Welfare Regimes and Drug Users
An institutional welfare state perspective
Vanhuysse, Pieter

Published in:
Second Multi-City Study on Quantities and Financing of Illicit Drug Consumption

Publication date: 2018

Document version
Publisher's PDF, also known as Version of record

Document license
Unspecified

Citation for published version (APA):
Welfare Regimes and Drug Users

Pieter Vanhuysse

An institutional welfare state perspective

Above and beyond the cross-city differences in drug policies described in Part 1 of this report, the cross-city variation in many of the outcome trends among drug users described in Part 2 can to some degree be deduced from larger differences in the governance environments and general policy inputs at the city level. One way of viewing large cities such as the ones studied in this book is by analyzing them as vectors of policy performances that can be measured by the quality of services they provide to their citizens (Kaufman et al., 2005; see also Taylor, 2005; Fuchs et al., 2010; Hudson, 2012). An influential measure of city performance in this respect is the yearly Mercer Index of Quality of Living in large cities, which is a relatively objective measure of the general quality of living in a given city, conducted on a yearly basis for more than 380 cities worldwide, based on detailed assessments and evaluations of 39 criteria or factors across 10 key categories.

As Figure 1 indicates, of the cities studied in this book, neither Moscow nor Bucharest, Belgrade or Sarajevo are included in the top-50 cities regarding quality of living in 2009. On the other hand, three of the cities studied, Copenhagen, Stockholm and Helsinki occupy respectively the 11th, 20th and 31st rank, with Quality of Living index values above that of the base city for comparison, New York. The social services and the public goods that cities provide are crucial in determining this quality of living ranking. In fact, most of the ten categories that make up the index in Figure 1 are in great part a function of the quality of governance and the resources available in a given city, including dimensions that are important to drug users such as the medical environment, public services and transport, and housing. The much higher satisfaction with their housing situation of the integrated drug users in Copenhagen, Stockholm, and Helsinki, for instance (Chapter on Social Position, Figure 13), is clearly consistent with these three cities’ high overall infrastructure provision as captured by the quality of living index.
However, there is little doubt that, to a large degree, the cross-city variation in outcome trends among drug users derives at the national level from differences in institutional and public policy constellations, particularly in terms of the setup, scope, and generosity of the larger welfare states in which these cities are placed. The analytical focus by Gøsta Esping-Andersen and others on the ways in which advanced welfare states provide different “social rights package deals” to their citizens has indicated that the advanced Western democracies cluster into at least four distinct welfare regime types, or “worlds of welfare” (e.g. Esping-Andersen, 1990, 1999; see also Arts and Gelissen, 2002; Castles, 1993; Sabbagh et al., 2007; Sabbagh and Vanhuysse, 2010; Vanhuysse and Goerres, 2012). Two of these worlds put much emphasis on welfare provision through flexible and deregulated markets. Liberal regimes (including Canada and the USA) provide smaller and largely flat-rate benefits. They are characterized by lower taxes and higher income inequalities, but they effectively promote new jobs and cheap household services. Radical regimes (including New Zealand and Australia) combine high benefit equality with low social security contributions, low levels of redistribution, and high levels of wage and job regulation. Two other welfare regime types rely to a high degree on state involvement in welfare provision. Conservative regimes (including Germany and France) allocate relatively generous welfare benefits mainly on the basis of previous earnings.
They tend to promote the interests of highly skilled and well-paid jobholders at the expense of young, unskilled, female and elderly workers and they put high family care burdens on women. The high cost of childcare makes it expensive for women to combine work with children, which adds to existing problems of labour market exclusion, high labour costs, and adverse retiree-to-worker rates. Lastly, social-democratic regimes (including Norway and Sweden) provide generous benefits on a universal basis. They promote women’s independence by providing extensive and relatively low-cost day-care facilities and by stimulating female employment through public sector absorption and active labour market programmes.

As applied to the countries hosting the cities studied, one key factor is differences in overall welfare state generosity. The main dividing line here is undoubtedly between the three Nordic cities in this report’s sample on the one hand, and the four other cities on the other. One core difference here relates to the ways in which welfare states provide safety nets for those in material or emotional distress and those who, for any number of other reasons, find themselves on the margins of the active labour market and of mainstream society (Esping-Andersen, 1990). In this respect, Nordic welfare states are well-known to be especially generous by international comparison, not just compared with poorer societies and newer democracies such as Serbia, Romania, Bosnia-Herzegovina and Russia, but even as compared to all other rich welfare states in the OECD world. In Esping-Andersen’s (1990) terminology, Nordic welfare states are the world champions in *decommodifying* citizens – i.e. making sure that all citizens can fall back on some degree of material safety, independently of their individual success in the market economy.

