Mapping European Welfare States: From Stereotypes in Comparative Social Policy to Realities on the Ground

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This study sets out to break through the existing thought boundaries of so many (the taken-for-granted, but wrong, assumptions that surround us; cf e.g. Trifiletti, 2003), by looking at European welfare state systems *in all of Europe*, in the farthest sense. A spectral data analysis is being conducted and the results of which are being discussed in the context of the up-to-date standing of comparative welfare state theory; referring to both, first, ideal-typical and, then, real-typical perspective and theory. The recently found breaking up of East-West and North-South boundaries within the European Union (Aspalter, 2023a) is particular interesting, and part of the investigative focus. Hence, extra thought and attention is given to the evaluation of welfare state development *on the ground*, as it is today, i.e. as it is with regard to up-to-date empirical data. Also, the study goes beyond the boundaries of the current European Union, and intends to capture all of Europe from Lisbon to Vladivostok. As a result, the study is also looking at new findings about many forgotten and shoved-aside countries that are yet to be fully integrated and put under the spotlight and microscope of international comparative social policy analysis. On top, the existence of certain myths, and their respective mantras, were sought to be exposed, and then discussed. Yet, in light of the general nature of the health care outcome data used, a common phenomenon in health care analysis has come to the fore, that is, when looking at health care outcomes, one looks about 20-30 years into the past in terms of policy/system implementation—i.e. a *time travel* goes on, as e.g. cancer, diabetes, etc. need on average a couple of decades before they appear, and then get diagnosed. This is so, because these modern mass diseases result from unhealthy food choices and lifestyle choices made in the past, and lack of welfare/health care provision in the past (i.e. over the past decades). In so doing, we here in the data results of this study have still seen the Southern Europe of the past in terms of health care system (health service provision), and lifestyles, etc.

Other studies, like e.g. (Aspalter, 2023a), looked at poverty outcomes, and these are *not time-travelling into the past*. Poverty outcomes today respond to welfare state systems and policies of today (that lack of social security, lack of social development today). Therefore, we, when it comes to *welfare state system analysis*, need the whole spectrum of different data present in the data analysis (e.g. poverty included, inequality included, etc.), more than one angle of perspective applied.

Comparative social policy can look back at great many improvements in the understanding and exploration of the welfare state, or welfare state systems as we should say. While in the beginning, in the 1950s, only a dichotomic worldview of welfare states existed (Wilensky and Lebeaux, 1958; Titmuss, 1958), a tricolor, but yet very European-centered, picture emerged in the 1970s (Titmuss, 1974). This did not change with Esping-Andersen's publications in 1989 and 1990. The tricolor view, on the contrary, seemed to have been written in stone, with the landmark 1990 book of his. For many this has become a religion (cf Van Kersbergen, 2019; Van Kersbergen and Vis, 2015). Others, following their own religion, have resorted to reflexively support (vote for) a four-fold world of welfare state systems in Europe, by adding a fourth, so-called 'Latin' or 'Mediterranean' welfare model. While the latter have had a real-typical perspective of welfare regime modelling in mind, and did not use a Weberian methodology (cf Aspalter, 2020a), they still are wandering paths of believes, rather than objects of hard empirical facts, i.e. quantitative data on the ground.

When we say, in Italy, or any 'northern' Mediterranean country, that family is most important, then what does that mean? Does it mean that the government spends most on families, on family welfare, on children's welfare? No, and that is the surprising fact that runs counter to any religious-looking notions that the Italian welfare state or the (northern) Mediterranean welfare state model is centered on the very same.

When focus means lack of support, then that logic has bitten in its own tail. Families have to fend for themselves in Italy, and for that reason families are the most important support system that there is in Italy, but it is *not* a government support system, it is *not* a welfare state support system. The Austrian, German and Luxembourgian welfare states, for example, spend far more on family support, than any (northern) Mediterranean welfare state system that there is, about three times as much as percent of GDP; almost the same record of family support can be seen in all Nordic countries (Eurostat, 2023; cf also esp. Trifiletti, 2020, 1999). Hence, empirical facts are omitted and ideas and stories, instead, take their place—and then, start to wander their own paths. We, therefore, need to come back to empirical data, lots of quantitative data, with additional support of lots of in-depth qualitative data (cf Trifiletti, 2003).

> *All countries in the world have families at the center of people's welfare, and that in all continents of the world.*

That is a fact. Kai Leichsenring (2020: 195) has shown that even e.g. in Sweden (the perhaps least family-oriented society and welfare state system that there is), still about 60 percent of care work is happening in the family. As Leichsenring noted so importantly,

> "*There is no society* in which more than 40 percent of all care work would be accomplished by *formal* care services. In particular, in a global context, it might therefore be misleading to title an ideal-type care regime 'family-based.'" (*emphases added*, Leichsenring, 2020: 195).
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> In other words, *all over the world* at least 60 percent of all care services are happening in the family: that is a very strong majority!

To argue that this or that country has a, for example, 'Mediterranean' welfare state (whatever is meant by that geographically and/or content-wise) based on having strong families and strong religion, is like telling the rest of the world their families are not strong; and/or telling the rest of the world they do not have strong religion, and only e.g. Israel has (cf Gal, 2010).

That is why it is so important, for any observer, to once in a while make a step backwards (in space) and look at the research object under scrutiny anew—from a higher and/or wider perspective. This is basic practice in the scientific enterprise. We need this fresh look at things, i.e. at welfare state systems; especially the ones outside of the better-known rich countries of the Western world.

Giuliano Bonoli (2021) was so right to call on the self-supporting and self-propagating ideas that have to be distinguished from real-life facts, and from real-life ideal types (cf Aspalter, 2020) and real-life real types (i.e. any other than Weberian types, cf Spiethoff, 1953; Engermann, 2000). What we believe ideal types, and real types, are is, time and again, different from the real-life ideal types and real-life real types on the ground, that are manifested in terms of empirical data; and that change with the very same.

This paper here is not addressing, not merely addressing, the Southern countries of the European Union. Far from it, it is addressing all countries in the European Union and those European countries that are not in the European Union. That is, our interest here shall include all countries spanning from the Atlantic islands of Portugal and Spain to the Russian islands off the coast of Vladivostok, 48 countries in total (sparing countries with small populations, as data there is too easily impacted by small changes, e.g. the opening of one new hospital, etc.).

We choose to throw our *investigative spotlight* on the area between the western fringes of the ideal-typical Christian Democratic Welfare Regime (Portugal in the south, and Ireland in the north) and the eastern fringes of the Selective Rudimentary Welfare Regime (the Russian Federation including their farthest regions in the northwestern Pacific). It is important to know what one is aiming, looking at, and not just following reflexively, or instinctively, this or that path in empirical analysis, be it in quantitative or qualitative investigations.

Therefore, what is of particular interest to this paper are the realities on the ground in countries that either belong or are in between the Selective Rudimentary Welfare Regime (of most countries that were part of the Soviet Union) and the

Christian Democratic Welfare Regime, the extended realm of the Christian Democratic Welfare Regime, truly a post-Esping-Andersen take on it, which include all countries between Portugal and Poland, and from Poland down to Croatia, including Greece, Cyprus and of course Ireland (Aspalter, 2023a).

There are many countries that have not made the transition, or not a positive transition yet, from the former Soviet/socialist model of welfare state system to a new one. Many are *en route* to the Christian Democratic Welfare Regime, a journey that had been taken successfully by Poland, Czechia, Slovakia, Hungary, Slovenia and Croatia before. Here we have based membership on quantitative data, not feelings, or ideas of any kind (Aspalter, Kim and Park, 2009; Aspalter, 2023a). Also, the Baltic states are very interesting, having left the former Soviet/socialist model decisively, but without any strong/decisive goal destination, as it seems (cf the discussions of e.g. Toots and Bachmann, 2010, as well as Aidukaite, 2006, 2009a,b).

Also, the dimension looked at is health care outcomes, as it in the past has generated strong scientific interest from medical science and health policy in particular, and, indeed, as it has shown very strong results in terms of applying ideal-type theory in particular and welfare state system comparison as a whole.

In addition to this, a great deal more studies need to be, in the following, devised and conducted that focus also on different perspective of the wide and far-reaching social policy spectrum. This is a task that other studies and other researchers definitely will pursue in many countless instances. What many have perhaps not noticed, not yet, is that comparative social policy has, for quite some long time now, become very popular in countries which formerly seemed to have been far away from the center of social policy research and thus the social policy debate. There is fast-growing interest and know-how in many countries, including e.g. Ukraine, Russia and Georgia (cf e.g. Verulava and Asatiani, 2020; UKR, 2018; Remington, 2011), where the scientific discussion and exploration is not only happening in English, but also increasingly so in their own local languages (of course).

