Public or Private Management? A Comparative Analysis of Social Policies in Europe

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Abstract

Across the world, political leaders and policy experts frequently use the labels 'public' and 'private' to organize social policies. A line seemingly separates public from private efforts, with social policies publicly organized in some countries and privately organized in others. According to this perspective, a public social policy is undertaken by government or deals with a public matter. When a social policy is private, non-public actors and institutions, like employers, undertake it or it deals with a private matter, like body control. This article examines whether public or private approaches to managing social policies are currently emphasized in European countries. I begin by defining social policy and then provide an overview of the public–private dichotomy in managing social policy. I review predominant typological frameworks of public–private organization of social policies and examine three welfare social policies and three social policies dealing with body control by comparing public–private organization of these six policy areas across 21 European countries. I conclude by discussing the limited diversity of public–private organizations of social policies in Europe.

Introduction

Across the world, political leaders and policy experts frequently use the labels 'public' and 'private' to organize social policies. A line seemingly separates public from private efforts, with social policies publicly organized in some countries and privately organized in others. According to this perspective, a public social policy is undertaken by government or deals with a public matter. When a social policy is private, it is undertaken by non-public actors and institutions, like employers, or it deals with a private matter, like body control. A closer look, however, often reveals a more complex picture of social policy organization in which both government and private actors and institutions participate.

While it is not uncommon to substitute the terms 'welfare state' with 'social policy', they are distinct. Here, I will examine *social policy* as an umbrella of approaches societies take to manage social risks, one approach being the welfare state. Sociologists and other social scientists have

developed typologies of welfare states that are frequently based on the degree to which government and private actors and institutions manage social risks. This research, however, has tended to focus on public management of social risks connected to paid work, such as education and retirement pensions. It has not gone to the same lengths in studying other kinds of social risks.

This article examines public–private organization of six social policies that manage social risks to ask: does government manage social risks to the same degree across social policy areas? Or does public–private organization vary across social policies? This article first defines social policy, then considers various types of social policies and the challenges they pose to the public–private dichotomy for social policy. After reviewing predominant typological frameworks of public–private organization of social policies, this article examines three welfare state social policies and three social policies dealing with body control, comparing public–private organization of these six policy areas across 21 European countries.

What Is Social Policy?

In his book, *Social Policy*, Richard Titmuss (1974: 23), often considered a founder of the study of social policy, defines policy as 'the principles that govern action directed towards given ends'. A broader definition of policy includes principles and intentions (King and Mori 2007: 7). Policy can be defined as a tool to influence people and their behavior (see Stone 1997: 259). Titmuss (1974: 30) later states, 'social policy is seen to be beneficient, redistributive and concerned with economic as well as non-economic objectives.' A prominent scholar of the welfare state, Esping-Andersen states (1999: 36; also see Skocpol and Amenta 1986: 132), 'Social policy means public management of social risks.' Social policy is *social* for three reasons: (1) an individual's situation 'has collective consequences ...'; (2) society recognizes risks as 'warranting public consideration ...'; and (3) many risks are beyond an individual's control (Esping-Andersen 1999: 37). A policy is social because it deals with risks that may affect more than a single individual, manages a risk beyond an individual's control, and because social sentiment is that the risk is of widespread concern.

The welfare state is a social policy, but it is important to emphasize that it is one kind of social policy (Esping-Andersen 1999: 33). A welfare state typically manages socio-economic risks, such as loss of income due to unemployment. It may prepare an individual for participation in the paid labor market through education and training. Or it may provide services less tied to the labor market, but important to an individual's well being, such as health care. Esping-Andersen (1999: 34–35) reminds us that welfare is not only provided by governments. Instead, it is necessary to focus on other actors and institutions to study 'the broader package of welfare production and distribution'. To get a fuller picture, Esping-Andersen (1999: 4, 73) articulates the idea of welfare regime, which is the combined

provision of welfare by state, market, and family. Some social policies manage other kinds of social risks, such as individuals' body control. An example is organ transfer. Notorious cases have recently been documented of individuals attempting to sell organs (BBC 2006), with some experts debating over the practices (Meckler 2007). Some social policies manage social risks found in families, such as physical punishment of children by parents (American Academy of Pediatrics 2000; United Nations 2006). An examination of public–private organization of social policy brings to the forefront how different policy goals, Titmuss' 'ends', are reached through public and private efforts. This article seeks to demonstrate that government has a significant role in social policy organization, but private actors and institutions do as well.

Public–private organization of social policies

How societies organize their social policies has been of immense interest for some time (Orloff 1993; White 1995). An important starting point to consider public–private organization of social risk management is Aristotle's (1997) conception of the state and its relationship to the household. Aristotle understood the state as consisting of a group of male citizens who, together, governed their societies. An individual male citizen governed his household, including his wife, slave, and children. The state could not dictate how a male citizen treated these household members, unless the male citizen inappropriately governed. Aristotle's conception designates a boundary between the state and private household. Government was not to cross this public–private boundary, unless male citizens determined a male citizen was inappropriately governing his household members. Social risks were managed by households, unless the household head failed to manage those risks.

For some years, management of social risks found in the labor market has been organized by public and private means. Governments have long instituted policies to protect individuals when they are incapable of obtaining sufficient resources on which to live (Rueschemeyer and Skocpol 1995). Indeed, the notion of private property necessitated government intervention, as Polanyi (1957: 141) writes. It was during the reign of England's Queen Elizabeth I that the Poor Law mandated collection of a tax to redistribute income to individuals who were 'deserving', including widows and children who could not work, and to create work for individuals who were considered capable (Trattner 1989). Elizabeth's government intervened only to affect specific categories and, by doing so, made a household issue, poverty of the deserving, into a public matter. Poverty of the non-deserving was not an entirely private issue, with Elizabeth's government intervening to make work available.

For many countries, the last century was a time when new social risks were identified along with new forms of social policies. Welfare social policies were established in many countries, managing risks of health and labor market

(Wilensky 1975). Private welfare social policies were also instituted, with labor unions and companies often managing social risks like health insurance for employees and their families. Other social policies were developed that intervened into household and individuals' activities, making what were private into public matters (Biesel 1997; Gallagher 2007). An important example is corporal punishment of children, which appears to be shifting from a household matter to a public issue (Donnelly and Straus 2005).

The public–private dichotomy for social policies

The term 'dichotomy' implies a boundary separating two parts into two exclusive domains. The public–private dichotomy for social policy means, therefore, that a social policy can be divided into public and private social policy domains. A close examination of public–private organization of social policies, however, indicates the 'reality is more complex' (Lister 1997: 120). Fraser advocates taking a hard look at public and private. 'These terms, after all, are not simply straightforward designations of societal spheres; they are cultural classifications and rhetorical labels. In political discourse they are powerful terms frequently deployed to delegitimate some interests, views, and topics to valorize others' (Fraser 1999: 131). As Lister (1997: 122) contends, the public–private dichotomy is an 'essentially contested construction', which Turkel (1992: 222) declares is 'increasingly determined by social forces.'

Lister (2005, 1997) rethinks the notion of a public–private divide, challenging the 'rigid' separation of public and private. Scholars have examined ways in which the public–private dichotomy for social policy is a boundary. Kvist and Sinfield's (1997) work demonstrates the importance of tax expenditures to governments' efforts to shape social policy outcomes. Tax expenditures are tax deductions, tax credits, tax breaks, 'departures from the normal tax structure ... designed to favor a particular industry, activity, or class of persons' (Surrey and McDaniel 1985: 3, cited in Howard 1997: 1).

Regulation by government of private social policies defies the rigid public–private dichotomy (Grønbjerg 1998: 137; Powell and Clemens 1998: xiii). Governments often regulate private welfare provision, from governments that mandate private provision (Rein and Turner 2001) to regulating individual's choices of retirement-income provision. Governments regulate other social risks. A woman's private decision to obtain an abortion is typically regulated by governments (Mooney and Lee 1995). Many governments designate in what circumstances a woman can legally obtain an abortion, with some governments imposing strict regulations (Rahman et al. 1998).

