J. The paradox of redistribution and the strategy of equality: welfare state institutions, inequality and poverty in the Western countries. *American Sociological Review* 1998;63:662-687.

58. Walker A., Wong C. *East Asian welfare regimes in transition: From Confucianism to globalisation* Bristol: Policy Press, 2005.

59. Kovacs JM. Approaching the EU and reaching the US? Rival narratives on transforming welfare regimes in East-Central Europe. *West European Politics.* 2002;25 175 Sp. Iss. .

60. European Union and World Health Organisation. *Health status overwiew for countries of central and eastern Europe that are candidates for accesion to the European Union.* . Brussels: European Union, 2002.