

Themes and Debates in Health Policy and Equity: Application to the issue of welfare state retrenchment

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Abstract: There are various ways of considering issues of health policy and equity, this paper provides an overview of existing theories within the field of health policy and equity followed by a critique of the different schools of thought that exist within the literature. A review of how scholars have interrogated, considered, and reflected upon the role of the welfare state in relation to health policy and equity will be provided. The relationship between health policy and its implications on equity is strongly correlated (WHO, 2013). The relationship between health systems and welfare states is examined through a political economy of health framework. This paper provides a review of the theories of the welfare states, retrenchment politics, and a discussion of the relationship between welfare state retrenchment and health inequalities.

Keywords: Welfare state, retrenchment, health inequalities, inequity, policy

INTRODUCTION:

There are various ways of considering issues of health policy and equity, this paper provides an overview of existing theories from a political economy of health lens within the field of health policy and equity followed by a description of the different schools of thought that exist within the literature. A review of how scholars have interrogated, considered, and reflected upon the role of the welfare state in relation to health policy and equity will be provided. By providing a deconstruction and analysis of individual parts that makes up the literature, this paper seeks to

highlight opportunities for research and outline the requirements for an ideological shift in order to decrease inequalities. The relationship between health policy and its implications on equity due to health systems are strongly correlated (WHO, 2013). This paper reviews that relationship through a political economy of health framework. Reaumer (1991) defines health systems as a “combination of resources, organization, financing, and management that culminate in the delivery of health services to a population”. A welfare state is explained as a complex system which offers social safety nets and a range of supports to its citizens during various life changes that may impact their health and well-being (Raphael & Mikkonen, 2010).

The Canadian welfare state is a multi-billion dollar system of government programs which provides citizens with services and provisions to deal with a wide variety of needs. This welfare state has undergone various changes from the time it was introduced in the 1940s after the Second World War (WWII). As the concept of state intervention led to promises of economic prosperity, Canadians started accepting increased intervention from the state in order to enhance social life. The nature of the welfare state continued to change overtime due to changes in the political climate of Canada, along with changes in the global economy and a shift towards neoliberal attitudes (Moscovitch, 2006). From the 1970s onwards, the Canadian welfare services began experiencing austerity measures which some account to increase in expenditures. By the 1980's austerity measures such as the privatization of provincial and social programs, introduction of user fees were some of the measures put in place to control social spending (Moscovitch, 2006). Research indicates that welfare states are important determinants of health and that inequalities are less prevalent in countries with generous welfare states (Bambra, 2011; Navarro 2006). This relationship is a complex system that can be studied using a critical theory which allows for a multi-level analysis of the players involved in determining the actors involved and the agents of change in society.

Political Economy of Health:

One approach under the critical theory paradigm is the Political economy of health (PEH) framework which helps unravel the connection between politics, economics, and society. This framework is useful in understanding the retrenchment of the welfare state in Canada as the current and the dominant mode of production in Canada is capitalism (Armstrong, Armstrong, & Coburn, 2001). Considering this mode a social construction, the PEH framework allows for a study developed based on the understanding that a comprehensive study cannot be conducted without a study of the individual parts. It encourages an approach which takes into account actors in history, ideas and discourses, as interrelated parts of an entire whole. It takes into account households, communities, and social relations of gender, employment, unemployment, and commodities. It allows for a discussion of power relations in relation to societal structures. Due to its historical examination of change overtime the PEH framework incorporates the determinants of health which are recognized as income, education, shelter, access to services, food insecurity, and living conditions that people experience (Raphael & Mikkonen, 2010). This perspective is important for understanding health policy and its derivation/changes in time as health increasingly becomes defined by politicians and corporations.

As a part of the critical theory paradigm the PEH approach helps demonstrate how the organization of services and provisions in society shapes the health of a population (Bryant,

2009). It reaffirms a systems thinking the approach which allows understanding how different entities in health policy are connected. By understanding which pieces are involved, which assumptions are being made, and how the system operates on a whole, an understanding of the application gap between research literature and policy implementation can be decreased. As disparities, inequalities, and inequities are studied it is noteworthy to understand the distinction between the three. A health disparity is the quantity separating a group from a reference point on a particular measure, measured from the most favourable group rate (HP, 2014). A health inequality is a single value that represents ‘the degree of variation in rates among unordered groups, weighted by group size (race and ethnicity)’ (CDC, 2007), whereas a health inequity is understood as the unfair distribution of health determinants such as resources between segments of the population based on social standing and other differentiating factors (CDC, 2007).