A very hot topic is also Turkey, which was not included in this study here (due to the investigative *spotlight circle* chosen that is set by the aim of the study, see above), as Turkey for sure is not falling in between the Selective Rudimentary model (the post-Soviet model) and the Christian Democratic model, in ideal-typical perspective.

Turkey is a very interesting case, some say it is or may be a ‘Mediterranean’ (whatever that means) and other (seemingly very reasonable ones) are supporting the idea of the welfare state system in Turkey being some mixed model, with different influences from far and wide (including Asian, neoliberal and continental European influences) (cf e.g. Grütjen, 2006; Elveren and Agartan, 2017; Kocamaner, 2020; Yörük, 2022).

The case of Turkey, for sure, deserves much greater attention in the mainstream social policy arena, more than it can be done justice in this study here; what would be a necessarily short depiction, as it is a very special case indeed (especially with the continued influences of President Erdogan); also, the great

majority of the territory of Turkey is not in (geographical) Europe—which leads to the follow-on imperative to, otherwise, also include Israel, and then Lebanon and Jordan, etc. (why not).

The countries of relatively greatest neglect in the social policy arena are in between Germany, Turkey and Russia. This is where our attention shall rest in this particular paper. Much less is known about Albania, North Macedonia, Azerbaijan, and Tajikistan, to name just a few, than it should. While the selected methodology is not suitable to gather and gain in-depth views of welfare state systems in these countries, the data collected serve certainly as a motivational-cum-supporting base for further studies, be they also quantitative or qualitative in nature.

There will be many, now, perhaps, thinking Central Asian countries why should they be included in a study on Europe. In real life, these countries, which we geographically call Central Asian countries, are in fact always in the same group as the Russian Federation, this is not only in part culturally and linguistically, and hence also politically, and societally, the case, but also in the United Nations and in the International Social Security Association, where these countries are part of the European region, and not in the Asia and the Pacific region. Therefore, it is very important to note that this study is not suited to make political assumptions or statements of any kinds, but rather, and just so, to make ideal-typical and real-typical welfare regime theory accessible to a scientific audience and, hopefully, to be advancing the very same theories; nothing more, nothing less.

On the Methodology Being Used

The objects under scrutiny are welfare state systems in all their facets, in all their complexity and comprehensiveness. As it is not possible—*in a meaningful way*—to reduce the data that can (possibly in a small study as this one) be collected, and put to use, i.e. analyzed, within the framework of welfare regime theory, both ideal-typical and real-typical ones, we are in the following employing a method that is rather commonly used in physics and chemistry (similar versions can also be found in economics). This is the *spectral data analysis method* (Aspalter, 2023a,b).

Like in physics and in chemistry, we are looking at emissions of data, emissions (i.e. outcomes) that we are able to analyze, and which are being directly causally associated with the contents and characteristics of the research objects under scrutiny.

The only difference, between social policy spectral data analysis and physics/chemistry spectral data analyses, is that we are on the inside of welfare state systems (*seemingly so*, but yet in Luhmann's terms we are actually still on the outside of welfare state systems, as geography does not matter, and only communication/rules/administrations/finances/etc. do in Luhmann's theory world, cf Luhmann's social system theory in Luhmann, 1984, 1997).

In physics things are too far away, in chemistry they are too small. In social policy, they are too complex, i.e. too rich in terms of data and in terms of perspectives, especially their causal interconnectedness and therewith resulting intellectual wickedness.

It is important to be in the clear what one wants to study and what one is talking about and/or measuring and then interpreting the results of these measurements. In our case here, we want to look at *welfare regimes*, mainly from an ideal-typical perspective, and then in the following, since our focus here is first and foremost an explorative one, also real-typical perspective, to some extent.

In the following part we will compile and compute quantitative data that represent *the outcomes (the emissions)* of welfare state systems, and when we (and only when we) look at the whole set of countries included in the study, all 48 of them, then we can make out, interpret and learn from patterns and shades of degrees of different outcomes here and there, by looking at groups and groupings of countries first and foremost, but also at special countries that are either placed alone or are traveling alone within the greater world where welfare regimes (ideal-type ones, and real-type ones) are to be found—which is basically the entire northern half of the Eurasian continent, or the 'European' region (which as a matter of fact culturally speaking can/could include much more countries, in the near Middle East, and particularly also all of Central and South America, and the Caribbean, as well as in fact the very north of Africa, e.g. Cabo Verde and others, plus perhaps also Canada, Australia, Aotearoa/New Zealand, etc.).

In the computation of the latest datasets, which are from the World Health Statistics Yearbook of the WHO, we will employ a new quantitative method, the *Standardized Relative Performance (SRP) Index* that Aspalter developed in 2006 and applied throughout the years; its use has been highlighted in the recent publication *Ten Worlds of Welfare Capitalism: A Global Data Analysis* (cf Aspalter, 2006a, 2023a).

The SRP index is based on a double-standardization method, standardizing each value in relation to the top-most and bottom-most value of the group of values, for each particular group of research entities.

> As the name Standardized Relative Performance Index is telling already, *we are measuring exactly the 'relative' performances of the research items under scrutiny*.

Hence, we can do what is in general stubbornly thought to be impossible, i.e. to compare not apples, with bananas and pears, but to compare *the performances* of apples, bananas and pears with one another, with a new quantitative method.

And, with it, we are comparing very different aspects of the same items (our research objects). For the first time, we can now combine the measurement of variables that are expressed in different measurement units. We can compare the number of years of life with e.g. the incidence of child mortality. We can

compare both with the expenditures of the health care system as percent of the GDP and the very same in terms of absolute spending per person.

Now, literally, we *can* compare apples with bananas, *and* compare them *as a group* with cucumbers and potatoes. As we look at and take measurement of their *relative* performance, and the '*exact distances' of relative performances* in each specific group of research objects *in relation to the top and bottom performers of each variable, each dimension (group of variables), or group of objects—each within one specific group or collective of research objects* (the group membership of which is not allowed to be changed, as this would/could change the top-most and/or bottom-most performance of this or that variable, dimension, or group of research objects).

The formula first used by Aspalter (2006a) and then repeatedly thereafter, and then, in 2017, independently compiled again by Antonelli and De Bonis, whose main source Caruana (2010) has not yet standardized the values in relation to the bottom performances, and hence his method was not functional in terms of combining values of different variables, dimensions and groups of objects. Aspalter's original formula of 2006 is the same used by Antonelli and De Bonis in 2017, i.e. eleven years later.

The original SRP Index formula used by Aspalter (2006a) goes like this:

("current value" – "lowest value") / ("highest value" – "lowest value") *10

Each time when values are being merged (by summing them up or by averaging them), they have to be subsequently be standardized again with the same formula, so that each step of the way, the highest value becomes 10 and the lowest value becomes 0 (of each variable or dimension, etc.). No negative values are allowed, they have to be calculated out (by adding the highest negative value to each value in that column, i.e. group of values of one variable).

It is important to have *data for each item* in the tabulation. One can, when carefully devising a spectral data analysis, use *proxy variables* (e.g. U5 mortality rates as proxy variables for poverty, as diseases of poverty and malnutrition are key causes of deaths of under 5 year olds around the world); as well as if needed *proxy data*. Therefore, in a few cases, carefully chosen/selected proxy data (where it really makes a lot/multiple sense to do so) may fill any possible data gaps that are caused by the usage of not fully complete data sets, especially when e.g. working with datasets of e.g. international government organizations that include a very large number of developing countries. Then, it is vital to control the case number of this, percentage-wise, to have only a very, very small percentage of proxy data being used; as well as to have and keep the research purpose and research question that one is following in clear sight—to make sure everything has a strong foundation, i.e. the final/overall research results are unshakable (fully

reliable) and of course super meaningful/fruitful (scientifically and practically speaking).

In other words, it is vital in general to measure meaningful emissions in a meaningful way (in a super reliable and fruitful way), and to work oneself through to factually meaningful interpretations of data and their results that lead to or secure meaningful (i.e. true *and useful*) research outcomes.

The Data and Results of the Spectral Data Analysis

In this study, the latest data from the World Health Organization as compiled in the World Health Statistics is being used for further analysis of welfare regimes that are based in Europe, from the very west to the very east of its fringes.

