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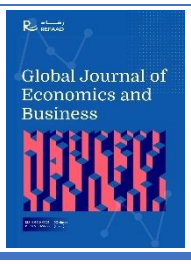

Conceptual Framework Depicting the Interrelationship between A Country's Welfare Regime and its Health System

إطار مفاهيمي يصور العلاقة المتبادلة بين نظام الرفاهية في بلد ما ونظامه الصحي

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Abstract:
The effectiveness of healthcare systems varies greatly, and the ability to achieve important health objectives varies between welfare regimes and nations. In order to improve our understanding of how health systems perform under various welfare regimes, this paper offers a framework that establishes this relationship. As a result, the purpose of this paper is to present a framework that could be utilized to construct a connection between a country's welfare system and its health system. The first stage is to establish the parameters of welfare regimes based on the notions of governance and power usage. The study goes on to discuss the concept of the health system, the performance of the health system, and how these concepts relate to welfare regimes. Within these constraints, health system performance focuses on three essential objectives: strengthening responsiveness to the population's expectations, ensuring fairness of financial contribution, and improving health. Once the fundamental objectives of health systems have been identified, they must be measured, and a conceptual relationship between welfare regimes and health systems must be established. By developing a framework for the interactions between welfare regimes and the health system, it is possible to understand the primary factors affecting the functioning of health system as well as to consider important policy issues and formulations.

Keywords: *Welfare Regime; Social Support; Health System; Healthcare Performance; Liberal Regime; Social Democratic Regime; Conservative Regime.*

الملخص:
تختلف فعالية أنظمة الرعاية الصحية اختلافًا كبيرًا، وتختلف القدرة على تحقيق أهداف صحية مهمة بين أنظمة الرفاهية والدول. من أجل تحسين فهمنا لكيفية أداء النظم الصحية في ظل أنظمة الرفاهية المختلفة، تقدم هذه الورقة إطارًا يؤسس هذه العلاقة. ونتيجة لذلك، فإن الغرض من هذه الورقة هو تقديم إطار يمكن استخدامه لبناء صلة بين نظام الرفاهية في الدولة ونظامها الصحي. تتمثل المرحلة الأولى في تحديد معايير أنظمة الرعاية الاجتماعية على أساس مفاهيم الحوكمة واستخدام السلطة. وتواصل الدراسة مناقشة مفهوم النظام الصحي ، وأداء النظام الصحي، وكيفية ارتباط هذه المفاهيم بأنظمة الرفاهية. ضمن هذه القيود، يركز أداء النظام الصحي على ثلاثة أهداف أساسية: تعزيز الاستجابة لتوقعات السكان، وضمان عدالة المساهمة المالية، وتحسين الصحة. بمجرد تحديد الأهداف الأساسية للنظم الصحية، يجب قياسها وإقامة علاقة مفاهيمية بين أنظمة الرفاهية والأنظمة الصحية. من خلال تطوير إطار للتفاعلات بين أنظمة الرفاهية والنظام الصحي، من الممكن فهم العوامل الأولية التي تؤثر على أداء النظام الصحي وكذلك النظر في قضايا وصياغات السياسة الهامة.

الكلمات المفتاحية: *نظام الرفاه؛ الدعم الاجتماعي؛ النظام الصحي؛ أداء الرعاية الصحية؛ النظام الليبرالي؛ النظام الاجتماعي الديمقراطي؛ النظام المحافظ.*

1. Introduction

The different qualitative arrangements between the state, the market and the household ultimately define a country's welfare regime. An examination of the roles played by the state, the market, and the household in the provision of welfare in different countries would indicate that there indeed are various welfare regimes. The political and economic system shapes a country's welfare regime that a country adopts: for instance, dictatorships as opposed to the democratic system or capitalism as opposed to socialism. The welfare regime will, in turn, influence the social policies of a country. Given this recognition, it is important to identify that while the levels of responsibility may vary between the state, the market and the household, each is still required to play a role. Terms such as "welfare pluralism" (Shi, 2017) or the "mixed economy of welfare" (Powell 2007:2) have evolved to communicate the concept that welfare is not limited to the state; it is made up of a mixed economy of providers (Dwyer & Shaw 2013:8).

The social policies of a country would include health, education, housing, municipal services and social security, amongst others and it can be expected that the welfare regime of a country would dictate the social policies it applies within the country (Gionvanella, Franco & Almeida, 2020). However, the key focus of this research is health, and although other policies impact the state of households' health, the main focus will be to expand on social policy as it applies to health. Achieving the optimum level of government regulation and/or intervention in social policy specific to health is optimal for any successful healthcare system (Binmadi & Alblowi, 2019). The provision of healthcare services and whose responsibility it is at the core of this research. When assessing the magnitude of government intervention within a specific type of welfare regime, it is necessary to acknowledge the social gradient within a society where health is shaped by the conditions in which people are born, grow, live, work and age.

There are significant differences in health system performance for countries with varied levels of education, income and social support (Humphries, 2015; Chindarkar, Howlett & Ramesh, 2017). Such differences are occasioned by the variations in welfare regimes. The differences in socially valued outcomes, such as health, education, housing, responsiveness and justice across countries, are impacted by changes in the design, content, and management of welfare regimes and health systems. With this recognition, it is crucial for decision-makers at all levels to recognize the variations in welfare regimes and the health system, pinpoint the variables that affect them and develop policies that will produce better outcomes in a range of contexts. The scientific underpinnings of health policy at the international and national levels can be strengthened by relevant, comparable data on welfare regimes, health systems, and their interrelationship.