History of the Welfare State

From a global perspective the latter half of the twentieth century brought with it democracy, economic wealth, better health, and the promise of social justice and social rights- concepts almost unheard of in older times. While the non-Western world continued to experience the older norms of dictatorship, war, starvation, Western society unleashed a trajectory bound by the welfare state (Castles et al., 2010). Authors argue the origin of the welfare states dates back to the last quarter of the nineteenth century during a period of time referred to as *The Great Transformation*. During this period, industrialism, capitalism, urbanization, and population growth were on the rise (Polanyi, 1957). The initiation, growth, and maturity of the welfare state have been theorized in many ways that take into account the aspects of globalization (Rieger, Leibfried, Veghte, 2003), and the shift from a ‘warfare state’ to a ‘welfare state’ (Kaufmann, 2010). Both Rimlinger (1971) and Alber (1982) agree with the social repercussions from WWI and WWII as being the triggering factors behind the growth of the welfare state (Castles et al., 2010). Notably, changes in the economy led to countries adapting different approaches to the welfare states.

While some countries such as Britain and Australia made major benefit cutbacks in light of the political crisis, others such as Scandinavia moved towards a more advanced stage of welfare development (Castles et al., 2010). Similar to the period after WWI, WWII created an impetus for policy expansion within states. Kaufmann (2003) notes this time as the period where social security became an international slogan. In the midst of war, *The Beveridge Report* was created, a document that is popularly known as one of the founding documents for the welfare state. This report led to a post-war reform where the warfare state and the welfare state were looked upon as one similar ideology. This was due to the catastrophe that war brought with it, along with the focus on state intervention for preserving rights and ensuring peace (Castles et al., 2010). As welfare state provisions began to expand after WWII with the support of economic growth from the War, the provisions got pushed even further due to the Cold War starting in 1947. Often referred to as the ‘Golden Age’ of the welfare states, social needs during this period were met better than ever by states due to centralized tax powers, post-war reconstruction, and the commitment to prevent another war (Castles et al., 2010). During this stage a sort of Keynesian consensus arose where high state intervention and high expenditure levels were accepted and encouraged in economies. Institutional differences were at play in different countries in determining the extent to which policies took root. For example the United States continued to remain a residual provider of welfare while the Scandinavian countries utilized their

resources to provide a full range of tax benefits. The different models in which welfare states were adapted and spread constitute the classifications suggested in Esping-Andersen's (1990) typology of welfare state regimes.

LITERATURE REVIEW:

Theories of the Welfare State:

Explanations of the welfare state range from functionalist socialist critiques, economic policy critiques to pluralist critiques. One classification for understanding the welfare states is the dichotomous typology which categorizes welfare states as residual or institutional (Olsen, 2002). Residual welfare states provide benefits as a last resort, through a stringent means-testing process, whereas institutional welfare states promote well-being and preventative approaches for everyone (Bryant, 2009). Each of these methods of explanation has their limitations. While functionalist accounts provide an explanation of the dominant trends at work within a country, they do not take into account the nuances that create inequalities or the differences in the political climates. Conversely, the other two critiques focus on the differences in states but are unable to look at history as both subjective and objective (Gough, 1978).

Contemporary literature on the modern welfare states is based on the changes in the welfare states after the 1970s (Myles & Quadagno, 2002). Research conducted on national social policies during the post-war decades served as a pre-cursor for comparative research. During the mid-1970s after two decades of accelerated expansion of the welfare states, research started becoming geared towards the differences of structure within industrialized nations. As the social policy agenda started leaning towards the politics of austerity after the golden age of welfare states surmised, it led to a political and economic model in which the modern welfare state became vastly different from the old (Myles & Quadagno, 2002). Wilensky and Tilton's (1975) work on welfare states and inequality and Esping-Andersen's (1990) work on the three worlds of welfare capitalism were two highly influential works that focused on why welfare states developed the way they had.

Additionally, theories of the first generation of welfare state studies focused on the rise of industrialism as the cause of increasing social services and expenditures in states (Wilensky and Lebeaux, 1958; Kerr et. al., 1960; Pryor, 1968; Rimlinger, 1971; Wilensky, 1975). The gist of these arguments being that industrialization leads to increased labour requirements, which in turn leads to problems for those with little labour to sell, thus directing states to play a larger role in maintaining a balance. The next set of theories focused on Marxist accounts of capitalism, while the third were based on the power resource theory. This theory rejected the pluralist notion that power is widespread and argued that the capitalist class was the most powerful in society due to their control over the means of production (O'Connor & Olsen, 1998). During the 1980's institutionalist accounts argued that the organization and structure of state institutions limit radical innovation in policies and creates distinct welfare states (O'Connor & Olsen, 1998).

