The political economy of health promotion: part 2, national provision of the prerequisites of health†

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SUMMARY

Governmental authorities of wealthy developed nations differ in their professed commitments and activity related to the provision of the prerequisites of health through public policy action. Part 1 of this article showed how nations identified as social democratic or liberal welfare states were those where such commitments are present. Nations identified as conservative or Latin welfare states were less likely to express such commitments. However, the political economy literature suggests that despite their expressed commitments to provision of the prerequisites of health, liberal welfare states fare rather poorly in implementing these commitments. The opposite is seen for conservative welfare states. Social democratic welfare states show both commitments and public policy consistent with this objective. Part 2 of this article documents the extent to which public policy activity that provides the prerequisites of health through public policy action differs among varying welfare state regimes. Despite extensive rhetoric concerning the prerequisites of health, nations identified as liberal welfare states do a rather poor job of meeting these goals and show evidence of adverse health outcomes. In contrast, social democratic welfare states fare better in providing such prerequisites—consistent with their rhetorical statements—with better health outcomes. Interestingly, conservative—and to a lesser extent Latin—nations fare well in providing the prerequisites of health despite their lack of explicit commitment to such concepts. Findings suggest that health promoters have to concern themselves with the broad strokes of public policymaking whether or not these policy activities are identified as health promotion activities.

Key words: government programmes; health policy; public health

INTRODUCTION

Part 1 of this article reported how wealthy developed nations differ in their expressed commitments to provision of the prerequisites of health (i.e. peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity) (Raphael, 2013). The term ‘explicit health promotion commitments’ was used to refer to rhetorical commitments found in policy documents and statements of governing authorities that endorse provision of the prerequisites of health through the implementation of healthy public policy (i.e. complementary approaches including legislation, fiscal measures, taxation and organisational change) (World Health Organisation, 1986). Canada was identified as a nation where such explicit commitments are provided within a health promotion framework, while France was identified as a nation where these commitments are lacking. It was also noted that despite its commitments, Canada does a poor job of providing the prerequisites of health, while France, though lacking these commitments, fares rather better. It was suggested that the political economy—or the form of a nation’s welfare state—was related not only to the
presence or absence of such commitments, but also to their implementation in public policy.

Three national examples of each of the four forms of the welfare state were identified and evidence presented as to whether their governing authorities express commitments to provide the prerequisites of health within a health promotion framework (Saint-Arnaud and Bernard, 2003). Nations identified as social democratic welfare states (e.g. Finland, Sweden and Norway) that emphasize universal welfare rights and provide generous benefits and entitlements were found to express such commitments. Liberal welfare states (e.g. Australia, Canada and England), which provide modest benefits and assist citizens only when the market fails to meet their most basic needs were also found to express these commitments. Interestingly, conservative welfare states (e.g. Belgium, France and Germany), which also offer generous benefits through social insurance plans, were not found to make such commitments. This was also the case for the Latin welfare states (e.g. Greece, Italy and Spain) which are seen as less supportive family-oriented versions of the conservative welfare regime.

It was suggested that it may be the form of the welfare state and not the professed commitments of governing authorities to provision of the prerequisites of health that is the primary determinant of whether public policy activity provides the prerequisites of health. The term ‘implicit health promotion activity’ was used to refer to public policy efforts that provide the prerequisites of health but do so in the absence of explicit commitments. In the implicit health promotion activity case, health promotion statements are less salient—or even absent—but public policy frameworks are consistent with the health promotion principle of providing the prerequisites of health. Table 1 outlines the proposed intersections of commitments to provision of the prerequisites of health, extent of public policy action that provides these prerequisites and the form of a nation’s welfare state.

Part 2 of this article examines the extent to which the rhetorical commitments of social democratic and liberal welfare states are translated into public policy activity. At the same time, it examines the activities of the conservative and Latin welfare states, which lack these rhetorical commitments. The nations included in this analysis expands beyond the 12 exemplar nations to include the 21 Western members of the Organisation for Economic Co-operation and Development (OECD) that have been reliably identified as fitting into the four welfare regimes—social democratic, conservative, Latin and liberal—by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003). The data are taken from OECD databases and reports.

The OECD prepares these indicators in close consultation with member nation authorities (Organisation for Economic Co-operation and Development, 2008a; Organisation for Economic Co-operation and Development, 2009a). In situations where the data collection and computation processes may not be strictly comparable, the OECD undertakes its own computations. For example with regard to the calculation of life expectancy, the OECD (OECD, 2009a) comments:

Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country’s life expectancy estimates by a fraction of a year. Life expectancy at birth for the total population is calculated by the OECD Secretariat for all countries, using the unweighted average of life expectancy of men and women (p. 16).

Therefore, any inaccuracies in comparable data reporting will probably be minor and since the

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<th>Table 1: Proposed intersections of commitments and policies towards provision of the prerequisites of health with nations' form of the welfare state</th>
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<tr>
<td><strong>Explicit commitment to provision of the prerequisites of health within a health promotion framework</strong></td>
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<td><strong>Yes</strong></td>
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<td><strong>Public policy efforts towards provision of the prerequisites of health</strong></td>
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<td>Social democratic welfare states</td>
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*a* Judgments of explicit and implicit commitments and policies based on published reviews of national profiles.

