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Cash Versus Services: 'Worlds of Welfare' and the Decommodification of Cash Benefits and Health Care Services

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Abstract

Welfare state models have focused almost exclusively on the study of cash benefits, and typologies established on this limited basis have been used to generalise about all forms of welfare state provision. This ignores the fact that welfare states are also about the actual delivery of services and/or that countries vary in terms of the relative emphasis that they place upon cash benefits and welfare state services. This article explores the cash and services mix in, and between, welfare states with reference to recent welfare state typologies, most notably Esping-Andersen's decommodification-centred 'worlds of welfare'. It compares the decommodification levels of the main cash benefits with the main area of service provision: health care. The resulting analysis suggests that when services are added into the comparative analysis of welfare state regimes there are five welfare state clusters: Social Democratic, Liberal, Conservative, and sub-groups within both the Liberal and Conservative regimes. The article concludes that, in order to maintain integrity or generalisability, future welfare state typologies need to reflect more adequately the role of services in welfare state provision.

Introduction

Welfare state modelling has long been a preoccupation of comparative social policy (Wilensky and Lebraux, 1958; Titmuss, 1974; Therborn, 1987; Esping-Andersen, 1990; Castles and Mitchell, 1993). Recently, the literature has been dominated by the extensive, and on-going, debate that has surrounded Esping-Andersen's influential analysis of welfare state decommodification and the resulting 'three worlds of welfare' typology (Esping-Andersen, 1990, 1999; Lewis, 1992; Leibfried, 1992; Castles and Mitchell, 1993; Orloff, 1993; Borchost, 1994; Daly, 1994; Kangas, 1994; Ragin, 1994; Ferrera, 1996; Bonoli, 1997; Goodin *et al.*, 1999; Sainsbury, 1994, 1999; Abrahamson, 1999; Pitruzzello, 1999; Arts and Gelissen, 2002; Kasza, 2002). However, what is remarkable about this debate is that, while there are numerous critiques about his range (Leibfried, 1992; Castles and Mitchell, 1993; Ferrera, 1996; Bonoli, 1997), his methodology (Kangas, 1994; Ragin, 1994; Pitruzzello, 1999) and the absence of gender in his typology

(Lewis, 1992; Orloff, 1993; Sainsbury, 1994, 1999; Bambra, 2004a), core procedures have attracted less attention: the analytical focus on cash benefits (Alber, 1995; Abrahamson, 1999; Kautto, 2002; Bambra, 2005) and the creation of regimes that generalise about all forms of social policy provision from this base (Kasza, 2002). This ignores the fact that welfare states are also about the actual delivery of services, such as health, education or social care, and that, far from being internally consistent, countries vary in terms of the relative emphasis that they place upon cash benefits and/or welfare state services (Korpi and Palme, 1998; Castles, 1998; Kautto, 2002). Indeed, welfare services may well account for the greatest differences both between and within countries' welfare state arrangements (Castles, 1998).

Health care is by far the largest area of welfare state service delivery, accounting as it does for an average of 6.6 per cent of GDP in the EU member states (Eurostat, 2001). Although it has been subject to extensive separate comparative analysis (Ham, 1997; Moran, 1999, 2000; Freeman and Moran, 2000; Freeman, 2000), health care has been a significant and notable omission from the broader welfare state literature and particularly the regimes debate (Bambra, 2005). However, as some commentators such as Ginsburg (1992) and Moran (1999) have suggested, it is a strong example of internal welfare state inconsistency in the provision of cash benefits and welfare services. They assert that there is a significant difference between the principles behind the UK's market-orientated cash benefit programmes and its state-dominated health care provision. This discrepancy has also been touched upon in exploratory research by the author on the health care provision of different welfare states (Bambra, 2005). This article takes such analysis further by examining in depth the cash and services mix in, and between, welfare states through the detailed comparison of the decommodification levels of the main cash benefits (pensions, sickness and unemployment) with the main area of service provision: health care.

The article proceeds with a brief outline of Esping-Andersen's 'three worlds of welfare' thesis and the subsequent debate that has emerged around it. It then discusses the concept of decommodification and presents an updated version of Esping-Andersen's cash benefit decommodification index and a similarly constructed health care services index. The results of these two indexes are compared and used to explore the internal and external diversity of countries' cash benefit and welfare service arrangements, and what they mean for the 'three worlds of welfare' and welfare state modelling.

The 'Three Worlds of Welfare'

In *The Three Worlds of Welfare Capitalism*, 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

TABLE 1. The three worlds of welfare.

Liberal	Conservative	Social Democratic
Australia	Austria	Denmark
Canada	Belgium	Finland
Ireland	France	Norway
New Zealand	Germany	Sweden
UK	Italy	
USA	Japan	
	Netherlands	
	Switzerland	

Source: adapted from Esping-Andersen, 1990: 52.

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 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, Conservative and Social Democratic (see Table 1).

In the welfare states of the Liberal regime (UK, USA, Ireland, Canada, Australia), state provision of welfare is minimal, benefits are modest and often attract strict entitlement criteria, and recipients are usually means-tested and stigmatised (Esping-Andersen, 1990: 26). In this model, the dominance of the market is encouraged both passively, by guaranteeing only a minimum, and actively, by subsidising private welfare schemes (ibid: 27). The Liberal welfare state regime thereby minimises the decommodification effects of state welfare and a stark division exists between those, largely the poor, who rely on state aid and those who are able to afford private provision.

