Welfare states and health inequalities

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Inequalities in health and mortality

• Inequalities exist in all countries and regions
• But the size and shape of these inequalities vary across time and space
  – Country variations larger among low educated
  – *This indicates the importance of the welfare state context*
• While there is not a clearly visible welfare state pattern, there are theoretical and empirically established links to welfare policies

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Health inequality theory: focus on resources

• The Social Determinants perspective:
  - ‘...health inequities arise from the conditions in which people are born, grow, live, work, and age and inequities in power, money, and resources that give rise to these conditions of daily life.’ (Marmot et al 2012)

• The Fundamental Cause perspective:
  - ‘...individuals and groups deploy resources to avoid risks and adopt protective strategies. Key resources such as knowledge, money, power, prestige, and beneficial social connections can be used no matter what the risk and protective factors are in a given circumstance.’ (Phelan et al 2010)
The size of should then be linked to

1. The distribution over social strata of key resources necessary to lead a good life:
   - Childhood conditions and education
   - Incomes and economic resources
   - Working conditions
   - Housing conditions
   - Health care
   - More...

2. But also differences between strata in actions and behaviours over the life course:
   - Perception, interpretation and action on difficulties etc
   - Specific health related behaviours
Welfare states and resources

- **Individual resources;** personal, familial or market generated
- **Collective resources,** generated by welfare state institutions, will assist with

  “…the collective matters that arise from the demands and possibilities that all individuals in all societies are facing during the life cycle” (Johansson 1979:56)
Collective resources include:

- ‘Cash’ – social insurances covering income loss due to e.g. illness, unemployment and old age, but also family policies.
- ‘Care’ – welfare services supplied free of charge or heavily subsidised, e.g. child care, health care, care for the old and disabled, as well as education.

Hence, the resources that can be deployed to lead a good life and avoid health problems are supplied also through the welfare state.
Welfare states and health inequalities – the theoretical argument:

• The supply and quality of collective resources are important for peoples possibilities to sustain their health and wellbeing, in particular when other resources are small

• Hence, countries with more ambitious welfare policies could be expected to have better health, but also smaller inequalities since the worse off should benefit most
Empirical Research on Welfare states and Health Inequalities
Different approaches and results

• To what extent does theoretical and methodological differences explain mixed findings in the literature?

• A total of 54 studies published Jan 2005-Feb 2013
  – Regime approach: 34
  – Institutional approach: 14
  – Expenditure approach: 8

• Most diverging results in the Regime type group, therefore further elaborations were made
  – By specific typology, by outcome (morbidity, mortality, best health), by data source, by number of countries
Figure 2

Source: Bergqvist, Åberg Yngwe, Lundberg BMC Public Health 2013; 13:1234
General findings of the review

• The Regime approach do not lead us much further
  – Clustering of countries according to one dimension is theoretically unlikely to be analytically useful
  – Nominal similarities obscure a multitude of differences

• The Institutional and Expenditure approaches are more promising
  – These approaches provide a possibility to use variables and measure both qualitative and quantitative differences in welfare policies
  – Existing studies of these types give clear indication that the welfare state context do matter for health inequalities

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Examples from work in the ongoing DRIVERS project and the recent WHO Europe Review
Key starting points for our work

- Important to focus on general welfare policy areas, not only specific interventions
- Important to look at what welfare states *do* in terms of
  - Social rights
  - Social expenditure
Social spending is linked with better health and smaller inequalities

Social spending is also linked with employment

Unemployment benefits and health

Two important dimensions: coverage and replacement rate.

Health improves with higher coverage but not with higher replacement rates among high and low educated alike.

Source: Sjöberg, Nelson, Ferrarini (2014) Decomposing the effect of social policies on population health and inequalities. DRIVERS working paper

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An interaction effect.

Much better health at higher replacement rates when coverage is high.

This effect is stronger for low educated, contributing to smaller inequalities.

Source: Sjöberg, Nelson, Ferrarini (2014) Decomposing the effect of social policies on population health and inequalities. DRIVERS working paper

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The risk to experience deteriorating health between 2006 and 2009 is lower at higher levels of unemployment insurance coverage, in particular among those with low education.

Some key findings

• A general effect of welfare regimes is difficult to establish

• However, there are clear relationships between social protection in terms of social rights and social expenditures, health and health inequalities

• New findings emerge when we disentangle different aspects of policies. Coverage rates appear crucial.

• The relationship is (often) curvilinear, indicating larger impact of improved social protection at lower levels

• Specific programmes have effects, but more extensive social protection in general may be most important
A general conclusion from a policy perspective

• Do something:
  – In countries who have little social protection some efforts will be important and contribute to better health and smaller health inequalities

• Do more:
  – In countries where social protection is established, there is room for increased coverage and generosity

• Do better:
  – In the countries that spend most there may still be room for increases, but in particular room for improvements of programmes and services

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Thank you!
Mortality per 100 000 by education
Men, 30-74 yrs, early 2000s
Mortality per 100,000 by education
Women, 30-74 yrs, early 2000s
Remaining life expectancy at 30
Women, Sweden 1986-2010
Two important dimensions: Coverage and replacement rate.

Health improves with higher coverage but not with higher replacement rates among high and low educated alike.

Source: Sjöberg, Nelson, Ferrarini (2014) Decomposing the effect of social policies on population health and inequalities. DRIVERS working paper
Health improves with larger efforts in terms of general unemployment benefits, but only among those with tertiary education. Increasing generosity in these programmes therefore tend to increase health inequalities.

Source: Sjöberg (2013). Labour market policies for young unemployed and their effect on health and health inequalities in Europe. DRIVERS paper

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Health improves with larger efforts in terms of unemployment benefits for youths, but more so among low educated youth. Increasing generosity in these programmes therefore reduces health inequalities.

Source: Sjöberg (2013). Labour market policies for young unemployed and their effect on health and health inequalities in Europe. DRIVERS paper
Health improves with larger efforts in terms of ALMPs generally, but more so among low educated youth.

Source: Sjöberg (2013). Labour market policies for young unemployed and their effect on health and health inequalities in Europe. DRIVERS paper.