I. Introduction

At one level of analysis, all social entities are "historical individuals" (Streeck & Yamamura 2001), defying generalization and requiring a thorough reconstruction of their evolution, as well as description of their peculiarities, in their own terms. Social policy or welfare regimes are no exception. There are probably no two systems of welfare provision around the world that are exactly alike. This observation gives occasion for the rejection of any categorization of such systems in terms of overarching regime types whatsoever. For once particular systems are subjected to close scrutiny, it becomes apparent that no pure type exists in the real world, that all systems are syncretic composites of mostly rather heterogeneous elements whose development simply does not follow any clear-cut logic, as the language of regime types would seem to imply (Kasza 2002). However, the observation, while correct, is not without its own quandaries. For even if we abstained from fitting particular systems into broader typologies, we would still have to spell out the sense(s) in which these systems are unique, and their uniqueness becomes visible only through comparison. But as soon as we start to compare, we will detect similarities and differences; more similarities with some and greater differences from other systems, and in order to capture and express them, we have to categorize our various systems. Some categorization is therefore inevitable. To analyse, we need concepts, and concepts categorize. There will of course always be differences among the chosen representatives of a given (ideal) type, but if our concepts are well construed, then these differences will be family differences, less significant than those the group at large exhibits vis-à-vis the members of some other group. If, on the other hand, our concepts turn out to be flawed or too simplistic, then we must revise them. But we cannot discard them altogether, for if we did, we would be stepping out of (social) science itself.
It is with these provisos in mind that the present paper speaks of East Asian Welfare Capitalism as a distinct variety of welfare capitalism. East Asian Welfare Capitalism is a relatively recent arrival, having emerged in the real world only during the past 40 years or so, and hitting the radar screens of social analysts even later. True, Japan had begun to modernize much earlier, and given its spectacular success, particularly after the Second World War, its rise had not gone unnoticed even in Europe; quite the contrary. Nor had the no less phenomenal rise of the four little "tigers" South Korea, Taiwan, Hong Kong and Singapore, which set in a few decades later. But it was only with the publication, beginning around the mid-1980s to early 1990s, of various studies that grouped all five countries together that the notion of East (or Southeast) Asian Welfare Capitalism gradually began to take root in the literature. Now, it became increasingly clear that neither Japan's rise nor that of the four tigers were isolated phenomena. Rather, these countries were spearheading the development of a whole region, paving the way first for a third generation of Asian growth economies (comprising mainly Thailand, Malaysia, and Indonesia) and later (with China and Vietnam) even a fourth such generation, set to lift themselves right into the centre of the world economy and thus eventually to transform the whole world order. Moreover, the countries in question seemed to be following relatively similar patterns of development, not unlike those of earlier "late" developers in continental Europe, such as Germany in the 19th century, with the state playing a substantial role as nurturer and "governor" (Wade 1990) of the market, as well as of other institutional sectors of society.

The present paper deals exclusively with social policy arrangements found in the region, and it restricts itself to the five presently most advanced exemplars of East Asian Welfare Capitalism, i.e. Japan and the four tigers. Both the history of the respective policies and their main characteristics are well documented by now (see, e.g., Jones 1993; Goodman et al. 1998; Ramesh 2000; Holliday & Wilding 2003; Walker & Wong 2005; Aspalter 2006). Less clear are these systems' future prospects in the face of mounting adaptation pressures. All economically advanced countries have sophisticated welfare mechanisms in place that address the (basic) needs of their citizens. But some of these mechanisms perform better and/or seem more sustainable than others against the background of growing external competition and internal problems, thus offering more lessons for the designation of viable reform options. Following a brief discussion of the key commonalities and differences of the five countries' social policy regimes, this question is at the centre of the paper's interest, and an attempt is made to venture some tentative answers.
II. East Asian Welfare Regimes: Historical Roots and Present Policy Mixes

Widespread agreement exists on the following characteristics of East Asian social policy regimes. These regimes are said to be (1) fairly residual, offering only very limited statutory protection, (2) hardly socially redistributive and therefore also (3) strongly status maintaining, (4) investment rather than consumption oriented, (5) predominantly regulatory, (6) commodifying rather than decommodifying, (7) pragmatically devised (and incessantly modified) rather than principle-driven, and (8) lean yet effective and successful, if success is measured by parameters such as longevity, good health and educational attainment of the population (all of which are remarkably high in the region), levels of (un-)employment, absolute deprivation and extreme poverty/misery (which are low and/or virtually absent), as well as social stability and integration (low crime, high cohesiveness). In short, they cost little and still deliver.

