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Worlds of Welfare and the Health Care Discrepancy

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The nature of welfare regimes has been an ongoing debate within the comparative social policy literature since the publication of Esping-Andersen's 'Three Worlds of Welfare' (1990). This article draws upon recent developments within this debate, most notably Kasza's assertions about the 'illusory nature' of welfare regimes, to highlight the health care discrepancy. It argues that health care provision has been a notable omission from the wider regimes literature and one which, if included in the form of a health care decommodification typology, can give credence to Kasza's perspective by highlighting the diverse internal arrangements of welfare states and welfare state regimes.

How we classify welfare state regimes is a central issue in the comparative social policy literature as the on-going debate about Esping-Andersen's 'Three Worlds of Welfare' regimes shows (Esping-Andersen, 1990, 1999; Lewis, 1992; Leibfreid, 1992; Castles and Mitchell, 1993; Orloff, 1993; Borchost, 1994; Daly, 1994; Kangas, 1994; Ragin, 1994; Ferrera, 1996; Shalev, 1996; Pierson, 1998; Goodin *et al*., 1999; Sainsbury, 1999a, 1999b; Pitruzzello, 1999; Arts and Gelissen, 2002; Kasza, 2002). However, what is remarkable about this debate is that, whilst there have been numerous critiques in the past about his range (Leibfreid, 1992; Castles and Mitchell, 1993; Ferrera, 1996), his methodology (Kangas, 1994; Ragin, 1994; Shalev, 1996; Pitruzzello, 1999), and the absence of gender in his typology (Lewis, 1992; Orloff, 1993; Borchost, 1994; Daly, 1994; Sainsbury, 1999a, 1999b), a core procedure has only recently attracted direct attention: this is Esping-Andersen's decision to organise the principle of classification around the study of income maintenance programs and to create regimes that generalise about all forms of social policy provision from this base (Kasza, 2002).

Kasza (2002: 283) argues that 'the concept of welfare regimes is not a workable basis for research' as it incorporates two flawed assumptions: firstly, that most of the key social policy areas, such as income maintenance, education, health or housing, within a welfare regime will reflect a similar, across the board approach to welfare provision, particularly in respect of the role of the state; and, secondly, that each regime type itself reflects 'a set of principles or values that establishes a coherence in each country's welfare package' (Kasza, 2002: 272). Kasza asserts that instead of an internal policy homogeneity or cohesion, welfare states and welfare regimes exhibit significant variation across different areas of social provision. He asserts that the incremental, piecemeal and cumulative nature of welfare policy making; the diverse histories of different policy areas within a country's welfare framework; the variation of policy actors across different fields; differences in the policy making process; and the influence on policy of external/foreign welfare models; all undermine the likelihood of cohesion and

coherence within a welfare state or, indeed, within a welfare state regime. The regime concept therefore 'does not capture the complex motives that inform each country's welfare programs' and, in pursuit of consistency, it ignores the fact that different areas of welfare state provision exhibit different cross-national variations (Kasza, 2002: 283). Kasza concludes that, in light of the internal diversity of welfare states, the best approach for future comparative research would be to abandon the concept of welfare state regimes and instead re-focus on individual policy comparisons and the development of policy-specific typologies.

This article takes up some aspects of Kasza's critique by examining the cross-national variation in provision of what is by far one of the largest areas of social welfare – health care – accounting as it does for an average of 6.6 per cent of GDP in the EU member states (Eurostat, 2001). Health care, although it has been subject to separate comparative analysis, has been a significant and notable omission from the broader welfare state literature and particularly the regimes debate (Ham, 1997; Moran, 1999, 2000; Freeman and Moran, 2000; Freeman, 2000). Some commentators have drawn passing attention to it as a strong example of internal policy inconsistency. For example, Ginsburg (1992: 28) highlights the fact that there is a significant difference between the UK and the broader characteristics associated with the 'liberal' welfare state concerning the provision of health care; if the labour market principles of the ideal type liberal regime were extended into health care, it would be expected that funding would come largely from the market; however, in the UK, the NHS is funded almost entirely by general taxation. These comments have not been developed any further, however they are significant: which other country classifications would become problematic if health care provision was included? What does this mean for the concept of 'welfare state regimes' and Kasza's critique of it?