Welfare State Typology:

One of the most popular bodies of literature available on welfare states is Esping-Andersen's *The Three Worlds of Welfare Capitalism* published in 1990. Esping-Andersen's (1990) argues that welfare states systematically influence social, political, and economic outcomes. He insists that the goals of a welfare state are most successfully met by a social democratic welfare state and least successfully by a liberal welfare state. This book was based on an analysis of approximately 18 rich capitalist democracies with a focus on the power resource theory and why countries varied in their reception of social services. The power resource theory suggests that "working-class mobilization is a critical determinant of the public provision of social welfare or, more specifically the extents to which public welfare system redistribute income and labor-markets risks" (Pontusson & Kwon, 2006). Esping-Andersen (1990) discussed the power resource theory and suggested that welfare states are sophisticated pathways created from which parties are in power. He highlighted the importance of the welfare state on working life, employment, and the labour market. Providing a broad introduction to the various origins of welfare states Esping-Anderson (1990) identified three types of welfare state typologies: the liberal welfare states, recognized by their means-tested assistance programs such as those found in Canada, the conservative welfare states recognized by their encouragement of familial values and insurance structures such as those in France; and the social-democratic welfare states which provide high levels of benefits and services for all strata such as those in the Netherlands.

In addition, liberal welfare states show a hesitation on replacing the focus from market relations to social rights. Conservative welfare states have 'status differentiating' welfare programs which are administered by employers and maintain the existing social status of people. Continental European countries depict higher social spending than liberal welfare states; however, this spending is focused on the income needs of the male breadwinner (Starke, 2006). The social democratic welfare state is directly aligned with social rights and focused on redistribution. Notable here is the fact that while both the Conservative and the Social Democratic states have high levels of social expenditure, the manner in which this is spent is fundamentally different-while social democratic states seek to decrease inequalities, conservative welfare states seem to keep in place existing system (Myles & Quadagno, 2002).

As a result, the division and identification of states in different clusters by Esping-Andersen have been widely critiqued by scholars. Firstly, the range of countries that were chosen to be reviewed in Esping-Andersen's work was limited. The categorization of states was also problematic. The exclusion of East Asian welfare states led to an inability to identify a full range of potential welfare states (Bambra, 2007; Korpi & Palme, 1998). The exclusion of gender and its impact on decommodification, and social stratification also lead to a lack of comprehensiveness of the welfare state typology. The concept was challenged by the notion that the decommodification was gender-neutral as it did not take into account women's roles as caregivers, thus making women more likely to be commodified before any benefits were available to them (Bambra, 2007). In response to these feminist critics Esping-Andersen (1990) added family to the state-market nexus (Hook, 2015). However, Andersen's (1990) work lacks clarity regarding how welfare states influence the aforementioned outcomes. Other scholars such as Klein (1991), Baldwin (1990), and Bambra (2007) have critiqued the three worlds of welfare to suggest that the tripartite scheme of welfare regimes can be either too broad or too narrow.

Furthermore, Esping-Andersen's (1990) work was also critiqued of lacking empirical validity as proven through replication of his work leading to substantially different results (Bambra, 2007). Despite being critiqued for numerous shortcomings, Esping-Andersen's (1990) work continues to withstand the test of time and provides the opportunity to understand why and how policies are created in states. The concepts of economic growth, political institutions, gender, and globalization result in different ways of understanding the origins and the restructuring of the welfare states. This has led to a distinction in old vs. new welfare states (Starke, 2006).

Critiques of Welfare State Theories:

Two major themes exist in the literature regarding the welfare state, the consensus model of theories and the conflict model of theories. Consensus model theories assume that policies are made based on rational consideration of choices (Bryant, 2009). Alternatively, the conflict model considers broad macro issues based on social class politics, inequalities, and influence in power (Bryant, 2009). The consensus school of thought understands welfare states as a response to problems that occurred due to the industrial revolution in the nineteenth century (Gough, 1978). This school views the creation of social policies as a result of rational solutions to social problems, while the latter school of thought views social policies as a moral response to social problems. Based on the consensus model any retrenchment in the welfare state would be unjust to citizens and their rights, and unquestionable. The latter school of thought focuses on the tensions inherent in societies and the role of power. This theory takes into account the role of political ideologies and power relations in relation to inequalities (Raphael et al., 2006).

In the 1960s and 1970s most theories explaining the emergence of the welfare state were based on structural functionalism and pluralist accounts. Durkheim's work on welfare states argued that political institutions arose in response to society's needs. This reflects a state's way of adapting to changes brought about by modernization as opposed to political machination (O'Connor & Olsen, 1998). Writings under this theory focused on interventions leading to economic development, or interventions focusing on individualism versus collectivism. Taking the structural functionalist theory further, authors such as Curright (1965), Rimlinger (1966), Wilensky (1975) and Labeaux (1965) examined other nations and concluded that it was the most developed nations which had the highest levels of expenditure on social welfare programs; creating a disconnect between politics and the determination of a welfare state. According to Goldthorpe (2010) functionalism can be explained as a deterministic approach which views the policies pursued in terms of their functions without studying the root causes that generate them. A few of the critiques of the functionalist paradigm are that it does not take into account the values of a society, or whether or not the society views and understands a 'social problem' as such. It does not consider human experiences or non-social forces, and instead focuses on objective determinants of history such as laws and processes.