*b* Welfare state designation based on Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).
OECD has been producing these reports for decades—with virtually no major corrections being introduced over that time—it can be assumed that these indicators are valid. Also, these indicators are consistent with what is known about the public policy approaches and health outcomes of these nations that is found in the political economy and population health literature. Though England has been identified and discussed in Part 1 as a liberal welfare state, the OECD only provides indicators for the UK as a whole. These data are used in this article.

The public policy areas examined are those that have been identified in the literature as strong determinants of whether a society provides its citizenry with the prerequisites of health: (i) processes that enable the negotiation of collective employment agreements that provide a modicum of employee rights, security and benefits; (ii) governmental and institutional activity that distributes national wealth in the form of benefits, supports and services; (iii) governmental and institutional activity that promotes employment training and reduces unemployment (active labour policy); and (iv) governmental and institutional activity that meets the early child development needs of citizens (Innocenti Research Centre, 2005, 2007, 2008; Commission on Social Determinants of Health, 2008; Organisation for Economic Co-operation and Development, 2008a, 2011).

These public policy areas are especially important in relation to the prerequisites of health because they serve to manage the extent of income inequality and poverty within a jurisdiction. Indicators of income inequality and poverty rates are therefore also examined. Not surprisingly, these public policy approaches have been related to health outcomes by international health and social development organisations such as UNICEF (Innocenti Research Centre, 2005, 2007) and the World Health Organisation through its numerous reports of the Commission on Social Determinants of Health (World Health Organisation, 2008b).

The article therefore looks at some important population health outcomes that could be expected to relate to these public policy differences.

If the provision of the prerequisites of health is shaped by the form of the welfare state—which may or may not be accompanied by rhetorical commitments to such provision—two important questions arise for health promoters:

(i) What are the implications of a nation’s placement in the welfare state regime typology for health promoters concerned with provision of the prerequisites of health through public policy action?

(ii) What are the implications for health promoters’ efforts of the presence or absence of explicit health promotion commitments to provision of the prerequisites of health by governmental authorities through public policy action?

PUBLIC POLICY AND THE PROVISION OF THE PREREQUISITES OF HEALTH

Public policies that provide the prerequisites of health take various forms. The focus in this article is on broad macro-level public policy approaches that involve the distribution of economic and social resources rather than specific programmes directed at those perceived as being in need. One public policy area that has been somewhat neglected by the health promotion literature is that of the rights of citizens to collective employment bargaining, sometimes through the facilitation of workplace unionization, at other times through employer provision of employment security and benefits (Organisation for Economic Co-operation and Development, 2004).

This neglect is puzzling as the extent of collective bargaining agreements has been associated with lower rates of poverty and income inequality, and generally stronger forms of the welfare state (Swank, 2005) all of which have been found to be strongly related to health outcomes (Navarro et al., 2004; Innocenti Research Centre, 2005, 2007). Working under a collective agreement is certainly related to higher wages and employment security as well as receipt of benefits in Canada (Jackson, 2010). The first indicator of interest examined here is the percentage of workers covered by collective agreements. Closely related to this is the percentage of workers who are members of unions. This latter indicator provides a measure of power balance between workers and owners and managers of the economy (Olsen, 2010).

Another important public policy area is that of investing in the population through provision of benefits, supports and services that provide the prerequisites of health (Raphael and Bryant, 2006). These investments involve
spending on universal programmes that benefit virtually all citizens such as early child education and care, employment training, pensions and provision of community-based health care and social services (Hemrijck, 2002). At other times this spending involves provision of adequate benefits to those who are unable to work because of illness, disability or unemployment due to the loss of jobs in a changing economy (Organisation for Economic Co-operation and Development, 2003, 2011). These expenditures are especially important with regard to families with children (Esping-Andersen, 2002a; Innocenti Research Centre, 2005, 2007).

Indicators of these public expenditures that provide governmental support for active labour policy and spending for early childhood education and care are examined. Key outcomes associated with all of these prerequisite-providing policies should be the extent of income inequality and poverty, and these indicators are also examined. Finally, health outcomes that may be related to these public policy activities such as life expectancy, infant mortality rates and suicide and homicide rates are looked at.

A shorthand way of thinking about these potential indicator differences is that nations that provide the prerequisites of health do so by ensuring that the meeting of citizens’ needs of income, housing and employment, health and social services does not fall by the wayside against the needs of those who manage the economy. This usually involves State intervention in the operation of the market economy (Esping-Andersen, 1985, 2009). Such a balance is not only seen in the Scandinavian social democratic welfare states but also the Continental conservative and Latin welfare states (Saint-Arnaud and Bernard, 2003; Pontusson, 2005). Such a balance is rather less apparent among English-speaking liberal welfare states (Alesina and Glaeser, 2004; Micklewright, 2004; Pontusson, 2005; Olsen, 2010).