The main focal point of the study is the center of the European region, roughly between Germany and Russia, bordering Turkey, Iran and India in the south. The chosen focus includes countries all the way down to Greece, Cyprus, Armenia and Georgia, and then further east to Tajikistan and Kyrgyzstan.

> Each study may set its own focal horizon, its investigational spotlight, its investigative territory. A too wide a focus and a too-narrow a focus are both detrimental to the objective at hand, in this case, to learn more about all European countries, or better European-centered countries (as we follow the European Region of UN/ISSA member countries that also include Central Asian countries).

In total 13 variables of health care outcomes have been included, all of which have been given equal weight. To keep things simple, in this study, no extra dimensions or sub-dimensions have been set up. The purpose of this study is to map the countries in the middle of the (geographical) territory of the European Region, looking at all of Europe, and not just the European Union.

The variables included comprise life expectancy at birth, healthy life expectancy at birth, maternal mortality rate, neonatal mortality rate, under-5 mortality rate, incidence of stunting below 5 years of age, tuberculosis rate, child and youth obesity, adult obesity (which has been age-standardized), hypertension rate, cardiovascular diseases incidence of people aged 30-70, as well as the number of doctors per population, and the number of nurses per population.

This composition of indicators includes both general health outcomes, regarding life expectancy and healthy life expectancy, as well as hunger/malnutrition (using the proxy variable of stunting of children aged below 5), communicable diseases (tuberculosis), and a greater range of non-communicable diseases and health-quality reducing and disease-inducing conditions such as obesity and hypertension. Non-communicable diseases are the main culprit behind avoidable premature deaths and sufferings due to ill-health in this part of the world in particular (but also in all parts of the world, including most countries in Africa). Last but not least, the health care security (as an

outcome of the health care system) in form of health care personnel has been measured by using the two proxy variables of doctors and nurses per population.

Life expectancy and healthy life expectancy SRPs, as well as the number of doctors' and nurses' SRPs, have been reversed, for low values of SRP, 0 or close to 0, to stand for the best performances overall throughout this study, within this group of countries that has been included in this study. Health care outcomes in general are marked by the lack of health, or lack of health care and (direct/actual) health care security (health care infrastructure, incl. personnel in particular).

One can use only positive SRPs (well-being indicators) *or* only negative SRPs (e.g. mortality and illness indicators), but for the most part, one needs, of course, to convert the one or the other into the other. So, in general, 0 either stands for the best performer (as in our case in this study) *or* for the worst performer, and so is 10. This is up to the researcher to choose, in each particular case. We, here, have chosen 0 to be the best performing investigation object, and 10 the worst.

Table 1/Part 1: Partial Results of SRP Indexes

(Standardized Relative Performance Indexes)

		1) LEab		D1	2) HLEab		D2	3) MMR	D3	4) NNMR	D4
			st'd	rev.		st'd	rev.		st'd		st'd
Albania	(towards CD)	78.0	6.1	3.88	69.1	6.8	3.24	15	2.24	8	3.04
Armenia	SR	76.0	4.7	5.32	67.1	4.9	5.14	26	4.14	6	2.17
Austria	CD	81.6	8.7	1.29	70.9	8.5	1.52	5	0.52	2	0.43
Azerbaijan	SR	71.4	1.4	8.63	63.6	1.5	8.48	26	4.14	10	3.91
Belarus	SR	74.8	3.8	6.19	66.0	3.8	6.19	2	0.00	1	0.00
Belgium	CD	81.4	8.6	1.44	70.6	8.2	1.81	5	0.52	2	0.43
Bosnia & Herz.	(towards CD)	76.8	5.3	4.75	67.2	5.0	5.05	10	1.38	4	1.30
Bulgaria	(towards CD)	75.1	4.0	5.97	66.3	4.1	5.90	10	1.38	3	0.87
Croatia	CD	78.6	6.5	3.45	68.6	6.3	3.71	8	1.03	3	0.87
Cyprus	CD	83.1	9.8	0.22	72.4	9.9	0.10	6	0.69	2	0.43
Czechia	CD	79.1	6.9	3.09	68.8	6.5	3.52	3	0.17	2	0.43
Denmark	SD	81.3	8.5	1.51	71.0	8.6	1.43	4	0.34	3	0.87
Estonia	BAL	78.9	6.8	3.24	69.2	6.9	3.14	9	1.21	1	0.00
Finland	SD	81.6	8.7	1.29	71.0	8.6	1.43	3	0.17	1	0.00
France	CD	82.5	9.4	0.65	72.1	9.6	0.38	8	1.03	3	0.87
Georgia	SR	73.3	2.7	7.27	64.7	2.6	7.43	25	3.97	5	1.74
Germany	CD	81.7	8.8	1.22	70.9	8.5	1.52	7	0.86	2	0.43
Greece	CD	81.1	8.3	1.65	70.9	8.5	1.52	3	0.17	2	0.43
Hungary	CD	76.4	5.0	5.04	67.2	5.0	5.05	12	1.72	2	0.43
Iceland	SD	82.3	9.2	0.79	72.0	9.5	0.48	4	0.34	1	0.00
Ireland	CD	81.8	8.8	1.15	71.1	8.7	1.33	5	0.52	2	0.43
Italy	CD	83.0	9.7	0.29	71.9	9.4	0.57	2	0.00	2	0.43
Kazakhstan	SR	74.0	3.2	6.76	65.0	2.9	7.14	10	1.38	5	1.74
Kyrgyzstan	SR	74.2	3.4	6.62	65.8	3.6	6.38	60	10.00	12	4.78
Latvia	BAL	75.4	4.2	5.76	66.2	4.0	6.00	19	2.93	2	0.43
Lithuania	BAL	76.0	4.7	5.32	66.7	4.5	5.52	8	1.03	2	0.43
Luxembourg	CD	82.4	9.3	0.72	71.6	9.1	0.86	5	0.52	2	0.43
Malta	(N.D.)	81.9	8.9	1.08	71.5	9.0	0.95	6	0.69	4	1.30
Moldova	SR	73.3	2.7	7.27	64.5	2.4	7.62	19	2.93	11	4.35
Montenegro	(towards CD)	75.9	4.6	5.40	67.0	4.8	5.24	6	0.69	1	0.00
N. Macedonia	(towards CD)	74.8	3.8	6.19	66.1	3.9	6.10	7	0.86	4	1.30
Netherlands	CD	81.8	8.8	1.15	71.4	9.0	1.05	5	0.52	3	0.87
Norway	SD	82.6	9.4	0.58	71.4	9.0	1.05	2	0.00	1	0.00
Poland	CD	78.3	6.3	3.67	68.7	6.4	3.62	2	0.00	3	0.87
Portugal	CD	81.6	8.7	1.29	71.0	8.6	1.43	8	1.03	2	0.43
Romania	(towards CD)	75.6	4.4	5.61	66.8	4.6	5.43	19	2.93	3	0.87
Russia	SR	73.2	2.7	7.34	64.2	2.1	7.90	17	2.59	2	0.43
Serbia	(towards CD)	75.9	4.6	5.40	66.9	4.7	5.33	12	1.72	4	1.30
Slovakia	CD	78.2	6.3	3.74	68.5	6.2	3.81	5	0.52	3	0.87
Slovenia	CD	81.3	8.5	1.51	70.7	8.3	1.71	7	0.86	1	0.00
Spain	CD	83.2	9.9	0.14	72.1	9.6	0.38	4	0.34	2	0.43
Sweden	SD	82.4	9.3	0.72	71.9	9.4	0.57	4	0.34	1	0.00
Switzerland	CD	83.4	10.0	0.00	72.5	10.0	0.00	5	0.52	3	0.87
Tajikistan	SR	69.5	0.0	10.00	62.0	0.0	10.00	17	2.59	14	5.65
Turkmenistan	SR	69.7	0.1	9.86	62.1	0.1	9.90	7	0.86	24	10.00
Ukraine	SR	73.0	2.5	7.48	64.3	2.2	7.81	19	2.93	5	1.74
U.K.	NLIB	81.4	8.6	1.44	70.1	7.7	2.29	7	0.86	3	0.87
Uzbekistan	SR	73.0	2.5	7.48	64.7	2.6	7.43	29	4.66	8	3.04

Notes: Calculated from WHS (2022); LEab = life expectancy at birth, HLEab = healthy life expectancy at birth, MMR = maternal mortality rate, and NNMR = neonatal mortality rate, rev. = reversed, st'd = standardized; CD = Christian Democratic Welfare Regime, SR = Selective Rudimentary Welfare Regime, SD = Social Democratic Welfare Regime, BAL = Baltic states (free-moving welfare state systems), NLIB = Neoliberal Welfare Regime, N.D. = not determined.