'Public' and 'private' have multiple meanings (Thornton 1991). Many significant contributions have been made to studies of public–private social policies, particularly on questions surrounding government-market relationships (Béland and Hacker 2004; Dobbin 1992; Graetz and Mashaw 1999; Hacker 2002; Howard 1997; Klein 2003; Minow 2002; Rein and Schmähl 2004; Shalev 1996). In some studies, public refers to government involvement.

Government involvement may support positive rights (Donnelly 2003; Fredman 2006). A positive right requires government intervention; they 'invite and demand government' (Holmes and Sunstein 1999: 40). For public welfare social policies, government provides social services like education and benefits like health insurance. Government may also regulate behaviors, such as banning corporal punishment of children. This type of ban reveals another meaning of public for social risk management. By banning corporal punishment of children, what was a private decision of parents, for instance, has become a public matter, subject to government intervention.

Private shares a similar duality. For welfare social policies, private usually refers to market-based provision, such as employer-provided services and benefits (Hacker 2002), but private may denote efforts of nongovernment organizations (Rekart 1993). Private may also signify services and benefits purchased or undertaken by family members or individuals (Gran 2003). For social policies that regulate behaviors, however, private typically means non-public. For this meaning of private, individual behaviors are not public matters; they are not subject to government intervention (Gallagher 2007). These are types of policies that involve negative rights (Donnelly 2003: 30). Negative rights, in contrast to positive rights, restrain government from 'a private realm' (Holmes and Sunstein 1999: 40). In this conceptualization, positive rights require government intervention, while negative rights restrict government intervention (for critical analysis, Holmes and Sunstein 1999). These research contributions suggest the public–private dichotomy for social policy is not a boundary, but a relationship of degree in which various public and private actors and institutions share social-policy arrangements. Rather than a boundary line, the public–private dichotomy is an area in which governments and various actors form relationships, sometimes contested, in undertaking social policy.

Types of public–private organizations of social policies

Research on welfare state social policies is recognized for development of typologies of public–private organization of social policies. Titmuss (1974: 23) conceptualized three types of welfare states: the universalist, the industrial achievement-performance, and the residualist models. For the universalist model, the public component is emphasized; it provides extensive protections to all citizens against a variety of socio-economic risks. The residualist model, on the other hand, emphasizes the private component to manage social risks. The public component only provides protections to those who do not succeed in the market place or whose family cannot provide support. Excluding the public component, the industrial achievement model relies on the private component to manage social risks.

The works of Gøsta Esping-Andersen have had tremendous impacts on studies of welfare states and social policies. Esping-Andersen (1999) conceptualizes three types of welfare regimes: social democratic, conservative,

Table 1. Public–private organization of social policies in European countries based on Esping-Andersen's (1999) typology

Strong Public-Weak Private	Moderate Public-Moderate Private	Weak Public-Strong Private	Strong/Moderate Public-Strong/ Moderate Private
(Denmark), Finland, (the Netherlands), Norway, Sweden	Austria, (Belgium), (France), Germany, Italy, Portugal, Spain	(Ireland), (Switzerland), (UK)	Czech Republic, Hungary, Poland, Slovakia

(Countries in parentheses moderately fit their characterizations, based on Esping-Andersen's 1999 typology).

and liberal. The social democratic model is similar to Titmuss' universalist model; the welfare state provides generous benefits for protection against an extensive list of social risks. Where the social democratic approach is dominant, private management of social risks is less common. The conservative model does not emphasize either public or private management of social risks. Government provides extensive benefits so individuals and families may maintain their status, but private actors and institutions are important to risk management. The liberal model is similar to Titmuss' residual model; it provides a safety net to individuals who cannot attain socio-economic well-being from the paid labor market. Risks tend to be privately managed in the liberal model. While Esping-Andersen is cautious about characterizing some welfare regimes according to these types, most of the nations appear to fit his classification.

Based on Esping-Andersen's characterization, for the early 1990s, nations fall into three categories of public–private organization of welfare social policies (see Table 1).

The Scandinavian countries are characterized by a strong public-weak private organization of social policies, although Denmark, according to Esping-Andersen, has a less satisfactory fit. To varying degrees, social policy organization of the continental European countries is characterized moderately public and private. An important exception is the Netherlands, which emphasizes public organization more than other continental European countries and perhaps better fits a strong public-weak private organization. Esping-Andersen suggests that Belgium and France do not perfectly fit his conservative regime type. Of the countries examined by Esping-Andersen, none of the European countries is clearly characterized as weakly public, strongly private in social policy organization, but three are oriented in that direction: Ireland, Switzerland, and the United Kingdom.

Esping-Andersen tackles questions about whether his typology adequately accounts for approaches of other OECD nations. For instance, he asks whether a 'Mediterranean Fourth World' (in which he places Italy, Portugal, and Spain) is distinct from the other approaches. His (Esping-Andersen

1999: 93–94) analyses indicate that the Mediterranean world fits within the conservative world where Italy, Portugal, and Spain currently reside. Other research places Turkey (Gough 2005) and Greece (Leibfried 1991) in this fourth world. Esping-Andersen (1990; 1999) did not include Eastern European countries in his analyses. Fenger's (2005: 14) work suggests that the Czech Republic, Hungary, Poland, and Slovakia form a post-Communist European type that mix characteristics of the social democratic and conservative approaches. The findings of Fenger indicate the public–private organization of these Eastern European countries' social policies is sufficiently different to be considered another type.

Do typologies of welfare regimes fit other kinds of social policies? Sheila Shaver (1999: 183) proposes extension of Esping-Andersen's framework to social policies on body control. In her comparative-historical study of legal processes, laws, and rights to abortions, Shaver (1999: 165, 170) contrasts 'body rights' with medical entitlement to abortion. A body right to abortion is when a woman has the right to control her body, including obtaining an abortion (Shaver 1999: 161). Medical entitlement is when a woman has the right to obtain health care, a social right, as part of her right to control her body (Shaver 1999: 171). Research of other scholars provides support for Shaver's work. Glendon (1987) finds Austria, Denmark, Greece, Norway, and Sweden approach abortion as a body right combined with social right.

Another social policy on body control is organ transfer social policies. Healy (2005) asks whether transfer of cadaveric human organs can be conceptualized within Esping-Andersen's three worlds. Healy points out that this typology can be thought of as the relationship between 'the state and the individual'. For organ transfers, Healy contrasts two forms of consent between an individual and the state: presumed consent and informed consent. He defines presumed consent as consent that is legally presumed to have been made. Informed consent, in contrast, requires an individual to indicate he or she has already made a decision to transfer organs. According to Healy, because liberal welfare regimes are less likely to rely on the state, they are more likely to have informed consent rules because of notions of individual responsibility. Conservative regimes are more likely to rely on the state, and thus, are more likely to presume consent. Healy predicts social democrat regimes will likely have presumed consent regimes. Healy (2005: 22) finds support for applying Esping-Andersen's typology of welfare regimes to organ transfer social policies. In sum, government intervenes less in liberal regimes, more in conservative regimes, and most in social democrat regimes.

The works of Shaver and Healy suggest that Esping-Andersen's typology may fit social policies on body control. This article assesses whether this welfare regime typology applies to public–private organization of welfare and body control social policies. It employs this typology to 'see the forest for the trees', identifying patterns across social policies and countries in how they organize their social policies (but see Baldwin 1996 for a review

of concerns about using such typologies). Identifying these patterns may suggest common approaches to managing social risks or important differences in how societies tackle common social risks.

Analyses of public–private organization of social policies

In this section, I investigate public–private organization of three welfare social policies, health care, education, and housing, then three social policies that manage body control, legalized abortion, corporal punishment, and organ transfers. Afterwards, I make comparisons across these policies and countries.

Public–private organization of health care policies

Health care is a social policy that is considered essential to a society's prosperity (Marmor and Barer 1994; Quadagno 2006). Health care policy is a social policy because it attempts to manage the health care of more than a single individual (Graetz and Mashaw 1999: 167). Health care can help an individual manage risks beyond her control through public health measures and access to treatments that she could not afford to pay on her own (Weitz 2006). Of course, health care is a policy of widespread interest to policy makers and voters, if just because all of us need health care at some time (Morone and Jacobs 2005).

