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Welfare regime types and global health: an emerging challenge

In recent years we have witnessed an increasing recognition of the political nature of population health. The fields of comparative social epidemiology and health policy research have experienced a surge since 2000. Among the most consistent set of findings brought about by this field of research has been an association between characteristics of the welfare state (that is, the mix of market, state and family in a country’s provision of goods and services) and population health. Most of these studies have followed the seminal work of Esping-Andersen and other authors that are in the tradition of power resources perspective. As a typology, Esping-Andersen classifies welfare states into three major types: social-democratic welfare states characterised by a high degree of “decommodification” (where more goods and services are provided by the state and fewer by the market); corporatist-conservative welfare states that emphasise the role of the family in addition to some state provision of services; and liberal welfare states where social welfare is mostly left to the market. Findings tend to confirm the expectation of better health outcomes (in particular child health outcomes) for social democratic welfare states (for example, Chung and Muntaner). While there have been efforts to expand this typology to east Asian and Mediterranean countries, difficulties emerge when we attempt to characterise the welfare state (or regime) of middle-income and low-income countries, home to the majority of the world’s population. Thus, “northern” welfare state typologies that centre on labour institutions (that is, the social pact between the organised labour, business associations and government) are not adequate, given that the informal economy accounts for a much bigger proportion of the gross national product in these countries. For example, in 2000 in countries such as Azerbaijan, Bolivia, Georgia and Panama, more than 60% of gross national product was produced through the informal sector. In this situation, key indicators such as unionisation rate tap into such a small proportion of the workforce that they are limited in their ability to predict population health status. On the other hand, other labour market characteristics such as child labour (%), working poor (%), employment-to-population ratio and gender-labour force participation gap differ greatly among low and medium income countries. In addition, potential effect modifiers of the labour-market relation to population health such as access to welfare services, including health care, also vary greatly among low and medium income countries.

None the less, a distinctive and important feature of the welfare state of low and middle income countries is the degree of interference from core countries leading to insecurity and instability with limited role of the state, as has been argued from dependency and world-system perspectives and, more recently, from the critics of neoliberal globalisation. Many poor countries are characterised by strong foreign inclusion in the countries’ affairs, inconsistent application of laws and limited role of the state, facing internal and external threats where governments cannot even play a vestigial governance role. As a consequence, the relative stability of welfare state typologies in wealthy countries during the last 50 years might be difficult to find elsewhere.

These observations warrant a creative application of welfare regime typologies onto less-developed countries, or better yet, to develop a new kind of typology. There have been some papers published on this issue. While the welfare state typology for wealthy countries is based on power resources, developmentalist and/or institutionalist models, typologies for developing countries have yet to achieve that level of theoretical sophistication. We believe that this new typology could be based on a power resources approach, but operating in a different political and economical environment (that is, the concept of “incorporating comparison”). Power resources in the government and the market (workers’ organisations that impact workers’ bargaining power) should be analysed. At the same time, what we have witnessed in the last 10 years in some low and middle-income countries requires new models: there has been a growth of “social democratic” welfare states in Latin America despite the seemingly unstoppable globalisation process. We need to model the relation of these states to wealthy countries and search for valid indicators of labour markets, social and health policies. Finally, for all these endeavours, quality comparable individual-level and aggregate-level datasets for the world’s deprived population are urgently needed.

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1 While this paper is not the place to critique these previous achievements in the field, excellent works, conducted by, for example, Dr lan Gough, use outcomes of the social structure then the determinants of those outcomes as explanatory factors. While this is an important contribution to the field of yet-to-develop and comparative public policy, we believe these outcomes of welfare, health care, wellbeing and health should be placed in a sound theoretical context to predict population health status and, more importantly, explain why that happens.

Aphorism of the month

“There is more than one way to skin a cat”

There is more than one way to skin a cat, and in public health one of the most productive lessons is when you realise how much influence you can gain by giving away control to champions who will progress an agenda with more passion, time and energy than could ever be given to it by public health professionals sitting in a bureaucracy with a wide ranging agenda, targets to meet and ‘beasts to feed’.

JRA