PUBLIC POLICY INDICATORS OF THE PROVISION OF THE PREREQUISITES OF HEALTH

Public policies establish the environment within which employees negotiate their wages and benefits. Collective agreements provide means by which wages and benefits are negotiated by employees as a group rather than individuals being left to do so on their own. The extent of such agreements is an important determinant of national-level unemployment and sickness benefits and pension levels (Swank, 2005).

Collective agreement coverage

Figures 1 and 2 show collective agreement coverage and union density for the 21 OECD nations classified by welfare state type for 2008 (Venn, 2009; Organisation for Economic Co-operation and Development, 2010b). Included within these are the 12 exemplar nations studied in Part 1 of this article. The key feature is that both the social democratic and conservative welfare state workforces—including all the exemplar nations—have high proportions of their workforces covered by collective bargaining agreements. The workforces of the Latin states have somewhat lower levels and the liberal welfare states—with the exception of Australia whose rate is not very high—have very low collective agreement coverage.

The high collective bargaining coverage of the social democratic welfare states is associated with very high union densities, which is not the case for the conservative and Latin welfare states. Labour unions have traditionally had strong influence upon public policy in the social democratic welfare state nations, which has been related to the growth of the Scandinavian welfare state (Esping-Andersen, 1985). Conservative and Latin welfare states have relatively low union density, but their high collective agreement rates are a result of employers belonging to associations that negotiate collective contracts that are voluntarily applied to their workforce (Organisation for Economic Co-operation and Development, 2004). There are also administrative extension of agreements in these nations that cover all employers in a given sector (Organisation for Economic Co-operation and Development, 2004). In liberal political economies such agreements do not exist. As a result, the low rates of union membership lead to small proportions of their workforces operating under collective agreements.

Overall public expenditures

Another means by which the prerequisites of health are provided involve welfare state interventions in the form of collecting revenues
through taxation and fees and using them to provide universal or targeted benefits to the population. In essence, these transfers offer direct support to individuals as well as provide social infrastructure. Bryant points out that these benefits include cash payments and in-kind benefits to families, public pensions, training as part of active labour market policies, and provision of early childhood, education, recreational and public health care spending (Bryant, 2010). Together these public expenditure indicators provide an overall measure of the extent of the welfare state. Evidence exists that the extent of expenditures is a potent predictor of the extent to which citizens are provided with numerous prerequisites of health such as education, food, shelter and health and social services (Innocenti Research Centre, 2005; Organisation for Economic Co-operation and Development, 2011). These public expenditures also include cash transfers that redistribute income and wealth from top to lower earners, thereby reducing poverty.

Figure 3 provides the percentage of the gross domestic product that these 21 OECD nations, classified by welfare state type, allocate in the form of overall public expenditures. Of particular note are the distinctively low levels of spending of all six liberal welfare states. (In light of the significant spending reductions announced by the newly elected government of the UK, we can expect the UK to shortly join the other liberal nations on many of these indicators.) The top seven spending nations represent a mixture of social democratic and conservative welfare states. Latin nations are mid-range in their spending. It is important to note that the slight liberal outlier, the UK, has recently elected a governing coalition that has promised spending cuts in most government departments.

**Fig. 1:** Collective agreement coverage, selected OECD nations by welfare state type, 2008. Source: Venn (Venn, 2009). Note: Block white identifies social democratic welfare states; grey identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003). Figures for Ireland are from Ireland: Industrial Relations Profile, EIRO, 2009, available at http://www.eurofound.europa.eu/eiro/country/ireland.pdf.
of between 25 and 40% (Helm et al., 2010). If this comes to pass, the UK will fall even more firmly within the liberal spending cluster.

**Income inequality and poverty**

Income inequality and poverty are excellent indicators of the extent to which national public policy manages the distributional effects of market economies. In every OECD nation except Switzerland, governmental intervention in the form of taxes and benefits significantly reduce the extent of income inequality and poverty (Rainwater and Smeeding, 2003; Smeeding, 2004, 2005; Innocenti Research Centre, 2005).

Figure 4 provides Gini coefficients for income inequality of the 21 nations classified by welfare state type (Organisation for Economic Co-operation and Development, 2008a). Here the higher levels of income inequality of the liberal and Latin nations are rather apparent. The social democratic welfare state nations show distinctively low levels of income inequality, but similar to findings for the public expenditure findings, the best performing seven nations are a mixture of social democratic and conservative nations.

Figure 5 shows a similar picture for the extent of poverty among families with children (Organisation for Economic Co-operation and Development, 2008a). Here the social democratic welfare state nations lead with lower levels, and the liberal and Latin nations show the highest poverty levels. The rather good performance of liberal welfare states UK and Australia is noted, with questions raised as to whether the newly elected UK government’s deep austerity programme will influence this nation’s standing for the worse.

**Active labour policy**

Active labour policy consists of a variety of programmes that nations use to eradicate high and persistent unemployment and reduce low pay
Fig. 3: Total public expenditures as percentage of GDP, selected OECD nations, 2007. Source: OECD Social Expenditure Database, http://stats.oecd.org/Index.aspx?datasetcode=SOCX_AGG. Note: Block white identifies social democratic welfare states; grey identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).