Table 1/Part 2: Partial Results of SRP Indexes

(Standardized Relative Performance Indexes)

		5) U5MR	D5 st'd	6) STUNT b5	D6 st'd	7) TUBERC.	D7 st'd	8) OBE 5-19	D8 st'd	9) ADULT OBE ag.st.	D9 st'd	10) HYPERT.
Albania	(towards CD)	10	2.00	9.6	5.89	15	1.18	7.6	4.26	21.7	5.10	41.8
Armenia	SR	11	2.25	9.1	5.58	23	1.96	4.8	1.67	20.2	4.08	47.3
Austria	CD	4	0.50	0.0*	0.00*	5	0.20	8.6	5.19	20.1	4.01	33.8
Azerbaijan	SR	19	4.25	**16.3**	10.00	58	5.39	4.9	1.76	19.9	3.88	41.0
Belarus	SR	3	0.25	3.9	2.39	26	2.25	7.6	4.26	24.5	7.01	**49.2**
Belgium	CD	4	0.50	2.3	1.41	8	0.49	7.0	3.70	22.1	5.37	30.0
Bosnia & Herz.	(towards CD)	6	1.00	9.1	5.58	26	2.25	5.4	2.22	17.9	2.52	44.2
Bulgaria	(towards CD)	6	1.00	6.4	3.93	19	1.57	10.8	7.22	25.0	7.35	45.2
Croatia	CD	5	0.75	0.0*	0.00*	7	0.39	10.9	7.31	24.4	6.94	48.4
Cyprus	CD	3	0.25	0.0*	0.00*	6	0.29	12.2	8.52	21.8	5.17	30.8
Czechia	CD	3	0.25	2.5	1.53	4	0.10	9.7	6.20	26.0	8.03	41.6
Denmark	SD	4	0.50	0.0*	0.00*	5	0.20	7.2	3.89	19.7	3.74	35.9
Estonia	BAL	2	0.00	1.2	0.74*	10	0.69	6.3	3.06	21.2	4.76	40.2
Finland	SD	**2**	0.00	0.0*	0.00*	4	0.10	9.1	5.65	22.2	5.44	35.9
France	CD	4	0.50	0.0*	0.00*	8	0.49	8.1	4.72	21.6	5.03	29.1
Georgia	SR	9	1.75	5.7	3.50	70	6.57	6.8	3.52	21.7	5.10	44.5
Germany	CD	4	0.50	1.6	0.98	6	0.29	8.9	5.46	22.3	5.51	29.7
Greece	CD	4	0.50	2.2	1.35	5	0.20	**13.8**	10.00	24.9	7.28	31.3
Hungary	CD	4	0.50	0.0*	0.00*	5	0.20	11.1	7.50	26.4	8.30	48.3
Iceland	SD	2	0.00	0.0*	0.00*	3	0.00	9.9	6.39	21.9	5.24	27.5
Ireland	CD	3	0.25	0.0*	0.00*	5	0.20	9.8	6.30	25.3	7.55	32.3
Italy	CD	3	0.25	0.0*	0.00	7	0.39	12.5	8.80	19.9	3.88	33.8
Kazakhstan	SR	10	2.00	6.7	4.11	69	6.47	6.5	3.24	21.0	4.63	41.9
Kyrgyzstan	SR	18	4.00	11.4	6.99	**105**	10.00	3.9	0.83	16.6	1.63	40.9
Latvia	BAL	4	0.50	0.0*	0.00*	23	1.96	7.0	3.70	23.6	6.39	43.9
Lithuania	BAL	3	0.25	0.0*	0.00*	29	2.55	6.8	3.52	26.3	8.23	48.0
Luxembourg	CD	3	0.25	0.0*	0.00*	6	0.29	8.3	4.91	22.6	5.71	30.5
Malta	(N.D.)	6	1.00	0.0*	0.00*	36	3.24	13.4	9.63	**28.9**	10.00	29.5
Moldova	SR	14	3.00	4.9	3.01	74	6.96	4.2	1.11	18.9	3.20	48.3
Montenegro	(towards CD)	2	0.00	8.1	4.97	16	1.27	7.6	4.26	23.3	6.19	45.1
N. Macedonia	(towards CD)	6	1.00	4.1	2.52	12	0.88	9.3	5.83	22.4	5.58	45.1
Netherlands	CD	4	0.50	1.6	0.98	4	0.10	7.0	3.70	20.4	4.22	30.5
Norway	SD	2	0.00	**0.0***	0.00*	**3**	0.00	9.1	5.65	23.1	6.05	30.5
Poland	CD	4	0.50	2.3	1.41	10	0.69	9.1	5.65	23.1	6.05	49.2
Portugal	CD	3	0.25	3.3	2.02	16	1.27	10.4	6.85	20.8	4.49	32.3
Romania	(towards CD)	7	1.25	9.7	5.95	64	5.98	8.1	4.72	22.5	5.65	48.4
Russia	SR	5	0.75	0.0*	0.00*	46	4.22	7.1	3.80	23.1	6.05	44.3
Serbia	(towards CD)	6	1.00	5.3	3.25	13	0.98	9.8	6.30	21.5	4.97	46.1
Slovakia	CD	6	1.00	0.0*	0.00*	3	0.00	8.1	4.72	20.5	4.29	42.7
Slovenia	CD	2	0.00	0.0*	0.00*	4	0.10	9.2	5.74	20.2	4.08	45.3
Spain	CD	3	0.25	0.0*	0.00*	7	0.39	10.8	7.22	23.8	6.53	27.2
Sweden	SD	3	0.25	0.0*	0.00*	4	0.10	6.7	3.43	20.6	4.35	30.2
Switzerland	CD	4	0.50	0.0*	0.00*	5	0.20	5.8	2.59	19.5	3.61	**21.9**
Tajikistan	SR	32	7.50	15.3	9.39	84	7.94	**3.0**	0.00	**14.2**	0.00	46.8
Turkmenistan	SR	**42**	10.00	7.6	4.66	47	4.31	4.7	1.57	18.6	2.99	39.0
Ukraine	SR	8	1.50	15.9	9.75	73	6.86	7.0	3.70	24.1	6.73	43.1
U.K.	NLIB	4	0.50	0.0*	0.00*	7	0.39	10.2	6.67	27.8	9.25	26.4
Uzbekistan	SR	14	3.00	9.9	6.07	66	6.18	4.0	0.93	16.6	1.63	45.7

Notes: Calculated from WHS (2022); U5MR = under 5 mortality rate, STUNT b5 = rate of stunting below 5 years, TUBERC. = tuberculosis rate, OBE 5-19 = obesity rate of 5- to 19-year-olds, ADULT OBE ag.st. = adult obesity age-standardized, HYPERT. = hypertension rate, st'd = standardized; CD = Christian Democratic Welfare Regime, SR = Selective Rudimentary Welfare Regime, SD = Social Democratic Welfare Regime, BAL = Baltic states (free-moving welfare state systems), NLIB = Neoliberal Welfare Regime, N.D. = not determined.

Table 1/Part 3: Partial Results of SRP Indexes

(Standardized Relative Performance Indexes)

