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drivers FOR HEALTH EQUITY

Welfare states and health inequalities

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Montreal, CIQSS International Conference 2014-05-05

Stockholms universitet

Karolinska Institutet

CHESS is a collaboration between Stockholm University and Karolinska Institutet.

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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)

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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

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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)

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- 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

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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

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Empirical Research on Welfare states and Health Inequalities

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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

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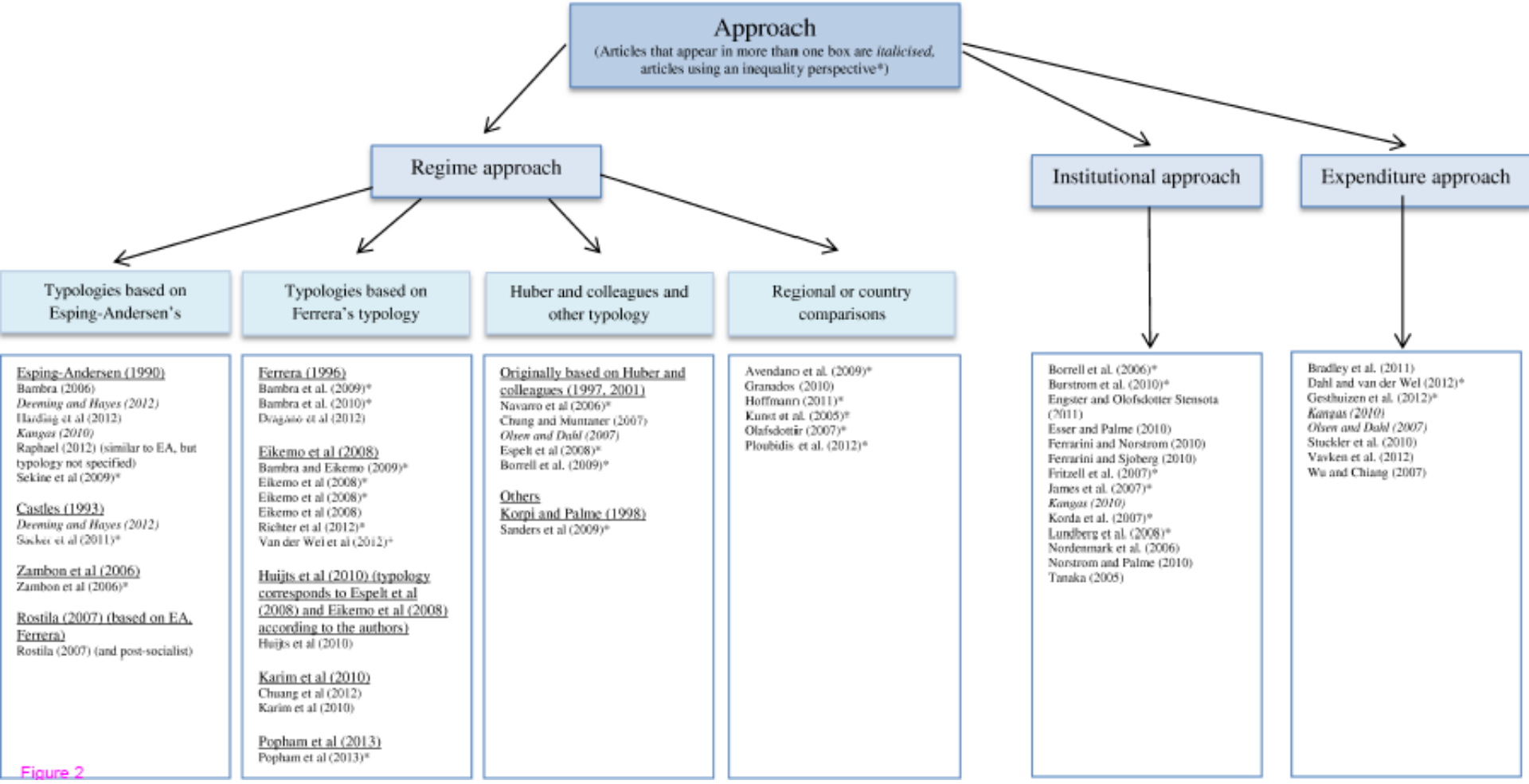