For instance, the influential Scruggs Welfare State Entitlement Database calculates an overall welfare state benefit generosity index for the 18 richest OECD democracies in order to measure the generosity of benefits provided by a given country’s welfare state as a whole (see also Scruggs, 2006). Not surprisingly, none of the former communist countries in the Second Multi-City Study’s sample make the list. In fact, new EU Member States such as Romania and Bulgaria tend to perform badly even when compared to other former communist countries (and somewhat older EU Member States) such as the Visegrad-four (Hungary, Poland, and the Czech and Slovak Republics), whether in terms of public expenditure on social programmes or in terms of poverty rates (Vanhuysse, 2009; Rat, 2009). But Sweden, Denmark and Finland occupy respectively the second-, third- and sixth-highest position within the Welfare State Entitlement Database sample, with another Nordic country, Norway, occupying the first position (see Figure 2).
These higher levels of overall welfare state generosity go some way towards explaining why respectively 23 and 26% of the socially integrated drug users in Stockholm and Helsinki (albeit only 7% in Copenhagen) can claim social security as their main source of income, as compared to virtually zero percent in all four of the former communist cities in this study’s sample (Chapter on Social Position, Figure 7). Similarly, the high Nordic welfare generosity is consistent with the higher levels of subjective security (“feeling secure”) and of life agency (“influence on own life”) among Nordic as compared to non-Nordic integrated drug users (Chapter on Social Position, Figures 11 and 12). And as regards the socially marginalized drug users, the overall welfare state generosity may help to explain why as much as 89 and 73% of these marginalized users in Stockholm and Helsinki (albeit only 7% in Copenhagen) can claim social security as their main source of income, as compared to respectively only 7, 6, 5 and 1% in Belgrade, Sarajevo, Moscow and Bucharest (Chapter on Social Position, Figure 7). In simple terms, the state provides a strong and meaningful social safety net in these Nordic societies for marginalized citizens generally and thereby also for drug users, whereas it does not do so in these former communist countries. As a result, marginalized users in these Nordic countries have to resort to a much lesser degree to deviant sources of income such as prostitution, begging and dealing or to criminal offenses leading to police contacts in general (Chapter on Social Position, Figure 8).
The generosity of prevailing welfare state models touches the lives of drug addicts also in a number of more specific ways via individual welfare state programmes. For instance, the larger resources spent on public housing in Nordic cities such as Stockholm, Helsinki and Copenhagen can explain why so much fewer socially integrated users (have to) depend on family, partners or friends for accommodation than in the other cities (Chapter on Social Position, Table 2). Moreover, Nordic welfare states, Sweden first and foremost, notoriously tend to spend very significant public resources on human capital investment and (re-)training, both through the provision of cheap early childhood-to-university education (Esping-Andersen, 2009; Vanhuysse, 2008) and through retraining and reskilling for marginalized or unemployed workers (Iversen and Stephens, 2008; Tepe and Vanhuysse, 2013). This goes some way towards explaining why both types of drug users – even marginalized ones – in Stockholm have higher levels of university education than in almost every other city studied (Chapter on Social Position, Figure 5b).

Similarly, as argued throughout this report, in addition to primary integration via work and tertiary integration via substitution, secondary integration of drug users can be promoted through compensation schemes such as unemployment benefits. As we have seen in the chapter on the Social Position (Figure 9), this tertiary integration mechanism via substitution is, seemingly paradoxically, comparatively small in cities such as Copenhagen and Helsinki. But this might in fact merely reflect the fact that the secondary mechanism, i.e. unemployment compensation, is so much larger in these Nordic cities. In fact, there is a major Nordic/non-Nordic divide along this dimension as well. On the Scruggs Unemployment Benefit Generosity Index specifically, Sweden, Denmark and Finland
occupy respectively the second-, fourth-, and eighth-highest position within a sample of 18 rich OECD democracies, with Norway again occupying the first position (see Figure 3). In other words, these Nordic countries are generous regarding the social safety net they provide to unemployed citizens even when compared with other rich democracies, and they are many times more generous when compared with the four former communist societies studied here. Not surprisingly therefore, if and when socially integrated drug users have no regular income, they can live from state welfare support in Stockholm and Helsinki, but need to live from family support in the former communist cities.

Similarly, health care and sickness benefit provision are a core concern for drug users as they are clearly a high-risk category for health problems. In this regard the much better access to health services reported by integrated drug users in Copenhagen, Stockholm and Helsinki, as compared to all four other cities studied, closely reflects the greater generosity of these welfare states in this domain. For instance, in terms of the Scruggs Sickness Benefit Generosity Index, Sweden, Denmark and Finland occupy respectively the second-, fourth-, and seventh-highest position within a sample of 18 rich democracies, with Norway again occupying the first position (see Figure 4). Better health access for drug users is in turn likely to have both private and social benefits. That is, in addition to leading to better health for the individual users, health access is also likely to benefit society as lower levels of hepatitis and HIV among drug users will lead to lower contamination across society. In Moscow, for instance, the high levels of HIV/AIDS incidence may be at least in part explained by the total absence of drug substitution policies combined with poor general access to health care services for drug users.
References