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, and therefore Esping-Andersen places it between the low decommodifying Liberal regime and the highly decommodifying Social Democratic regime (1990: 27).

The 'third world of welfare', the Social Democratic (Nordic countries), is the clearly the smallest regime cluster. Its provision is characterised by universal and comparatively generous benefits, 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. 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 'a mix of highly decommodifying and universalistic programs' (Esping-Andersen, 1990: 28).

The 'worlds of welfare' debate

This 'three worlds' typology has sparked a volatile and ongoing debate (Sainsbury, 1999; Goodin *et al.*, 1999; Pitruzzello, 1999; Arts and Gelissen, 2002; Kasza, 2002) and, indeed, much of the burgeoning comparative welfare state literature since 1990 can be seen as a 'settling of accounts' with Esping-Andersen (Pierson, 1998: 175). This debate has been dominated by three principle critiques: the range (Leibfried, 1992; Castles and Mitchell, 1993; Ferrera, 1996; Bonoli, 1997), the methodology (Kangas, 1994; Ragin, 1994; Pitruzzello, 1999) and the omission of gender in the analysis (Lewis, 1992; Orloff, 1993; Borchost, 1994; Daly, 1994, Sainsbury, 1999). Two other critiques of the 'three worlds of welfare' typology, and indeed of welfare state modelling as a whole, have been less prominent: the usefulness of the regimes concept (Kasza, 2002) and the focus on cash benefits (Alber, 1995; Abrahamson, 1999; Kautto, 2002).

The limited range

The range of countries used to construct Esping-Andersen's typology has met with criticism (Leibfried, 1992; Castles and Mitchell, 1993; Ferrera, 1996; Bonoli, 1997). Leibfried (1992), Ferrera (1996) and Bonoli (1997) assert that a distinctive fourth type of welfare state regime is emerging in the countries of the Latin rim of the European Union (Spain, Portugal, Greece and, to a lesser extent, Italy). Leibfried (1992) describes these welfare states as 'rudimentary' because they are characterised by their fragmented system of welfare provision, which consists of diverse cash benefit schemes that range from the meagre to the generous, and a health care system that provides only limited and partial coverage.

Castles and Mitchell (1993) similarly challenge the notion that there are only three worlds of welfare. They cross-classify the same 18 OECD nations used by Esping-Andersen and examine their high and low aggregate expenditure levels, and their high and low degrees of benefit equality. On the basis of this analysis, they claim that a fourth, 'radical', world of welfare should be added to the thesis (Castles and Mitchell, 1993: 107). They argue that the UK, Australia and New Zealand constitute a 'radical' form of welfare state regime, one in which 'the welfare goals of poverty amelioration and income equality are pursued through redistributive instruments rather than by high expenditure levels' (Castles and Mitchell, 1993: 107).

The methodological approach

A more general methodological critique of Esping-Andersen has been developed through the use of cluster analysis. Kangas (1994) performed a cluster analysis of indicators of sickness insurance for the same 18 OECD countries. The

results broadly confirmed Esping-Andersen's 'three worlds' thesis, although the existence of a coherent Liberal regime was questioned: no clear Liberal regime cluster was identified as, while the UK, Ireland, New Zealand and Australia were merged together, the USA and Canada were separate outliers. However, a more comprehensive cluster analysis (Pitruzello, 1999) of all three of Esping-Andersen's decommodification factors (sickness, pensions and unemployment) revealed a number of significant discrepancies. Pitruzzello's research showed significant support for the existence and distinctiveness of welfare regimes, but it challenged the empirical accuracy of the 'three worlds' typology: the antipodes were identified as a distinctive fourth cluster and a sub-group of the corporatist cluster emerged. This suggested that there could be four or five 'worlds of welfare' (Pitruzello, 1999: 23–50).

The gender blind 'worlds of welfare'

This is perhaps the most developed and influential critique of the 'three worlds of welfare' (Esping-Andersen, 1999; Bambra, 2004). Feminist commentators (such as Lewis, 1992; Borchost, 1994; Bussemaker and Kersbergen, 1994; Daly, 1994; Hobson, 1994; Lewis and Ostner, 1995; Sainsbury, 1994, 1999) have argued that Esping-Andersen's 'three worlds of welfare' typology is deeply flawed because it marginalised women in its analysis. Aside from the overt absence of women in Esping-Andersen's analysis, the critique revolves around three other issues: the gender blind concept of decommodification (Daly, 1994; Hobson, 1994; Lewis, 1992), the unawareness of the role of women and the family in the provision of welfare (Borchost, 1994; Bussemaker and Kersbergen, 1994; Daly, 1994), and the lack of consideration given to gender as a form of social stratification (Bussemaker and Kersbergen, 1994). These criticisms have in turn led to both theoretical attempts to 'gender' Esping-Andersen's analysis (for example, Orloff, 1993; O'Connor, 1993), and the construction of alternative welfare state typologies in which gender has been a more overt and centralised part of the analysis (for example, Lewis, 1992; Lewis and Ostner, 1995; Sainsbury, 1999). These alternative typologies, although often flawed themselves (Esping-Andersen, 1999), have undermined confidence in the comprehensiveness and generalisability of the 'three worlds of welfare' thesis, especially in respect to any claims about women, welfare and the family.

The 'illusion' of welfare state regimes

Kasza (2002) has questioned the validity of the regimes concept itself. He argues that the concept of welfare regimes incorporates two flawed assumptions: firstly, that most of the key social policy areas, such as income maintenance (cash benefits), education, health or housing, within a welfare regime will reflect a similar, across the board, approach to welfare provision; 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 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's critique has been shown to be particularly applicable to health care (Bambra, 2005) although it is not without its own limitations (Bambra, 2004a).