		D10	11) CVD (30-70)	D11	12) DRs		D12	13) NURSs	D13	
		st'd		st'd		st'd	rev.		st'd	rev.
Albania	(towards CD)	7.29	11.4	1.72	18.8	0.3	**9.70**	60.5	1.2	**8.75**
Armenia	SR	9.30	19.9	5.88	44.0	5.0	**5.01**	49.6	0.7	**9.34**
Austria	CD	4.36	10.4	1.23	52.9	6.6	**3.35**	105.6	3.7	**6.32**
Azerbaijan	SR	7.00	27.2	9.46	31.7	2.7	**7.30**	64.3	1.5	**8.55**
Belarus	SR	10.00	23.8	7.79	45.4	5.3	**4.75**	110.0	3.9	**6.09**
Belgium	CD	2.97	10.6	1.32	60.8	8.1	**1.88**	200.8	8.8	**1.20**
Bosnia & Herz.	(towards CD)	8.17	18.7	5.29	21.6	0.8	**9.18**	57.3	1.1	**8.92**
Bulgaria	(towards CD)	8.53	24.2	7.99	42.1	4.6	**5.36**	47.9	0.6	**9.43**
Croatia	CD	9.71	16.1	4.02	34.7	3.3	**6.74**	81.2	2.4	**7.64**
Cyprus	CD	3.26	8.2	0.15	31.4	2.6	**7.36**	52.5	0.8	**9.18**
Czechia	CD	7.22	14.3	3.14	41.5	4.5	**5.47**	89.3	2.8	**7.20**
Denmark	SD	5.13	10.8	1.42	42.2	4.7	**5.34**	105.4	3.7	**6.33**
Estonia	BAL	6.70	14.9	3.43	34.7	3.3	**6.74**	66.1	1.6	**8.45**
Finland	SD	5.13	9.6	0.83	46.4	5.4	**4.56**	**223.1**	10.0	**0.00**
France	CD	2.64	10.6	1.32	32.7	2.9	**7.11**	117.8	4.3	**5.67**
Georgia	SR	8.28	24.9	8.33	51.1	6.3	**3.69**	55.5	1.0	**9.02**
Germany	CD	2.86	12.1	2.06	44.3	5.0	**4.95**	141.9	5.6	**4.37**
Greece	CD	3.44	12.5	2.25	63.1	8.5	**1.45**	**37.3**	0.0	**10.00**
Hungary	CD	9.67	22.1	6.96	60.6	8.1	**1.92**	69.2	1.7	**8.28**
Iceland	SD	2.05	8.7	0.39	41.4	4.5	**5.49**	167.8	7.0	**2.98**
Ireland	CD	3.81	9.7	0.88	34.9	3.3	**6.70**	179.8	7.7	**2.33**
Italy	CD	4.36	9.0	0.54	39.5	4.2	**5.85**	62.7	1.4	**8.63**
Kazakhstan	SR	7.33	22.4	7.11	40.7	4.4	**5.62**	72.9	1.9	**8.08**
Kyrgyzstan	SR	6.96	20.3	6.08	22.1	0.9	**9.09**	56.0	1.0	**8.99**
Latvia	BAL	8.06	21.6	6.72	34.0	3.1	**6.87**	44.3	0.4	**9.62**
Lithuania	BAL	9.56	19.3	5.59	50.8	6.3	**3.74**	100.8	3.4	**6.58**
Luxembourg	CD	3.15	9.7	0.88	30.1	2.4	**7.60**	121.7	4.5	**5.46**
Malta	(N.D.)	2.78	10.5	1.27	28.6	2.1	**7.88**	94.8	3.1	**6.91**
Moldova	SR	9.67	24.1	7.94	31.0	2.6	**7.43**	46.8	0.5	**9.49**
Montenegro	(towards CD)	8.50	22.3	7.06	27.4	1.9	**8.10**	53.7	0.9	**9.12**
N. Macedonia	(towards CD)	8.50	22.7	7.25	28.7	2.1	**7.86**	37.9	0.0	**9.97**
Netherlands	CD	3.15	10.3	1.18	40.8	4.4	**5.61**	116.4	4.3	**5.74**
Norway	SD	3.15	8.7	0.39	50.5	6.2	**3.80**	184.2	7.9	**2.09**
Poland	CD	10.00	17.0	4.46	37.7	3.8	**6.18**	68.7	1.7	**8.31**
Portugal	CD	3.81	11.0	1.52	54.8	7.0	**3.00**	74.1	2.0	**8.02**
Romania	(towards CD)	9.71	21.0	6.42	29.8	2.3	**7.65**	73.9	2.0	**8.03**
Russia	SR	8.21	24.2	7.99	38.2	3.9	**6.09**	62.3	1.3	**8.65**
Serbia	(towards CD)	8.86	22.0	6.91	31.1	2.6	**7.41**	60.9	1.3	**8.73**
Slovakia	CD	7.62	15.5	3.73	35.6	3.4	**6.57**	60.5	1.2	**8.75**
Slovenia	CD	8.57	11.4	1.72	32.8	2.9	**7.09**	104.6	3.6	**6.38**
Spain	CD	1.94	9.6	0.83	44.4	5.1	**4.93**	61.4	1.3	**8.70**
Sweden	SD	3.04	8.4	0.25	**70.9**	10.0	**0.00**	118.5	4.4	**5.63**
Switzerland	CD	0.00	**7.9**	0.00	43.8	5.0	**5.05**	182.6	7.8	**2.18**
Tajikistan	SR	9.12	**28.3**	10.00	**17.2**	0.0	**10.00**	47.5	0.5	**9.45**
Turkmenistan	SR	6.26	27.7	9.71	22.2	0.9	**9.07**	44.3	0.4	**9.62**
Ukraine	SR	7.77	25.5	8.63	29.9	2.4	**7.64**	66.6	1.6	**8.42**
U.K.	NLIB	1.65	10.3	1.18	30.0	2.4	**7.62**	88.5	2.8	**7.24**
Uzbekistan	SR	8.72	25.3	8.53	23.7	1.2	**8.79**	112.8	4.1	**5.94**

Notes: Calculated from WHS (2022); CVD 30-70 = cardiovascular diseases, people aged 30 to 70, DRs = no. of doctors per population, NURSs = no. of nurses per population, rev. = reversed, st'd = standardized; CD = Christian Democratic Welfare Regime, SR = Selective Rudimentary Welfare Regime, SD = Social Democratic Welfare Regime, BAL = Baltic states (free-moving welfare state systems), NLIB = Neoliberal Welfare Regime, N.D. = not determined.

Table 1 is displaying the raw data of the 13 included variables, their standardized values, i.e. the SRP Indexes (SRPs), thereof, as well as the reversed value of the SRPs in case they had to be reversed (for matter of compelling logic and statistical/scientific necessity). Table 2, in the following, has used the sums of SRPs of each country, which had to be standardized again (i.e., the SRP formula was applied once more), and rearranged according to the overall outcome.

> With the help of the Aspalter's SRP Index now not only can e.g. welfare state systems (or health care systems, etc.) be ranked (as before), but, and this is of most importance, the *exact distances of performances* of each variable can now be determined and examined.

Additionally, which really causes technical/methodical breakthroughs here, *each variable can be merged with other variables*. Sets of variables can now (and not before) be combined into dimensions (and sub-dimensions), and on top *groups of performers (i.e. groups of welfare state systems) can be identified* and these groups again can be examined in terms of their overall group performances, by themselves and in relation to one another, and in relation to outsider systems/countries that had not been, cannot or should not be (due to the scientific principle of parsimony) classified in any group at all as well (cf Aspalter, 2023a,b).

The results as presented in Table 2 are fully in line with ideal-typical welfare regime predictions (Aspalter, 2006b, 2011, 2017, 2019b, 2020b, 2023) (cf also Table 3).

The excellent performance of Switzerland, and Belgium, are particularly noteworthy, and reflect an open secret: that, in general, Christian Democratic Welfare Regime members are almost performing on par—as a whole—with, or if not exactly at par then very close to—or higher than—Social Democratic Welfare Regime members. In this case, Switzerland, a very rich country, has outperformed Sweden clearly, and this is not reflected accordingly in the current mainstream discourse of welfare regime comparison (for an exception see e.g. Van Voorhis, 2002), be it ideal-typical or real-typical welfare regime comparison. This is extraordinary. Of special significance here is Belgium, the case of which is really what makes the point here.

> Our focus on health care outcomes does not come from nowhere.

Health care analysis combined with welfare regime analysis, in the past two decades, has been a hotbed of new findings and knowledge breakthroughs. This has led to a great number of works by researchers in the field of medical science and health policy science (see Marmot and Wilkinson, 1999, Marmot, 2002; Bambra, 2005a, 2006, 2007a, 2019; Eikemo et al., 2008; Chung and Muntaner, 2007, 2008; Bambra and Eikemo, 2009; Bambra et al., 2009; Abdul Karim et al.,

2010; Regidor et al., 2011; Brennenstuhl et al., 2012; Chuang et al., 2012; Kim et al., 2012; Kim, 2016; Mackenbach, 2019; Béland, 2023; Aspalter, 2023b).

This study carries this line of work further into the search (and *re*-search) for welfare state system realities in the eastern half of Europe in the wider sense (the 'cultural' Europe, not the 'political' Europe, which mostly is equaled with the European Union for the most part by most), while also throwing a fresh look at the southern rim of members of the ideal-typical Christian Democratic Welfare Regime.

As we can learn from our study here, *time* is an important causal and general variable in welfare state system development, and hence welfare regime development; in real-typical perspective more than on ideal-typical perspective in general (see especially Bonoli, 2007, and Pearson, 2004).