There are several frameworks for evaluating the effectiveness of the health system, which is evidence of the value placed on this enterprise. When combined, these frameworks offer a wealth of concepts and methods. However, there is a gap in the literature because as far as the researchers could determine, no framework has sought to connect welfare regimes to health systems, which provides room for this research. In order to provide a logical and consistent framework, it is important to understand the objectives of health systems.

1.1. Research Objective

This research aims to ascertain if there is an inter-relationship between a country's identified welfare regime and its health care system. Given that a welfare regime drives a country's decisions, it would be expected that the social policies would be a reflection of the countries' identified regime. A persuasive and practical framework for evaluating health system performance in the context of various welfare regimes is essential.

In order to answer the research objective, the literature review will first address the welfare regime, how this has developed and what attributes identify a specific regime. A model will be presented depicting the different welfare regimes and the different attributes which contribute to each classification. The three broad categories of welfare regimes as developed by the seminal author Esping-Andersen (1990) namely the liberal regime, the social democratic regime and the conservative regime will be used as the three broad categories. The second part of the literature review will address the health component, specifically identifying the various attributes applicable to each health system if it is a liberal health system, a conservative health system or a social democratic health system.

To this end, a conceptual framework has been developed, depicting the relationship between the various welfare regimes, the social policies applied and their health care systems. Given that a welfare regime would dictate the social policies of a country, specifically its health, we would expect the health system to mirror the welfare regime in terms of the policy. This conceptual framework will be applied to validate or refute the claim that the social policy would mirror the welfare regime. This exercise will be carried out by using three examples, one country from each category. This article serves as both a framework and a guide for the additional development and refinement work that academics and other decision-makers will undertake in the coming years. This framework will primarily be used to structure the healthcare system according to various welfare regimes, which will enhance health system performance.

2. Methodology

The study involves the analysis of published documents, notably those on health systems published by academics, industry professionals, and the South African government. A content analysis of many research publications and policy documents on health industry was done for the study. The reading and study of public papers employing a content analysis research approach is a viable and reliable research method according to researchers like Mensah et al. (2017) and Maama (2021). In order to fully understand the important objectives and their ramifications, the documents and literature were read from front to back. To download research papers and policy documents about healthcare delivery in South Africa, the study accessed the websites of research databases and other government organizations in charge of health. These documents underwent a thorough evaluation to ascertain how well healthcare is managed in the context of different welfare regimes.

In order to discover pertinent studies to include in the study, the literature search began with a recent systematic literature assessment evaluating the effectiveness of primary care in various welfare regimes. For the literature search, a number of keywords were selected, including health system, welfare regime, health leadership, operational management in the health sector, and health policies and regulations. The study then looked for studies that had been published in the databases such as Web of Science, Scopus, Emeralds, Elsevier, and PubMed, starting with those that focused on health system efficiency. Studies that addressed one or more definitions of the health system and welfare regimes evaluated the impacts on quality, outcomes, or costs, and presented or quoted original, peer-reviewed studies were all taken into consideration. In an effort to authentically portray the materials studied, the study only cited a subset of these publications, choosing those that highlight concepts that are particularly pertinent to the current study.

3. Literature Review

3.1. Welfare Regimes

Many historical personalities have been consumed by the provision of welfare through the state, the market and the household. Although the classification by Esping-Andersen (1990) created a framework for researchers for further research, it was by no means the birth of welfare regimes. Starting with Plato's most enduring work was his lengthy dialogue, The Republic (Jowett, 1881). At the core of Plato's ideology is his deep insight that the desire for power corrupts and destroys people. He argued that this danger in a never-ending pursuit for self-gratification would always undermine political unity (Lee, 2003:10). Plato developed a constitution that addresses aesthetics and ethics through the desire for unity in politics leading to a happy civil society. "These philosophers" do not seek control (power) for personal gain and are reluctant rulers; rather, their service of governing is to acquire knowledge of all that is good (Korab-Karpowicz, 2005:2; Lee, 2003:15). Plato believed that decision-making about the right political order should not be left solely to public opinion as they lack the foresight and could only stand to learn from their mistakes, which would be counterproductive. According to Plato, the ideal state would be a combination of aristocracy, oligarchy, and democracy (Korab-Karpowicz, 2005:2).