The dominance of cash over services

This critique focuses on Esping-Andersen's decision to organise the principle of classification around the study of cash benefit programmes (Alber, 1995; Abrahamson, 1999; Kautto, 2002). The 'three worlds of welfare' typology is largely based on a comparison of the decommodification of three cash benefit programmes: pensions, sickness benefits and unemployment benefits. This ignores the fact that welfare states are also about the actual delivery of services, such as education, health or social services (Kautto, 2002). It is suggested that countries vary in terms of the emphasis that they place upon welfare state services and/or social transfers: the Social Democratic welfare states have high spending on both cash benefits and welfare services; the Conservative countries are more inclined to fund cash benefits than welfare services; and the Liberal countries are divided into two sub-groups, one that is prepared to spend a little more on services and the other that is consistently low in all forms of social expenditure (Castles, 1998). These differences are not adequately reflected in Esping-Andersen's typology.

The later two critiques have been less extensively explored both empirically and within the regimes debate. This article will now examine what they may mean for the 'welfare modeling business' (Abrahamson, 1999) and the construction of typologies through the detailed comparison of a more up-to-date reconstruction of Esping-Andersen's decommodification index with a current index of health care services decommodification.

Decommodification

It is important to acknowledge the importance of going beyond aggregate measures of welfare and so, in comparing the relative role of cash benefits and welfare services, 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). 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 (Esping-Andersen, 1990: 21). In the twentieth century, the introduction of social rights that entailed entitlement to social welfare 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 (1990: 22). However, it must be noted that under capitalism, while the pure commodification of labour is possible, its pure decommodification is not (O'Connor, 1993: 61). The issue is therefore the relative degrees of protection from dependence on the labour market provided by the welfare state in the form of cash benefits. When extended to cover health care provision, decommodification refers 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 (Bambra, 2005).

Decommodification indexes

The cash benefit and health care decommodification indexes are constructed in the same way as Esping-Andersen's original indexes (Esping-Andersen, 1990: 54; Bambra, 2004a, b, 2005) even though this methodology has met with some criticism within the literature (Castles and Mitchell, 1993; Kangas, 1994; Ragin, 1994; Pitruzello, 1999). It is important to replicate Esping-Andersen's method to ensure compatibility and comparability.

Countries

The decommodification indexes include the same 18 OECD countries used by Esping-Andersen in the 1980s: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK and the USA.

Data and sources

The data used to compile the indexes relate to the years 1997, 1998 and 1999. The majority of data that have been used are of an international nature (such as that published by the Eurostat, UN or the OECD). The international nature of these data has helped to minimise any cross-national differences over their measurement, definition and collection. These measures should ensure data comparability both between countries and between Esping-Andersen's original index and the ones in this article.

Measures

The cash benefits decommodification index is based on the assessment of a number of factors relating to the three main cash benefit programmes: pensions,

TABLE 2. Cash benefit index measures.

Pensions	Unemployment	Sickness
(1) Minimum pension benefits for a standard production worker earning average wages	(1) Pre-taxation benefit replacement rates for a standard worker during the first 26 weeks of unemployment	(1) Pre-taxation benefit replacement rates for a standard worker during the first 26 weeks of sickness
(2) Standard pension benefits for a normal worker	(2) Number of weeks employment prior to qualification for benefit	(2) Number of weeks employment prior to qualification for benefit
(3) Contribution period required for a minimum pension[1]	(3) Number of waiting days before benefits are paid	(3) Number of waiting days before benefits are paid
(4) Individual's share of pension financing	(4) Usual number of weeks in which benefit can be maintained	(4) Number of weeks in which benefit can be maintained
(5) Percentage of the (relevant) population covered by the program	(5) Percentage of the (relevant) population covered by the program	(5) Percentage of the (relevant) population covered by the program

Note: [1]Esping-Andersen uses the contribution period for the standard pension as his measurement. However, due to data availability problems, the contribution period for the minimum pension benefit has been used here.
Source: based on Esping-Andersen, 1990: 54.

TABLE 3. Health care index measures.

Health care
(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

Source: Based on Bambra, 2005.

unemployment and sickness (see Table 2) (Esping-Andersen, 1990; Bambra, 2004b).

The health care services decommodification index has been constructed through the assessment of three measures (see Table 3).

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 (Bambra, 2005).

TABLE 4. Degrees of decommodification.

	Cash benefits		Health care services	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Finland	34.6	7.5	50	7.3
Norway	34.0	7.4	60	8.8
Sweden	34.7	7.5	50	7.3
Germany	27.7	6.0	27.6	4.0
Netherlands	28.0	6.1	28.8	4.2
Switzerland	29.7	6.4	30	4.4
Australia	13.5	2.9	20	2.9
Japan	18.3	4.0	30	4.4
USA	14.0	3.0	9	1.3
Ireland	22.1	4.8	40	5.8
New Zealand	11.5	2.5	40	5.8
UK	15.4	3.3	60	8.8
Austria	31.1	6.7	39.6	5.8
Belgium	31.9	6.9	39.6	5.8
Canada	27.9	6.0	40	5.8
Denmark	29.0	6.3	40	5.8
France	31.5	6.8	39.8	5.8
Italy	27.6	6.0	40	5.8
Total	462.5	100	684.4	100