The latter point is usually brought home by highlighting the comparatively low levels of public spending on welfare, both in terms of government expenditure and GDP share, in East Asia. However, even though it is certainly true that especially northwest European countries tend to spend a much higher proportion of their GDP for social purposes than do their East Asian counterparts, the respective figures must be read with caution. For not only are comparisons difficult because the regulatory mechanisms in the two regions are quite different, so that not everything that would fall under public finance in Western countries would be deemed such in the East (see, e.g., Kwon 1998 with reference to Singapore), social security development in East Asia obviously also set in much later than it did in regions that industrialized earlier; it is, in fact basically a post World War II phenomenon there (Hort & Kuhnle 1990: 165), whereas the earliest traces of such developments in (continental) Europe date back to the late 19th century. This has to be taken into account if one is to arrive at a sound judgement. Contrary to the conviction held by some social policy analysts, lower levels of spending do not necessarily reflect purposive strategies of "social dumping", despite widespread anti-welfarist rhetoric among the local political elites. Rather, they reflect first and foremost lesser progression of "developmental time". Of course, European welfare states and even American social policy mechanisms emerged chronologically earlier than those in East Asia. But when considering levels of social and economic modernization at the point at which Asian countries introduced their first social security programmes, then these countries actually appear to have started them earlier than most European nations, not later. They also seem to be following a "remarkably similar (...) sequence" (ibid.: 166) of programme
development – with measures of occupational injury protection, some form of health insurance and old age security provision coming first and generally preceding the establishment of unemployment benefits and/or family allowances. Thus, one should not read too much into numbers alone. Whereas much of East Asia is still building up its social security/policy systems, and experimenting with various models and mechanisms, Europe and North America have of late begun to reorient and partly retrench theirs because the "mature" welfare states (Pierson 2001) that now exist in that part of the world have, to a certain extent, become a part of the problem they are meant to address.

One often noted (and sometimes deplored) observation is that unemployment protection was virtually absent or at least miniscule in East Asian welfare regimes until very recently. However, so was unemployment itself (Chan 2001) in economies that grew at double-digit numbers for decades and hence suffered less from the lack of protection of workers who were unable to find a job than from a shortfall of employable labour – which was overcome partly through the importation of foreign labour and partly through a rapid expansion of female labour market integration, much along the lines of earlier Western developments. In 1994, Japan was the first East Asian country to introduce unemployment insurance following the extended stagnation of its economic growth at the beginning of that decade. In 1995, South Korea and Taiwan followed suit, just before the onset of the Asian Financial Crisis in 1997/8, which hit South Korea particularly hard (on South Korea, see Shin 2003). By regional standards, unemployment skyrocketed during that crisis, temporarily reaching levels of close to 7 per cent in Korea and Hong Kong, but still staying below 5 per cent in the three other countries. In Hong Kong, this development gave rise to calls for the introduction of some form of unemployment insurance in this "special administrative region" too, but given the less than fully democratic nature of its political system, such calls could be more easily fended off there than in South Korea and Taiwan, both of which experienced a rapid extension of their social policy programmes after democratization. Like Hong Kong, Singapore has no unemployment insurance to this date – but while unemployment continued to hover around 6 per cent in Hong Kong since the late 1990s and even surged above 8 per cent in the early years of the new millennium, in Singapore it rarely exceeds the 4 per cent mark; in December 2005 it had in fact dropped to as low as 2.5 per cent, bringing the rate for the whole of that year down to 3.2 per cent (Straits Times, 2 February 2006). Since then, it has stayed below 3 per cent due to continuous high economic growth. The "objective" need for unemployment insurance remains therefore less pronounced here than elsewhere in the region, even though there is now growing awareness in Singapore that structural
unemployment, especially among the un- or low-skilled segments of the workforce, as well as the elderly, is gradually becoming a permanent problem that will not go away by itself due to rapid tertiarization of the economy and the departure of industries utilizing predominantly cheap labour.

There are two main strategies the Singaporean government pursues to address this problem: first, by upgrading the skills of those affected to make them re-employable (complemented by very active job counselling), and second, by upgrading the job profiles in fields that Singaporeans, spoiled by decades of "miracle growth" (World Bank 1993), previously shunned – in short, by introducing various workfare-programmes that, coincidently, have recently made a surprising comeback in most Western countries as well (Saunders 2005). In 2007 it added an income supplement scheme that boosts the incomes of some 438,000 low-wage earners by 10 per cent or more annually through tax-financed government top ups (Straits Times, 16 February 2007). To people outside the workforce, on the other hand, Singapore offers only very minimal protection that barely helps them get by: occasional (and discretionary) grocery vouchers, a letter of support asking utility providers to stall payment requests if someone temporarily cannot pay his or her bills, etc. Moreover, it offers shelter and highly subsidized public housing as well as public health, so that people's most basic needs are taken care of. But the main source of support for the truly needy is supposed to be each person's family that is morally and legally entrusted with this responsibility.