Many years after Plato, in 1723, the Scotsman Adam Smith (1723–1790) left his mark on history with his contributions in The Wealth of Nations (Smith, 1776). Throughout The Wealth of Nations, Smith is concerned about the poor and the ideal form of government, favouring a system that he calls "natural liberty", where the market largely governs itself, through greed for profit and competition that will counter excessive profit and abuse of the household, with limited state intervention (Smith, Raphael & Macfie, 1977). He further explains that government's function should be limited to three roles: to protect its citizens from outside forces, to protect individuals from each other by enforcing justice, and lastly to be the developer and maintainer of certain public works that cannot be done on an individual level (Smith et al., 1977). Smith was studied by Hegel in his early years, but Hegel differed somewhat from Smith as he felt that there is a need for specific government interventions. The contributions of Hegel (1770–1831) are considered to have redirected Western philosophy. He challenged the traditional logic of "syllogism" and presented his new way of thinking called "dialectical" thinking, which claims that "only the whole is true" (Spencer, Krauze & Appignanesi, 1996). This grand idea challenged Aristotle's classical static view that is concerned with separate or distinct parts – and presents the "whole", which can be explained as the interrelation of all elements. A further dissection of Hegel's theory would lead us to the "triadic structure" that consists of the thesis, antithesis and synthesis that are stages to be moved through to emerge at a higher rational thought (Spencer et al., 1996). Governments should be there to provide oversight, regulation and, when necessary, intervention without bureaucratising society. Hegel, like Plato, believed that the masses lacked the experience and political education to be directly involved in decision-making (Hegel, Knox & Pelczynski, 1964:74).

The ideas presented by Hegel appealed to Karl Marx (1818–1883) and Friedrich Engels (1820–1895), who were the products of the intellectual environment in which they found themselves and thus developed an interest in philosophy. Engels was horrified by the poverty that was exacerbated and accentuated by the growth of the big cities in England. Together they created what they called "scientific socialism". Following the Marxists' influence came another British economist, John Maynard Keynes. The influence of his book, published in 1936, was profound

both on economic thinking and on economic practices (Friedman, 1997:3) and developed its own branch of economic thought called "Keynesian Economics", which continued well into the 1960s (Smith, 2011:2). Keynes generally supported free-market capitalism; however, he strongly believed that governments have a role to play in supporting the economy. Finally, Smith presented free-market capitalism, which has been the world's foremost economic model for the last 200-plus years, today termed "economic liberalism" (Balaam & Veseth, 2005:48-49). His optimism for this form of governance was matched by the thinking of Karl Marx, who stood on the opposite side of the pendulum. Karl Marx advocated communism, believing that governments should provide and care for their citizens in all aspects. Keynes believed that the government should support the economy where markets failed. However, he generally endorsed free-market capitalism, thereby advocating for a balance between the two extremes.

The preceding discussion on ideologies through the ages highlights the different levels of social involvement by the state and how each of their viewpoints came to bear on the history of the world. Now in the 21st century we are faced with yet the same problems of how and to what extent governments should manage the affairs of their citizens. In the current century, one of the more influential minds has been Thomas Piketty (born 7 May 1971). A French economist with a focus on wealth and income inequality, his published work Capital in the Twenty-First Century (2013) looks at the last 250 years with reference to wealth concentrations and the distribution of wealth. According to The Economist, Piketty can be seen as the modern version of Karl Marx ("A modern Marx"). His work draws on more than a decade of research, showing the historical changes in the concentration of income and wealth. He emphasises how private wealth grossly exceeded national income and the highly unequal society of the 18th and 19th centuries. He argues that only a burst of rapid growth or government intervention would ensure that the economic world is not plunged back into the "patrimonial capitalism" that worried Karl Marx. His recommendation is for the state to intervene by way of global taxes on wealth to prevent the soaring inequality which would result in economic and political instability (The Economist, 2014).

The conclusions of these great thinkers, heavily influenced by their current and historical circumstances, diverged profoundly, but the common factor among all of them was their attempt at understanding the way humans lived and how they might live in the future, and the organisation and extent to which governments should manage their citizens. Each of these thinkers was consumed in one way or another with society and more specifically the level of state intervention in the lives of its citizens.

Having considered the contributions of historical personalities that impacted welfare regimes over time, it is opportune to state that the liberal view favours the free market and social grants are used as a poverty alleviation mechanism, but only when it is clear that people cannot participate in the economy for reasons beyond their control (Dinbabo, 2011:197). A conservative regime provides social welfare benefits based on compulsory membership in different welfare schemes, such as National Health Insurance (NHI). There are limitations in this type of social regime as the results of this system are restricted by elements such as income maintenance benefits and the ability to earn an income. This is because the corporate element of the economy and employers are the maintainers of the social security system (Dinbabo, 2011:197). In the social democratic view or the universal view, the state makes generous universal provisions with the aim of providing comprehensive social security and equality. There is a high degree of benefit equality and the objective is to eliminate the dual role of the state and the market (Dinbabo, 2011:198).

Titmuss (1974) and Esping-Andersen (1990) provided insight into the classification of the welfare system in different ways. Titmuss (1974:42) classified the welfare system as a "residual", "industrial-achievement" and "institutional-redistribution" system. He advocated that the residual model had its roots in the "Poor Law" where this model was limited to those in need and it was conditional. This model was reliant on the informal sector, such as the household or voluntary organisations as service providers. Implementing the "industrial-achievement" model would directly result from social needs based on merit, work performance and production. The third model proposed by Titmuss (1963:16), the "institutional-redistribution" model was an extension of the Keynesian beliefs of social and economic interventions by the state, where social needs should be universal, and welfare is provided as a right of citizenship (Dinbabo, 2011:196).