Method

The process of scoring for each of the three constituent schemes in the cash benefits decommodification index (pensions, unemployment and sickness) replicates that used by Esping-Andersen (1990: 50–54) and is by way of the numerical description of the relationship of an individual country's score to the mean (and standard deviation) for four (one–four) of the five factors that make up each index. On the basis of the values on each of these four indicators for the 18 nations, a score of one for low decommodification, two for medium and three 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). These individual factor scores are then added together to get a final score which is then weighted by factor five – the percentage of the (relevant) population covered by the programme. In line with Esping-Andersen's approach and his concern for the importance of replacement rates, these variables have been given extra weight (multiplied by the factor of two) in each index. Finally, the results of these three separate indexes – pension, unemployment and sickness – have been combined to give the overall cash benefits decommodification score for each country (see Tables 5, 6, and 7) (Bambra, 2004b).

The process of scoring in the health care decommodification index is identical: the numerical description of the relationship of an individual country's

TABLE 5. Pension decommodification index data (1998/9).

	Minimum pension benefits for a standard production worker earning average wages (expressed as a replacement rate %)	Standard pension benefits for a normal worker (expressed as a replacement rate %)	Contribution period required for a minimum pension (in years) (i)	Individual share of pension financing (%)	Labour market coverage (take-up rate %) (ii)	Index Score (iii)
Finland	–	60	R	1.5	91	(16.4)
Norway	34	79.8	R	2.6	79	13.4
Sweden	23.4	70	R	0	87	13.9
Germany	0	35.3	5	6.8	84	7.6
Netherlands	–	–	R	3.4	70	(10.5)
Switzerland	19.5	–	–	4.2	76	(9.9)
Australia	20.6	25.6	R	–	50	(6.5)
Japan	1.3	18.4	25	6.2	76	4.6
USA	–	24.9	10	5.2	87	(7.0)
Ireland	30.3	46.4	3	2.0	82	9.8
New Zealand	25.8	35.8	R	–	50	(6.5)
UK	5	19.6	10	3.3	77	5.4
Austria	33.9	–	1.5	3.7	89	(15.1)
Belgium	41.9	63	R	4.4	84	14.3
Canada	13.4	29.3	R	2.9	81	10.5
Denmark	2	27.6	R	2.7	83	9.1
France	40.1	–	–	0.8	85	(15.3)
Italy	20	–	5	2.9	89	(10.7)
Mean	22.23	41.21	8.50	3.29	79	10.4

Notes: (i) R = residency requirement.

(ii) The statistical sources merely use phrases such as 'all employees' or 'all residents' so these are approximate coverage rates that are based on the fact that the largest group that is most often excluded from coverage are part-time workers (Eurostat, 1997b). Means-tested programmes receive a score of only 50% for population covered. This scoring is intended to reflect the lack of rights associated with means-tested programmes (Esping-Andersen, 1990: 54).

(iii) Figures in brackets are where there are missing values for some factors and the index figure is therefore based on the averaging out of available factor data.

Sources: Clasen, 1994: 65–6; Stahlberg, 1997: 85; Eurostat, 1998: Figures 3.1, p. 51; 3.2, p. 52; Tables 3.1, p. 54–8; 3.2, p. 61–6; Eurostat, 2000: Tables 3, p. 163–97; 6, p. 289–367; 10, p. 533–91; OECD, 1988: Tables 1.1, p. 16; 2.2, p. 21; Chart 2.1, p. 19; OECD, 1995a: 13–30; OECD, 1995b: 222; OECD, 1996: Tables 1.3, p. 19; 2.7, p. 40; 2.8, p. 41; OECD, 1997: 17–29; US Census Bureau, 1999: 339–56; 378–94).

TABLE 6. Unemployment decommodification index data (1998/9).

	Benefit replacement rates (%) for a standard worker during the first 26 weeks	Number of weeks of employment prior to qualification for benefit	Number of waiting days before benefit is paid	Usual number of weeks in which benefit can be maintained	(Relevant) population covered by the programme (take-up rate %) (iii)	Index Score (iv)
Finland	53	43	7	71	91	9.1
Norway	62	52	3	156	79	10.3
Sweden	80	26	5	43	87	10.4
Germany	37	52	0	52 (ii)	84	9.2
Netherlands	70	26	0	26	70	9.1
Switzerland	70	–	–	–	76	–
Australia	–	–	–	–	50	–
Japan	37	–	–	–	76	(7.6)
USA	50	–	–	–	87	(7.0)
Ireland						
New Zealand	26	–	–	–	50	(2.5)
UK	16	104	3	26	77	4.6
Austria	22	52	0	20 (i)	89	7.1
Belgium	46	45	0	unlimited	84	10.0
Canada	55	–	–	–	81	(8.1)
Denmark	60	52	0	52	83	9.1
France	57	16	8	60	85	8.5
Italy	30	104	0	26	89	6.2
Mean	46.71	50.92	2.42	49.00	79	7.8

Notes: (i) For every 52 weeks past employment, an employee is entitled to 20 weeks unemployment benefit.

(ii) Levels vary with contribution record e.g. 6 months contributions provide an entitlement to 12 months unemployment benefit. The minimum 6 months has been used in this case.

(iii) The statistical sources merely use phrases such as 'all employees' or 'all residents' so these are approximate coverage rates that are based on the fact that the largest group that is most often excluded from coverage are part-time workers (Eurostat, 1997b). Means-tested programmes receive a score of only 50% for population covered. This scoring is intended to reflect the lack of rights associated with means-tested programmes (Esping-Andersen, 1990: 54).