The strong emphasis on the family is not unique to Singapore or, for that matter, East Asia as a whole. Its best known European equivalent is the Roman Catholic Church's doctrine of subsidiarity, which is particularly influential in southern Europe and, generally, in parts of Europe where Catholicism traditionally had a strong foothold; including Germany, where, as in Singapore, parents can sue their children if the latter are unwilling to carry out their filial duties. The Nordic or Scandinavian countries, on the other hand, where such traditions are weak and which also form the most secular part of contemporary Europe, have gone furthest in socializing such responsibilities by shifting them to tax-financed (cradle to grave) public care facilities and through the institutionalization of generous public health and pension systems. This makes their welfare states very costly, but also quite women-friendly, as care giving in the home continues to be seen as (primarily) women's work around the world. Given the existence of public facilities and their costliness, it is not surprising that the Nordic countries also enjoy the highest rates of female labour market participation in the world. Their
welfare systems both facilitate this and make it financially necessary for families who wish to enjoy the living standards that many Westerners have become accustomed to.

Female employment is now also quite high in East Asia and will in all likelihood stay high in the foreseeable future; in Singapore, for example, the female labour force participation rate was 50 per cent in 2003 (Human Development Report 2005), and in Japan the respective figure was 48.3 per cent in 2004 (Ministry of Internal Affairs & Communication 2005). This has numerous implications, not the least of which is growing pressure towards the introduction of more family- and women-friendly work and welfare arrangements (see, e.g., Roberts 2005 on the Japanese case; for a discussion of such arrangements in the German context, see Schmidt 1992). Like all welfare states, East Asian social policy regimes were initially premised on the reality and desirability of the male breadwinner, female housewife family model. However, this model is increasingly being eroded; both empirically and normatively. With growing levels of education come new aspirations. Hence more and more women seek paid employment not just to top up the family budget, but also for the intrinsic gratifications it has to offer, which include earning an income of one's own, the challenges of a career and the pleasures of participating in the "public sphere", to which this gives (much improved) access. Housework must therefore be done during the "second shift", but if both husband and wife work full time in paid employment, then the rationale, underpinned by what are essentially premodern (and hence outdated) value systems, for segregating family duties along gender lines begins to lose its plausibility. Part time work, on the other hand, is typically associated with various disadvantages in paid employment; including lower career ceilings. As long as traditional gender relations prevail and women view their engagement in the labour market as merely supplementary to that of their husbands, such segregation may work. But as they move on to pursue their own careers, they increasingly begin to question it – less sternly as yet in Asia than in the West (Bulbeck 2005), but considering, once again, the passing of "developmental time" rather than simply making synchronic comparisons, the trends are visible enough. Moreover, having an independent income also gives women greater bargaining power in the family, including a genuine exit option if the husband (or spouse or partner) proves unresponsive to their concerns. The results are rising divorce rates and increasing levels of singlehood, which are still low by Western standards but nevertheless moving in directions familiar to Western observers (for some recent trend data on Hong Kong, see Estes 2005; for the region as a whole, Jones 2005).

Another trend, which has basically the same background, is a steep fertility decline (Feeney & Mason 2002). Fertility is low (in fact, mostly below the replacement level) in all
economically advanced countries, but it tends to be lowest in countries whose public care services are least developed. Not only do families have fewer children than in the past, they increasingly make a conscious choice to stay childless, and so do women who want to have a career but find themselves in an environment that offers too little support for the reconciliation of paid work and family responsibilities. In Japan, for instance, they are increasingly "deferring and even forgoing marriage and childbirth to pursue work and career, or because they fear marriage will constrain them to traditional gender roles and limit their freedom" (Peng 2003: 215).

Low fertility means greater wealth for the individual (single or family) household in the short-term, but fewer people to secure this wealth in the long-term, as well as rising dependency ratios and growing care burdens for families. So at the same time that the demand for care rises (due to increased longevity, and therefore growing numbers of frail elderly), the capacities of families to provide such care diminishes because fewer children have to shoulder greater financial and in-kind burdens of care delivery. Moreover, rising numbers of family break-ups through divorce also mean more and more people – both men and women – are living alone in old age, so that there will be nobody in the household that can be resorted to when care is needed; for women this problem is, paradoxically, exacerbated by their higher life expectancy because they often outlive their husbands even if the couple stays married until "parted by death", thus experiencing a higher incidence of "solitary survivorship". To be sure, East Asia continues to have high rates of co-residency, i.e. three-generation families, where elderly people live with their children. In Japan, for instance, this is true of more than half of all elders to this date (Peng, ibid.: 217), compared to just over 10 per cent in Germany. But such arrangements are coming under growing strain and are in fact on the decline in Japan no less than they are elsewhere in the developed world (see Yamato 2006). Eventually, the "nuclearization" of families and the shrinking of household sizes will lead to problems that cannot be ignored, especially as and when people (including the elderly) are becoming more politically conscious and vociferous.