Fig. 4: Gini coefficients of income inequality, selected OECD countries, by welfare state type, mid-2000s. Source: Organisation for Economic Cooperation and Development (Organisation for Economic Cooperation and Development, 2008a). Note: Block white identifies social democratic welfare states; grey shading identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).
and poverty among the working age population (Organisation for Economic Co-operation and Development, 2004). These may include formal classroom training, on-the-job training programmes, subsidies to private-sector employers, job-search assistance, training programmes for youth and direct job creation for adult workers. Figure 6 documents the liberal welfare state nations’ rather frugal support of active labour policy. Here Ireland is an exception among the liberal welfare states. The Latin welfare state nations are in the mid- to low-range though Greece is a very low spender. Similar to previous findings, the top seven nations represent a mixture of social democratic and conservative welfare states.

### Early child development

Early child development is an important prerequisite of health since the beginnings of life have strong effects upon health (Irwin et al., 2007). These experiences are both immediate—shaping young children’s health—and long-lasting—providing the foundations for either good or poor health during later periods of the life span. The quality of early child development is shaped by the economic and social resources available to parents and the extent to which governments provide support and a range of benefits to families and their children (Esping-Andersen, 2002a; Innocenti Research Centre, 2008).

Figure 7 provides an indicator of public spending on childcare and early education (Organisation for Economic Co-operation and Development, 2010a). There is a clear clustering of four liberal welfare state nations on the lower end of support for early child development. All four social democratic welfare state nations are among the top seven spenders as are France and Belgium. The UK and New Zealand break away from the liberal cluster of lower spending nations. Greece, with Canada, is an exceptionally low spender.
Fig. 6: Public spending on active labour policy as a percentage of GDP, selected OECD nations, by welfare state type, 2007. Source: OECD (OECD, 2008b). Note: Block white identifies social democratic welfare states; grey identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).

Fig. 7: Public expenditure on childcare and early education services as percentage of GDP, selected OECD nations, by welfare state, 2005. Source: OECD (2010c). Note: Block white identifies social democratic welfare states; grey identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).
HEALTH INDICATORS

Four global indicators of health outcomes are examined here: life expectancy, infant mortality and homicide and suicide rates.

Life expectancy
Life expectancy is seen by the OECD as a reflection of living standards, lifestyle and education, and access to quality health services (Organisation for Economic Co-operation and Development, 2009). No obvious pattern is seen between average life expectancy and welfare state type (Figure 8). In fact, the top seven spots are represented equally by each of the four welfare types. Further examination that looked at improvements in life expectancy and welfare state type (Figure 8). In fact, the top seven spots are represented equally by each of the four welfare types. Further examination that looked at improvements in life expectancy from the period 1960–2006 found that three of four social democratic welfare state nations were in the lower one-third of nations’ increases, and three of four Latin welfare state nations were in the top one-third of nations in life expectancy increases (see Supplementary data, Appendix S1 and S2 as online supplementary information).

Infant mortality
The OECD sees the rate at which babies <1 year of age die as an indicator of how economic and social conditions affect the health of mothers and newborns (Organisation for Economic Co-operation and Development, 2009). Quite a different picture is seen for infant mortality rates than is the case for life expectancy (Figure 9; Organisation for Economic Co-operation and Development, 2009). Five of the six liberal welfare states are found in the lowest performing seven nations, while the predominant members of the top seven nations are social democratic welfare states. This is of some significance as infant mortality is usually seen as especially important: ‘The infant mortality rate is a particularly sensitive indicator that, internationally, well reflects the overall human development, health and education status of women and the strength of the public health environment of a nation’ (Butler-Jones, 2008, p. 23).

Suicides and homicides
The OECD states: ‘The intentional killing of oneself is evidence not only of personal breakdown, but also of a deterioration of the social context in which an individual lives’ ((Organisation for Economic Co-operation and Development, 2009a), p. 27). Yet, outside of the low rates of the Latin nations, no clear pattern is seen for the other welfare types (Figure 10).
Fig. 9: Infant mortality rates, selected OECD nations by welfare state type, 2007. Source: OECD (OECD, 2010d). Note: Block white identifies social democratic welfare states; grey shading identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).

Fig. 10: Suicide rates among selected OECD nations, 2006. Source: OECD (OECD, 2009c). Note: Block white identifies social democratic welfare states; grey shading identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).
but this is not the case for homicide rates (Figure 11; Organisation for Economic Co-operation and Development, 2009b). There, four of the six liberal welfare states are located among the worse seven performing nations. Wilkinson and Pickett among others have commented on how strongly the homicide rate correlated with the extent of income inequality (Kaplan et al., 1996; Daly et al., 2001; Wilkinson and Pickett, 2009).

EXPLICIT/IMPLICIT HEALTH PROMOTION FOCUS AND THE PROVISION OF THE PREREQUISITES OF HEALTH

Table 2 summarizes standings of the 12 exemplary nations—differing in their form of welfare state—on policy indicators related to provision of the prerequisites of health as well as the selected health outcomes. A simple metric was used to generate this table. Based on their score for each indicator, a nation is identified as falling into either the top seven, middle seven or bottom seven of the 21 OECD nations included in these analyses.