As Table 2 demonstrates, countries vary according to their reliance on public and private financing mechanisms for health care (OECD 2007b). Finances are one way public–private relationships shape health-care policies. Table 2 first indicates proportions of public and private expenditures on health care.

All of the examined countries primarily rely on public expenditures, but there are important differences (Green-Pedersen 2002; Hinrichs 2002). The range of public expenditures as a proportion of total expenditures is from 55.6 percent (Switzerland) to 91.4 percent (the Czech Republic). The Czech Republic and Slovakia have the highest proportional reliance on the public sector, with 90.5 and 89.4 percent, respectively, of total health expenditures from public sources. Switzerland and Greece have the strongest reliance on private sources, with 44.4 and 43.9 percent, respectively.

One kind of private expenditure is out-of-pocket expenses (Braun and Gilardi 2006). Out-of-pocket expenditures range from 24.6 percent of private expenditures (the Netherlands) to 100 percent in the Czech Republic and Slovakia. Those health systems that have the highest proportion of public expenditures tend to have the highest proportion of their private expenditures coming from out of pocket. The Czech Republic, Denmark, Norway, and the Slovak Republic have high public expenditures and to the degree they have private expenditures, those private expenditures largely are out of pocket. In some of the health systems with relatively higher proportions of private expenditures, out-of-pocket expenditures are the

Table 2. Public–private organization of health care policies (2000): proportions of expenditures and coverage

	% Public Expenditure	% Private Expenditure	Of Private Expenditure: % out of pocket	% Public Health Insurance Coverage	% Private Health Insurance Coverage
Austria	69.4	30.6	61.4	99	31.9
Belgium	72.1	27.9	–	99	57.5
Czech Republic	91.4	8.6	100	100	Neg
Denmark	82.5	17.5	91.4	100	28 (1998)
Finland	75.1	24.9	81.9	100	10
France	75.8	24.2	43.0	99.9	92
Germany	75	25	42	90.9	18.2
Greece	56.1	43.9	–	100	10
Hungary	75.5	24.5	87	100	Neg
Ireland	73.3	26.7	50.6	100	43.8
Italy	75.4	24.6	91.9	100 (1997)	15.6 (1999)
Netherlands	63.4	36.6	24.6	75.6	92
Norway	85.2	14.8	96.6	100	Neg
Poland	70	30	–	–	Neg
Portugal	68.5	31.5	–	100	14.8
Slovakia	89.4	10.6	100	100 (1999)	Neg
Spain	71.7	28.3	83	99.8 (1997)	13
Sweden	85	15	–	100	Neg
Switzerland	55.6	44.4	74.1	100	80
Turkey	62.9	37.1	–	66 (1997)	<2
United Kingdom	80.9	19.1	–	100	10

–: Missing.
Neg: Negligible.
Source: OECD 2007b.

largest proportion (Austria, Hungary, Italy, Spain, and Switzerland), indicating individuals and families directly pay for their health care to a large extent.

Public health insurance coverage is extensive in these European countries. Government coverage ranges from 66 percent (Turkey in 1997) to 100 percent (in 14 of the 21 countries; in another four countries, governments insure 99 percent of the population). Even when the public component of a health-care system provides broad insurance coverage, private components often have a significant role. In 6 of the 18 health-care systems where the public component provides nearly universal coverage (≥99 percent), over 25 percent of their populations have private coverage, with France and Switzerland's private component insuring over 80 percent of their populations. In only one country does a larger portion of the population enjoy private insurance coverage than public, which is the Netherlands. Lower public insurance coverage, however, does not necessarily mean greater private

coverage. In 1997, Turkey's public component covered 66 percent of the population, but its private component provided coverage to less than 2 percent of the population.

These analyses demonstrate that public–private organization of health policies varies across European countries. Important patterns emerge, some of which support typologies. The Scandinavian and Eastern European countries tend to have substantial public expenditures, with a range of 75.1 percent (Finland) to 91.4 percent (the Czech Republic). In general, continental European and Mediterranean countries have lower public proportions, ranging from 56.1 percent (Greece) and 63.4 percent (Netherlands) to 75.4 percent (Italy) and 75.8 percent (France). Of the 21 countries, only three do not have public insurance coverage of 99 percent or higher: Germany, the Netherlands, and Turkey. All Scandinavian countries and Eastern European countries do have 100 percent public coverage, although data are not available for Poland. Despite their proportionately lower public expenditures, the continental European and Mediterranean countries have nearly universal coverage, but not for Germany (90.2 percent), the Netherlands (75.6 percent), and Turkey (66 percent). For health social policies, public plays a large role in organization of health social policies.

The public–private typology (see Table 1) does fit health-care policies. Countries whose health policies are characterized as publicly organized, including the Scandinavian and Eastern European countries, do publicly organize health care. Those countries whose social policies are moderately publicly organized, which include continental and Mediterranean countries, do emphasize public more than private organization of health care.

Public–private organization of education policies

Education policy is important to national economies, political systems, and civil societies (Lareau 2003). Education policy is a type of social policy based on Titmuss' (1974) conception. Education policy manages various risks that affect groups of people, primarily young people, for whom those risks are to a large degree beyond their control (Heckman 2006). Education manages risks of labor market participation, providing skills to enable an individual to hold a paid job (Jencks and Phillips 1998). It enables an individual to participate in political systems and civil society, offering resources to think critically and vote and participate effectively (Janoski 1998). As T. H. Marshall (1950) noted, as a social right education can enable an individual to use more effectively her civil and political rights. The same can be said of human rights (Turner 2006). Education, of course, offers advantages to the individual receiving the education, but education benefits others by raising employment and wage levels, which generate tax revenue and non-monetary benefits (Green-Pedersen 2002; Usher and Cervenan 2005).

According to the OECD, high levels of school enrollment are present in these 21 countries. Proportions of public and private expenditures differ across these countries (see Table 3).

Examining total expenditures, in general public expenditures on education outweigh private expenditures. The highest proportion of public expenditure is in Finland (100 percent) then Turkey and the United Kingdom (97.4 percent). The lowest is in Greece (63.8 percent).

These indicators of overall expenditures, however, conceal important patterns by education level (Einhorn and Logue 2004: 515). The OECD (2007b) provides data according to pre-primary education (for 3 year olds or younger), then primary, secondary, and post-secondary, non-tertiary, and then tertiary education. These categories roughly are equivalent to US preschool, elementary and secondary, and post-secondary education, respectively. I first note differences across level of education according to proportion of public and private expenditures. For countries for which data are available, government contributes the highest proportion of funds to pre-primary education across all countries, over 80 percent for 14 countries and 63.1 percent for Germany, with the exception of Ireland, which is 40.2 percent.

For primary, secondary, and post-secondary/non-tertiary education, however, for all examined countries, the public component is 90 percent or more, except for Germany, Switzerland, and the United Kingdom, which are over 80 percent. Tertiary education in two thirds of the 21 European countries is less publicly funded. Private expenditures outweigh public in Portugal (76.7 percent) and Poland (55.1 percent), with Austria near parity (49 percent). In contrast, public proportion is higher for the tertiary education level, compared with primary, secondary, and post-secondary/non-tertiary education levels for Belgium, France, and Germany. Comparing expenditure proportions for elementary and secondary with tertiary education levels, public proportion is considerably lower for Austria (by 44.8 percent), Denmark (by 36.8 percent), Ireland (by 19.3 percent), the Netherlands (by 15.4 percent), Norway (21.7 percent), Portugal (by 76.6 percent), Spain (13.6 percent), and Sweden (by 22.5 percent). The private component plays a substantial role in education for some countries: more than 30 percent for Austria (tertiary), Denmark (tertiary), Germany (preschool), Greece (overall), Ireland (preschool), and Poland (tertiary).

These analyses indicate that for nearly all of the examined countries, education primarily is publicly organized, not private. Important differences exist by level of education. Pre-tertiary education primarily is publicly organized, but for most countries, the tertiary level tends to be privately organized. The exceptions are three of the continental European countries: Belgium, France, and Germany.