In contrast to the functionalist approach, welfare states have also been studied using the pluralist paradigm. This school of thought encourages the inclusion of human experiences and conflicts in the development of social policy. However, it conceives of power to be diffused equally amongst interest groups, assuming that interest groups and the state exist at a neutral level where neither is dominant. Titmuss et. al (1958) goes on to identify short-comings of the

pluralist model in stating that pluralist theories cannot be used to explain the tenets of the welfare state as it fails to take into account crucial aspects of the capitalist society.

Welfare States, Health Policy and Social Determinants of Health

The World Health Organization (WHO) defines health policy as the “decisions, plans, and actions that are undertaken to achieve specific health care goals within a society” (WHO, 2016). In order to understand the relationship between health policy and equity, it is necessary to distinguish between inequity and inequality. Braveman (2003) defines equity as a normative concept that focuses on the distribution of resources which leads to a particular type of inequality. A health inequality is described as the result of an unfair or unjust process (Braveman, 2003). Not all health inequalities are unjust, for example the health disparities between young adults and the elderly population would not be considered unjust (Braveman, 2003). The concept of health inequities is often examined through human rights principles as the WHO sets the right to health as the right to ‘the highest attainable standard of health’ (Braveman, 2003). Raphael (2010) argues that the right to health requires a focus on the Social Determinants of Health (SDH). SDH are defined as the primary living conditions that shape population health. Based on decades of research, the SDH theory affirms that factors such as income and wealth distribution, access to education, food, housing, social class, un/employment, among other factors determine health (Raphael, & Mikkonen, 2010). A country’s welfare state structure determines the policies that are adapted and promoted. The relationship between the political climate of a country and the level of inequality experienced by people has been widely studied (Bambra, 2011). Welfare states mediate health through the social determinants of health. Epidemiological studies have almost invariably concluded a positive relationship between population health and generous welfare states such as those of Social democratic countries (Bambra, 2011).

Established in Canadian policies since the mid-1970s, SDH has been widely studied and critiqued over the years. The relationship between SDH and health inequalities gained international popularity through documents such as the Black Report (1980), the Whitehead report (1987), and more recently the Acheson report (1998) and the Marmot review (2010) (Raphael, 2010). The results of these reports echo similar findings on the relationship between health disparities, policies, and social class, for example the determination of life expectancy, the age of disease onset, and quality of life-based on SDH and policies and laws at the municipal, provincial, and federal levels (Raphael, 2010). This influence of policies and laws dictated by the government on health disparities comprises the literature on the role of welfare states and health inequities. Numerous social theorists examine these issues according to the school they draw from. For example, the positivist school of thought which only considers scientific knowledge driven through calculated measures as authentic considers a social policy to be dependent on empirical testing. No value is placed on the process of inquiry, while neglecting the influence of power in shaping inequalities.

Additionally, authors such as Woodill (1992) and Wilson (1983) classify the positivist school of thought to be unsatisfactory when it comes to studying social, political, or health inequalities (Bryant, 2009). Based on the concept of fixed reality Lincoln and Guba (1994) associate the positivist school of thought with context-stripping, in which political, social, and

economic factors are not taken into account. Moreover, this school of thought is often associated with the biomedical or clinical model that which focuses on individual and lifestyle choices, emphasizing individual behaviors as causes of illness. While there is increased awareness about SDH, debates between the medical and behavioural fields are still prominent. This can be traced back to the critical theory of knowledge paradigm versus the medical approach, which stems from the positivist paradigm seeking an objective reality (Lincoln & Guba, 1994). An SDH approach suggests that class-theories lead to social relations that promote inequity. Income inequality and relative social deprivation are arguably the most popular proxy measures for the class in health literature pertaining to the social determinants of health (Mikkonen & Raphael, 2010; Bryant, 2009; Muntaner et al., 2015). The relationship between poverty, lack of access to material resources necessary for living, and gross health inequalities has been the focus of major work in public health since the 1970s.

Spending on social services increased from the 1960's onwards. As expenses increased so did questions and critiques on the sustainability of the welfare system. Theories of industrialism based in the positivist school of thought were largely called upon to explain the welfare state. As the first generation of welfare studies focused on theories of industrialism (Wilensky & Lebeaux, 1958; Kerr et. al., 1960; Rimlinger, 1971), the search for a single proximate cause behind the boom in the welfare state expenditures continued (Myles & Quadagno, 2002). Literature from this time focused on the relationship between a post-industrial world, increased Gross Domestic Product (GDP) expenditures on social services, and the creation of public policy as an impersonal development unrelated to party politics or the balance of power. According to the critical paradigm the political economy of health in Canada is that of a biomedical nature (Bryant, 2009). Since the 1970s Canadian policy development changed to an individualistic framework wherein humans were considered to be rational beings, and a positivist approach to policy creation was adopted while focusing on individual behaviors and responsibilities to maintain health and well-being (Bryant 2009). The nature of policy creation in Canada follows a pluralistic model in which the rationality of political players and the power of the people are thought of as the main principles of influence, negating a focus on power distribution (Bryant, 2009). In this pluralist model the conflicting interests of governing parties are not taken into account, and policy creation is thought to be a calculated and rational process depicting interests of groups (Bryant, 2009).