How do the nations that profess commitments to provision of the prerequisites of health fare in achieving these commitments? It was proposed earlier (see Table 1) that social democratic welfare state nations’ rhetorical commitments to the provision of the prerequisites of health would be realized in public policy activity. As shown in Table 2, the exemplary social democratic nations of Finland, Norway and Sweden are found to be in the top or middle one-third of the 21 OECD nations examined for every indicator of public expenditure. Finland and Sweden are placed high in the top one-third in terms of employment bargaining and union density indicators as well as income inequality and poverty. Norway falls in the top or middle with regard to these indicators. Not surprisingly, virtually all the social democratic nations’ rankings in income inequality and poverty are among the top performing nations.

![Homicide rates among selected OECD nations, 2005. Source: OECD (OECD, 2009d). Note: Block white identifies social democratic welfare states; grey identifies conservative welfare states; dotted indicates Latin welfare states; and black indicates liberal welfare states as described by Saint-Arnaud and Bernard (Saint-Arnaud and Bernard, 2003).](https://academic.oup.com/heapro/article-abstract/28/1/112/572553/15-March-2019)
<table>
<thead>
<tr>
<th>Welfare state type</th>
<th>Public commitments through expenditures as % of GDP</th>
<th>Key social determinants</th>
<th>Health and social outcomes</th>
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<tr>
<td></td>
<td>Public spending</td>
<td>Active labour</td>
<td>Early childhood</td>
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<td><strong>Social democratic</strong></td>
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<td>Norway</td>
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<td><strong>Conservative</strong></td>
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<td><strong>Latin</strong></td>
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<td>Greece</td>
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The liberal welfare state exemplar nations’ ratings, despite their professed commitments to provision of the perquisites of health, are predominantly among the bottom one-third—with all others being in the middle one-third—of OECD nations in their public expenditures. Canada is in the bottom one-third of nations on every indicator of public expenditure, income inequality and poverty, and collective agreement coverage. Its middle placement with regard to union density belies a rather low score. Australia and the UK show similar placement. All income inequality rankings are among the bottom one-third performing nations, and poverty rates are either in the bottom or middle category of the 21 nations examined.

What is very interesting is the very good performance of the conservative nations on many of these indicators. Outside of Germany’s bottom group placement for expenditures on early childhood, every conservative nation’s public expenditure scores was among the top one-third of OECD nations. Union density provided a more mixed picture, but collective agreement rates were all either among the top or middle nations. Except for Germany’s bottom placement for poverty rates, all income inequality and poverty rates were among the middle performing nations. Conservative nations’ lack of explicit health promotion commitments do not seem to interfere with their public policy approaches towards provision of the prerequisites of health.

Latin nations’ scores show a very mixed pattern that suggests performance midway between the conservative and liberal nations. The predominant placement for the governmental expenditures, and bargaining and unionization measures, and inequality and poverty rates is in the middle group of nations, followed by the bottom placement, and then the top placement.

In terms of health indicators, the most obvious differences are seen in infant mortality where the previously found excellence of the social democratic and the lesser performance of the liberal nations are apparent. The Latin nations show a clear superiority in their lower suicide rates. Homicide rates appear to reflect effects associated with income inequality and the public policies that spawn such inequality such as reduced social infrastructure, the income gap between rich and poor, and general economic insecurity (Daly et al., 2001; Wilkinson and Pickett, 2009).

**IMPLICATIONS FOR HEALTH PROMOTERS**

Earlier the following key questions were raised:

(i) What are the implications of a nation’s placement in the welfare state regime typology for health promoters concerned with provision of the prerequisites of health through public policy activity?

(ii) What are the implications for health promoters’ efforts of the presence or absence of explicit health promotion commitments to provision of the prerequisites of health by governmental authorities through public policy action?

This analysis suggests that health promoters must pay attention—regardless of the presence or absence of explicit governmental commitments to provision of the prerequisites of health—to how a wide range of public policies provide these prerequisites. Placing one’s health promotion activities within the context of the form of the welfare state of one’s nation seems to be essential as this placement provides a context for understanding both the present situation and the means of improving upon it. There are both general implications of these findings for health promoters as well as specific implications for health promoters in each of the various forms of the welfare state.

**General implications**

It must be recognized that health promotion is an explicitly political activity in that it is concerned with the distribution of economic and social resources amongst the population and the political forces that shape this distribution. This point has repeatedly been made in the health promotion literature but has had little penetration into health promotion consciousness (Signal, 1998; Seedhouse, 2003; Bambra et al., 2005; Sparks, 2009).

More recently, the Commission on the Social Determinants of Health stated: ‘The unequal distribution of health-damaging experiences is not in any sense a “natural” phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic
arrangements, and bad politics’ [(World Health Organisation, 2008a), p. 1]. What exactly is involved in the recognition—and then response to—the conclusion that the provision of the prerequisites of health is a political activity?

Since the broad strokes of public policy appear to be of vital importance with regard to the provision of the prerequisites of health, health promoters must be prepared to become actively engaged within the political realm in which public policy is made (Signal, 1998; Bambra et al., 2005; Raphael, 2006). They must also consider the political and economic structures as well as the ideological discourses that so often accompany these societal structures (Navarro et al., 2004; Grabb, 2007; Raphael, 2009). Recognizing the ideological tendencies of these differing welfare states should help to identify the supports and barriers to implementing public policy that provides the prerequisites of health.