One solution is to open one's borders to immigration and/or one's labour markets to foreign labour. In much of Asia, many menial household tasks and care services are being relegated to cheap, readily available live-in maids. The region will probably continue to tap this resource in the foreseeable future, not least to release middle class women into paid work (see Chan 2006, focusing on Hong Kong). But this policy has its limitations too (there is, for instance, growing concern among families about the degree to which they can, or should, entrust maids with the raising of their children), and to the extent that it does, it will have to
be supplemented by other measures – collective welfare measures such as those found in Scandinavia where fertility rates are higher than anywhere else in Europe precisely because of their women-friendliness. Generous welfare states are not just a drain on a country's purse. When well devised and intelligently constructed, they can also absorb some of its problems and prepare it for a sustainable future.

A marked future-orientation is indeed one of the cornerstones of all East Asian welfare regimes, expressing itself in high government spending on education and, at least initially, on public health care as well. Thus, in Hong Kong, education is "the largest policy area in terms of public expenditure", accounting for roughly 23 percent of the government's budget (Mok 2003: 60f.), and in Singapore, where education's share comes second only to national defence, the respective figure is 21.4 percent (in 2004; see Ministry of Finance 2005). South Korea and Taiwan also invest heavily in education and so does Japan (for details on South Korea, see Shin 2003; for Taiwan, see Holliday 2005). As a result, East Asia's workforce is now regarded as one of the best trained in the world. But given that manufacturing is gradually moving out of all these countries, even more will have to be done in the future if they want to compete globally at the highest level, as they are determined to do. The trend in health care provision, on the other hand, offers a more mixed picture. During the mid-1960s, health care's proportion of the overall government expenditure peaked at just under 20 percent in Singapore (Lim 1989). Thereafter, it declined steadily, although in real terms government health expenditure continued to grow; it now amounts to less than 5 percent of the total budget and 1.6 percent of the country's GDP (Khan 2001; Statistics Singapore 2002; UNDP 2006). While basic health services and facilities are heavily subsidized, the burden of paying for care was nevertheless increasingly shifted to the private sector, mainly to employers and the clients themselves. In Hong Kong, the emphasis of state-provision is on secondary care rather than primary care, i.e. on more costly inpatient treatment, which is almost free for all citizens. Total health expenditure as percentage of GDP is about 4.5 percent in Singapore (in 2003; see UNDP 2006: 301) and amounted to 3.7 percent in Hong Kong during the late 1990s (Holliday 2003). But in Singapore, roughly two thirds of these costs are borne privately, whereas in Hong Kong the government takes charge of the bulk of the bill; in the first few years of the new millennium, healthcare consumed 12.7 per cent of public expenditure (Government of the HKSAR 2003: 20). Both Taiwan and South Korea are spending more on health care than the two cities, namely around 6 percent of GDP, of which about half is financed collectively and half privately (UNDP 2006; Holliday 2003). In Japan, which spends
slightly less than 8 percent of its GDP on health, three quarters of the costs are borne publicly (UNDP 2006).

Throughout the region, health expenditure is rising because of population ageing, but also because of growing prosperity and increasing demand for, as well as supply of, services that were previously unaffordable or did not exist at all – medical technologies keep pushing the boundaries of the professions' capabilities. But the approaches taken to financing such care are quite diverse. Taiwan introduced a national health insurance programme guaranteeing every citizen access to health care "as a social right" (Kwon 1998: 50), whose premiums the government covers up to 40 percent for low-income groups, in 1995 (Son 2001). Programmes existing during pre-democratic times had covered only groups deemed essential to the support of the state. South Korea had a national health insurance, financed through contributions paid jointly by employers and employees, in place as early as 1977. Ten years later, the programme was extended, with the government paying half the contributions for those previously not covered (Kwon, ibid.). Yet, with large co-payments and out-of-pocket expenses, a sizeable fraction of the actual costs (61 per cent for outpatient and 39 per cent for inpatient treatment) must still be borne by the patients themselves (Kwon 2002); similar provisions are in place in Taiwan (Ku 2003). Japan had achieved universal health insurance coverage by 1961, "well before many other industrialized countries" (Oberländer 2003: 88). Originally modelled on the Bismarckian system of Wilhelmine Germany, the system combines universal coverage with a uniform fee schedule for all providers. It is financed primarily through employee and employer contributions, which are kept low because the government subsidizes the insurers. Hong Kong's system is largely tax financed and essentially "a slimmed-down version of Britain's National Health Service" (Holliday 2003: 76). And in Singapore the key mechanism for financing costly inpatient services is the Central Provident Fund (CPF), inherited from its former colonial master and forming the centrepiece of the country's entire social policy framework. In addition, various very cheap (and voluntary) insurance schemes exist to cover parts of the costs of expensive catastrophic diseases.