While Germany *in terms of overall inequality and povertization outcomes* fares relatively poor being surpassed by southern-rim and eastern-rim members of the Christian Democratic Welfare Regime (cf Aspalter, 2023a), the *health care outcome arena* still paints a rather orthodox picture of positionings of countries that in fact do reflect extremely well also real-typical welfare regime theories of well-known authors, particularly (Leibfried, 1992; Ferrera, 1996; 1997, 1998a,b, Ferrera and Hemerijk, 2003).

This is a new particularly encouraging finding for real-typical welfare regime studies on the welfare state systems in the South of Europe, which in the past have mostly focused on social assistance and family values (not family benefits). That is, it makes great sense to expand real-typical analytical enterprise and to continue building real-typical descriptive theories, here and there, in one form or the other.

Here, new real-typical comparative studies are warranted that also, and in particular, include Greece and Cyprus; and perhaps also hopefully also Malta (with its special political history and hence historical/political influences); and if some want, also more countries around the Mediterranean Sea, for exploratory purposes.

The eastern rim quite nicely (neatly), as it happens, follows the mid-ranging southern-rim members when one is once again applying an ideal-typical perspective and its theory and method (cf Table 3). Behind this group, again in a super neat fashion, there is a group that in theory (cf Aspalter, 2023a) is catching up with the group of countries that have already joined the Christian Democratic Welfare Regime: these new members are Poland, Czechia, Slovakia, Hungary, Slovenia and Croatia (cf also Aspalter et al., 2009).

Serbia for example, which is located in the center of the following group (the second group) behind this first group of countries. Albania, North Macedonia, Bosnia and Herzegovina, Kosovo, Montenegro, Romania and Bulgaria, and of course Serbia in their center, are either follow-on-countries of Yugoslavia that have their own common more recent history with e.g. Croatia and Slovenia, and most of them were also formerly part in the Austro-Hungarian Empire, of which partially Romania was also part. Both Romania and Bulgaria, on top, are now—together with the first group of countries—members of the European Union,

which is, no doubt, a driving force for them to catch up and follow their western/northern neighbors.

The countries in the second group—Serbia and surrounding countries—are, hence, *en route* into realms of welfare state system policies that are marked and featured by characteristics and levels of welfare known to be representative for members of the new *extended circle* of the Christian Democratic Welfare Regime (cf Aspalter, 2023a; cf e.g. also Bjegović-Mikanović, 2019; Vuković and Perišić, 2011). Our empirical investigation of health care outcomes is supporting and mirroring this find, one to one.

Table 2: Final Results of SRP Indexes (Standardized Relative Performance Indexes)

	Ideal-Typical Welfare Regime Membership	Sum of SRPs of ALL 13 VARIABLES	**FINAL SRP Index**		Ideal-Typical Welfare Regime Membership	Sum of SRPs of ALL 13 VARIABLES	**FINAL SRP Index**
Switzerland	CD	15.507	**0.000**	Poland	CD	51.411	**4.716**
Sweden	SD	18.678	**0.417**	Lithuania	BAL	52.340	**4.838**
Norway	SD	22.761	**0.953**	Croatia	CD	52.572	**4.869**
Belgium	CD	23.051	**0.991**	Hungary	CD	55.570	**5.262**
Iceland	SD	24.153	**1.136**	Belarus	SR	57.171	**5.473**
Finland	SD	24.608	**1.195**	Bosnia & H.	(towards CD)	57.623	**5.532**
Netherlands	CD	28.761	**1.741**	Albania	(towards CD)	58.294	**5.620**
Austria	CD	28.926	**1.763**	Latvia	BAL	58.949	**5.706**
France	CD	30.421	**1.959**	Montenegro	(towards CD)	60.792	**5.948**
Denmark	SD	30.709	**1.997**	Armenia	SR	61.854	**6.088**
Luxembourg	CD	30.782	**2.006**	Serbia	(towards CD)	62.169	**6.129**
Germany	CD	31.032	**2.039**	N. Macedonia	(towards CD)	63.837	**6.348**
Ireland	CD	31.456	**2.095**	Russia	SR	64.019	**6.372**
Spain	CD	32.112	**2.181**	Kazakhstan	SR	65.613	**6.582**
Italy	CD	33.988	**2.428**	Bulgaria	(towards CD)	66.507	**6.699**
Portugal	CD	35.430	**2.617**	Georgia	SR	70.155	**7.178**
Cyprus	CD	35.613	**2.641**	Romania	(towards CD)	70.203	**7.184**
Slovenia	CD	37.767	**2.924**	Uzbekistan	SR	72.391	**7.472**
U.K.	NLIB	39.952	**3.211**	Moldova	SR	73.970	**7.679**
Greece	CD	40.261	**3.251**	Ukraine	SR	80.969	**8.599**
Estonia	BAL	42.153	**3.500**	Kyrgyzstan	SR	82.361	**8.781**
Slovakia	CD	45.615	**3.955**	Azerbaijan	SR	82.743	**8.832**
Czechia	CD	46.367	**4.053**	Turkmenistan	SR	88.828	**9.631**
Malta	(N.D.)	46.731	**4.101**	Tajikistan	SR	91.638	**10.000**

Notes: calculated from WHS (2022), using Aspalter's Standardized Relative Performance Index (cf Aspalter, 2006a, 2023a); CD = Christian Democratic Welfare Regime, SR = Selective Rudimentary Welfare Regime, SD = Social Democratic Welfare Regime, BAL = Baltic states (free-moving welfare state systems), NLIB = Neoliberal Welfare Regime, N.D. = not determined.

Not a surprise, but a tough report from reality, is the result for the United Kingdom, with its highly loved National Health Service (NHS). While the NHS is a good system in terms of systems design, it suffers a great deal from input deprivation in terms of finances and human resources (cf Aspalter, 2012a; as well as Taylor and Powell, 2017). In our most-updated data analysis, the United Kingdom is on par with Greece, a country that has for long had great economic and fiscal difficulties. While recent economic difficulties of the UK are indeed troublesome for the development of the welfare state system, and of course the NHS, in the UK, the main problem in the UK over the last three decades was its neoliberal philosophy and as a consequence of that neoliberal politics, and neoliberal health

care reforms that started at the heydays of Tony Blair's *third way politics* (cf Powell, 2001; Lavalette and Penketh, 2003; Aspalter, 2012; Taylor and Powell, 2017).

According to Table 2 it is clear now that not only has the UK managed to lower its *relative performance in terms of health care outputs* (of course not on purpose, and with political neoliberalism to blame) to the level of a relatively poor Southern European country, Greece, but it also fell behind a number of other countries like Ireland, Spain, Italy, Portugal, Cyprus and Slovenia!

> *Hence, 'the level of economic development,' i.e. in terms of e.g. GDP, is not a causal factor of health condition or health output performances*, even though *on average*, and for the casual or not so carefully proceeding observer or analyst, this may appear to be the case, even though *it is not*.

In general, in the social sciences (including economic science) it is quite easy to arrive at (easy to wrongfully accept) a *specious correlation* and to jump to wrong conclusions and theoretical considerations and normative strategies from there. There are poor countries, and always have been, that have great levels of health care and health outputs/performances, which exhibits an entirely obvious non-correlation to their respective economic status (past development).

The historical high performances in terms of health outcomes with concomitant relative lower/low economic development levels of Sri-Lanka, Viet Nam, Mauritius, Costa Rica, Belarus and Cyprus, to name just a few of such cases, are the proof of this often-cited and widely-as-truth-accepted *specious* correlation between health care outcomes/performances and economic development levels (cf Aspalter, 2021, 2020c; Hort and Zakharov, 2019; Martínez Franzoni and Sánchez-Ancochea, 2016; Ranaweera, 2008). Specious correlations, quite often, are tricky to identify, and this is one such case.

In most cases health care development and health care security infrastructure development preceded economic development: e.g. the United States in the years after the Civil War (and then having disappeared, and never really again appeared); Germany and Austria in the 1880s; China during Mao-Ze Dong with its 'barefoot doctors' and near universal coverage of health care, and then not again during the 1990s, and then again starting from 2003, Cuba after the Communist revolution, Brazil in 1978, to just name some hugely significant cases (Aspalter, 2001; Skocpol, 1992; Chow and Aspalter, 2003; Farias, 2003; Mesa-Lago and Aspalter, 2023).

Yet, as if this were not enough, there were and are very-resource rich countries, e.g. most of OPEC countries, that have proven to be great laggards and non-developers in terms of health care provision (infrastructure/security), i.e. so far unexplained negative deviant cases so to speak; and their performance was mirrored with relative much higher levels of health care development and health outputs by much poorer/resource-poorer countries at the same time (Aspalter, 2023b).