To accomplish this, health promoters must become familiar with the political economy of health and the disciplines of public policy analysis and change. Luckily, there are accessible volumes that provide a comprehensive introduction to the political economy of health (Navarro, 2002, 2007; Navarro and Muntaner, 2004), public policy analysis and change (Brooks and Miljan, 2003; Bryant, 2009) and the political economy of the welfare state (Esping-Andersen, 1990, 1999, 2009). The numerous reports of the Commission on Social Determinants of Health also provide important information on the public policy components of prerequisites of health-related issues (World Health Organisation, 2008b). Some of the implications of some of these issues for health promoters have also been outlined (Raphael and Bryant, 2006; Raphael et al., 2008).

Another key concept that should become the basis of health promotion understanding and activity is that of de-commodification. According to Eikemo and Bambra: ‘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’ (p. 4). Generally, social democratic welfare state nations have exhibited the greatest extent of de-commodification, the liberal nations the least. Conservative and Latin states usually show an intermediate level (Esping-Andersen, 1990, 1999; Saint-Arnaud and Bernard, 2003).

To illustrate the concept’s relevance to these prerequisites of health issues, Bambra created two indices of de-commodification and examined scores of 18 OECD nations for 1998 (Bambra, 2005): cash benefits (e.g. replacement rates during illness and unemployment, duration of unemployment illness and benefits, pension generosity, etc.) and health-care services (e.g. public health-care coverage and public versus private expenditure). The social democratic welfare state nations of Finland, Norway and Sweden, together with the conservative welfare state nations of Belgium, France and Austria were clearly placed in the quadrant reflecting a greater extent of de-commodification for both cash benefits and health-care services. Interestingly, Italy, Denmark and Canada just made it into this quadrant as well.

The USA and Australia were in the quadrant representing a lesser extent of de-commodification for both domains, while Ireland, the UK and New Zealand were low for cash benefits but high for health-care services. Switzerland, Germany and the Netherlands were high for cash benefits but low for health-care services.

A more recent report and re-conceptualization by Menahem creates an index of de-commodified security that is more closely related to the concept of provision of the prerequisites of health (Menahem, 2010). He assessed the approaches of five northern European nations (primarily social democratic), seven continental nations (all conservative), three southern nations (all Latin) and seven liberal nations towards provision of three types of income: (i) replacement income for the risks of old age, unemployment, sickness and disability plus survivors’ pensions; (ii) reimbursements and benefits in kind: costs of health care, family allowances, housing benefits; and (iii) allowances and benefits in kind paid as part of measures to combat social exclusion (income support, etc.).

These are the rankings of the nations included in the study reported in this article from highest to lowest on his de-commodified security index: Sweden, Finland, Denmark, Netherlands, France, Germany, Austria, Luxembourg, Norway, Switzerland, Belgium, Italy, Canada, UK, Greece, Spain, Australia, Ireland and USA. The social democratic welfare states score highest, followed by the conservative, Latin and liberal welfare states. His findings demonstrate how differing welfare states provide differing degrees of security—
which clearly has close proximity to the concept of the provision of the prerequisites of health to citizens.

The findings reported here therefore are consistent with earlier ones: ‘Recent public health research has found a positive relation between levels of decommodification, income inequality and measures of population health such as infant mortality’ [(Bambra, 2007; Eikemo and Bambra, 2008), p. 4]. This appears to be so since the extent of de-commodification appears to represent an ideological commitment on the part of nations to provide citizens with the opportunity to live a good quality of life if they are unable—for a variety of reasons—to earn a market wage. This commitment appears to not only support the health of those most likely to experience adverse living conditions and poor health, the unemployed, infirm and disabled, but it also appears to have a general health enhancing effect across the population serving to reduce social and health-inequalities by enhancing the quality and distribution of the social determinants of health across the population (Graham, 2004, 2007).

Another concept that health promoters need to become familiar with is how these welfare state traditions come about. Since these differences—found to be related to the prerequisites of health—are rather consistent over time (Swank, 2005), it is important to understand the historical traditions that lead nations to adopt these different approaches to public policy. Esping-Anderson and others identify various factors that shape the form of the welfare state (Esping-Andersen, 1990; Olsen, 2002; Alesina and Glaeser, 2004). These are the extent and form of class mobilization, the extent and form of political coalition building, and the extent to which the middle classes have formed loyalties to societal institutions such as the welfare state or the economic marketplace.

Social democratic nations are marked by their history of coalition building between labour and other sectors that have led to the development of universalist public policies that have secured the loyalties of the middle class (Esping-Andersen, 1985, 1990). Conservative—and in its weaker version, the Latin welfare state—garnered the loyalties of the middle class by establishing hierarchical social insurance schemes that provide a variety of protections against risk through work-based contributions directed towards the primary—usually male—wage earner. Over time, the social democratic, conservative and Latin welfare state nations have achieved high collective bargaining rates that reflect union strength in the social democratic nations and cohesion building or corporatist tendencies in the conservative and Latin nations.