The public–private typology (see Table 1) does fit education. The typological framework best fits primary, secondary, and pre-tertiary education levels, education levels in which most young people in these countries participate. The Scandinavian and Eastern European countries have

Table 3. Public–private organization of education policies (2003): proportions of expenditures

	Overall % Public Expend.	Overall % Private Expend.	% Public Expend. pre-primary (≤3 years)	% Private Expend. pre-primary (≤3 years)	% Public Expend. primary, secondary and post-secondary non-tertiary education	% Private Expend. primary, secondary and post-secondary non-tertiary education	% Public Expend. tertiary education	% Private Expend. tertiary education
Austria	89.7	10.3	78.8	21.2	97.2	3.8	92.7	7.3
Belgium	79.3	20.7	97.2	2.8	95.9	4.1	86.7	13.3
Czech Republic	82.6	17.4	95	5	94.5	5.5	83.3	16.7
Denmark	65.6	34.4	81	19	97.5	2.5	96.7	3.3
Finland	100	0	91.1	8.9	99.2	0.8	96.4	3.6
France	80.2	19.8	95.6	4.4	92.4	7.6	81.3	18.7
Germany	75	25	72.1	27.9	82.1	19.9	87.1	12.9
Greece	63.8	36.2	–	–	93	7	97.4	2.6
Hungary	93.6	6.4	93.7	6.3	94.9	5.1	78.5	21.5
Ireland	83.6	16.4	–	–	96.2	3.8	83.8	16.2
Italy	73.4	26.6	90.6	9.4	97.1	2.9	72.1	27.9
Netherlands	77.7	22.3	97	3	94.1	5.9	78.6	21.4
Norway	97.5	2.5	84.6	15.4	–	–	96.7	3.3
Poland	95.4	4.6	85.5	14.5	96.9	3.1	69	31
Portugal	93.1	6.9	–	–	99.9	0.1	91.5	8.5
Slovakia	80.4	19.6	85.5	14.5	91.8	8.2	86.2	13.8
Spain	87.7	12.3	87.2	12.8	93.4	6.6	76.9	23.1
Sweden	78.2	21.8	100.0	Neg	99.9	0.1	89	11
Switzerland	85.3	14.7	–	–	86.4	13.6	–	–
Turkey	97.4	2.6	–	–	97.4	2.6	95.2	4.8
United Kingdom	97.4	2.6	94.6	5.4	86.5	13.5	70.2	29.8

Source: OECD 2007a; –: Missing; Neg: Negligible.

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proportionately higher public expenditures, ranging from 97.8 percent for Denmark to 99.2 percent for Finland to 99.9 percent for Sweden and, in Eastern Europe, from 91.7 percent in the Czech Republic to 97.6 percent for the Slovak Republic (with data missing for Poland). Nevertheless, the Mediterranean countries also emphasize public over private expenditures, ranging from 91.7 percent in Greece to 99.9 percent for Portugal (with data missing for Turkey). With the exception of Germany, which only has public expenditures of 80.5 percent, the range is 93 percent for France to 95.8 percent for Austria. Relative to Germany, even Ireland and Switzerland more strongly rely on public rather than private, with the United Kingdom at 96 percent. Thus, although the Scandinavian countries as a group are publicly organized as expected, other countries also heavily rely on public expenditures for education.

Public–private organization of housing policies

Housing policy manages social risks of critical importance to all individuals and fits Titmuss' (1974) conception of social policy (Kleinman 1998). For many people, housing is beyond their control, whether the person is young or old and relies on others for shelter. In most wealthy countries, housing is considered a necessity and as a result social sentiment is that the risk of not having shelter is of widespread concern (Conley and Gifford 2006; Lux 2003). Despite its importance as a social policy, researchers (Conley and Gifford 2006: 78; Kemeny 2006: 7) question whether extant welfare-regime typologies fit housing social policies: is housing social policy different?

Table 4 presents data on proportion of home occupation across the 21 countries for three kinds of housing: social rented, owner occupied, and private rented.

'Social rented' is housing that, according to Norris and Shiels (2004: 7), is made available by rules that favor 'households that have difficulties in accessing housing in the market'. Norris and Shiels (2004) indicate that this kind of housing is usually rented by government or non-profit organizations. An individual does not obtain social rented housing from market competition. Although the highest proportion of social rented housing does not reach public proportions of health and education expenditures, social rented housing comprises more than 20 percent of homes in the Netherlands, the Czech Republic, Austria, the United Kingdom, and Poland. In the middle range of 10 to 20 percent are found two continental European countries (France and Germany), three Scandinavian countries (Denmark, Finland, and Sweden), and Ireland. None of the Eastern European countries fall within this range. Social rented housing plays a small part of housing policy in the Mediterranean countries, less than 10 percent across these countries.

For these 21 European countries, the category with the largest proportion of home occupation is owner-occupied housing (Doling 2006), with the exception of Switzerland. In some countries, owner occupied housing

Table 4. Public–private organization of housing policies (2006): proportion of home occupation

	% Social rented	% Owner Occupied	% Private rented
Austria	26	52	17
Belgium	9	70	15
Czech Republic	38	45	9
Denmark	20	62	12
Finland	17	67	14
France	17	48	31
Germany	19	45	34
Greece	1	72	29
Hungary	4	91	3
Ireland	12	73	13
Italy	5	76	15
Netherlands	42	48	6
Norway (2001)	4	77	15
Poland	23	70	3
Portugal	8	58	24
Slovakia	7	82	3
Spain	2	77	17
Sweden	13	59	24
Switzerland (2000)	4	35	58
Turkey	2	58	27
United Kingdom	26	59	13

Sources: Norris and Shiels 2004; Statistics Norway 2001, 2002; Brown n.d.

makes up 70 percent or more of housing, including three Mediterranean (Greece, Italy, and Spain) and three Eastern European (Hungary, Poland, and Slovakia) countries. Except for the Czech Republic, France, Germany, the Netherlands, and Switzerland, owner-occupied housing is more than 50 percent of the housing available in these European countries.

Homes that are rented by private landlords are rare in Hungary, Poland, and Slovakia. In other countries, the proportion is high, with over 25 percent of homes in France, Germany, Greece, Switzerland, and Turkey rented by landlords. Distinct patterns do not emerge by geographic group for private housing rentals. The continental European countries range from 10.8 to 51 percent, as a group the highest proportion. The Mediterranean countries range from 15 percent (Spain) to 27 percent (Turkey). The Scandinavian countries tend to cluster between 12 and 24 percent, neither among the highest nor among the lowest. Eastern European countries tend to have the lowest proportion, ranging from 3 percent in Poland to 17 percent in the Czech Republic.

The public–private typology (see Table 1) does not fit housing policies, as previous research would suggest (Hoekstra 2003). Instead, the dominant pattern is that housing in these European countries is found in the market,

either owner occupied or rented from a private landlord. Across all countries, private housing, both owner occupied and private landlords, is the most common form of housing. This finding suggests that public–private organization of welfare social policies is not homogeneous across social policies within a country.

Public–private organization of abortion policies

Abortion policies are a kind of social policy based on Titmuss' (1974) conception. Abortion policies are social because they affect more than one individual. Abortion social policies intervene into a woman's ability to control her body and the fetus she is carrying (Luker 1985). As abortion is a birth control policy, it influences birth cohort and population size, matters of interest to policy makers with implications for everyone (Macura et al. 2005). Abortion policy can have legal impacts, such as creation of legal precedent that affects other decisions an individual can make (Halfmann 2001).

Abortion social policies that permit a woman to request a legal abortion without condition can be considered most private because she can make this decision without government interference. Abortion social policies that prohibit a woman from obtaining a legal abortion in all situations are most public because government has intervened into this decision. Across these European countries, governments have legalized abortion, making an abortion decision a matter of social policy (Pinter et al. 2005).

The United Nations published a study in 1999 that examined legal abortion policies across seven domains. These domains are situations in which a woman can decide to have a legal abortion. The greater the number of domains that are *not* restricted, the more privately organized is legal abortion (see Table 5).

The public–private organization of abortion is private in two thirds of the examined 21 countries. A woman can obtain an abortion in all seven situations, including upon request.

Legal abortion is oriented to public organization in seven countries, but to varying degrees. The governments of Finland and the United Kingdom permit abortions in all six situations, but not upon request. Governments of Poland, Portugal, and Spain intervene further, neither permitting legal abortion upon request nor for economic or social reasons. Legal abortion is more publicly organized in Switzerland, where a woman is allowed to obtain a legal abortion only for health reasons. Legal abortion is most publicly organized in Ireland, where a woman can obtain a legal abortion only if the pregnancy endangers her life.