Approaches to Health Inequalities

The social and political nature of a country can create unfair systematic differences experienced by different social groups, leading to the creation of health inequalities. These potentially avoidable conditions have been recognized in literature and have consistently demanded attention. However, with varying approaches towards the understanding of inequalities and the impact of these approaches on policy it is important to review what each of these approaches entails and how they are grounded theoretically (NCCHPP, 2016). While a multi-sectoral intervention is encouraged by scholars, policy-makers must ensure that their approach towards tackling health inequalities is inclusive. In such that they do not focus solely on disadvantages faced by the most disadvantaged group, nor on the health status gaps faced by people within the same groups, instead, they should examine inequalities across a health gradient in order to improve the health of the entire population in relation to all groups (NCCHPP, 2016). The

approach a state takes shapes the policy development and outcomes in a state (Bryant, 2009). Policy approaches can be categorized under larger social paradigms, namely the structural paradigm, positivist paradigm, interpretive paradigm, and the critical theory paradigm (Bryant, 2009). The following approaches that have been identified as the predominant ones by the National Collaborating Centre for Healthy Public Policy (NCHPP) can be categorized under the aforementioned social theories.

Positivist Paradigm: This paradigm holds that human behavior can be best explained through universal laws and that the only authentic knowledge is scientific, measurable knowledge (Bryant, 2009). Its goal is to predict and control conditions. It suggests that science is neutral and does not take into account any influence of power. The limitations of this paradigm are that it promotes a biomedical way of studying health and health inequalities. Doing so leads to context-stripping and the promotion of lifestyle changes instead of an understanding of the impact of political, social, and economic contexts. Solutions related to health inequalities are related to shifts in individual lifestyles and focuses on medical interventions. This paradigm has prevailed in social sciences research due to its quantifiable nature along with the depoliticized approach which allows for top-down interventions (Bryant, 2009).

Structural Functionalist Paradigm: This paradigm views society as a system of checks and balances, it is a consensus theory which vies for a natural order in society held together by cooperation and orderliness. This paradigm acknowledges that changes may be required in society. However the approach towards these changes is often deemed to be medical interventions. Illnesses are considered a form of deviance that disturbs the normal flow of society. Its broad focus on social structures considers how these shape society as a whole (Parsons, 1964).

Interpretive Paradigm: This approach focuses on the way individuals understand themselves and others through shared systems of meaning (Bryant, 2009). Developed as a critique of positivism interpretivist findings acknowledge that meaning is created as investigations proceed. A few approaches under this paradigm include ethnography which is a qualitative research process seeking cultural interpretation, and participant observation in which a participant participates in ongoing activities to understand the situation, amongst others (Bryant, 2009; Kawulich, 2005). In relation to health inequalities the interpretive paradigm aims to understand inequalities as experienced by individuals. A limitation of this perspective is its lack of the consideration of social relations and the importance of power distribution in determining health (Bryant, 2009).

Critical Theory: Under this social theory society is critiqued as a whole using a cluster of perspectives which challenge the positivist and interpretivist paradigms (Bryant, 2009). With a focus on socioeconomic contexts this theory focuses on the distribution of power amongst the 'haves' and the 'have-nots'. Approaches that are based on critical theory include the political economy approach, intersectionality, and the life course approach. The political economy <http://jrdsjournal.wixsite.com/humanities-cultural>

approach focuses on social, political, and economic characteristics to explain the relationships between politics, economy, and health systems and conditions. It emphasizes the importance of state intervention in liberal democracies in order to tackle health inequalities (NCCHPP, 2016). The intersectionality approach focuses on identifying discrimination and disadvantages faced by people in various social positions and helps in creating robust public health policies. The life course approach tackles the issue of health inequalities by considering how lived experiences produce long-term experiences, life trajectories, and cumulative effects. It encourages long and short term policies that encompass the needs of individuals during different stages of life (NCCHPP, 2016). One limitation of critical social theory is that in its focus on power and domination it may neglect to review other actors at play (Bryant, 2009).