This article attempts to answer these questions through the construction of a health care decommodification index that it compares and contrasts with Esping-Andersen's *The Three Worlds of Welfare* regimes typology to highlight both the internal inconsistencies in welfare state provision (Kasza, 2002) and the variance in welfare state regime composition across different areas of social provision.

Decommodification

In *The Three Worlds of Welfare Capitalism* (1990), Esping-Andersen argues that 'existing theoretical models of the welfare state are inadequate' (1990: 2) as their analysis relies too heavily upon the misleading comparison of aggregate welfare state expenditure. The focus on total expenditure figures conceals the variety of state approaches to welfare; as 'even if the lion's share of expenditure or personnel serves welfare aims, the kind of welfare provided will be qualitatively different, as will its prioritisation relative to competing activities' (1990: 1). He asserts that it is therefore more beneficial to focus upon what a welfare state does, rather than on how much money it is afforded. On this basis, Esping-Andersen (1990: 52) presents a three-fold typology of welfare state regimes based largely on the principle of labour market decommodification: liberal (UK, USA, Ireland, Canada, Australia); conservative (Germany, France, Austria, Benelux countries and Italy); and social democratic (Denmark, Finland, Norway and Sweden).

It is important to acknowledge the importance of going beyond aggregate measures of welfare, and so, in constructing a health care typology, the concept of decommodification,

as pioneered in comparative welfare research by Esping-Andersen, has been kept. Decommodification refers to '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. However, as O'Connor notes, whilst the pure commodification of labour is possible, its pure decommodification is not (O'Connor, 1996: 61). The issue under discussion below is therefore the relative degree of protection from dependence on the labour market that is provided by different welfare states.

This concept of decommodification can be extended to cover health care provision. Health decommodification would thereby refer to 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 is independent from the market. In this context, health decommodification is not used, at least in explicit terms, as a means of analysing the extent to which an individual's actual health status is determined by their market position. In extending the concept of decommodification to cover health care, and by producing an initial index based around it, it is expected that the resulting typology will be used as a means of supplementing, critiquing or informing other welfare state typologies as it has been developed on complimentary rather than separate grounds.

Health care index

This health care index is one way in which the concept of health care decommodification could be operationalised and used in coordination with other welfare state typologies, most notably that of Esping-Andersen. It is constructed in the same way as Esping-Andersen's labour market indexes, even though this methodology has certain drawbacks, such as the use of averaging, and has met with some criticism within the literature (Castles and Mitchell, 1993; Kangas, 1994; Ragin, 1994; Shalev, 1996; Pitruzello, 1999). The index has to replicate Esping-Andersen's method to ensure compatibility.

Countries

The health care index includes 18 countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, UK, and USA.

Data and sources

The data upon which the health care decommodification index is based focuss on the public/private mix of health provision, the ease of access to public provision, and the coverage provided by the health system. The majority of data used in the health care decommodification index are taken from the OECD's international survey, 'Health data 1998: A Comparative Analysis of 29 Countries' (OECD, 2000). This is supplemented where necessary with data from the WHO 'Health for All' database (WHO, 2002).

Comparability

A number of measures have been taken to enhance comparability between the health care decommodification index and the labour market ones utilised in Esping-Andersen's typology. Firstly, whilst the OECD now contains 29 countries, the health care index only includes the original 18 OECD countries that were used by Esping-Andersen in his calculations. Secondly, the data used have been of an international nature in order to minimise cross-national differences in measurement, definition and collection. Thirdly, Esping-Andersen's indexes were based upon data from 1980 and the health decommodification index therefore has to use data from the same year in order to maintain comparability and compatibility. Finally, Esping-Andersen's method of index construction has been copied.

Measures

The health decommodification index has been constructed through the assessment of three measures:

1. Private health expenditure as a percentage of GDP – this factor refers to the extent of private financing by identifying the extent of a country's total income that is spent on private health care.
2. Private hospital beds as a percentage of total bed stock – this factor is used to express the extent of private provision at a practical level within a health care system.
3. The percentage of the population covered by the health care system – this shows the extent of general access provided by the public health care system.

These factors have been selected because they assess the financing, provision and coverage of the private sector and are, therefore, useful indicators of the varied role of the market in a health care system: The larger the size of the private health sector, in terms of expenditure and consumption, the larger the role of the market and, therefore, the lower the degree of health decommodification.

