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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.[1–3] The fields of comparative social epidemiology and health policy research have experienced a surge since 2000.[3–6] 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.[4 7–12] Most of these studies have followed the seminal work of Esping-Andersen[13] and other authors[14 15] that are in the tradition of power resources perspective.[16] 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[11]).

While there have been efforts to expand this typology to east Asian[17 18] and Mediterranean countries[4 12 19 20] 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.[21] 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.[21 22] 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,[6 23] as has been argued from dependency[24–31] and world-system[32–34] perspectives and, more recently, from the critics of neoliberal globalisation.[35 36] 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.[23 37–39] 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.[i] 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"[40]). 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.[41] 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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REFERENCES

1. **Bambra C,** Fox D, Scott-Samuel A. Towards a politics of health. *Health Promot Int* 2005;**20**:187–93.
2. **Muntaner C,** Lynch JW, Oates GL. The social class determinants of income inequality and social cohesion. *Int J Health Serv* 1999;**29**:699–732.
3. **Muntaner C,** Oates GL, Lynch JW. Social class and social cohesion: a content validity analysis using a nonrecursive structural equation model. *Ann N Y Acad Sci* 1999;**896**:409–13.
4. **Navarro V,** Shi L. The political context of social inequalities and health. *Int J Health Serv* 2001;**31**:1–21.
5. **Franco A,** Alvarez-Dardet C, Ruiz MT. Effect of democracy on health: ecological study. *BMJ* 2004;**329**:1421–3.
6. **Shandra JM,** Nobles J, London B, *et al*. Dependency, democracy, and infant mortality: a quantitative, cross-national analysis of less developed countries. *Soc Sci Med* 2004;**59**:321–33.
7. **Conley DW,** Springer KW. Welfare state and infant mortality. *Am J Soc* 2001;**107**:768–807.
8. **Muntaner C,** Lynch JW, Hillemeier M, *et al*. Economic inequality, working-class power, social capital, and cause-specific mortality in wealthy countries. *Int J Health Serv* 2002;**32**:629–56.
9. **Navarro V,** Muntaner C, Borrell C, *et al*. Politics and health outcomes. *Lancet* 2006;**368**:1033–7.
10. **Chung H,** Muntaner C. Political and welfare state determinants of population health. *Soc Sci Med* 2006;**63**:829–42.

[i] While this paper is not the place to critique these previous achievements in the field, excellent works, conducted by, for example, Dr Ian 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.

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11. **Chung H,** Muntaner C. Welfare state matters: a typological multilevel analysis of wealthy countries. *Health Policy* 2007;**80**:328–39.
12. **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. *Int J Health Serv* 2003;**33**:419–94.
13. **Esping-Andersen G.** *The three worlds of welfare capitalism*. Princeton, NJ: Princeton University Press, 1990.
14. **Huber E,** Stephens JD. *Development and crisis of the welfare state: parties and policies in global markets*. Chicago, IL: University of Chicago Press, 2001.
15. **Castles FG,** Mitchell D. Worlds of welfare and families of nations. In: Castels FG, ed. *Families of nations: public policy in western democracies*. Brookfield, VT: Dartmouth, 1993:93–129.
16. **Korpi W.** *The democratic class struggle*. London: Routledge and Kegan Paul, 1983.
17. **Goodman R,** Peng I. The east Asian welfare states: peripatetic learning, adaptive change and nation-building. In: Esping-Andersen G, ed. *Welfare states in transition*. London: Sage, 1996.
18. **Wong J.** *Healthy democracies: welfare politics in Taiwan and South Korea*. Ithaca, NY: Cornell University Press, 2004.
19. **Moreno L,** Arriba A. *Welfare and decentralization in Spain*. EUI Working Paper EUF. Florence: European University Institute, 1999.
20. **Ferrera M.** The 'southern model' of welfare in social Europe. *J Eur Soc Policy* 1996;**6**:17–37.
21. **Rodgers G.** Realizing decent work in Asia. The 14th Asian Regional meeting. Busan, Repiblic of Korea: International Labor Office (ILO), 2006.
22. **Chung H,** Muntaner C. Country typology of employment relations. In: Benach J, Muntaner C, Santana V, eds. *Employment conditions and health inequalities—final report to the WHO Commission on Social Determinants of Health*. Employment Conditions Knowledge Network (EMCONET), WHO Commission on Social Determinants of Health. Geneva: World Health Organization (in revision)
23. **Sandbrook R,** Eldeman M, Heller P, *et al*. *Social democracy in the global periphery—origins, challenges, prospects*. New York: Cambridge University Press, 2007.
24. **Amin S.** *Accumulation on a world scale*. New York: Monthly Review Press, 1970, 1974.
25. **Arrighi G.** Labour supplies in historical perspective: a study of the proletarianization of the African peasantry in Rhodesia. *J Dev Stud* 1970;**VI**:197–234.
26. **Baran PA.** *The political economy of growth*. New York: Monthly Review Press, 1957.
27. **Cardoso FH.** Dependency and development in Latin America. *New Left Rev* 1972;**74**.
28. **Dos Santos T.** The structure of dependence. *Am Econ Rev* 1970;**60**:231–6.
29. **Frank AG.** *Latin America: underdevelopment or revolution*. New York: Monthly Review Press, 1969.
30. **Warren B.** Imperialism and capitalist industrialization. *New Left Rev* 1973;**81**:3–45.
31. **Valenzuela SJ,** Valenzuela A. Modernization and dependency: alternative perspectives in the study of Latin American underdevelopment. *Comp Polit* 1978;**10**:543–57.
32. **Wallerstein IM.** *The capitalist world-economy*. Cambridge: Cambridge University Press, 1979.
33. **Hopkins TK,** Wallerstein IM. Patterns of development of the modern world-system. *Rev (Fernand Braudel Center)* 1976;**I**:111–45.
34. **Arrighi G.** *The long twentieth century: money, power, and the origins of our times*. New York: Verso, 1994.
35. **Navarro V.** *Neoliberalism, globalization, and inequalities: consequences for health and quality of life*. Amityville, NY: Baywood Publishing Company, 2007.
36. **Labonte RN.** *Fatal indifference: the G8, Africa, and global health*. Ottawa, ON: International Research Development Centre, 2004.
37. **Gough I.** *Welfare regimes: on adopting the framework to developing countries*. Bath: Global Social Policy Programme, Institute for International Policy Analysis, University of Bath, 1999.
38. **Gough I,** Wood G, Barrientos A, *et al*. *Insecurity and welfare regimes in Asia, Africa, and Latin America: social policy in development contexts*. Cambridge, UK: Cambridge University Press, 2004.
39. **Gough I,** McGregor JA, eds. *Wellbeing in developing countries: from theory to research*. Cambridge, UK: Cambridge University Press, 2007.
40. **McMichael P.** Incorporating comparison within a world-system perspective: an alternative comparative method. *Am Soc Rev* 1990;**55**:385–97.
41. **Pan American Health Organization**. *Mission Barrio Adentro: the right to health and social inclusion in Venezuela*. Caracas, Venezuela: Pan American Health Organization, 2006.

Aphorism of the month

''There is more than one way to skin a cat''

There is more than 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''.

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