Keeping in mind the various approaches to health inequalities and the understanding of the relationship between welfare states and health policy, strategic steps can be taken to decrease health inequalities while working with the existing political and economic conditions. As the Canadian welfare state continues to undergo changes due to political, global, and economic factors it is important to ensure that those impacted by unfavorable living conditions do not continue to suffer. The next section of this paper provides a discussion on policy making and opportunities to implement change, along with an identification of barriers that are in place.

DISCUSSION:

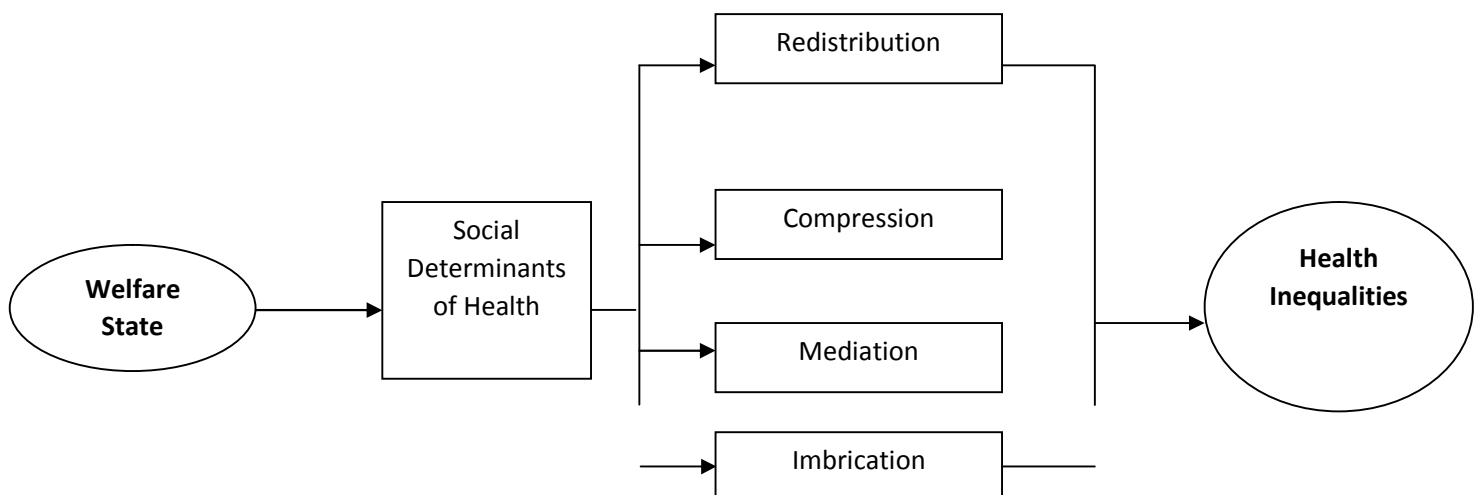
The Welfare States and Health Inequalities

Some scholars such as Weinstock (2015) and Kelly (2007) argue that health inequalities researchers have failed to create a compelling case for the involvement of SDH in policy-making and that development of an evidence base for political action is required. Other critiques state that positive action is often blocked by the political confines of a government due a dominant policy paradigm that may be in place in a country. The promotion of the 'health behaviorism cult' which focuses on individualistic health behaviors can thus be viewed as a consequence of the widespread public sector culture (Scott-Samuel & Smith, 2015). Presently, there is a limited range of theories that explain health inequalities in relation to their origins and implications (Schrecker & Smith, 2015). The relationship between welfare states and health inequalities has widely been examined in the literature (Navarro et al., 2006; Bambra, 2005; Raphael, 2010). Along with an analysis of population health, the nature of health systems within various welfare states has also been analyzed. Epidemiological studies have concluded that population health is positively correlated with generous welfare states and social provisions (Navarro et al., 2006; Bambra, 2011; Castles et. al; 2010). However, nations with the most generous welfare states do not boast the lowest numbers of health inequalities, as demonstrated by Scandinavian welfare states (Bambra, 2011). Navarro et. al (2006) conducted a 50-year longitudinal study to test the empirical link between political parties and redistributive policies. They found that welfare states are important determinants of health as policies aimed at reducing social inequalities have a salutary impact on health indicators (Navarro et al., 2006; Bambra, 2011).

The relationship between welfare states and health is one that is based on the complex interactions between political traditions and the balance of power. The mechanisms by which politics affect policy were explored in the past decade but were limited to analyses of selected OECD countries (Navarro et al., 2006). It has been found that redistributive policies are

positively associated with health outcomes (Navarro et al., 2006; Muntaner et al., 2011; Acemoglu et al., 2013). If these findings are present, the question then rises about the lack of widespread implementation of redistributive policies at the system level. This delay in a call to action is attributed by some to barriers such as a preoccupation with individual responsibilities, consistent with the emergence of neoliberal governance (Kapilashrami et al., 2015; Muntaner et al., 2015; Scambler & Scambler, 2015; Cohen & Marshall, 2016; Baum, 2011). Solutions to helping public health advocacy groups realize their full potential include the implementation of multi-sectoral efforts that increase state intervention while holding corporations accountable for their hand in the production of health inequalities (Cohen & Marshall, 2016).