(iv) Figures in brackets are where there are missing values for some factors and the index figure is therefore based on the averaging out of available factor data.

(Sources: Eurostat, 1997b: 31–40; 45–55; 57–67; 91–8; 103–12; 115–25; 137–46; 147–56; 169–79; 181–93; 195–203; 213–20; Eurostat, 1998: Figures 3.1, p. 51; 3.2, p. 52; Tables 3.1, p. 54–8; 3.2, p. 61–6; Eurostat, 2000: Tables 3, p. 163–97; 6, p. 289–367; 10, p. 533–91; OECD, 1995b: 222; OECD, 2000: Vol. 3, Table 1, p. 137).

TABLE 7. Sickness decommodification index data (1998/9).

	Benefit replacement rates (%) for a standard worker during the first 26 weeks of sickness	Number of weeks of employment prior to qualification for benefit	Number of waiting days before benefit is paid	Usual number of weeks in which benefit can be maintained	(Relevant) population covered by the programme (take-up rate %) (iii)	Index Score (iv)
Finland	70	0	9	43	91	9.1
Norway	100	2	0	52	79	10.3
Sweden	80	0	1	no limit	87	10.4
Germany	77(ii)	0	0	78	84	10.9
Netherlands	70	0	0	52	70	8.4
Switzerland	–	–	–	–	76	–
Australia	26.7	–	–	–	50	(2.5)
Japan	–	–	–	–	76	–
USA	0	n/a	n/a	n/a	0	0
Ireland	26.6	39	3	52	82	5.7
New Zealand	38.3	–	–	–	50	(2.5)
UK	17.5	26	3	52	77	5.4
Austria	57.7(i)	2	3	52	89	8.9
Belgium	60	26	1	52	84	7.6
Canada	–	–	–	–	81	–
Denmark	100	8	0	52	83	10.8
France	50	26	3	52	85	7.7
Italy	100	0	3	26	89	10.7
Mean	62.4	10.75	2.17	51.18	79	7.9

Notes: (i) 6 weeks benefit at a replacement rate of 50%, remaining weeks at 60%.
(ii) 6 weeks benefit at a replacement rate of 100%, remaining weeks at 70%.
(iii) The statistical sources merely use phrases such as 'all employees' or 'all residents' so these are approximate coverage rates that are based on the fact that the largest group that is most often excluded from coverage are part-time workers (Eurostat, 1997b). Means-tested programmes receive a score of only 50% for population covered. This scoring is intended to reflect the lack of rights associated with means-tested programmes (Esping-Andersen, 1990: 54).
(iv) Figures in brackets are where there are missing values for some factors and the index figure is therefore based on the averaging out of available factor data.
Sources: Eurostat, 1998: Figures 3.1, p. 51; 3.2, p. 52; Tables 3.1, p. 54–8; 3.2, p. 61–6; Eurostat, 2000: Tables 3, p. 163–97; 6, p. 289–367; 10, p. 533–91; OECD, 1988: Tables 1.1, p. 16; 2.2, p. 21; Chart 2.1, p. 19; OECD, 1995a: 13–30; OECD, 1995b: 222; OECD, 1996: Tables 1.3, p. 19; 2.7, p. 40; 2.8, p. 41; OECD, 1997: 17–29).

TABLE 8. Health care services index data (1998).

	Private health expenditure (% of GDP)	Private hospital beds (% of total bed stock)	Public health care system coverage (% of population)	Index score
Finland	1.7	4.7	100.0	50
Norway	1.3	0.32	100.0	60
Sweden	1.5	20.3	100.0	50
Germany	2.3	50.1	92.2	27.6
Netherlands	2.4	22.4(ii)	72.0	28.8
Switzerland	3.1	22.4(ii)	100.0	30
Australia	2.6	54.9	100.0	20
Japan	1.6	71.2	100.0	30
USA	7.5	81.6	45.0	9
Ireland	1.7	22.4(ii)	100.0	40
New Zealand	1.8	25.8(iii)	100.0	40
UK	1.0	3.7	100.0	60
Austria	2.2	29.7	99.0	39.6
Belgium	0.9	61.8	99.0	39.6
Canada	2.9	0.8	100.0	40
Denmark	2.7	0.0	100.0	40
France	2.2	35.4	99.5	39.8
Italy	2.3	24.0	100.0	40
Mean	2.0(i)	22.3(iv)	95.2	38.0

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

score to the mean (and standard deviation) for two (one and two) of the three factors that make up the index. These individual factor scores are then added together to get a final score which is then weighted by factor three – the percentage 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 (see Table 8). Coverage is used as a weight because, as with the use of coverage/take-up rate in the cash benefit decommodification index, it is the most important issue for public health care systems. A health care system that has a high proportion of public funding and provision but that only provides service access to a small proportion of the population cannot be regarded as highly decommodifying.