Esping-Andersen made his contribution in 1990 with his original work entitled "Welfare Capitalism", where he addressed the economic problems surrounding the provision of social services. He argued that the welfare state could not be seen in isolation and welfare regimes required closer examination (Esping-Andersen, 1990:24-25). His argument was that the system evolved from a country's historical reforms and political movements, and that through this the welfare regime had a direct impact on determining the social categories that define a set of class preferences and modes of political behaviour (Esping-Andersen, 1990:32).

According to his model there are broadly speaking three types of welfare regimes that dictate the social policies implemented:

- A liberal regime: Low level of state intervention; market forces establish a high level of social security, and the state would contribute modestly (Isakjee, 2017:5). Social rights are weak and there is little redistribution of income (Dwyer & Shaw, 2013:9).

- A social democratic regime: High level of state intervention; universal benefits are granted at generous levels (Isakjee, 2017:6). Strong social rights and high levels of income redistribution (Dwyer & Shaw, 2013:9).
- A conservative regime: The state plays a complementary role, and the household is the core; based on principles of insurance contributions (Isakjee, 2017:6). Relatively strong social rights, but income redistribution levels are low (Dwyer & Shaw, 2013:9).

Table 1 shows the roles of the state, the market and the household and how they differ according to the regimes as determined by Esping-Andersen (1990) in his research.

Table (1): Esping-Andersen's welfare regimes summarised

	Liberal Regime	Conservative Regime	Social Democratic Regime
Role of family in provision of welfare	Marginal	Central	Marginal
Role of market in provision of welfare	Central	Marginal	Marginal
Role of State in provision of welfare	Marginal	Subsidiary	Central
Strength of social rights	Minimal	High (for breadwinner)	Maximum
Key examples	USA	Germany	Sweden

Source: Esping-Andersen (1990:24-25)

Each regime is discussed in the following paragraphs to identify the attributes and to support the classification of the countries that have been cited as examples.

Liberal regime – attributes

In a liberal regime, we can expect the state to play a minimal role and the market will determine the household's welfare requirements. Benefits provided by the state would be on a modest scale and they would provide for a specific group of the population, usually the low-income earners, working-class or state dependants. Another characteristic of this type of regime would be the strict entitlement rules, and there would generally be a stigma attached to this kind of welfare provision. Benefits would be modest, to encourage greater reliance on the market (Esping-Andersen, 1990:26). Social grants would only be used as a poverty reduction tool where households are unable to participate in the economy for reasons beyond their control.

Conservative regime – attributes

Under the conservative regime social benefits are linked to compulsory membership of various social insurance schemes. The private sector or employers are expected to provide social security to their members and the shortfall should be filled by communities at large. Social policy outcomes are dependent on income maintenance benefits, the ability to earn an income, and the contributions by the private sector (Dinbabo, 2011:197).

Social democratic regime – attributes

The state is generous in the provision of services to achieve comprehensive social security and equality. There is more emphasis on equality in benefits and less emphasis in terms of minimal needs. This regime is largely prevalent in Scandinavian states such as Sweden (Dinbabo 2011:198). Sweden has been classified under this regime by many notable authors, including Esping Andersen (1990), Leibfried (1993), Castles and Mitchell (1993), Ferrera (1996), Bonoli (1997), Korpi and Palme (1998), Pitruzello (1999) and Bambra (2005). Sweden is seen as a social democratic regime as they have a comprehensive welfare state and collective bargaining. Most workers belong to labour unions and there is state-provided free education, free health care as well as generous guaranteed pension payments (Sanandaji, 2012:12). There is a commitment to social cohesion, welfare provision to protect vulnerable households, and full participation by the public in social decision-making (Sanandaji, 2012:12).

Based on the preceding discussion it would be fair to conclude that a country would in essence be categorised in one of these three welfare regimes. This classification does not mean that certain attributes would not be interchangable between the different regimes but holistically it would be possible to categorise a country in one of the three identified categories.

3.2. Health Systems

There are many discussions of the different social policies developed from the different welfare regimes. Venkataramani et al. (2021) defined social policy as a deliberate intervention by the state to redistribute resources amongst its citizens to achieve a welfare objective. The authors indicated that the major element in defining the social policy field is the idea of social welfare. For this research, social welfare policy would imply any form of "deliberate and authoritative intervention by the state in terms of addressing social problems and redistributing

resources as well as benefits with the objective to empower disadvantaged groups of people" (Beland et al., 2021; Dinbabo, 2011:33).

In this article, the main focus will be to expand on social policy as it applies to health. In this context it is necessary to determine the extent to which governments 'should' manage and provide for the health care of the country, taking cognisance of the sustainability of such a health system. Emphasis will be placed on filtering the social provision of services and concentrating on the provision of healthcare services, specifically the provision of health services and who should be responsible for them. Health system is all the resources, players, and institutions involved in financing, supervising, and delivering healthcare to citizens (Giovanella et al., 2018). The health system is defined broadly as a result of this fundamental intent requirement. The primary intent criterion of health system has the significant benefit of including all actors and institutions whose primary goal is to promote health in evaluating health system performance. Additionally, it is crucial to understand that when efforts are made to influence other sectors, such as educating the population or lowering socioeconomic inequities, they are unquestionably a part of the health system (Chindarkar, Howlett & Ramesh, 2017). The primary intent criterion is met by these intersectoral action activities since they aim to promote health.