Authors such as Bambra (2005), Pierson (1998), Abrahamson (1999) and Kautto (2002) provide critiques of Esping-Andersen's work in stating the need for an analysis of outputs rather than inputs, as literature becomes saturated with 'settling of accounts with Esping-Andersen' (Pierson, 1998). Beckfield et. al (2013), Raphael and Bryant (2009) and Graham (2004) argue that assigning countries to static categories suggests that countries are consistent in their policies, which is inaccurate. It is crucial to take into account the historical and cultural contexts within which policy changes take place, along with examining the structure of power in welfare states which lead to the implementation of policies as well as impact living conditions (Raphael & Bryant, 2015). Roots of health inequalities are often related back to the unequal distribution of power, social class and class relations act as links between the political context and health inequalities (Ottersen et al., 2014). The following model created from Beckfield et. al's (2013) work on an institutional theory of welfare state demonstrates the four facets through which the welfare state governs health inequalities. SDH are distributed, compressed, mediated and imbricated to create health inequalities based on the old institutionalism which emphasizes that ideas are codified by law, activated by policies, and enforced by the institutional agents depicted below:



Welfare State Retrenchment

The Canadian welfare state is often studied in isolation. In such that its situational context is paired with the United States due to its similarities. There are a greater number of studies that focus on exclusive comparisons with the United States, or other European countries (Leman, & Kahn 1980; Myles & Forcese, 1981). There are debates present amongst scholars regarding the possibility of austerity. While some authors argue that socioeconomic problems lead to an environment of constant austerity, others argue that path dependency of policies and the configuration of a political system dictate the amount of retrenchment (Starke, 2006). The Canadian situation is focused on specific policies of specific aspects of welfare expenditure (Myles & Guppy, 1984; Cameron, 1986). An analysis of pension quality in Canada shows that Canada ranks midway amongst fifteen OECD countries in a comparative analysis of government expenditure between twenty OECD countries (O'Connor, 1998). Canada is found to be in a deteriorating position since the early 1980's where it ranked third amongst the eighteen OECD countries. O'Connor (1998) states that the Canadian welfare state presents a mixed result in regards to the four dimensions of welfare states which she identifies as decommodification, solidarity, redistribution and full employment (See Figure 2 for a timeline of events that caused the retrenchment of the broader welfare state). With education and health being the best aspects of Canada's welfare effort, she recognizes that these may be universal in equality rather than outcome of equality. She concludes that a major critique of the Canadian welfare system is that while it helps reduce inequalities, it does so in a very class-influenced way on a broader level, as opposed to being successful in promoting equity for target groups.

Figure 2: Timeline of events that caused the retrenchment of the broader welfare state (Castles et al, 2010)

1970s	Collapse of the Bretton Woods financial system
1970s	Economic slowdown resulting from two oil price shocks
1970s	Second wave of globalization increasing competition between nation states for capital, leading to a newly asymmetric balance of power between labour and capital
1980s	Deregulation and internationalization of capital markets, increasing trade
1989	Collapse of communism leading to confirmation that public intrusion in economic affairs leads to inefficiencies

The politics of welfare state retrenchment focus on the political and economic circumstances that allow for retrenchment. Welfare state retrenchment has been popularly discussed by Paul Pierson (1996) who examines the resiliency thesis. His work analyses the retrenchment regimes of Ronald Reagan in the US and Margaret Thatcher in Britain. The changes brought about by these 'true neoliberal believers' led to market reforms across many areas. Surprisingly, however, the level of government spending under both these regimes actually increased instead of decreased (Pierson, 1996). Pierson (1996) offered three reasons for such an

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unimaginable growth, one being the socio-psychological theory that individuals will respond more strongly to the chance of loss than to the opportunity of making an improvement. Second, that due to the logic of collective action the forbearance of immediate costs in return for the diffusion of long-term benefits leads to loss of support from groups. Lastly, those historical legacies have been in a way 'locked-in', in such that governments are bound to honor the promises of their predecessors (Pierson, 1996). This resilience thesis is widely acknowledged in the literature (Starke, 2006). While Esping-Andersen (1990) denotes that theories explaining welfare state growth should also be able to explain welfare state retrenchment, however, authors such as Pierson (1996), Palier (2001) and numerous others argue that the politics of the present welfare states is vastly different.