Liberal nations with their modest benefits targeted to the least well-off—representing the weakness of labour movements and the dominance of business interests—have been less able to secure the loyalties of the middle class to the welfare state. Instead the middle classes have given their loyalties to the economic marketplace (Esping-Andersen, 1985, 1990). Key to shifting these loyalties appears to be convincing the middle classes of the benefits that would accrue from public policies that provide the prerequisites of health.

There are two key public policy directions that would shift this landscape. The process of achieving collective employment bargaining could be facilitated either through the strengthening of trade unions or the introduction of cross-sectoral bargaining. The first course of action is more common in the social democratic nations, while the second is common among the conservative and Latin nations. Either—or both—would serve to strengthen the influence of workers against the interests of the business sector. This is especially important in the liberal nations which appear to have the weakest commitments to providing the prerequisites of health.

The second policy direction would be to distribute risk across the population through introduction of universalist health and social assistance schemes that minimize individual susceptibility to adverse life-course and accidental events (Shaw et al., 1999; Esping-Andersen, 2002b; Seedhouse, 2003). In Canada, the middle classes have come to support the Medicare system since it is perceived as reducing risks associated with disease and illness. Canadians—like those in other liberal welfare state nations—need to be provided with other examples of universal programmes that would reduce risk and build loyalty to welfare state policies rather than loyalties to the health-threatening insecurities associated with the economic marketplace (Leys, 2001; Macarov, 2003). Provision of universal affordable childcare would be one such policy—Pharmacare would be another—that would gain the support
of the middle class for an expanded welfare state (Lexchin, 2001; Friendly and Prentice, 2009).

SPECIFIC IMPLICATIONS FOR HEALTH PROMOTERS WITHIN THE FOUR WELFARE STATE TYPES

The recommendations presented in the previous sections are relevant to all health promoters. But there are specific issues that arise with regard to each form of the welfare state.

Liberal welfare states
Liberal nations are distinguished by their explicit commitments to provision of the prerequisites of health with rather little seen in terms of policy indicators of the implementation of these commitments. In Canada, this state has been associated with rather significant efforts towards research related to the prerequisites of health at the same time that objective conditions deteriorate (Bryant et al., 2011). In this case, knowledge creation, dissemination, translation and exchange of prerequisites of health-related information appear to be necessary but insufficient means of creating prerequisites of health-providing public policy.

Instead, it is especially important for health promoters in liberal welfare states to acknowledge the structural barriers—related to the operation of the political and economic system—to having governmental authorities implement public policy that provides the prerequisites of health. These include the strong influence of the business sector, governmental adherence to this sector’s wishes for deregulation and a weakened welfare state, and the ideological discourse that justifies these imbalances of power (Grabb, 2007; Raphael et al., 2008; Langille, 2009). There is strong evidence that provision of the prerequisites of health by governmental authorities are much more likely—even in liberal welfare state nations—when nations are governed by parties such as Labour in Australia, New Zealand and the UK, and the New Democratic Party in Canada. The USA has no significant left party presence, suggesting that the future concerning the prerequisites of health is rather bleak.

It is in these liberal nations therefore that profound shifts in political power are required and such action probably requires the support of the labour movement and social democratic parties of the left (Navarro and Shi, 2001; Brady, 2003, 2009; Navarro et al., 2004). Brady outlines the components of such a strategy: build citizen coalitions, shift values and ideology of the public, and strengthen political parties of the left and ensure their achieving power (Brady, 2009).

Social democratic welfare states
In the social democratic welfare states, the health promotion rhetoric regarding the provision of the prerequisites of health overlay longstanding public policy traditions that emphasize the provision of citizens’ economic and social security. These nations have economic and political structures—and an accompanying ideological discourse—that support the health promotion principle of governmental provision of the prerequisites of health through public policy activity.

The task for health promoters in these social democratic welfare states is to continually reinforce the value of these policy efforts through continuing research, education and public policy advocacy. The key message that needs to be repeated was inadvertently presented in the California Newsreel documentary Unnatural Causes: Is Inequality Making us Sick (Adelman, 2008) where a Swedish union leader—in relation to the rather bleak situation of unemployed factory workers in the USA—comments: ‘When you look around, you realize how lucky you are to live in Sweden’.

By ensuring citizen understanding of the value of strong de-commodifying public policy, there will be continuing public support of the kinds of public policy that has been demonstrated to be of such value in promoting health. The social democratic welfare states are assisted in this task since there is a long tradition of such public policy. As Swank points out: ‘Generally, welfare states are path dependent in that the cognitive and political consequences of past policy choices constrain and otherwise shape efforts at programmatic and systemic welfare retrenchment’ (Swank, 2005, p. 187).

Conservative and Latin welfare states
The conservative—and to a lesser extent Latin—nations also implement public policy that
supports the prerequisites of health but do so with rather less explicit recognition of their health promotion implications. Suggestions that these nations lag behind in health promotion activities are not entirely accurate. They may not explicitly emphasize health promotion concepts such as the provision of the prerequisites of health but actually do a rather good job of implementing them. Political ideology and politics—rather than health promotion rhetoric—therefore play a key role in conservative and Latin welfare states’ provision of the prerequisites of health. Such policy efforts need to be supported in the conservative welfare states and strengthened in the Latin welfare states. Some of the suggestions provided for the liberal welfare states about supporting the labour movement and parties of the left would apply here as well.