In contrast to welfare social policies, governments of many European countries stay out of abortion decisions. The public–private typology (see Table 1) does not readily fit abortion. Legal abortion as a body control social policy is a private matter in all Scandinavian and continental European countries. Even when government does intervene, it is to a degree, with

Table 5. Public–private organization of abortion policies (1999): reasons for which a woman can obtain a legal abortion

	On request	Economic or social	Fetal impairment	Rape or incest	Preserve mental health	Preserve physical health	Save woman's life
Austria	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belgium	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Czech Republic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Finland	No	Yes	Yes	Yes	Yes	Yes	Yes
France	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Germany	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Greece	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hungary	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ireland	No	No	No	No	No	No	Yes
Italy	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Netherlands	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Norway	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Poland	No	No	Yes	Yes	Yes	Yes	Yes
Portugal	No	No	Yes	Yes	Yes	Yes	Yes
Slovakia	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Spain	No	No	Yes	Yes	Yes	Yes	Yes
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Switzerland	No	No	No	No	Yes	Yes	Yes
Turkey	Yes	Yes	Yes	Yes	Yes	Yes	Yes
United Kingdom	No	Yes	Yes	Yes	Yes	Yes	Yes

Source: United Nations 1999.

the Irish government strongly intervening. Similar to housing social policies, abortion as a social policy on body control is privately organized in most European countries.

Public–private organization of corporal punishment policies

As a social policy, corporal punishment of young people has received significant attention in the last 5 years and is a social policy based on Titmuss' (1974) conception (Council of Europe 2008). In 2006, the UN Secretary-General's *Study on Violence against Children* was published, and the UN Committee on the Rights of the Child published a General Comment on corporal punishment. This attention suggests a young person's inability to control her body has collective consequences (Donnelly and Straus 2005). Bans on corporal punishment of children have focused on the young person's circumstances and are another indicator of public–private organization of social policies (Rosenbury 2007).

In many societies, governments are employing social policies to ban corporal punishment of children (see Table 6).

To study public–private organization of corporal punishment, this article examines bans of corporal punishment in state penal institutions, schools,

Table 6. Public–private organization of corporal punishment policies (2007): settings in which corporal punishment is banned

	State penal institutions	Schools	Homes
Austria	Yes	Yes	Yes
Belgium	Yes	Yes	No
Czech Republic	Yes	No	No
Denmark	Yes	Yes	Yes
Finland	Yes	Yes	Yes
France	Yes	No	No
Germany	Yes	Yes	Yes
Greece	Yes	Yes	Yes
Hungary	Yes	Yes	Yes
Ireland	Yes	Yes	No
Italy	Yes	Yes	Yes
Netherlands	Yes	Yes	Yes
Norway	Yes	Yes	Yes
Poland	Yes	Yes	No
Portugal	Yes	Yes	No
Slovakia	Yes	Yes	No
Spain	Yes	Yes	No
Sweden	Yes	Yes	Yes
Switzerland	Yes	Yes	No
Turkey	Yes	Yes	No
United Kingdom	Yes	Yes	No

Source: Global Initiative to End Corporal Punishment (2007).

and households. A state penal institution is most public, with rules and regulations in place that govern nearly aspect of a young person's life, including exit from the institution. A school is less public; a young person is subject to school rules and policies, but a school exerts less control over the young person compared to prison. Among the most private domains is the household. In the private household, a young person is less subject to government rules and regulations. A score of 3 indicates corporal punishment of young people is banned across all three settings. Scoring 2 denotes corporal punishment is banned across two settings, and scoring 1 designates it is banned in one setting.

With the exception of two of the examined countries, corporal punishment of young people is banned in state penal institutions and schools. As a matter of social policy, governments of the Czech Republic and France will not intervene into schools or households to prevent an adult from corporally punishing a child. In these two countries, young people do not control their bodies in school or household settings. Even with their state penal institutions, these governments have not explicitly prohibited corporal punishment as disciplinary measures of children. In only 10 of the 21 examined countries, however, is corporal punishment banned in the household. Corporal punishment of a child remains a private matter in most of the examined European countries.

The Scandinavian countries maintain their emphasis on public in public–private organization of social policies on corporal punishment. Corporal punishment is banned in all three settings, indicating social policies on corporal punishment are publicly oriented. In contrast, in ten countries, corporal punishment of young people is banned in settings that are more public, but not in the private household: Austria, Belgium, Ireland, Portugal, Spain, Sweden, Turkey, and the United Kingdom. The four Eastern European countries take a divergent path when it comes to the private household, with only Hungary banning corporal punishment in all three public-to-private settings. A dominant approach is not found in the continental European countries. Austria, Germany, and the Netherlands have banned corporal punishment in all three settings, but Belgium and France have not. In the Mediterranean countries, Greece and Italy have banned corporal punishment of young people in all three settings. Spanish and Portuguese governments have not banned corporal punishment in the home, which is true for the governments of Ireland, the United Kingdom, and Switzerland. Public–private organization of corporal punishment policies suggest the public–private typology (see Table 1) does not readily apply when social policies intervene into households to affect parent–children relationships.

Public–private organization of organ transfer social policies

Analyses of social policies on abortion and corporal punishment indicate many European governments do not significantly intervene into a parent's decision

to control her child's body through corporal punishment or into a woman's decision to control her body by obtaining a legal abortion. Are European governments similarly reluctant to intervene into other forms of body control?

Organ transfer policies are a kind of social policy, based on Titmuss' (1974) conception (Price 2000). Across European countries, governments have established social policies that intervene into individuals' decisions on whether or not to transfer a body organ (Healy 2005; see Table 7). As medical science has enabled an individual to transfer an organ to another individual, ethical and legal concerns have arisen over such practices (Caplan 2004; Sharp 2006; Truog 2005).

Table 7 indicates whether or not government intervenes into organ transfer decisions. A high score indicates government strongly regulates organ transfers.

Nearly all of the 21 examined countries have restrictions on sale of organs during the seller's life. Only Ireland and Portugal do not. Restrictions on the sale of organs after the seller's death are restricted in each country but Ireland. Governments of nine countries restrict organ transfers to genetically related individuals. All have nationally recognized systems of organ transfers, nearly all of which require a record of the donation (except Poland), and most require authorization before the transfer (except Germany and Switzerland). Greece and Sweden do not require an individual to be on a waiting list before receiving an organ.

Organ transfer social policies challenge the public–private typology of social policies (see Table 1). Across all European countries, organ transfer social policies tend to be publicly organized. The most publicly organized are Denmark, Finland, France, and the United Kingdom. Although not to the same degree, organ transfer social policies are publicly organized in the other examined countries.

An analysis of European organization of social policies

Rather than 'either public or private', results indicate that public–private organization of social policies is often better characterized as a matter of degree of public to private. To characterize a national approach to social-policy organization, I examine patterns across all six social policies. Does organization of social policies tend to be more public or more private when examining these 21 European countries?

Rather than a dichotomy of public or private, I examine the *degree* to which a social policy is public or private. The goal here is to identify degrees by which social policies are public or private, as well as overall patterns in public–private organization of social policies. One objective is to identify limited diversity (Gran 2003; Kvist 2007; Ragin 2000), that not all possible social phenomena exist. Rather than dominant types, do these analyses suggest complex and varied organization of public–private social policies across European countries?