Coming back to the case of European countries, we can see that of course a great number of southern-rim and eastern-rim countries of the Christian Democratic Welfare Regime have invested great many efforts in expanding and upgrading welfare provision in general. Some worked on greater degrees of universalism, particularly also in health care security—especially e.g. Slovenia early on and Croatia also recently.

> Thus, the borders between what is thought to be Western European welfare state systems, to what is thought to be Southern European welfare state systems and Eastern European welfare state systems *have for quite some time now, in reality, ceased to exist!*
>
> This *new* empirical reality is evident in quantitative data, especially in new *inequality and poverty data across all European welfare state systems* (cf Aspalter, 2023a).

While 'personal income' (and *not* 'national income') *of course* is related to better health outcomes, due to better nutrition (access to vegetables and fruits that one can afford), weight control, more exercise, psychological sense of security, etc. (cf Pöschl and Valkova, 2015, Navarro, 2009; Marmot, 2002; Marmot and Wilkinson, 1999). This actually can be regarded as a *forgone conclusion*, which now has been tested, and many times over confirmed. And so is of course the positive impact of education—which leads to much more money on average, when comparing millions of people—and so on, i.e. housing ownership, wealth resources, etc. (cf Pöschl and Valkova, 2015; Doling, 2010; etc.).

> The impact of politics on health, especially the impact of politics on inequality and herewith directly on poverty, is of greatest importance of social policy cum health policy experts and their research studies (cf e.g. Navarro et al., 2006; Navarro, 2009; Aspalter, 2023a).
>
> The impact of politics on poverty (cf e.g. Brady, 2009; Brady and Burroway, 2012; Brady and Burton, 2019) is most vital, i.e. this is a 'causal' relationship in the fullest sense.
>
> This again means *diseases of poverty* and *health risks related to poverty* are causally dependent on politics, political paradigm and political practices, a.k.a. *welfare regime politics in the widest sense*.

The health output/performance data in the years to come are set to mirror the earlier development of inequality and poverty patterns (cf the data in Aspalter, 2023a) across the entirety of Europe. Here is where the workings of different grand types of welfare state systems are at work, where they matter, i.e. where

they decide (apart from other personal factors) who can live how long and how good or how terrible a life (pertaining to health conditions, diseases, health limitations, pain, etc.) (cf e.g. also Chung and Muntaner, 2007, 2008; Hurrelmann et al., 2011; Richter et al., 2012; Aspalter, 2023a).

> For long, and which is a general conundrum of the social sciences, too many experts were quoting each other, manifesting, popularizing and with it perpetuating ideas that slowly, but surely, separated themselves from realities on the ground.

Stereotypes, apart from *swimming with others' opinions and believes*, hence, have all along come to hijack scientific discourse, i.e. social policy discourse, especially in the last two decades (for myth-busting evidence on the Southern European model see e.g. Marí-Klose and Moreno-Fuentes, 2015; Marí-Klose and Moreno, 2015; on Swedish gender equality 'outcome' myth/mantra see Eydal and Rostgaard, 2015; Esping-Andersen, 2016; Martinsson et al., 2016; Lykke, 2016; Timsit, 2019; on trans-gender equality in Nordic countries see e.g. Van Der Ros, 2013; on the cradle-to-the-'grave' myth see Hort, 2009, 2014; on Swedish welfare in general see Lindbom, 2001; Pritchard, 2014; Mahama et al., 2023; on any family/family care 'model' myth from a global perspective see Leichsenring, 2020; on the reality of the NHS in the UK see Penketh and Lavalette, 2003; Aspalter, 2012a; Taylor and Powell, 2017).

> *Another major stereotype (myth) that our dataset is breaking (busting) is that everything in the European Union is better than in non-EU states*.

The situation of health care infrastructural and the health situation on the ground in both Bulgaria and Romania are much worse off than in non-EU countries, like for example Belarus, Armenia, Russia and Kazakhstan, all of which are members of the *Selective Rudimentary Welfare Regime*; and (of course) not expected to join the European Union anytime soon(!). This is indeed an unpredicted find of our study. This cannot be explained on economic grounds, or development grounds, alone. New in-depth case studies need to clarify and fully explain, and help mitigate and prevent the perpetuation (or worsening) of the current health care state in both Bulgaria and Romania, and here again Romania, whose GDP (and hence economic resources) is much higher than that of Bulgaria (or countries like Armenia, etc.).

The good story once again is Belarus (cf Aspalter, 2023; Hort and Zakharov, 2019), which seems to have made the transition from the communist/socialist system to current system—that is *healthcare-wise* and *welfare-state-system-wise*—smoothly (and not politically speaking, not at all), with the help of economic and other development opportunities of being located next to Poland and the Baltic states (*as until recently*).

For Russia, poverty and inequality outcomes are much worse than health care outcomes, which is rather significant, as health care has not been on the top of the policy agenda in the Russian Federation for the last two decades, also when looking at health care expenditures. On the contrary to the Russian Federation, Kazakhstan did focus greatly on health care outcomes and has made significant improvement over the last years (cf e.g. Amagoh, 2017; Kainu et al., 2017; Avdeyeva, 2011; Cook, 2010, 2007; Dashkina, 2008). Of course, there are great regional differences within the Russian Federation, e.g. between the west and the east of the Ural mountains, and within the eastern parts of the Russian Federation themselves (which are extremely diverse in economic and social differences), which leads to the necessity to investigate each region and territory, also in terms of urban versus rural differences, and the situation of ethnic minorities throughout all of the Russian Federation (cf e.g. Kainu et al., 2017).

Same as with groups of countries in the southern rim and the eastern rim of the ideal-typical Christian Democratic Welfare Regime, *time* is of essence in determining health care outcomes, based on past/former inequality and poverty outcomes.

As in the case of the United Kingdom and Germany, Russia was set already on course of a major worsening of its health care outcomes. This was before the Russian invasion of Ukraine. The Russian War in Ukraine will certainly turn health care needs *and* health output statistics upside down. The *relative* share of aged male population (of total male population) will increase; and there will be a new enormous *absolute* share of impaired young male population. The Russian situation in terms of health care outcomes and, as a following thereof, government financial capabilities, and hence health care investment, will be disastrous, to say the least; apart from the effects of the war itself (of course).

The Ukraine situation is a bit different, and more disastrous, due to the fact that its overall population was bombed, and hence killed and maimed (and their houses/villages/cities destroyed) by Russian bombardments, and the fact that their population size is only about one third of that of Russia. Hence, more male population in the Ukraine will *proportionally speaking* suffer from war injuries and incapacitation, and hence will have a greater need (*proportionally speaking!*) for medical and rehabilitation care. Ukraine, before the war, was marked by lower levels of health care (and other social) investments, as compared to Russia. There hence was a relatively stark contrast with Russia in health care, but also pension benefits (which, too, have strong health care and health outcomes implications, due to their impact on diseases of poverty, due to lack of proper nutrition, and the ability to afford health care).

Hence, in comparison, the situation in Ukraine will be ‘a bit’ closer to that of Viet Nam (after the American War there) where the homeland was bombed by foreign invaders. And particularly in the east of Russia the younger male population will have *largely* reduced (more than decimated) and *largely* turned into welfare recipients and service- and care-dependents in their families. Hence, regional social and economic inequalities in Russia are becoming (and yet set to become) ever more unequal—*likely* to the point of annihilating the current/past

socio-political contract of the Russian Federation in these parts of the Russian Federation where very large shares of the young male population were used as *cannon fodder* (as it is called).