In addition, one of the themes running through the national case reports for the conservative and Latin welfare states presented in Part 1 of this article was that governmental authorities’ lack of recognition of the health-related aspects of their public policy making resulted in a failure to track and evaluate any health-inequalities reducing effects of such policy (Raphael, 2013). One task then for health promoters is to impress upon policy makers that their efforts to promote economic and social security of their citizens—associated with these welfare states’ emphasis upon societal solidarity and reduction of risk (Saint-Arnaud and Bernard, 2003)—may also have beneficial health effects. Directing attention to other nations’ activities and carrying out public education as to the importance of the prerequisites of health would assist in this task.

CONCLUSION

Findings indicate that it is important to consider what nations actually do in the realm of public policy—rather than say in their statements and documents—about providing the prerequisites of health. The liberal welfare states of Australia, Canada and England are usually held out as leaders in health promotion. But despite their governmental authorities’ commitments to the provision of the prerequisites of health, these nations actually have a rather poor track record of providing the prerequisites of health through public policy action when compared with numerous other OECD nations, many of which have given little explicit attention to this health promotion concept. The main task in these liberal welfare states is to build social and political movements that will demand prerequisites of health-supporting public policy.

The social democratic welfare states of Finland, Norway and Sweden have no such problems: their commitments to the provision of the prerequisites of health are manifested in their public policy activity. Their performance on a variety of prerequisites of health-related indicators shows the positive effects of their commitments. The value of such commitments and the public policy that supports these commitments needs to be reinforced through research, education and public policy advocacy.

In contrast, the conservative—and to a similar though lesser extent Latin—nations provide the prerequisites of health in the relative absence of explicit health promotion-related commitments. The problem here is that the lack of recognition of the health-related aspects of their public policy directions leads to a neglect of evaluation of the health-related effects of these public policy directions. The task here is to educate policy makers and the public as to the health-related components of public policy and strengthen the link between health prerequisites and public policy activity.

The analyses presented here also suggest that public policy indicators of the provision of the prerequisites of health and health outcomes should be included in health promotion analyses and advocacy. Especially important policy indicators include collective agreement coverage and union density and state commitment to the provision of the prerequisites of health through the collection of revenues and expenditures that benefit the citizenry. Also of importance is the collection of data on income inequality and poverty rates as these are potent predictors of a variety of health-related outcomes.

It is important to collect data on intermediate impact policy indicators such as income inequality and poverty rates because some of the health effects of commitments to provide the prerequisites of health may take time to materialize. Infant mortality rate however, is a sensitive indicator of population health and was closely linked to these policy indicators. Life expectancy—less linked to these policy indicators—may take time to reflect shifts in the provision of the prerequisites of health. A similar disparity is seen in the case of suicide...
and homicide rates. In this analysis, homicide rates are more closely linked to policy indicators and welfare state type than suicide rates. Wilkinson suggests that this is the case because of a process of self-comparison whereby income inequality becomes converted into feelings of anger, shame and envy (Wilkinson, 1996).

These intermediate public policy indicators therefore may provide a good road map to future health developments. At the very minimum they provide an excellent snapshot as to income distribution effects of public policy directions. Even in the absence of an immediate link to health outcomes, provision of these identified prerequisites of health can be seen as important in itself, though it would be expected that their presence will eventually come to have health-related effects.

One conclusion seems obvious. Despite professed commitments to provision of the prerequisites of health, liberal welfare states show the worse indicators of public policy that provides these prerequisites. They also show evidence of adverse infant mortality outcomes. This is the case even though these nations are known for their health promotion declarations. The poor performance of liberal welfare states suggests the hypothesis that the emergence and high rhetorical profile of health promotion activity in these nations reflect an attempt to transcend some of the ideological barriers of the liberal welfare state rather than actually implement public policy that provides the prerequisite of health.

In all types of welfare states then, health promoters must recognize the political components to the provision of the prerequisites of health and assure that their focus is on effecting public policy that supports health. This may require greater emphasis on analysing and influencing macro-level public policy than may presently be the case. Such activity has not been a traditional area of health promotion activity—especially in the liberal political economies—but needs to be explicitly identified as an essential area of health promotion activity.

The means by which such activity can be carried out have been described (Bryant et al., 2007; Bryant, 2010). These involve both knowledge transmission and advocacy in those jurisdictions where there appears to be State receptivity to these concepts, such as the social democratic and conservative welfare states. In the liberal welfare states—and perhaps the Latin welfare states—where receptivity to these principles is less, building of broad social and political movements in support of prerequisites of health-related public policy may be necessary (Raphael, 2009). An essential component of such activity would be educating the public as to the vital role that prerequisites of health—and their public policy antecedents—play in shaping their health (Raphael, 2006).

SUPPLEMENTARY DATA

Supplementary data are available at HEAPRO online.

REFERENCES


Syracuse University, Syracuse, New York.