The main function of Singapore's CPF, which is a compulsory savings scheme for employees, is to set aside a limited amount of money that can be drawn upon after retirement. Despite its multi-purpose nature, it can thus be seen as a rudimentary pension scheme, although nobody believes the amounts that scheme holders are obliged to keep in the fund will suffice to secure them a decent living once they are retired. It is, however, better than nothing, with which the elderly were left in Hong Kong until recently, were no public
retirement scheme existed before the government introduced the Mandatory Provident Scheme in 2000 as a vehicle for individual savings, to which employees and employers each contribute 5 per cent of the wage or salary (Lui 1999). Korea established a national pension scheme in the 1980s, but coverage had reached no more than 27 percent of the working population by 1994 (Kwon 1998: 52). Following various extensions, it is now said to cover the entire population (Kim 2003). Taiwan had been planning a national pension system following the introduction of health insurance, but delayed it in the wake of the 1997/98 Asian financial crisis; it took therefore until July 2005 before the system was finally introduced through the implementation of the National Pension Act. And Japan has a two-tiered system that guarantees a basic, tax-financed pension to every citizen which is supplemented by an earnings-related employee pension.

Despite the sometimes bewildering diversity of the concrete measures taken and policies practised, several analysts argue that East Asian welfare regimes have enough in common to warrant subsumption under a common category. While earlier efforts to typify an East Asian welfare model focused on shared cultural roots (as in the notion of a Confucian welfare model proposed by Jones 1993), the approach preferred here is forward-looking and emphasizes the goal-orientation of social policies, their directionality in terms of some overarching objective(s) towards whose realization these policies are all ultimately geared: economic growth. It is for this reason that Holliday (2000) calls East Asian social policy systems "productivist regimes". In such regimes, says Holliday (ibid.: 709), "all aspects of state policy, including social policy", are subordinated "to economic/industrial objectives", from which everything else flows. They are welfarist "by any reasonable yardstick" (ibid.: 711) – and they are even more so if one extends, following Luhmann (1981) and Schnapper (2005), the notion of a welfare state beyond its classical conceptualisation as an agency in charge of providing social security proper –, but their strong orientation towards fostering economic growth and creating wealthy and strong nations arguably makes them unique in the world of welfare capitalism. And although the 21st century will doubtless bring about new challenges that they, like any welfare system, will have to tackle, Holliday believes "it highly unlikely that they will move beyond productivist welfare capitalism in the foreseeable future" (ibid.: 721; see also Holliday 2005). The region has fared extremely well with its brand of welfare capitalism, and the age of globalization may indeed turn this brand into a model for the rest of the world.

The present paper shares this assessment – with two qualifications. First, Japan's dismal economic performance during the last one and a half decades suggests that its variety
of welfare capitalism may prove as unsustainable as the "German model" with which it shares many characteristics and which distinguish both systems from the liberal, Anglo-American world of welfare capitalism that appears set to dominate the stage for years to come (Streeck & Yamamura 2003). In other words, East Asian welfare capitalism is not just a model for success, but also in need of adaptation to new economic realities, and this is true particularly of its most developed exemplar. However, the point, if true, confirms Holliday's point more than putting it into question, as it is precisely those elements of the Japanese (and German) system whose function it was to shield their economies to a certain extent from market pressures that are now increasingly seen as brakes to dynamism. Removing them would make Japanese welfare capitalism more, not less productivist – and this is precisely the direction that recent reform initiatives have taken in Japan (Schoppa 2006). Second, the remarkable recovery of the Nordic countries, which underwent a deep crisis in the late 1980s/early 1990s, suggests their variety may prove a viable and attractive alternative to purely productivist welfare capitalism – provided they debunk the idea of "politics against markets" (Esping-Andersen 1985) that originally drove the development of social policies in these countries because such politics cannot stem the tide of an increasingly open, integrated world economy. That is exactly what the Nordic countries are doing. Their example shows that it is possible to combine economic dynamism and innovation with low levels of social inequality, and hence to provide significant social security even in the face of growing market pressures and competition. In other words, not all is lost to the cause of social solidarity (see Stjernø 2005).