Table 7. Public–private organization of organ transfer policies (2003): government intervention into organ transfer decision

	Restrictions on sale of organs	Able to sell rights to organ post mortem?	Does the national system require record of donation?	Genetically related	Authorization required?	Nationally recognized system	Must be on waiting list
Austria	Yes	Yes	Yes	No	Yes	Yes	Yes
Belgium	Yes	Yes	Yes	No	Yes	Yes	Yes
Czech Republic	Yes	Yes	Yes	No	Yes	Yes	Yes
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Finland	Yes	Yes	Yes	Yes	Yes	Yes	Yes
France	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Germany	Yes	Yes	Yes	Yes	No	Yes	Yes
Greece	Yes	Yes	Yes	No	Yes	Yes	No
Hungary	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ireland	No	No	Yes	Yes	Yes	Yes	Yes
Italy	Yes	Yes	Yes	No	Yes	Yes	Yes
Netherlands	Yes	Yes	Yes	No	Yes	Yes	Yes
Norway	Yes	Yes	Yes	No	Yes	Yes	Yes
Poland	Yes	Yes	No	Yes	Yes	Yes	Yes
Portugal	No	Yes	Yes	Yes	Yes	Yes	Yes
Slovakia	Yes	Yes	Yes	No	Yes	Yes	Yes
Spain	Yes	Yes	Yes	No	Yes	Yes	Yes
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	No
Switzerland	Yes	Yes	Yes	No	No	Yes	Yes
Turkey	Yes	No	Yes	No	Yes	Yes	Yes
United Kingdom	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Council of Europe 2004.

Table 8. (a) Coding of social policies

Fuzzy score	Health, Education, and Housing: Proportion Public (%)	Abortion	Corporal Punishment	Organ Transfer
7	100	7	Bans in all 3 settings	7
6	80–99	6		6
5	60–79	5		5
4	40–59	4	Bans in 2 settings (not home)	4
3	20–39	3		3
2	1–19	2		2
1	0	1	No bans	1

Each social policy is recoded for comparative analyses (see Table 8a).

A score of 7 is designated when a country's social policy is fully public; a score of 1 is designated when it is fully private. A social policy is scored 7, fully public, if it receives the highest score for the particular policy. For welfare policies, a score of 7 designates 100 percent public. For body control policies, a score of 7 indicates government intervention is strongest. A welfare social policy is scored 1, fully private, if that policy receives the lowest public score, which is private, expenditures are 100 percent.

A score of 6 is given when the social policy is strongly public, which for welfare policies is a percentage from 80 percent up to 99 percent. A score of 5 indicates a stronger orientation towards public than ambiguity. For welfare policies, a score of 5 is designated when expenditures are between 60 and 79 percent. Maximum ambiguity is scored 4, which for welfare policies indicates expenditures from 40 to 59 percent. A score of 3 is given when a social policy is more oriented to private than the point of maximum ambiguity. For welfare policies, this score is given when public expenditures are between 20 and 39 percent. A score of 2 is designated when the social policy is strongly private, but not fully in the private set. For welfare policies, this score is given when public expenditures range from 10 to 19 percent. A score of 1 is given when welfare policies are below 10 percent.

For abortion and organ transfer policies, their scores parallel the number of circumstances in which governments intervene to shape body control. Social policies on corporal punishment only have scores of 7, 4, and 1 because this article examines three types of bans. A score of 7 is designated if all three bans are in place; a score of 4 if bans are in place for state penal institutions and schools, but not homes; and a score of 1 if no bans are in place.

To characterize national approaches to organization of social policies, a combinatorial approach is taken in which all six social policies are considered together as a single case what Kvist (2007: 7) calls 'configuration

of concepts'. This study seeks to emulate Kvist's (2007) notion of configuration of concepts through examining degrees to which six social policies are public to private, then combinations of these six social policies to identify patterns across the 21 European countries. This approach allows us to treat each social policy as a subset of a country's overall approach to public–private social policy organization. It permits us to determine that a country's approach to health policy, for instance, is strongly public, but its approach to abortion policy is weakly public (Ragin 2008: 2.1). Using this approach, I am able to study combinations to compare public–private organization of social policies across these European countries.

Two important patterns emerge from analyzing organization of European social policies. Nine of the 21 countries share a public–private organization of these six social policies (see Table 8b).

Austria, the Czech Republic, Denmark, Finland, Germany, Hungary, Italy, Norway, and Sweden tend to organize four of their social policies publicly, health, education, corporal punishment, and organ transfers, but privately organize housing and abortion social policies. This group contains all of the Scandinavian countries, but only two Eastern European countries and two continental European countries. Only one of the Mediterranean countries (i.e., Italy) takes this public–private approach to organizing their social policies.

Table 8. (b) Public-private organization of social policies in European countries

Nation	Health (Expend)	Education (Expend)	Housing (Social)	Legal Abortion	Corporal Punishment	Organ Transfer
Austria	5	6	2	1	7	6
Belgium	5	5	2	1	4	6
Czech Republic	6	6	3	1	2	6
Denmark	6	5	3	1	7	7
Finland	5	7	2	2	7	7
France	5	6	2	1	2	7
Germany	5	5	2	1	7	6
Greece	4	5	2	1	7	5
Hungary	5	6	2	1	7	7
Ireland	5	6	2	6	4	5
Italy	5	5	2	1	7	6
Netherlands	5	5	4	1	7	6
Norway	6	6	2	1	7	6
Poland	5	6	3	3	4	6
Portugal	5	6	2	3	4	6
Slovakia	6	6	2	1	4	6
Spain	5	6	2	3	4	6
Sweden	6	6	2	1	7	6
Switzerland	4	6	2	4	4	5
Turkey	5	6	2	1	4	5
United Kingdom	6	6	3	2	4	7

One third of the 21 countries organize their social policies using a different approach. Belgium, Poland, Portugal, Slovakia, Spain, Turkey, and the United Kingdom publicly organize their social policies on health, education, and organ transfer and privately organize their social policies on housing and abortion, but their social policy on corporal punishment is ambiguous. Three of the five Mediterranean countries organize their social policies in this manner, as do two Eastern European countries.

The remaining countries (France, the Netherlands, Ireland, Greece, and Switzerland) take different approaches. France, the Netherlands, and Ireland tend to organize their health, education, and organ transfer policies publicly, but they do not publicly organize their housing policies. Important differences exist among the three nations for their social policies on abortion and corporal punishment. In France, abortion and corporal punishment social policies are privately oriented, but organ transfer policies are public. The Netherlands' abortion policy is privately organized, but corporal punishment is publicly organized.

Ireland is unique among the 21 European countries. Ireland's organization of social policies emphasizes a public approach for all social policies, including abortion, except for housing. Both Greece and Switzerland have ambiguous social policies on health, but publicly oriented social policies on education and organ transfers and privately oriented social policies on housing. Although Greece orients abortion social policy towards private, the Swiss policy is ambiguous, as is true for its social policy on corporal punishment. In Greece, social policies on corporal punishment and organ transfers are publicly oriented.

A pattern emerges from employing this approach to examine welfare social policies of the 21 examined countries. Health and education social policies more strongly belong in the set of public social policies, while housing social policy is privately oriented. All but the systems of Greece and Switzerland organize both their health and education social policies in public ways. Both Greece and Switzerland have ambiguously public–private health policies, but their education policies are more publicly organized.

Two dominant patterns emerge for body control social policies. Two thirds of the examined countries can be characterized as ambiguous towards corporal punishment, but are oriented to treating abortion as a private matter, or corporal punishment is a public matter while abortion is a private matter. Two thirds of the examined countries organize abortion as a private matter, but considering this latter group, if I expand the discussion to countries when corporal punishment is a public matter, a total of ten countries treat abortion policy as more private than public. Across all 21 countries, organ transfer social policies are publicly organized.

Discussion

Organization of social policies across European countries does not rely on public or private approaches. Indeed, public–private organization of social

policies across European countries challenges typologies. Given that social policy approaches are not exclusively publicly or privately organized, a single public or private label does not suffice.

Welfare social policies tend toward public organization for health and education, but housing social policies tend to be privately organized. As other scholars have noted (Kemeny 2001: 55), housing is different, and welfare social typologies do not readily characterize this policy. Social policies on body control are not consistently public or private. Organ transfer social policies tend to be publicly organized, abortion policies tend to be privately organized, and corporal punishment to be either publicly organized or ambiguous, but not private. This result suggests that factors driving establishment and organization of social policies on body control may be disparate (Twigg 2002).

While a one-size-fits-all approach does not characterize these six social policies, important patterns dominate public–private organization of social policies. With the noted exception of corporal punishment, across 16 of the 21 countries, health, education, and organ transfer social policies are publicly organized, but housing and abortion social policies are privately organized. Even though the welfare typology does not fit, these two dominant patterns indicate the diversity of public–private organization of social policies is limited. Analyses indicate public–private organization of specific social policies often is similar across countries.

