The welfare state: a glossary for public health

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ABSTRACT

Recently, there has been a surge in comparative social epidemiology, and a sizeable amount of this has examined the relation between different aspects of the welfare state and population health. Such research draws strongly, though usually implicitly, on welfare state theories and concepts. In this glossary, we explicitly define these concepts in order to enable more researchers, practitioners and policy-makers to engage with and contribute to this exciting and fruitful area of public health research.

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 the socioeconomic position on health,[1–4] 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.[5–15] 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 (for example, 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 (for example, 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 relations between welfare states and health.[15 17]

Therefore, in this glossary, we outline those welfare state-related terms that 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 that 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 the second world war.[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 that 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*).[5–15]

GOLDEN AGE OF WELFARE

The *golden age of welfare* refers to the classic *welfare state*, which was established across Europe shortly after the second world war and lasted until the *crisis of the welfare state* in the 1970s.[23–25] 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 United States and United Kingdom and then across continental Europe).[26–28] The classic *welfare state* was based on two main mechanisms. Firstly, it was founded on a cradle-to-grave public *universalism*, both in terms of coverage of the population and the range of welfare services that were provided. Secondly, in following Keynesian economics to a greater (for example, France) or lesser extent (for example, United Kingdom), 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 (for example, the purchaser/provider split in national health systems such as Sweden and the United Kingdom)[30 31]; entitlement restrictions and increased qualifying conditions (for example, the population coverage of unemployment benefit in the United Kingdom decreased from 90% in 1980 to 77% in 1999; in Germany it decreased from 100% to 84%, and in Norway, from 100% to 79%),[32–34] 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* (for example, in the United Kingdom, 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 (for example, by tying the receipt of benefits to training as is the case in Scandinavia).[34] Although initially limited to the United Kingdom and the United States, 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.[35–37] Reforms of this nature are considered by some to have lessened the influence of the *welfare state* in moderating the relation between market position and health, and has thereby led to increased health inequalities in some countries, most notably the United Kingdom.[4]

WELFARE STATE REGIMES

According to Esping-Andersen,[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*.[5–15]

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*, while 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 relation 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 that looks at the influence of *welfare state* arrangements on women's social roles and the differences between the health of men and women.[43–46]

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

Box 1: Welfare state regimes

Liberal/residual
In the *welfare states* of the liberal regime (United Kingdom, United States, 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 programmes 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* programmes.[16]

Southern
It has been proposed that the southern European *welfare states* (Italy, Greece, Portugal and Spain) comprise a distinctive, southern, *welfare state regime*.[53–55] 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 healthcare 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 argue that the United Kingdom, 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]

Eastern European
According to Esping-Andersen, these countries are clearly the most underdefined and understudied region in terms of *welfare state* development.[35] The formerly Communist countries of Eastern 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]

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 wellbeing," 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 (for example, 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 healthcare services) are granted for everyone on the basis of *(social) citizenship*. This implies that despite prevailing socioeconomic 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 (for example, the National Health Service within the United Kingdom),[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 (that is, 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—for example, 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—for example, child benefit in the United Kingdom), occupational benefits (for example, 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 United States or the working tax credit in the United Kingdom).[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 (for example, Norway, Germany), whereas in others they are provided at a standard flat rate (for example, UK). The relative levels of *social transfer* have important repercussions for income, and therefore health, inequalities within and between countries.[51]

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