Beland et al. (2021) articulated many goals for social systems, particularly the healthcare system. However, Kromydas (2017) highlighted the need to distinguish between instrumental goals, whose pursuit is merely a means to another end, and intrinsic objectives, which are appreciated in themselves, to have an informed discussion about the goals of any health system. According to Reibling, Ariaans and Wendt (2019), the health system has three primary objectives: health, responsiveness, and fairness in financial contribution. All nations should regularly evaluate these core goals, which should also serve as the cornerstone for evaluating the effectiveness of health system. As a result, assessments of goal attainment concentrate on quantifying these three objectives and connecting goal attainment to resource utilization in order to measure effectiveness and performance.

Additionally, there are cross-system goals for the health system that could be significant and should be the focus of additional investigation and review (Wendt et al., 2010; Adler et al., 2016). The contribution of the health system to economic production is one of the more crucial cross-system objectives since health and health systems can either boost or decrease economic output. For instance, certain employment-based insurance plans may make it more difficult for workers to move around and affect macroeconomic performance. In this context, in evaluating health system, it is important to answer the following question: how much does the healthcare system influence things like education, democracy and economic growth? Meanwhile, there is mounting evidence that bettering one's health can boost economic growth. Although these are crucial topics for further study, normal evaluation of the health system's performance does not include them due to the nature of the cross-system interactions and the complexity of measurement (Yuda, 2018).

Health is shaped by the conditions in which people are born, grow, live, work, are governed and age, and these conditions, in turn, are shaped by the way in which money, power, and resources are distributed at global, national and local levels. The relationship between health and the social gradient within a society has been established by studies such as "The Marmot Review: Fair Society, Healthy Lives" (Marmot, Allen, Goldblatt, Boyce, McNeish, Grady & Geddes, 2010) and "The Acheson Report – The Independent Inquiry into Inequalities in Health" (Smith, Morris & Shaw, 1998). These studies concluded that the relationship between health and social factors cannot be denied and the evidence from these studies confirms the importance of social factors in determining health.

3.3. Welfare Regimes and Health Systems

A substantial body of literature has examined the validity of welfare regimes concerning broad social welfare policies in the context of health systems. Self-interest, ideological orientation, and institutional structures have all been found to be important drivers in many earlier studies (Powell & Yoruk, 2017). Evidence suggests that different welfare regimes provide welfare, particularly healthcare in different ways, both qualitatively and quantitatively. Some studies have found significant socioeconomic disparities in morbidity and mortality across Europe using data from national health surveys or national longitudinal mortality studies (Eikemo et al., 2008; Alves, 2015; Powell & Yoruk, 2017; Reibling et al., 2019). Surprisingly, egalitarian nations like Sweden and Norway do not appear to make any exceptions in this regard, despite the fact that the general health of their population is among the best in the world (He, 2018). This has led to widespread conversations about how social inequities in health should be addressed and measured, as well as public debate and political mobilization within the Social Democratic welfare states (Wendt et al., 2009). This raises the question of how closely welfare regimes relate to socioeconomic health disparities. Previous research has revealed that the overall health of the population varies significantly depending on the welfare system (Bambra, 2005).

According to Eikemo et al. (2008), Anglo-Saxon countries have the lowest prevalence rates of ill-health, whereas the Southern and Eastern European countries with the lowest average years of education have the highest overall prevalence rates (apart from the lower incidence of limiting long-term sickness in the South). This is consistent with the majority of prior research on changes in population health caused by welfare regimes (such as newborn mortality or total mortality) (Wendt et al., 2009). In particular, the Scandinavian welfare regime performed worse than the Anglo-Saxon and Eastern European social regimes in terms of educational health

inequalities (Eikemo et al., 2008). From a global standpoint, he (2018) documents that only Sweden exhibits relatively minor inequality, maybe due to the robustness of the Swedish welfare state. These findings are unexpected because we anticipated Scandinavian welfare states to do particularly well in terms of the degree of health equity given their large welfare support.

These unexpected findings in the Scandinavian region may be due to the influx of emigrants in these countries. Over the past two decades, significant immigration has occurred in the hitherto homogeneous Scandinavian nations (Hovden & Mjelde, 2019). In Scandinavian welfare states, immigrants are frequently marginalized and denied the full benefits of the universalistic system (Alves, 2015). They are also more prone to endure unemployment and social marginalization. These groups also frequently belong to the social groups with the lowest levels of education (Jakobsen et al., 2019). A study that compared those born in Sweden to those who were immigrants from Poland, Turkey, and Iran found a high correlation between ethnicity and poor self-reported health, which was mediated by socioeconomic position, inadequate acculturation, and prejudice (Mock-Munoz de Luna, 2019). Another study discovered significant differences between ethnic Pakistanis and native Norwegians in terms of self-rated health, the prevalence of diabetes, and distress (Syed et al., 2006).

Apart from this, two significant flaws exist despite the fact that these country-specific assessments and cross-national comparisons have shed light on numerous sources of the legitimacy of contemporary welfare regimes. First of all, most prior studies were broadly focused on the entire social policy regime, and little knowledge was acquired regarding the legitimacy of the health system, a crucial welfare component. Second, it has been discovered that the Esping-Anderson typological model of Western welfare regimes, which was the foundation for the majority of earlier investigations, has minimal application to other social welfare systems. This evidence demonstrated that grouping welfare regimes accounted for a sizable portion of the difference in health systems. This lends credence to the value of this study which provides a framework, highlighting how welfare states relates to the diversity in health inequality metrics. Here, we demonstrate that health system disparities were not found to be patterned in accordance with welfare regime.