The overarching difference between the two dominant patterns across these European countries is public–private organization of corporal punishment social policies. In one approach, corporal punishment social policy is publicly organized; in the other approach, corporal punishment social policies cannot be characterized as either publicly or privately organized.

These findings raise questions for future research on social policies. Two immediate, related questions revolve around difference. Why are body control social policies different? Why are housing social policies different? Perhaps the better question is: why do countries publicly organize some social policies, but not others?

Conclusion

Three conclusions emerge from this article's analyses. First, a policy is rarely purely public or private. A better characterization is that while social policies often emphasize public or private qualities, most represent joint public and private efforts. The implication of this complexity is that a one-size fits all label of 'public' or 'private' is misleading because there is no stark line separating public and private qualities for most social policies. This empirical complexity in social-policy arrangements challenges a pervasive conceptualization of a public–private dichotomy in social policy and warrants greater attention from scholars and policy makers.

Second, diversity exists in the policy arena. Within any policy, there is no universally public or private approach that is dominant. Instead, in some countries, a public emphasis exists; in another, a private emphasis does. The implication of this diversity is that each country has a mixed approach to public and private social policy. The public–private organization of welfare and bodily control social policies is heterogeneous. Consequently, it is not easy to characterize countries by one public or private approach to social policies. This conclusion poses challenges to extant typologies of social policies.

Finally, despite diversity within a policy area and diversity across social policies within each country, this diversity is limited. A large variety of social policy arrangements is possible; yet, across policy areas and within countries, not all possible configurations are established. Are these potential policy configurations pursued without success? Or are some public–private configurations considered less amenable than other social policy options?

In this article, I demonstrated that social policy arrangements can rarely be characterized as public or private. Transcending the one-size fits all label that is inherent to the private/public dichotomy will enable scholars to explore a richer terrain of institutional and organizational policy arrangements.

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Short Biography

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Note

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References

American Academy of Pediatrics 2000. 'Corporal Punishment in schools: Policy statement.' *Pediatrics* **106**: 343.

Aristotle 1997. *Politics*. Translated by Peter L. Phillips Simpson. Chapel Hill, NC: University of North Carolina Press.

Baldwin, Peter 1996. 'Can We Define a European Welfare State Model?' Pp. 29–44 in *Comparative Welfare Systems*, edited by Brent Greve. London, England: Macmillan.

BBC 2006. 'Organ Sales "Thriving" in China.' September 27, 2006 BBC News Online.

Béland, Daniel and Jacob Hacker 2004. 'Ideas, Private Institutions, and American Welfare State "Exceptionalism": The Case of Health and Old-Age Insurance, 1915–1965.' *International Journal of Social Welfare* **13** (1): 42–54.

Biesel, Nicola K. 1997. *Imperiled Innocents*. Princeton, NJ: Princeton University Press.

Braun, Dietmar and Fabrizio Gilardi 2006. 'The Diffusion of Health Care Reforms in OECD Countries.' Presented to ECPR Workshop, Cyprus.

Brown, Martin No date. 'Country Note: Housing Finance in Switzerland.' Bank for International Settlements. www.bis.org/publ/wgpapers/cgfs26brown.pdf. Accessed August 8, 2007.

Caplan, Arthur 2004. 'Organs.com: New Commercially Brokered Organ Transfers Raise Questions.' *The Hasting Center Report* **34**: 8.

Conley, Dalton and Brian Gifford 2006. 'Home Ownership, Social Insurance, and the Welfare State.' *Sociological Forum* **21** (1): 55–82.

Council of Europe 2004. 'Replies to the Questionnaire for Member States on Organ Trafficking.' Steering Committee on Bioethics, European Health Committee. Strasbourg, France: Council of Europe.

Council of Europe 2008. *Eliminating Corporal Punishment*. Strasbourg, France: Council of Europe.

Dobbin, Frank 1992. 'The Origins of Private Social Insurance.' *American Journal of Sociology* **97**: 1416–1450.

Doling, John 2006. 'A European Housing Policy?' *European Journal of Housing Policy* **6** (3): 335–49.

Donnelly, Jack 2003. *Universal Human Rights*. Ithaca, NY: Cornell University Press.

Donnelly, Michael and Murray Straus 2005. *Corporal Punishment of Children in Theoretical Perspective*. New Haven, CT: Yale University Press.

Einhorn, Eric S. and John Logue 2004. 'Can the Scandinavian Model Adapt to Globalization?' *Scandinavian Studies* **76**: 501–34.

Esping-Andersen, Gøsta 1990. *The Three Worlds of Welfare Capitalism*. Princeton, NJ: Princeton University Press.

Esping-Andersen, Gøsta 1999. *Social Foundations of Postindustrial Economies*. New York, NY: Oxford University Press.

Fenger, H. J. M. 2005. 'Welfare Regimes in Central and Eastern Europe. Incorporating Post-Communist Countries in a Welfare Regime Typology.' Nig Annual Work Conference.

Fletcher, Ruth 2005. 'Reproducing Irishness: Race, Gender, and Abortion Law.' *Canadian Journal of Women and the Law* **17** (2): 365–404.

Fraser, Nancy 1999. 'Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy.' Pp. 109–42 in *Habermas and the Public Sphere*, edited by Craig Calhoun. Cambridge, MA: Massachusetts Institute of Technology Press.

Fredman, Sandra 2006. 'Human Rights Transformed.' Oxford Legal Studies Research Paper No. 38/2006.

Gallagher, Susan 2007. *Don't Look Now*. faculty.uml.edu/sgallagher/privacyproject.htm, accessed September 3, 2007.

Glendon, Mary Ann 1987. *Abortion and Divorce in Western Law*. Cambridge, MA: Harvard University Press.

Global Initiative to End Corporal Punishment 2007. 'Global Report 2006.' www.endcorporalpunishment.org. Accessed August 7, 2007.

Gough, Ian 2005. 'European Welfare States.' Paper presented to the New Frontiers of Social Policy conference, World Bank.

Graetz, Michael J. and Jerry Mashaw 1999. *True Security*. New Haven, CT: Yale University Press.