Results

In order to meaningfully compare the results of the two different indexes, the different index scales have been equalised (see Table 4). The individual country score for each index has been translated into a percentage of the total decommodification score produced by that index. So, for example, France's

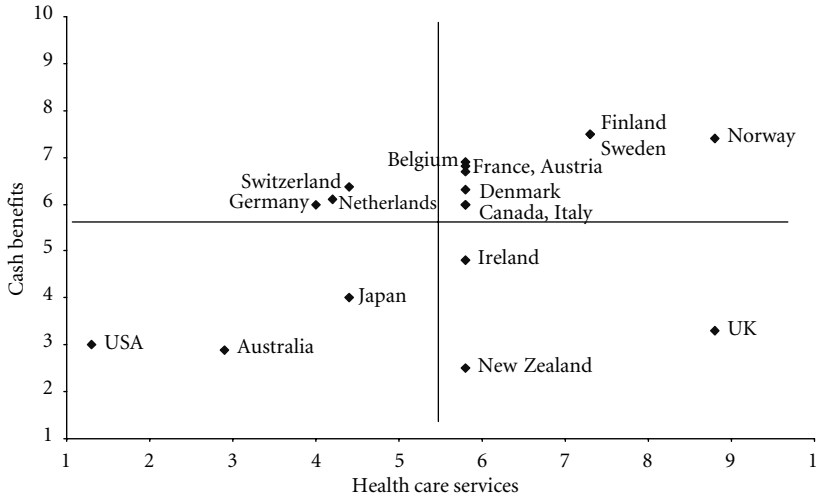

Figure 1. Decommodification of cash benefits compared with health care services.

unadjusted cash benefits decommodification score was 31.5 and its health care services score was 39.8, but when adjusted and expressed as a percentage of the total decommodification in the respective index they are 6.8 and 5.8.

The cash benefits index shows a wide variety of scores from 2.9 (Australia) to 7.5 (Sweden). The health services index has a similar spread with scores ranging from the outlier score of 1.4 (USA) to 9.0 (Norway and UK). Some countries have very similar scores in both the cash benefits and health care services indexes: Australia scores 2.9 for cash benefit decommodification and 2.9 for health care services decommodification, Canada and Italy both score 6.0 for cash benefits and 5.8 for health care services. Other countries have very divergent scores with either cash benefits or health care services exhibiting higher decommodification levels. For example, Germany scores 6.0 for cash benefits but only 4.0 for health care services, whereas the UK scores only 3.3 for cash benefits and 8.8 for health care services.

These differences in internal decommodification scores can be more adequately explored by plotting the countries' cash benefit decommodification scores against their health care services decommodification score (Figure 1).

Figure 1 also demonstrates the inter-relationships of the countries and how they divide into five groupings based on their above/below average scores (depicted by the cross-hairs). The first group of countries (Finland, Norway and Sweden) score highly in both cash benefit and health service decommodification. The second group of countries (Germany, Switzerland and the Netherlands) score more highly on cash benefits decommodification; and the third group of countries (Ireland, New Zealand and the UK) score more highly on health care service decommodification. The fourth group of countries (Australia, Japan and

the USA) have low scores for both cash benefit and health service decommodification. The decommodification scores of the fifth group of countries (Austria, Belgium, Canada, Denmark, France and Italy) are very close to the index average for both cash benefits and health care services.

Discussion

These results suggest that there is significant internal diversity within the welfare state arrangements of some countries. Ireland, New Zealand and the UK all have higher decommodification scores for health care services than would be expected from their 'Liberal' regime cash benefits score. Similarly, Germany, the Netherlands and Switzerland score lower for health care than would be expected from their 'Conservative' cash benefit score. This indicates that certain welfare states do vary internally in terms of the emphasis that they place upon different types of social provision, with some focusing on cash benefits and others on welfare services (Korpi and Palme, 1998; Castles, 1998; Kautto, 2002). Therefore it cannot be assumed that a country's approach to one aspect of welfare state provision can be generalised to explain all others (Kasza, 2002: 284; Bambra, 2005). However, the results also show that some countries are more consistent in their approach to welfare state provision. Most notably, the Social Democratic countries score similarly above average for cash benefits and health care services, and the USA, Japan and Australia score similarly low.

More significantly, the comparison of the two indexes also raises more questions about the differences between countries and the number of different types of welfare state regimes (Leibfried, 1992; Castles and Mitchell, 1993; Kangas, 1994; Ragin, 1994; Ferrera, 1996; Bonoli, 1997; Pitruzzello, 1999). The comparison suggests that there are five possible welfare state groupings when cash benefits and health care services are compared with one another. The composition of the high scoring group – Finland, Norway, Sweden – reflects a tenant of welfare regime theory: the existence of a distinctive Scandinavian regime that provides consistently high levels of provision (Titmuss, 1974; Therborn, 1987; Esping-Andersen, 1990; Leibfried, 1992; Castles and Mitchell, 1993; Ferrera, 1996; Bonoli, 1997; Korpi and Palme, 1998; Esping-Andersen, 1999; Sainsbury, 1999; Korpi, 2000). The position of countries such as Germany, Switzerland and the Netherlands, to some extent reflects comments that the Conservative regime countries tend to place more emphasis upon cash benefits in their welfare mix (Castles, 1998), and the division of the Liberal regime countries – Australia, Canada, Ireland, New Zealand, the UK and the USA – into two distinctive groups, one that is consistently low in welfare decommodification and one that is more service orientated, gives credence to claims about a fourth – radical (for example, Castles and Mitchell, 1993) – world of welfare that is a sub-type of the Liberal regime.