4. The Construction of the Framework

The framework demonstrating a relationship between welfare regimes and health systems is presented in Figure 1. The framework was developed based on the literature reviewed in the previous sections. The framework presents all the welfare regimes identified in the literature and their corresponding health system. The vertical axis represents the mindset of the populace as well as governments, ranging from the social democratic regime to the conservative regime and then the liberal regime. The horizontal axis represents the health systems applied by the liberal regime, the conservative regime and the social democratic regime. The nine blocks depict the different health systems as applied by the different welfare regimes.

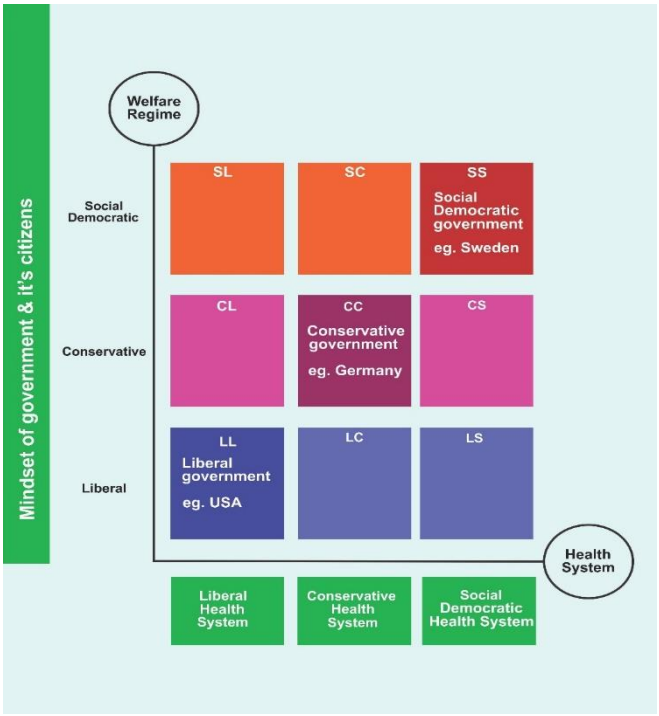

Figure (1): Conceptual framework depicting the interrelationship between welfare regimes and health systems

In the social democratic healthcare system (Block SS), the state would be concerned with providing for all the needs of its citizens and it would go beyond provision. There would be engagement with the populace at all levels to ensure that their needs have been considered. Thus, block SS would incorporate Universal Health Care (UHC), the principle of equity and the efficiency/good governance of health service provision. The health system in this block would be as extensive as possible and this form of government would love and care for its citizens. A country which is classified as Social Democratic and applies the same social democratic health care system would be mainly funded through government and is financed primarily through taxes system is mainly funded through government and is financed primarily through taxes (Esping-Andersen 1990; Leibfried 1993; Castles & Mitchell 1993; Ferrera 1996; Bonoli 1997; Korpi & Palme 1998; Pitruzello 1999; Bambra 2005).

A healthcare system as applied by a conservative welfare regime (Block CC) would be a country with a mirrored conservative healthcare system. This would imply that the state would provide for the needs of its citizens as it feels best, taking cognisance of the limitations imposed by financing. The state would be reaching for UHC; however, the principle of equity and efficiency/good governance would not be prioritised. This regime would apply the pater familiar concept whereby the state would exercise autocratic authority over its citizens and provide health services as it sees fit, with little or no consultation between the government and the populace.

In the health system as applied by the liberal regime (Block LL), the country would be classified as having a liberal welfare regime with a liberal health care system. The state would provide the bare minimum for its citizens and there would be little or no consultation with the populace. The free market would dictate. Table 2 below presents the various welfare regimes and their corresponding health system.

Table (2): Welfare regimes and health systems

SL	Social democratic regime following a liberal health system
SC	Social Democratic regime following a conservative health system
SS	Social Democratic regime following a social democratic health system
CL	Conservative regime following a liberal health system
CC	Conservative regime following a conservative health system
CS	Conservative regime following a social democratic health system
LL	Liberal regime following a liberal health system
LC	Liberal regime following a conservative health system
LS	Liberal regime following a social democratic health system

We then direct the discussion towards validating the conceptual framework in the following section.

4.1. Validation of Conceptual Framework

The conceptual framework, as seen in Figure 1 will now be validated by examining three specific countries, looking at each country and ascertaining if their classification in terms of welfare regimes is reflected in their social policy, specifically health.

Block SS

An example of this form of health system would be Sweden, where the health system is mainly funded through the government and is financed primarily through taxes (Esping-Andersen,1990; Leibfried, 1993:133; Castles & Mitchell, 1993:94; Ferrera, 1996:17; Bonoli, 1997:351; Korpi & Palme, 1998:661; Pitruzello, 1999; Bambra, 2005:35).