Method

The process of scoring in the health decommodification index replicates that used by Esping-Andersen (1990: 50–54) in respect to labour market data, and is by way of the numerical description of the relationship of an individual country's score to the mean (and standard deviation) for two (1 and 2) of the three factors that make up the index. On the basis of the values on each of these two indicators for the 18 nations, a score of 1 for low decommodification; 2 for medium; and 3 for high decommodification was given. Following Esping-Andersen, the classification into three scores has been done on the basis of one standard deviation from the mean with adjustment where necessary for extreme outliers (1990: 54). Finally, this score has been weighted by factor 3 – the per cent of the population covered by the health care system on the basis of 100 per cent coverage providing a weighting of 10, 92 per cent coverage a weighting of 9.2 and so on. Coverage is used as a weight because, as with Esping-Andersen's similar use of coverage/take-up rate in the labour decommodification index (1990: 54), it is the most important issue for public health care systems. A health care system that has a high proportion of public

Table 1 Health care decommodification index

Australia	20
Austria	30
Belgium	40
Canada	50
Denmark	50
Finland	50
France	40
Germany	27
Ireland	40
Italy	40
Japan	30
Netherlands	30
New Zealand	50
Norway	50
Sweden	50
Switzerland	29
UK	60
USA	8
Mean	39

funding and provision but that only provides service access to a small proportion of the population cannot be regarded as highly decommodifying.

Results

The assessment and combination of these factors (see appendix for details of individual factor data) produces a health care decommodification index (see Table 1).

This index shows a wide range of scores, from the USA's outlier score of 8 to the highest score of 60 awarded to the UK. The majority of countries fall between a smaller range of 30 (Austria, Japan, Netherlands) and 50 (Canada, Denmark, Finland, New Zealand, Norway and Sweden). The scores of some countries are surprisingly high, most notably the 'liberal' countries of Canada, New Zealand and the UK, which all have above average scores. In order to make a more informed comparison between the results of the health care index and Esping-Andersen's typology, the mean plus/minus Standard Deviation, method used to construct the index can be continued in order to place the countries into one of three groups. This process produces a comparable health care typology (see Table 2).

Discussion

These results show both a number of differences and a number of similarities within the classification of countries between the health care index and that of more conventional, labour market centred welfare state typologies (Titmus, 1974; Therborn, 1987; Esping-Andersen, 1990; Leibfreid, 1992; Castles and Mitchell, 1993; Ferrera, 1996; Bonoli, 1997; Korpi and Palme, 1998). In specific relation to Esping-Andersen's 'three worlds of welfare' the health care typology is in some ways complimentary, as a broad similarity exists

Table 2 Health care decommodification typology

Group 1	Group 2	Group 3
Australia	Austria	Canada
US	Belgium	Denmark
	France	Finland
	Germany	New Zealand
	Ireland	Norway
	Italy	Sweden
	Japan	UK
	Netherlands	
	Switzerland	

Table 3 Worlds of welfare and health care

Worlds of welfare	Health care
Liberal	**Group 1**
Australia	Australia
Canada	USA
Ireland	
New Zealand	
UK	
USA	
Conservative	**Group 2**
Austria	Austria
Belgium	Belgium
France	France
Germany	Germany
Italy	Ireland
Japan	Italy
Netherlands	Japan
Switzerland	Netherlands
	Switzerland
Social Democratic	**Group 3**
Denmark	Canada
Finland	Denmark
Norway	Finland
Sweden	New Zealand
	Norway
	Sweden
	UK

over the classification of a number of countries (see Table 3). Denmark, Norway, Finland and Sweden are all placed, as expected, within the high decommodification group 3. Similarly, the USA and Australia are placed within the lowest decommodification group 1, and Austria, Belgium, France, Germany, Italy, Japan, the Netherlands and Switzerland, are placed within the medium group 2. However, the health care index can also be used to critically engage with Esping-Andersen's typology, as there are also significant differences.

The health care group classification of four countries, Canada, Ireland, New Zealand, and UK, differs remarkably from that within the wider 'worlds of welfare' typology (see Table 3).

In Esping-Andersen's typology, Canada, New Zealand and the UK are all placed within the low decommodifying liberal regime, however the health care typology places them firmly within the higher scoring group 3 alongside countries that are considered as the more usual suspects, such as Sweden and Norway. Ireland is also placed within a different group in the health care typology as it is in the medium health care group, whereas it is placed in the low labour market group.