The identification of two additional groupings, sub-regimes, within the Conservative and Liberal 'worlds of welfare', suggests that welfare services in these countries are based upon different, politically structured, principles from their respective cash benefit programmes. The Conservative sub-group countries – Germany, Switzerland and the Netherlands – all score more highly on cash benefits than welfare services, and the Liberal sub-group countries – Ireland, New Zealand and the UK – all score more highly on services than cash benefits. The imbalance within these countries' welfare mix perhaps reflects Kasza's assertions that welfare policy making is politically inconsistent and disjointed. He asserts that the cumulative nature of welfare policy making – the diverse histories of different policy areas, the variation of policy actors across different fields, differences in the policy-making process and the influence on policy of foreign welfare models – all undermine the likelihood of a coherent approach to welfare provision within a country (Kasza, 2002). These differences would be particularly apparent in a comparison of such diverse aspects of welfare policy as cash benefits and health care services which, as Kasza points out, aside from a common normative role in satisfying human need, have very little in common with one another. However, it should also be noted that, in contrast to Kasza's overall conclusion that welfare states are too internally inconsistent to validate the regimes concept, the majority of the 18 countries analysed in this article have shown consistency in their cash benefits and welfare services mix. It is perhaps therefore the case that certain countries, such as Sweden on the one hand or the USA on the other, are more cohesive and uniform in their welfare state construction and the political philosophy behind it, than others, such as the UK or Germany, that demonstrate a more fragmented approach to cash benefits and welfare services.

Conclusions

This examination of the cash versus services mix of welfare state arrangements – through the comparison of decommodification levels of cash benefit programmes and health care services – has highlighted the importance of welfare services. In demonstrating significant internal inconsistency within some countries' provision of cash benefits and health care services, this article has reinforced and expanded the findings of earlier research on health care decommodification (Bambra, 2005) as well as Kasza's more general critique of the 'illusory' nature of welfare state regimes (Kasza, 2002). More significantly, though, the inclusion of services has suggested that welfare states divide into not three (Esping-Andersen, 1990, 1999), or four (Castles and Mitchell, 1993; Korpi and Palme, 1998; Korpi, 2000; Bambra, 2005), but five different clusters (Pitzurello, 1999): (1) Finland, Norway, Sweden; (2) Germany, Netherlands, Switzerland; (3) Australia, Japan, USA; (4) Ireland, New Zealand, UK; (5) Austria, Belgium, Canada, Denmark, France and Italy. However, it is unclear as to whether the extra two clusters should be considered as distinctive regime types or merely as subgroups of the

Liberal and Conservative 'worlds of welfare', perhaps reflecting different political attitudes to the roles of cash benefits or welfare services. Further research into the five clusters, perhaps incorporating other services such as social care or education, is needed before firmer conclusions can be drawn.

Welfare states cannot be accurately analysed and classified by cash benefit programmes alone. Welfare state modelling, and the construction of typologies, needs to encapsulate the full diversity of a welfare state, or welfare state regime, by examining as many aspects of provision and service delivery as possible. Services are a vital element of welfare state provision and they need to be more adequately reflected in comparative research. It will be more fruitful if future attempts at welfare state modelling combined both cash and services (Daly and Lewis, 2000).

References

Abrahamson, P. (1999), 'The welfare modeling business', *Social Policy and Administration*, 33: 4, 394–415.

Alber, J. (1995), 'A framework for the comparative study of social services', *Journal of European Social Policy*, 5: 2, 131–49.

Arts, W. and Gelissen, J. (2002), 'Three worlds of welfare or more?', *Journal of European Social Policy*, 12: 2, 137–58.

Bambra, C. (2004a), 'The worlds of welfare: illusory and gender-blind?', *Social Policy and Society*, 3: 3, 201–11.

Bambra, C. (2004b), 'Weathering the storm: convergence, divergence and the robustness of the worlds of welfare', *Social Policy Journal*, 3: 3, 3–23.

Bambra, C. (2005), 'Worlds of welfare and the health care discrepancy', *Social Policy and Society*, 4: 1.

Bonoli, G. (1997), 'Classifying welfare states: a two-dimension approach', *Journal of Social Policy*, 26: 3, 351–72.

Borchost, A. (1994), 'Welfare state regimes, women's interests and the EC', in D. Sainsbury (ed.), *Gendering Welfare States*, London: Sage.

Bussemaker, J. and Kersbergen, K. (1994), 'Gender and the welfare state: some theoretical reflections', in D. Sainsbury (ed.), *Gendering Welfare States*, London: Sage.

Casties, F. G. (1998), *Comparative Public Policy: Patterns of Post-War Transformation*, Cheltenham: Edward Elgar.

Castles, F. G. and Mitchell, D. (1993), 'Worlds of welfare and families of nations', in F. G. Castles (ed.), *Families of Nations: Patterns of Public Policy in Western Democracies*, Aldershot: Dartmouth.

Clasen, J. (1994), 'Social security – the core of the German employment centred social state?', in J. Clasen and R. Freeman (eds.), *Social Policy in Germany*, London: Harvester Wheatsheaf.

Daly, M. (1994), 'Comparing welfare states: towards a gender friendly approach', in D. Sainsbury (ed.), *Gendering Welfare States*, London: Sage.

Daly, M. and Lewis, J. (2000), 'The concept of social care and the analysis of contemporary welfare states', *British Journal of Sociology*, 51: 2, 281–98.

Esping-Andersen, G. (1987), 'Citizenship and socialism: decommodification and solidarity in the welfare state', in G. Esping-Andersen and L. Rainwater (eds.), *Stagnation and Renewal in Social Policy: The Rise and Fall of Policy Regimes*, London: Sharpe.

Esping-Andersen, G. (1990), *The Three Worlds of Welfare Capitalism*, London: Polity.