Block CC

An example of this form of health system would be the health system administered in Germany (Dinbabo, 2011:197). Germany has the world's oldest social health insurance system, first introduced in 1883, which has evolved and changed over time (Bärnighausen & Sauerborn, 2002:1559). There is social cohesion, a mix between state-funded services and private sector, a unified compensation system and subsidising of the poor. In Germany, the traditional source of funding for its social health insurance was a wage-based insurance contribution; however; its ageing population means wage and salary earners have declined as a proportion of the total population, making it more difficult to fund its social health insurance system from traditional sources. Consequently, the German government has been forced to inject additional funds from general revenues into the system to ensure its sustainability (World Health Organization, 2010). The German health system was founded on the principles of social cohesion, free choice of providers (patients have freedom to choose their service providers; Germany has more than 100 multiple payer systems; also, there is a unified compensation system for the providers, negotiated price schedules and competition based on need), solidarity (meaning fair financing and equity; ethical platform, same benefit package, payment according to needs and subsidising of the poor) and subsidiarity (problems are addressed at the lowest possible level) (Reid, 2011). Individuals can choose to be a member of the publicly administered Social Health Insurance (SHI) or private health insurance, not both. 87.7 percent of the population are under the public

insurance fund and the rest are private, with only 0.2 percent of the population with no insurance, and the social health insurance scheme has to accept everyone.

Block LL

An example of this form of health system would be the United States of America prior to the implementation of Obamacare, which was implemented in the presidency of Barack Obama. America has a culture of conservatism (free market economic model) and the social welfare burden has been left to the free market. There is no unified welfare system (Karger & Stoesz, 2014:2-3). There was significant reliance on the private sector to supplement benefits for those not entitled to them (Dinbabo, 2011:197). Public health insurance has only become a reality in the USA in recent years, but the social assistance is still minimal. The Affordable Care Act was passed in 2010 together with a companion reconciliation bill which together promise access to affordable health insurance to more than 30 million Americans who were previously uninsured. The country's health system is ranked as the most expensive in the world, where R20 trillion was spent in 2010, approximately R50 000 per capita, which translates into 20 percent of GDP. The American system is described as pro-rich and unfriendly to the poor.

Based on the above examples, it is evident that the social policies within certain countries mirror the welfare regimes of those countries, but what of the case of South Africa?

South Africa transitioned from an apartheid society to a democratic nation in 1994 when the first democratic elections were peacefully concluded. Under the apartheid rule, social policies were designed for the White racial group, in the form of social pensions, and Patel (2008:73) notes that social welfare policy was modelled on Western European institutional social policies for the White minority. With the abolishment of apartheid, the social welfare system needed to be reengineered and this was done in accordance with the country's constitutional mandate to promote social and economic justice, democracy, human dignity, and freedom (Dinbabo, 2011:46). All spheres of the South African government are subject to the rule of law laid down by the Constitution, which is the supreme law in South Africa.

There have been profound political and social changes in the post-apartheid era and the South African government has taken the lead in introducing significant social welfare policy changes (Makino, 2004:1). This intervention was driven by the extreme inequalities and poverty rates in South Africa. According to StatsSA (2017:1), the poverty rate was 49.2% in 2017 and the official unemployment rate was 29.1% in 2018 (StatsSA, 2019).

Progress regarding social policies came in the form of the White Paper on Developmental Social Welfare (1997) and the South African ANC-led government adopted the neoliberal policies of a social welfare system, using the means test or conditionality before offering social security grants. There would be two main conditions for the most vulnerable to benefit from the grants – the age of the individual and the amount of money/property they own (Dinbabo, 2011:217). The substantial spending by the South African government on social welfare policies makes it difficult to categorise South Africa as a liberal regime, as the Social Assistance Act 13 of 2004 and the Social Security Agency Act 9 of 2004 provide for social grants (Dinbabo, 2011:217).

In Noyoo's (2017) research, he revisits the welfare regime framework as composed by Esping-Andersen (1990) and applies this to the South African context. His conclusion is that South Africa has a hybrid welfare regime typology (Noyoo, 2017:13). This hybrid welfare regime has two elements: firstly, the liberal welfare regime, which evolved out of colonialism and apartheid and which provides for the needs of the privileged in South Africa. The second element, the social democratic regime, appears to copy the Scandinavian redistribution model as evidenced by South Africa's provision of "bundles of services like the social wage that is defined by various state subsidies like free water, free electricity, free housing, universal access to certain services for the poor" (Noyoo, 2017:14). Universal health care, which would be a comprehensive care system, is not affordable in South Africa, given the small tax base in the country and that households would still have to bear additional out-of-pocket expenses. Although noble, the social democratic regime as adopted by countries such as Sweden is not a viable option for South Africa, given the limitations of funding.

Based on the preceding discussion and with reference to Figure 1, South Africa would fit into the heuristic model as follows: on the vertical axis, South Africa would be somewhere between a social democratic regime and a liberal regime, as its policies are striving towards a social democratic system, but the country is not there yet (see Figure 2). Having established South Africa's position on the vertical axis, the social policies of the country and specifically the health system currently being administered need to be considered to determine where South Africa could be placed on the horizontal axis, namely the health system being employed.