Table 3: The Ten Worlds of Ideal-Typical Welfare Regimes (part 1)

	1.	2.	3.	4.
	The Ideal-Typical Social Democratic Welfare Regime	**The Ideal-Typical Christian Democratic Welfare Regime**	**The Ideal-Typical Neoliberal Welfare Regime**	**The Ideal-Typica Pro-Welfare Conservative Welfare Regime**
Main Characteristics of this Ideal Type	1. Implementation of *Universal* Social Rights 2. Universalism in social security provision is dominant 3. Strong emphasis on individualism and defamilialization 4. High levels of *income* equality are achieved through high redistribution via the social insurance system and the taxation system 5. High levels of gender equality are sought after, in theory and as a policy paradigm, but in reality there is still a rather huge gender gap, especially regarding the strong gender segregation on the labor market, in terms of public versus private employment 6. Strong emphasis on productive public investment in the education and the health care delivery 7. Strong emphasis on active labor market policies 8. Social service provision is comprehensive, financed and provided by the government (mainly the local governments) 9. Asset- and means-tested social assistance programs serve an additional auxiliary role (that create poverty traps) 10. Youth unemployment and unemployment of young adults has become systematic.	1. Implementation of *Performative* Social Rights 2. Principles of subsidiarity and solidarity are both dominant in social policy making 3. Division-based (=Bismarckian) social insurance systems, i.e. occupationally and regionally divided social insurance systems 4. Strong focus on poverty-trap creating asset- and means-tested social assistance (AMTs) provision. There is a perpetual dual system with social insurance for the better-off and social assistance for the weak and the disadvantaged (non-privileged), and especially also women to a larger degree 5. Family status is being emphasized with regard to social insurance and social assistance entitlements 6. Income equality is rather high, but the results for wealth equality are mixed 7. Strong emphasis on productive social welfare, especially in education, but also health care in terms of government financing 8. Active labor market policies are dominant 9. Principle of subsidiarity is strong in terms of social service provision, and lets NGOs and the Church run and/or be part of social service, as well as health care and education provision 10. Youth unemployment is high (with strong exceptions particularly in the past, especially in Western Central Europe)	1. Implementation of *Clientelistic* Social Rights 2. Incompleteness of social security systems (either missing or being starved, cut or ill-conceived, or condemned for meaninglessness) 3. Strong focus on asset- and means-testing in social welfare and social service provision, oppressing the poor and women alike 4. Strong emphasis on workfare programs 5. Generally large income inequality and large wealth inequality 6. Significantly higher rates of poverty than in most other country at the same level of development 7. Deliberate absence of public social investment in education and health care (deliberately oppressing the poor, the working and lower middle classes) 8. Strong emphasis on passive labor market policies, and lack of active labor market policies 9. Lower levels of vertical redistribution due to regressive taxation and/or only partial/differential coverage by division-based (=Bismarckian) social insurance 10. Private welfare organizations carry the brunt of social welfare services, without large-scale public funding, mostly funded by religious organizations and private donations	1. Implementation of *Productive* Social Rights 2. Work-oriented social security systems with full coverage in terms of risks covered, including both division-based (=Bismarck insurance systems and provident fund systems, wi universal, and rather universalized, health care systems are also on the rise 3. Increasing importance o universalism in social secu provision 4. Emphasis on asset- and means-tested social assista systems and services, whic increase and cement pover 5. Strong emphasis on soc investment in public educa provision and financing; pu health care provision and/o public health care financin plus here and there largely strong regulation of, and fi policies for public provisio the housing sector 6. Direct vertical redistribu is shunned, but indirect redistribution is emphasize 7. Relatively (and sometin absolutely) high wealth equality, plus moderate inc equality 8. Sole emphasis on passiv labor market policies is the norm 9. Private providers are dominant social service provision, as well as religi welfare NGOs 1. Low rates of unemploy are common, in global comparison
Countries/ regions	Denmark, Finland, Iceland, Norway, Sweden	Austria, Belgium, Croatia, Cyprus, Czechia, France, Germany, Greece, Hungary, Italy, Ireland, Luxembourg, Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, Switzerland	Australia, Canada, New Zealand, United Kingdom, United States	Hong Kong, Japan, Mac Mainland China, Malay Taiwan, Thailand, Singapore, South Korea Viet Nam; plus also (marginally) Indonesia a Mongolia

Table 3: The Ten Worlds of Ideal-Typical Welfare Regimes (part 2)

	6.	7.	8.	9.
	The Ideal-Typical Slightly Universal Welfare Regime	**The Ideal-Typical Selective Rudimentary Welfare Regime**	**The Ideal-Typical Communist/Socialist Welfare Regime**	**The Ideal-Typic Exclusion-Base Welfare Regim**
Main Characteristics of this Ideal Type	1. Implementation of *Slightly Universal* Social Rights 2. Emphasizing only small-scale social security systems in terms of population coverage, as well as benefit entitlements 3. Strong focus on 'unconventional' universal social security programs that focus on basic human needs, (e.g. food security, free-of-charge medicine, universal access to employment) 4. Growing emphasis on social investment in education and health care 5. Extremely high levels income and wealth inequality 6. Extremely high or high levels of poverty 7. Mortality rates are still relatively very high, with a strong downward trend 8. For the most part, there are appalling housing and sanitary conditions 9. Super high fragmentation of social programs, regarding social assistance system as well as social service systems 10. Social services are mostly provided by religious NGOs and the local governments, in addition to a wide range of state-/country-wide programs that are funded by the state and/or central government	1. Implementation of *Selective Rudimentary* Social Rights 2. There is a renewed echo of some socialist ideas with regard to social security systems, especially e.g. solidarity with pensioners, or health care, etc. 3. Welfare state system financing is limited to a minimum 4. Social policy has selected a few areas of welfare state provision, e.g. pension, prenatal family policies or health care; and more or less condemned the rest of it to a very meager existence/oblivion 5. Still comparatively very low life expectancy rates, though having improved a lot in the past 6. High levels of poverty 7. High levels of income and wealth inequality 8. The government still serves as the main social service and welfare provider, in the absence of strong NGOs 9. Very high homeownership rate in global comparison, which is very positive indeed	1. Implementation of *Full Universal* Social Rights 2. Universal employment and universal income security—however, at extremely low levels 3. Universal health care services, paired with widespread deterioration of the physical health care infrastructure, i.e. buildings and equipment, due to lack of government finances in recent years 4. Infant and child mortality rates in Cuba are among the very lowest in the developing world, also outperforming e.g. the US 5. Free-of-charge universal education 6. High net income and wealth equality when including free universal health care and education services, etc. 7. High rates poverty among the entire population (due to economic sanctions from abroad and the outcomes of communist policies in place) 8. Homeownership rate is among the very highest in the world 9. Housing conditions are generally poor 10. Unemployment rate is among the lowest in the world 11. Social welfare and other social services are well developed in terms of coverage and directly provided by the state	1. Implementation of So Rights *Based on Ethnic O* 2. Deliberate emphasis o exclusion of certain parts (permanent) population fr social welfare entitlement 3. Strong focus on highl developed *division-based* (=Bismarckian) social insu systems 4. Strong reliance on a f workforce, which in some make up the majority of th population 5. Strong gender segrega and/or gender inequality, based on dominant cultura religious believes and para 6. On top, even among t 'privileged' (so-called 'loc 'native') populations, a ve degree of wealth and inco inequality is common 7. Strong public interest investing in education and care 8. Massive chronic yout unemployment, due to cul peculiarities, as well as so legacies 9. Welfare and social se provision rests mainly on shoulders of religious NG
Countries/ regions	Bangladesh, Bhutan, Fiji, India, Mauritius, Nepal, Sri Lanka	Armenia, Azerbaijan, Belarus, Russia, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan, Ukraine, Uzbekistan	Cuba	Bahrain, Israel, Kuwait Oman, Qatar, Saudi Ar United Arab Emirates

Note: The findings are based on Aspalter (2017, 2019b, 2020b, 2023).

Meta Conclusions

There needs to be both more light thrown on (work invested in) *real-typical and ideal-typical studies* with regard to health care system infrastructure and benefits, as well as health outcomes. The narrower the investigative spotlight of a study or research program is, the more interesting real-typical welfare regime theories and studies will be. This is to be predicted from the nature of *both* types of theories and types of methodologies (cf Aspalter, 2012b).

Thanks to empirical investigations using quantitative data sets, we are able to look at a *greater variety and number* of welfare state systems at the same time, while also being able to provide constant updates of the data situation that stands for the real situation on the ground. With the use of quantitative data sets, the study of ideal-typical welfare regime analysis has been largely empowered (i.e. energized), and made easier: e.g. it has become easier to nail down movements in between, towards or from certain groups, and of course to determine and qualify membership statuses of *all* countries and regions in question.

The use of quantitative data analyses, on top of qualitative analyses (case studies, etc.), has facilitated a great deal additional *myth busting and reality checks* of all kinds: welfare regime reality checks, welfare state system reality checks, health care system reality checks, health output reality checks, inequality and poverty reality checks, and so forth.

Thus, many more of such eye-opening studies will follow, be they backward-looking, forward-looking, sideward-looking, or inward-looking, be it e.g. in cis-people/trans-people studies (cf e.g. a first qualitative study of Koning, 2018), in migrant studies (cf first eye-opening studies by Lillie et al., 2023; Mahama et al., 2023; Křížková and Šimon, 2022; Levitt et al., 2016), in economics, demography, anthropology, geography, sociology, psychology, medical sciences, communication and digital sciences, as well as *our*storical studies.

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