III. The Enabling State: Work, Health, and Education

Gilbert (2002) has argued that the (Western) welfare state is undergoing a transformation that goes beyond mere adjustments, because it changes its very nature. The aggregate result of two decades of incremental change amounts to a paradigm shift in the Western world of welfare capitalism: from consumption to investment, from passive accommodation to active moulding, from welfare to workfare. Gilbert calls the new system that is beginning to take shape in the West the "enabling state". The enabling state is concerned about making its clients "fit" for successful participation in the market, rather than taking them out of the market and supplying them with (income substituting) safety nets if they prove unemployable under prevailing conditions. On the one hand, this entails the removal of protection rights
enjoyed by the insiders of the labour market that raise labour costs and thus, indirectly, serve to exclude growing numbers of outsiders who cannot be efficiently employed at such "distorted" rates, as well as of disincentives to work, such as high and/or long lasting unemployment benefits that make it individually rational to decline job offers considered unattractive. On the other hand, it entails a concerted effort to upgrade a country's human capital stock through offering a state-of-the-art, lifelong education at the highest level and thus opportunities to attain skills enhancing workers' employability and competitiveness. In short, the enabling state prepares workers better for the market while at the same time pushing them into it.

To the world of productivist welfare capitalism none of this is new. But the changes go well beyond labour market reforms; they affect, indeed, the whole range of social policies, and they generally involve a shift of responsibility for people's welfare from collective mechanisms to more individualized, market-based solutions. Thus state-administered or funded pension systems are gradually supplemented by private savings schemes designed to compensate for income losses accruing from inevitable cuts in public pension levels; several Western countries have accumulated pension commitments that are virtually unrealizable (Giddens 2000). The response to this cannot simply be to raise taxes because that may well become self-defeating. Not only does it discourage capital investment that holds the promise of creating desperately needed jobs (and of enlarging one's fiscal revenue basis), it also encourages middle-class flight to "greener pastures", as exemplified by several hundred thousand French who have migrated to Britain to save taxes (Gilbert 2002: 35f.). But when the most productive segments of one's workforce, those whose services are actually demanded in the market, leave while the weakest stay, then one's capabilities of caring for the latter also diminish. So the only feasible response appears to consist in a policy package that combines a lowering of public pension entitlements to a modest level of "sufficiency" (Kersting 2000) with improved possibilities of self-help – in the labour market and beyond.

Another problem that needs to be brought under control is the constantly rising health care costs. Germany, for instance, not only spends more on old age security than do most other OECD countries (Eurostat 2005), it also has one of the world's most costly health care systems into which the country channels around 11 percent of its GDP annually, second only to the United States. At the same time, it has been neglecting its education system for decades, severely compromising the quality of its once world-class universities and producing constantly rising numbers of "functionally illiterate" youths whose future prospects are more than gloomy. A veritable generation conflict is thus looming; and if this conflict is not
addressed soon, the young may well respond by voting with the feet: a recent survey of "generation good-bye", as it has been baptized, revealed that close to 60 percent of the students currently enrolled at German universities think it likely that they will (have to) emigrate because neither Germany nor, for that matter, continental Europe as a whole, offers sufficiently attractive economic opportunities to them (Spiegel Online 2005).

Health care and education are two fields in which East Asia can teach continental Europe important lessons. The most significant of these is the confirmation of an insight that has been widely known for decades, but has not been sufficiently heeded by European policy makers and social scientific health care analysts: the fact that health care's impact on people's health status is remarkably small (Williams 1990; Castilla 2004), at least if this status is measured by the commonly used indicators, such as infant mortality rates at birth, life expectancy and so forth. Various estimates suggest that medical care accounts for no more than between 10 and 20 percent of the 20th century gains in life expectancy, which probably reflect the greatest jump in the history of humankind (Wildavsky 1977; Easterlin 2000; Economist 2004). The rest is believed to be attributable to better nutrition, sanitation, hygiene, housing, various environmental factors, personal behaviour or lifestyle, and, last but not least, education (McKeown 1979; Pincus et al. 1998; Puska 1999; Lleras-Muney 2005). This conjecture seems to be supported by the observation that rich countries – or special administrative regions – like Singapore and Hong Kong, that spend relatively little on health care, fare no worse on these indicators than do the United States and Germany (UNDP 2006: 315). In fact, a recent ranking of health care systems by the World Health Organization (2000) using eight standard measures put Singapore at number 6, whereas the German and the American systems made it only to numbers 25 and 37, respectively (Hong Kong, which was not included in the ranking, seems to perform even better on these indicators than Singapore; see Estes 2005). Further support for the conjecture comes from the experience of several much poorer regions or countries, such as Costa Rica, Kerala in India, Sri Lanka, and China before its transition to capitalism, which have been enormously successful in improving longevity rates without being able to pour vast amounts of money into health care. What they have done instead, was to secure relatively cheap basic health care for all (Sen 1999).