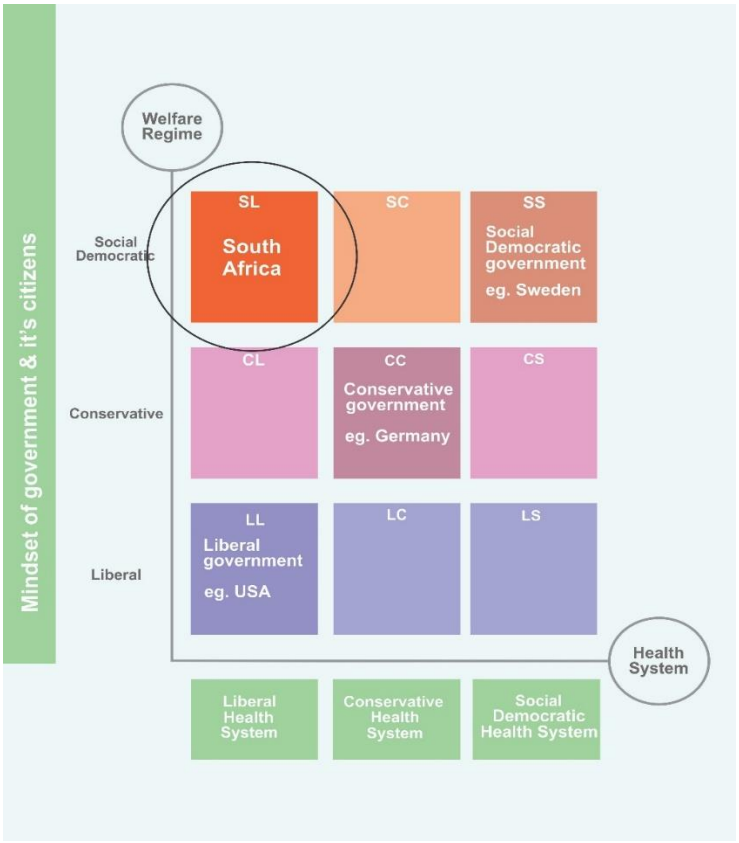

Figure (2): South Africa's interrelationship between its welfare regime and health system

However, these health policy changes should be viewed against the backdrop that South Africa does not possess the tax resources to fund universal health care to the same extent as Sweden. The evidence above indicates that the health system which has prevailed in South Africa till this point would be a hybrid health system – consisting of a social democratic regime combined with a liberal health system. Therefore, in terms of the heuristic model seen in Figure 2, South Africa would currently form part of block SL (social democratic regime with a liberal health system). The current health system in South Africa is not functioning efficiently due to poor service delivery and other financial limitations. A social democratic healthcare system, towards which the South African government is working, would offer universal coverage by way of a comprehensive care package, but affordability would be a big factor in this decision. A projection of costs to fund the total healthcare expenditure for the entire population of South Africa would require around R1 180 billion. Comparing this to the current total government spending for 2018/2019 of around R434 billion reveals a shortfall of R746 billion, which would require around 14 million personal income taxpayers to fund the healthcare spending. Currently there are around 7.1 million PAYE personal income taxpayers (National Treasury, 2019:34), who together are responsible for the total healthcare spend in South Africa, amounting to R434 million. This implies that with a population of roughly 58 million people at least 50.9 million people (87.8%) do not contribute towards healthcare expenditure, but they receive almost all of the R208.8 billion of the healthcare expenditure budget. This shortfall in the budget is a very real and imminent threat to the proposed national health insurance.

5. Conclusion

This study has contributed to the literature and policy debate by providing a framework demonstrating a relationship between welfare regimes and health systems. We hope to encourage a more rational and well-informed discussion on the interaction of welfare regimes and health systems by introducing a clear framework that establishes this interaction. This would help improve key healthcare delivery areas such as health system goal attainment and performance, organization of key health system functions, and the technical content of health service provision. A lot of the assertions regarding what functions and what does not function under different welfare regimes are used in the discussion of health system design. Adopting this framework for health system performance will create the groundwork for a change in the ideological debate around health policy to one that is more grounded in fact. It this case researchers and policymakers should eventually be able to offer empirical responses to issues like the connection between the structure of health finance and the level, distribution, and responsiveness of health.

The framework further offers a foundation for a more scientific discourse on health policy by considering how welfare regimes influence health systems and the most critical potential elements for explaining variation in health system performance. The focus of attention on the policy options available to governments for improvement will be on the annual evaluations of the performance of the health system. The institutionalization of performance evaluation on a global scale may aid the continuous discussion of the state's role in health systems. The framework should serve as a foundation and motivate researchers to find answers to the following questions. Which welfare regime can improve health system performance? What proof do we have that the state can improve performance by implementing these policies? Then, if the data indicates it has the potential to do so, the state's ethical obligation is to improve performance. This paradigm for evaluating health system performance is still under development and will undoubtedly change as operationalization moves forward and data on the relationship between welfare regimes and health systems becomes available. Creating such a long-term agenda will assist all nations in better articulating their responses to their respective populations' complex and evolving health requirements.

Suggestions for Future Studies:

The study documented that different welfare regimes provide welfare in different ways, both qualitatively and quantitatively. However, the extent to which racial composition of a country influences the different welfare regimes remains undocumented. As a result, more investigation into the racial composition of different welfare regimes and their would help explore this topic further.

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