Esping-Andersen, G. (1999), *Social Foundations of Post-Industrial Economies*, Oxford: Oxford University Press.

Eurostat (1997), *Your Social Security Rights when Moving within the EU*, Luxemburg: Eurostat.
Eurostat (1998), *Social Protection for Dependency in Old Age in the 15 EU States and Norway*, Luxemburg: Eurostat.
Eurostat (2000), *Social Protection in the EU Member States*, Luxembourg: Eurostat.
Eurostat (2001), *Budgetary Challenges Posed by Ageing Populations: The Impact on Public Spending on Pensions, Health and Long-Term Care*, Luxembourg: Eurostat.
Ferrera, M. (1996), 'The southern model of welfare in social Europe', *Journal of European Social Policy*, 6: 1, 17–37.
Freeman, R. (2000), *The Politics of Health in Europe*, Manchester: Manchester University Press.
Freeman, R. and Moran, M. (2000), 'Reforming health care in Europe', in M. Ferrera and M. Rhodes (eds.), *Recasting European Welfare States*, London: Frank Cass.
Ginsburg, N. (1992), *Divisions of Welfare: A Critical Introduction to Comparative Social Policy*, London: Sage.
Goodin, R., Headley, B., Muffels, R. and Dirvin, H. (1999), *The Real Worlds of Welfare Capitalism*, Cambridge: Cambridge University Press.
Ham, C. (ed.) (1997), *The Politics of Healthcare Reform: Learning from International Experience*, Buckingham: Open University Press.
Hobson, B. (1994), 'Solo mothers, social policy regimes, and the logics of gender', in D. Sainsbury (ed.), *Gendering Welfare States*, London: Sage.
Kangas, O. (1994), 'The politics of social security: on regressions, qualitative comparisons and cluster analysis', in T. Janoski and A. Hicks (eds.), *The Comparative Political Economy of the Welfare State*, Cambridge: Cambridge University Press.
Kasza, G. (2002), 'The illusion of welfare regimes', *Journal of Social Policy*, 31: 2, 271–87.
Kautto, M. (2002), 'Investing in services in West European welfare states', *Journal of European Social Policy*, 12: 1, 53–65.
Korpi, W. and Palme, J. (1998), 'The paradox of redistribution and the strategy of equality: welfare state institutions, inequality and poverty in the Western countries', *American Sociological Review*, 63: 662–87.
Korpi, W. (2000), 'Faces of inequality: gender, class and patterns of inequalities in different types of welfare states', *Social Politics*, 7: 2, 127–91.
Leibfried, S. (1992), 'Towards a European welfare state', in Z. Ferge and J. E. Kolberg (eds.), *Social Policy in a Changing Europe*, Frankfurt: Campus-Verlag.
Lewis, J. (1992), 'Gender and the development of welfare regimes', *Journal of European Social Policy*, 2: 3, 195–211.
Lewis, J. and Ostner, I. (1995), 'Gender and the evolution of European social policy', in S. Leibfreid and P. Pierson (eds.), *European Social Policy*, Washington, DC: Brookings Institute.
Moran, M. (1999), *Governing the Healthcare State: A Comparative Study of the UK, the USA and Germany*, Manchester: Manchester University Press.
Moran, M. (2000), 'Understanding the welfare state: the case of health care', *British Journal of Politics and International Relations*, 2: 2, 135–60.
O'Connor, J. S. (1993), 'Gendering welfare state regimes', *Current Sociology*, 44: 2, 48–77.
OECD (1988), *Reforming Public Pensions*, Paris: OECD.
OECD (1995a), *Private Pensions in OECD Countries: Canada*, Paris: OECD.
OECD (1995b), *Employment Outlook*, Paris: OECD.
OECD (1996), *Labour Market and Older Workers*, Paris: OECD.
OECD (1997), *Private Pensions in OECD Countries: Australia*, Paris: OECD.
OECD (2000), *Labour Force Statistics*, Paris: OECD.
Orloff, A. (1993), 'Gender and the social rights of citizenship: the comparative analysis of gender relations and welfare states', *American Sociological Review*, 58: 303–28.
Pierson, C. (1998), *Beyond the Welfare State*, London: Polity.
Pitruzello, S. (1999), *Decommodification and the Worlds of Welfare Capitalism: A Cluster Analysis*, Florence: European University Institute.

Ragin, C. (1994), 'A qualitative comparative analysis of pension systems', in T. Janoski and A. Hicks (eds.), *The Comparative Political Economy of the Welfare State*, Cambridge: Cambridge University Press.
Sainsbury, D. (1994), *Gendering Welfare States*, London: Sage.
Sainsbury, D. (1999), 'Gender, policy regimes and politics', in D. Sainsbury (ed.), *Gender and Welfare State Regimes*, Oxford: Oxford University Press.
Stahlberg, A. (1997), 'Sweden: on the way from standard to basic security?', in J. Classen (ed.), *Social Insurance in Europe*, Bristol: Policy.
Therborn, G. (1987), 'Welfare state and capitalist markets', *Acta Sociologica*, 30.
Titmuss, R. (1974), *Social Policy*, London: Allen & Unwin.
United States Census Bureau (1999), *Statistical Abstract of the USA*, Washington: US Census Bureau.
Wilensky, H. and Lebaux, C. (1958), *Industrial Society and Social Welfare*, New York: Russell.
World Health Organisation (WHO) (2002), 'Health for all database', accessed 1 March 2004 at http://www.curo.who.int/.