Of course medical care delivers more than just longer lives. It improves the quality of people's lives, for instance through greater mobility, enhanced vision and pain relief, to name but a few. And while it is true that Singapore's and Hong Kong's populations are still much younger than those of the average West European nation, that argument has its limitations because Britain, which until recently spent significantly less on health care than its
continental European counterparts, achieved results quite comparable to them, and Japan, which also spends much less, but has the oldest population of all OECD countries, enjoys a life expectancy that is amongst the highest in the world and has a health care system that is judged to perform well despite receiving less than the OECD-average GDP share (Jeong & Hurst 2001; World Health Organization 2000). In other words, while there is doubtless room for expanding the public health care budgets of Singapore (Phua 2002) – a view that seems to be confirmed by a significant boost in government spending on health care in 2007 (Straits Times, 16 February 2007) – and Hong Kong, especially because their demographic transitions are still largely matters of the future, their experience, in conjunction with those of several other countries, shows that very high health standards are attainable despite low spending. This is a lesson not just for high spenders but for all countries.

But the lesson does not end here. For not only is health care's impact on people's health status limited; it also has a fairly limited effect on people's life chances more generally. To see this, it is probably best to ask oneself what one should expect of health care in the first place, what one wants it to do. This, in turn, raises the question as to what constitutes a good or meaningful life, and how much one can expect the community to contribute to one's ability of leading such a life. Following the renowned ethicist Norman Daniels (1996), one can expect quite a bit, but not much more than what is required to guarantee fair equality of opportunity to pursue a life plan one has reason to value. To this end, however, one needs more than just good health care, for instance a good education. Education enables us to develop our general capabilities to function in the contemporary world, and in this sense enhances the range of options that become available to us. Health care contributes to these freedoms, as it helps us maintain or restore normal species-typical functioning threatened or compromised by ill health. Yet, like all factors that have a role to play in this, its contribution is a limited one. Therefore, despite our inclination to seeing health care as special, in our budget allocations we have to trade it somewhat for other valuable goods and services, and the prudent course of action would be to restrict its share to the minimum required for securing this limited purpose.

This normative argument for rationing health care receives further support from an empirical observation. In a world economy characterized by fierce competition, ever shorter product replacement cycles coupled with rapid technological innovation and knowledge reinvention, education assumes greater importance both for the society at large and for the individual. Without a good education, people are increasingly marginalized in the labour market, and this is true especially of high wage economies, because in such economies many
unskilled or low skilled workers become virtually unemployable. (Re)training is their only chance of (re)integration, and such training is costly. Given the growing significance of education and the limited impact of health care on people's health status, priorities have to be set accordingly. East Asian countries seem to be making the right trade-offs by prioritizing education over health care – their governments spend more or at least as much on the former than they do on the latter. Interestingly, their Scandinavian counterparts are moving in the same direction. Thus, while spending more in both areas – between 5.7 to 8.6 percent of the GDPs on health care and 6.5 to 8.4 percent on education (UNDP 2006: 301; 319) –, the governments of Finland, Sweden, Norway and Denmark are making similar trade-offs by emphasizing investment into the future much stronger than several continental European countries, especially Germany which spends just over half as much on public education as on public health care, namely 4.8 versus 8.7 per cent, respectively.

In preparing people to succeed in the market, a government may, indirectly, even enhance their health status, as safe(er) employment, higher incomes and a good education tend to be associated with health conscious life styles (McMurray 2004), a better ability to understand health risks, less docility towards doctors trying to deny certain patients scarce (but effective) treatment (Aaron & Schwartz 1984), etc. At the same time, they reduce the risks of unemployment-related disease, psychological stress, social status loss and even premature death: the long-term unemployed suffer significant declines in life expectancy (Kieselbach 2000). Once a decent level of basic care is secured for all, the health-enhancing effect of education may thus be greater than that of additional health care would be (Fuchs 1979; Lleras-Muney 2005). This is not to deny that there are significant inequalities in the access to proper health care – in East Asia and elsewhere. However, it is more than doubtful that an expansion of (public) health services beyond the level of basic care would actually benefit the weakest sections of the population (Castilla 2004); the main beneficiaries of the British National Health Service are, for instance, not the worst-off but the middle classes because they are in a much better position to utilize the facilities it offers (Goodin & Le Grand 1987). So even if one were concerned primarily about the plight of the poor and the protection of the vulnerable, one would still be well advised to prioritize (more and better) education over (more and better) health care should it prove difficult to fund both sectors equally well.