Gran, Brian 2003. 'A Second Opinion. Rethinking the Public-Private Dichotomy for Health Insurance.' *International Journal of Health Services* **33** (2): 283–313.
Green-Pedersen, Christoffer 2002. 'New Public Management of the Danish and Swedish Welfare States.' *Governance* **15** (2): 271–94.
Grønbjerg, Kirsten 1998. 'Markets, Politics, and Charity.' Pp. 137–50 in *Private Action and the Public Good*, edited by Walter Powell and Elisabeth Clemens. New Haven, CT: Yale University Press.
Hacker, Jacob 2002. *The Divided Welfare State*. New York, NY: Cambridge University Press.
Halfmann, Drew 2001. *Dissertation: 'Interests in Contexts and Institutional Democracy: The Politics of Abortion Policy in Liberal Welfare States, 1950–2000.'* New York, NY: University Department of Sociology.
Healy, Kieran 2005. 'The Political Economy of Presumed Consent.' *Theory and Research in Comparative Social Analysis*, Paper 31. Los Angeles, CA: University of California at Los Angeles, Department of Sociology. Downloaded September 1, 2007.
Heckman, James J. 2006. 'Skill Formation and the Economics of Investing in Disadvantaged Children.' *Science* **312**: 1900–2.
Hinrichs, Karl 2002. 'Health Care Policy in the German Social Insurance State.' *The Review of Policy Research* **19** (3): 108–40.
Hoekstra, J. 2003. 'Housing and the Welfare State in the Netherlands.' *Housing, Theory, and Society* **20** (2): 58–71.
Holmes, Stephen and Cass R. Sunstein 1999. *The Cost of Rights*. New York, NY: W. W, Norton and Company.
Howard, Christopher 1997. *The Hidden Welfare State*. Princeton, NJ: Princeton University Press.
Janoski, Thomas 1998. *Citizenship and Civil Society*. New York, NY: Cambridge University Press.
Jencks, Christopher and Meredith Phillips 1998. *The Black-White Test Score Gap*. Washington, DC: Brookings Institution Press.
Kemeny, Jim 2001. 'Comparative Housing and Welfare.' *Journal of Housing and the Built Environment* **16**: 53–70.
Kemeny, Jim 2006. 'Corporatism and Housing Regimes.' *Housing, Theory, and Society* **23** (1): 1–18.
King, Peter N. and Hideyuki Mori 2007. 'The Development of Environmental Policy.' *International Review for Environmental Strategies* **7** (1): 1–20.
Klein, Jennifer 2003. *For All These Rights*. Princeton, NJ: Princeton University Press.
Kleinman, Mark 1998. 'Western European Housing Policies.' Pp. 242–56 in *European Integration and Housing Policy*, edited by Mark Kleinman, Walter Matznetter and Mark Stephens. New York, NY: Routledge Press.
Kvist, Jon 2007. 'Measuring the Welfare State – Concepts, Ideal Types and Fuzzy Sets in Comparative Studies.' Forthcoming in *Welfare Reform in Advanced Societies*; edited by Jochen Clasen and Nico Siegel. Downloaded on August 17, 2007 from Compasss website (www.compasss.org).
Kvist, Jon and Adrian Sinfield 1997. 'Comparing Tax Welfare States.' *Social Policy Review* **9**: 249–75.
Lareau, Annette 2003. *Unequal Childhoods*. Berkeley, CA: University of California Press.
Leibfried, Stephan 1991. 'Towards an European Welfare State: on Integrating Poverty Regimes in the European Community.' Working Paper 2/91, Centre for Social Policy Research, Bremen University.
Lister, Ruth 1997. *Citizenship: Feminist Perspectives*. New York, NY: New York University Press.
Lister, Ruth 2005. 'Being Feminist.' *Government and Opposition* **40** (3): 442–63.
Luker, Kristin 1985. *Abortion and the Politics of Motherhood*. Berkeley, CA: University of California Press.
Lux, Martin 2003. 'Efficiency and Effectiveness of Housing Policies in the Central and Eastern Europe Countries.' *European Journal of Housing Policy* **3** (3): 243–65.
Macura, Miroslav, Alphonse L. MacDonald and Werner Haug 2005. *The New Demographic Regime*. New York, NY: United Nations Population Fund.
Marmor, Theodore and M. L. Barer 1994. *The Determinants of Health of Populations*. New York, NY: Aldene de Gruyter.

Marshall, T. H. 1987 (1950). *Citizenship and Social Class*. London, England: Pluto Press.
Meckler, Laura 2007. 'Kidney Shortage Inspires a Radical Idea.' *Wall Street Journal* November 13, 2007: A1.
Minow, Martha 2002. *Partners, Not Rivals*. Boston, MA: Beacon Press.
Mooney, Christopher Z. and Mei-Hsien Lee 1995. 'Legislating Morality in the American States.' *American Journal of Political Science* **39** (3): 599–627.
Morone, James and Lawrence Jacobs 2005. *Healthy, Wealthy, and Fair*. New York, NY: Oxford University Press.
Norris, M. and P. Shiels 2004. *Regular National Report on Housing Developments in European Countries*. Dublin, Ireland: Stationery Office.
OECD 2007a. 'Education at a Glance 2003: Table B3.2a: Relative proportions of public and private expenditure on educational institutions, as a percentage, by level of education.' Paris, France: www.oecd.org. Accessed May 10, 2007.
OECD 2007b. 'Health Statistics.' Paris, France: www.oced.org. Accessed May 10, 2007.
Orloff, Ann Shola 1993. *The Politics of Pensions*. Madison, WI: University of Wisconsin Press.
Pinter, B., E., Aubeny, G., Bartfai, O., Loeber, S., Ozalp and A. Webb 2005. 'Accessibility and Availability of Abortion in Six European Countries.' *European Journal of Contraception and Reproductive Health Care* **10** (1): 51–8.
Polanyi, Karl 1957. *The Great Transformation: The Political and Economic Origins of our Time*. Boston, MA: Beacon Press.
Powell, Walter W. and Elisabeth S. Clemens 1998. *Private Action and the Public Good*. New Haven, CT: Yale University Press.
Price, David 2000. *Legal and Ethical Aspects of Organ Transplantation*. New York, NY: Cambridge University Press.
Quadagno, Jill 2006. *One Nation, Uninsured*. New York, NY: Oxford University Press.
Ragin, Charles C. 2000. *Fuzzy Set Social Science*. Chicago, IL: University of Chicago Press.
Ragin, Charles C. 2008. *Redesigning Social Inquiry: Fuzzy Sets and Beyond*. Chicago, IL: University of Chicago Press.
Rahman, Anika, Laura Katzive and Stanley K. Henshaw 1998. 'A Global Review of Laws on Induced Abortion, 1985–1997.' *International Family Planning Perspectives* **24** (2): 56–64.
Rein, Martin and John Turner 2001. 'Public-Private Interactions.' *Review of Population and Social Policy* **10**: 107–33.
Rein, Martin and Winfried Schmähl (eds) 2004. *Rethinking the Welfare State: The Political Economy of Pension Reform*. London, England: Edward Elgar.
Rekart, Josephine 1993. *Public Funds, Private Provision*. Vancouver, BC, Canada: University of British Columbia Press.
Rosenbury, Laura 2007. 'Between Home and School.' *University of Pennsylvania Law Review* **155** (4): 833–98.
Rueschemeyer, Dietrich and Theda Skocpol (eds) 1995. *States, Social Knowledge, and the Origins of Modern Social Policies*. Princeton, NJ: Princeton University Press.
Shalev, Michael 1996. *The Privatization of Social Policy? Occupational Welfare and the Welfare State in America, Scandinavia and Japan*. London, England: Macmillan.
Sharp, Lesley 2006. *Strange Harvest*. Berkeley, CA: University of California Press.
Shaver, Sheila 1999. 'Body Rights, Social Rights, and Reproductive Choice.' Pp. 157–185 in *States, Markets, and Families*, edited by Julia S. O'Connor, Ann Shola Orloff and Sheila Shaver. New York, NY: Cambridge University Press.
Skocpol, Theda and Edwin Amenta 1986. 'States and Social Policies.' *Annual Review of Sociology* **12**: 131–57.
Statistics Norway 2001. Table 5.03. www.ssb.no/english/subjects/05/03/; accessed September 3, 2007.
Statistics Norway 2002. Table 13: Private households, by tenure status and type of household. Persons and persons per household, by tenure status. 3 November 2001. www.ssb.no: accessed August 8, 2007.
Stone, Deborah 1997. *Policy Paradox*. New York, NY: W. W. Norton and Company.
Surrey, Stanley S. and Paul R. McDaniel 1985. *Tax Expenditures*. Cambridge, MA: Harvard University Press.

Thornton, Margaret 1991. 'The Public/Private Dichotomy.' *Journal of Law and Society* **18** (4): 448–63.
Titmuss, Richard M. 1974. *Social Policy: An Introduction*. New York, NY: Pantheon Books.
Trattner, W. I. 1989. *From Poor Law to Welfare State*. New York, NY: The Free Press.
Truog, Robert D. 2005. 'Are Organs Personal Property or a Societal Resource?' *American Journal of Bioethics* **5** (4): 14–6.
Turkel, Gerald 1992. *Dividing Public and Private*. Westport, CT: Praeger Publishers.
Turner, Bryan 2006. *Vulnerability and Human Rights*. University Park, PA: Pennsylvania State University Press.
Twigg, Julia 2002. 'The Body in Social Policy.' *Journal of Social Policy* **31** (3): 421–39.
United Nations 1999. *World Abortion Policies 1999*. New York, NY: United Nations Population Division, Department of Economic and Social Affairs.
United Nations 2006. *The United Nations Secretary General Study on Violence against Children*. New York, NY: United Nations.
Usher, A. and A. Cervenan 2005. *Global Higher Education Rankings 2005*. Toronto, ON, Canada: Educational Policy Institute.
Weitz, Rose 2006. *The Sociology of Health, Illness, and Health Care*. Florence, KY: Wadsworth Publishing.
White, Joseph 1995. *Competing Solutions*. Washington, DC: Brookings Institution Press.
Wilensky, Harold 1975. *The Welfare State and Equality*. Berkeley, CA: University of California Press.