These mixed results both confirm and undermine welfare regime theory as on the one hand the majority of countries have health decommodification scores and group positions that broadly correspond with their labour market regime ones, but on the other hand, there is a notable shift in the position of a number of the liberal regime countries. Canada, New Zealand and the UK are found in the low scoring labour market group and, conversely, they are also located in the high scoring health care group. These results lend support to a number of different explanations: Firstly, the extreme shift in location of Canada, New Zealand and the UK gives credence to the claims of other welfare regime typologists, most notably Castles and Mitchell (1993), about the existence of a fourth – radical – world of welfare that includes Canada, New Zealand and the UK. Secondly, the results also support the tenant of welfare regime theory – the existence of a distinctive Scandinavian welfare regime that provides consistently high decommodification across different areas of welfare provision. Conversely though, the results also enhance Kasza's critique of the actual concept of welfare state regimes, as the positioning of these three countries is so varied when a different policy area is considered, that talk of 'regimes' seems to be more out of convenience than empirical reality (Kasza, 2002: 284). Fourthly, the results are open to accusations that health care provision is 'just different' from the rest of the welfare state package in these 'hybrid' countries and that this is not reflective of any broader internal policy inconsistency (Ginsburg, 1992: 28).

Conclusions

The comparison of one policy area through a health care decommodification typology has been somewhat inconclusive and perhaps leaves more questions than answers. It has provided indicative support to Kasza's critique of regime theory by placing a cloud over the consistency and cohesion of welfare state provision within countries and the variation in regime composition across different policy areas. It has also highlighted that welfare states cannot be accurately analysed and classified by income maintenance alone, and that comparative research and the construction of typologies should try to encapsulate as much as possible of the full character of a welfare state regime by examining as many aspects of provision and delivery as possible. However, this has not been a demolition of regime theory, as the health decommodification index, whilst quite critical of Esping-Andersen's regimes, has given support to those regime theorists who argue for more than three regimes. More significantly, this process has shown that it will take more than the development of one specific policy comparison typology to fully address the questions of internal welfare consistency and the validity of regime theory. Further comparative research on other individual policy areas will be needed to fully tackle this issue and operationalise Kasza's critique.

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Appendix: Data and scores

Table A1 Private health expenditure as a percentage of GDP

	1980	Score
Australia	2.7	1
Austria	2.4	1
Belgium	1.1	2
Canada	1.8	2
Denmark	1.0	2
Finland	1.4	2
France	1.6	2
Germany	1.8	2
Ireland	1.6	2
Italy	1.4	2
Japan	1.9	2
Netherlands	2.0	2
New Zealand	0.7	3
Norway	1.1	2
Sweden	0.7	3
Switzerland	2.3	1
UK	0.6	3
USA	5.2	1
Adjusted Mean*	1.5	

Note: *Adjusted for extreme outliers (USA).
Source: OECD (2000: Chapters 3, 5, 7).

Table A2 Private hospital beds as a per centage of total bed stock

	1980	Score
Australia	38.8	1
Austria	27.8	2
Belgium*	18.2	2
Canada	2.0	3
Denmark	0.0	3
Finland	4.9	3
France	35.8	2
Germany	47.6	1
Ireland*	18.2	2
Italy	15.4	2
Japan	67.2	1

Table A2 *Continued*

	1980	Score
Netherlands*	18.2	2
New Zealand**	23.7	2
Norway	4.3	3
Sweden	6.6	2
Switzerland*	18.2	2
UK	1.5	3
USA	78.6	1
Adjusted Mean***	21.8	

Notes: *EU average.
**Unadjusted Index mean.
*** Adjusted for extreme outliers (USA and Denmark).
Sources: OECD (2000: Chapters 3, 5, 7); WHO (2002).

Table A3 Public health care system coverage (percentage of population)

	1980
Australia	100.0
Austria	99.0
Belgium	99.0
Canada	100.0
Denmark	100.0
Finland	100.0
France	99.3
Germany	91.0
Ireland	100.0
Italy	100.0
Japan	100.0
Netherlands	74.6
New Zealand	100.0
Norway	100.0
Sweden	100.0
Switzerland	96.5
UK	100.0
USA	42.0
Mean	94.5

Source: OECD (2000: Chapters 3, 5, 7).

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