The politics of retrenchment is based on an entirely different situation than the politics of welfare state expansion. In a newer more complex political environment bound by lock-ins of previous policies and historical legacies, it is difficult to make major changes and attain buy-in from lobby groups. With a contrast for governments between increasing social expenditures and 'credit-claiming', to cutting social expenditures and 'blame avoidance' it is difficult to avoid consequences of shifting to a less generous system. The question being asked now in literature is regarding how cutbacks are taking place within welfare states despite these theories of resilience (Starke, 2006). While some authors such as Korpi and Palme (2003) and Allan and Scruggs (2004) challenge the notion that welfare states are resilient to change, others such as Ross (2000) and Green-Pedersen (2002) argue that the nature of cuts depends on current politics and other dependent variables. Starke (2006) highlights the difficulty in attaining a true measure of retrenchment, due to differences in the definition of retrenchment and the difficulties in understanding causal mechanisms of cut-backs.

Welfare state retrenchment and Health Inequalities

Regardless of retrenchment being a politically parlous task, it is not impossible. Critics have highlighted changes in numerous countries' welfare states which have over time led to significant reductions in programs, for example in countries such as New Zealand, the United Kingdom, and the United States. In Canada, a metric of retrenchment is the employment status, employer benefits, lack of unionized work, and pension programs. Other examples are the toughening of the qualifying criteria for social programs, stagnation (high economic growth paired with inflation), and an increase in trade union suits. Changes in the composition of taxation and spending are also noteworthy. Through the processes of cost-containment and recommodification of labour for example, the governing bodies are able to present austerity measures in a credit-claiming manner. The post-welfare state model of the Canadian social security programs suggests that Canada is moving towards the ideology that governments cannot do it all on their own. An example of which could be non-governmental actors such as employers, communities, and others playing a more active role in providing social programs. As Canada transforms its social expenditure from a universalist model to a residual model, the laissez-faire ideology continues to grow. Major income security programs built in 1914, the provision of child tax credits (1918), and benefits for the elderly were some of the strongest factors of the Universalist welfare state model. As Canada's economic growth decreased due to the world oil price shock and increased in inflation, increasing deficits and debt led to a reduction in social and public expenditure in the 1980's and 1990's. As rising unemployment led

to high demands on welfare states, health inequalities exacerbated (Bambra, 2009; Pope et al., 2013). Studies have found a quantifiable impact on rising levels of unemployment and negative impacts on health (Bambra, 2009; Pope et al., 2013). Thus, there is awareness in literature and in the policy-making realm of the relationship between inequalities, health disparities, and living conditions. Yet there continue to be changes in the welfare state that impact population health negatively, but are not major enough to cause wide-alert amongst the public.

CONCLUSION:

An examination of existing literature shows that it is important to analyze the hyper-concentration of wealth and its relation to health inequalities (Raphael & Bryant, 2009; Scambler & Scambler, 2015; Scott-Samuel & Smith). These inequalities also need to be examined through multiple social positions such as ethnicity, gender, caste, and other levels of advantage and disadvantage (Kapilashrami et al., 2015). According to Weinstock (2015), issues of health inequalities must be presented as issues of justice, a dictation of 'health above all policies' is simply too contradictory to the current capitalist and economic policy goals that states employ. The distribution of power and the top-down approach to the reduction of inequalities based on a focused model excludes a consideration of the life course, as well as the class struggle. Notably, policy makers are on the opposite side of those experiencing the most systematic discrimination avoidable by structural readjustments. The neoliberal shift that started decades ago is physically making those already disadvantaged in society sicker (Schrecker & Bambra, 2015). A comprehensive political strategy aimed at reducing health inequalities is required, one that takes into account the research that shows that targeting programs too closely has consequences as well. Therefore, targeting health inequalities as a gradient throughout the population would lead to coordinated policies. It is important not to rate or judge welfare states by their levels of expenditure as not all spending counts equally (Esping-Andersen, 1988).

Additionally, there are tensions noted in the literature regarding health policies, health inequalities, and inequity lacking representation on the political agendas of liberal and conservative welfare states. A focus on health behaviours, the emergence of neoliberal governance, and the attempted implementation of programs to help reduce inequality that is not comprehensively equipped have all been identified as barriers to the path of reducing inequalities. Radical change requires disruptive actions. The policy making process by wealthy elites who are pressured by corporate interests leads to policies that are ineffective at reducing inequalities. Systematic change requires campaigning, mass-mobilization that leads to people-power.

In conclusion, the move towards a more comprehensive system which provides benefits as a citizen-right as opposed to a last resort is required. To achieve this ideological shift, it is important to grow away from the liberal tradition of individualism and focus on social rights, equity, and state responsibility in Canada. However, any chances for change would depend on the institutional, political, and functional context, while keeping in mind the character of the counter-forces that states may be up against. As discussed previously, theories of path-dependency and opportunity to be able to make radical changes continue to be a challenge. However, with a coordinated approach that brings together multiple-systems including buy-in from the public and with a focus on equity, roots for an ideological shift can be planted.

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