But while East Asia seems to be making the right trade-off between investment- and consumption-oriented welfare policies, not everything is well with its social realities. For instance, even though one finds nothing in the region that resembles the extreme misery
suffered by the inhabitants of North American inner city ghettos or South American favelas, there is no dearth of relative poverty, especially in Singapore and Hong Kong whose income distribution is highly skewed in favour of the well-off. As mentioned earlier in this paper, Singapore recently introduced a new income supplement programme to give its poor a leg-up (Straits Times, 16 February 2007), and while measures such as these certainly help, a country whose per capita income ranks amongst the highest in the world would certainly be capable of doing more without endangering its economic competitiveness. This is a field in which East Asia could learn more from Europe, and once again, primarily from Nordic Europe because Scandinavia not only ranks high on economic competitiveness (World Economic Forum 2006), it also has the lowest poverty rates in the OECD, coupled with acceptable (and declining) levels of unemployment, good public health and pensions (Kuhnle et al. 2003; Bonoli 2006) and remarkably low income disparities (Fritzell 2003). On top of that, its variety of welfare capitalism is very women-friendly, as mentioned before. These and other virtues/attributes (e.g., its children-friendliness) have repeatedly earned it the highest scores in intra-European justice evaluations of welfare regimes (Merkel 2001; berlinpolis 2005).

The Nordic countries appear to be moving in a direction that may well reflect a healthy balance between productivist and "non-productivist" (Offe 1992) elements of a well-designed social policy package. During the past 15 years or so, they have strengthened the workfare elements, demanding greater flexibility of the labour force. At the same time, they have retained strongly solidaristic and universal health care and pension systems addressing the basic needs of the whole population. And they seem to have found an answer to the demographic transition as well, consisting of a high level of female labour market integration combined with the setting up of quality childcare and old age facilities that turn care into a profession, rather than depending on the unpaid "labour of love" by women who are rightfully demanding equality of status and recognition.

As is well known, learning from others rarely means importing/copying their solutions wholesale and implementing them one-to-one at home. Rather, it involves the willingness to think beyond the present and familiar, and to probe one's "received" solutions or established policies in the light of alternatives, which, upon reflection, may be partially adopted and locally adapted. But while in the past such learning was largely unidirectional, the East – East Asia – now has to teach the West important lessons too. Beyond what has already been indicated, these lessons cannot be spelled out in detail here. But one example deserving serious consideration for such cross-continental fertilization of reform debates is certainly the Singaporean health care system which, while not without its own problems, offers very
interesting clues as to how one can build an effective, yet comparatively cheap system that balances an inevitable degree of paternalism protecting people against their own weakness of will and short-sightedness with a high degree of liberty permitting those who are able and willing to care for themselves to make their own choices (Schmidt 2004).

IV. Conclusion

In conclusion, it seems that developments both in East Asia and in the West by and large confirm a hotly contested argument of Wilensky (1975; 2002), namely that virtually all countries that grow affluent as a result of successful industrialization of their economies will sooner or later establish some mechanisms of collective, state-run or -regulated welfare provision. Nowadays one might add that the instalment of some such mechanism could be one of the very conditions of success itself, as a comparison between Latin America, which was well ahead of Asia other than Japan after World War II, and East Asia suggests. Latin America is not only the region with the highest levels of inequality in the world, it has also left its poor almost completely unprotected (Barrientos 2004) and unprepared to play any significant role in economic/industrial development (de Ferranti et al. 2004). East Asia, on the other hand, pursued the opposite strategy and is now one of the pillars of the world economy, no longer a "peripheral", dependent participant, but a key member of the "core". The region enjoys unprecedented prosperity, and even though its welfare regimes are only marginally redistributive, all segments of society have benefited from its "shared growth", so that everyone's living standards are now much higher than those of their ancestors. Looking more specifically at the design of welfare regimes, it seems that Europe is presently moving in the direction of Asian productivism, but there are also signs that East Asia may eventually need a greater dose of European non-productivism (see Gough 2004; see also Low & Aw 2004 for the idea of introducing a "participation income" that recognizes non-economic contributions to society's welfare), adding to the North Atlantic liberalism that has been the strongest force shaping the world's socio-economic development during the past 20 years. The overall pattern is therefore one of growing convergence – not to be understood as sameness or identity, but as increasing similarity of welfare regimes and of the polities and policies of socio-economically advanced countries more generally (Schmidt 2006), which, in turn, is a result partly of adaptations to similar environmental conditions and partly of mutual learning across regime types and world regions.
References