Figure 2

Source: Bergqvist, Åberg Yngwe, Lundberg BMC Public Health 2013; 13:1234

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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

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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

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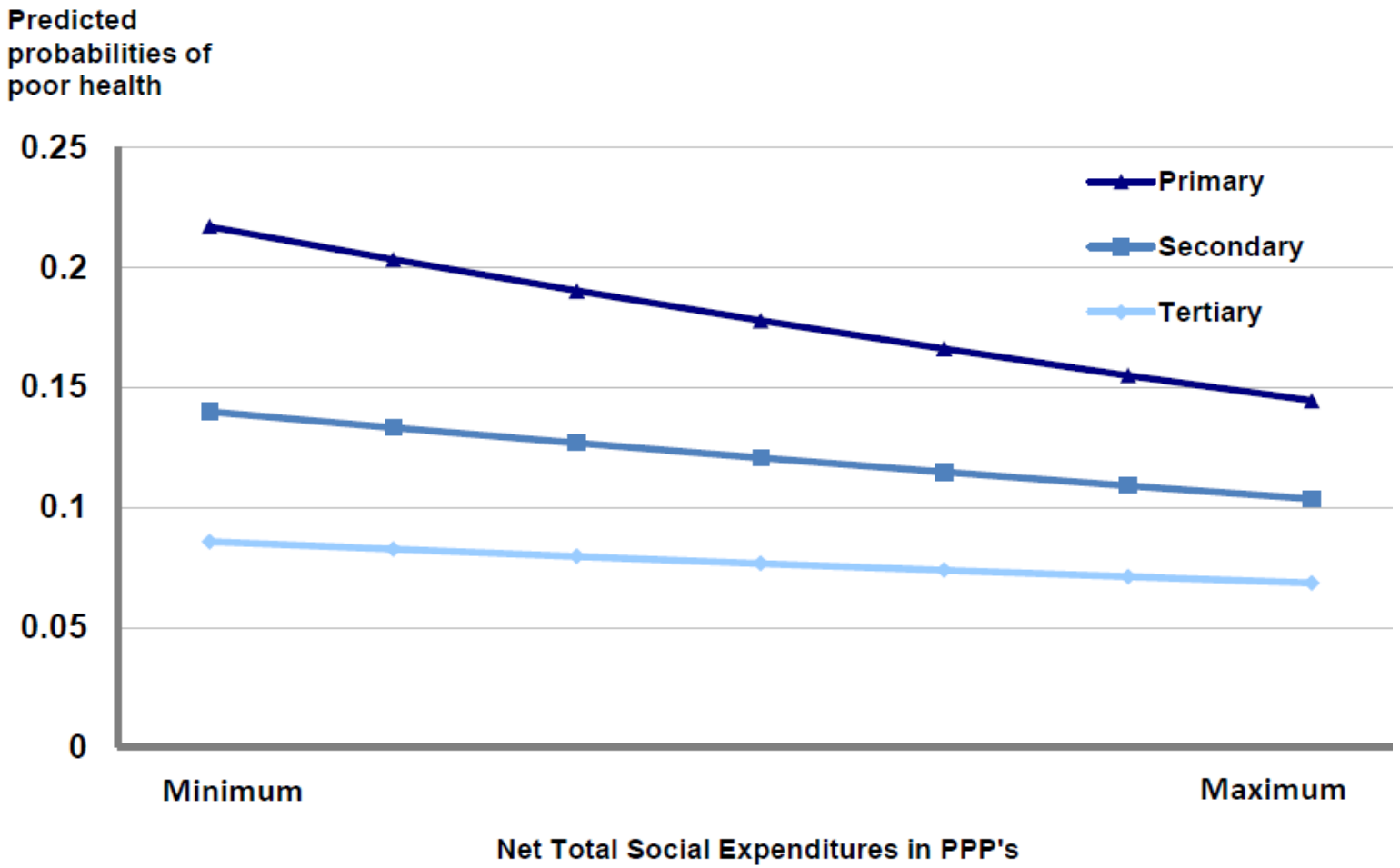
Social spending is linked with better health and smaller inequalities



Source: Dahl & van der Wel, Soc Sci Med 2013;81:60-69

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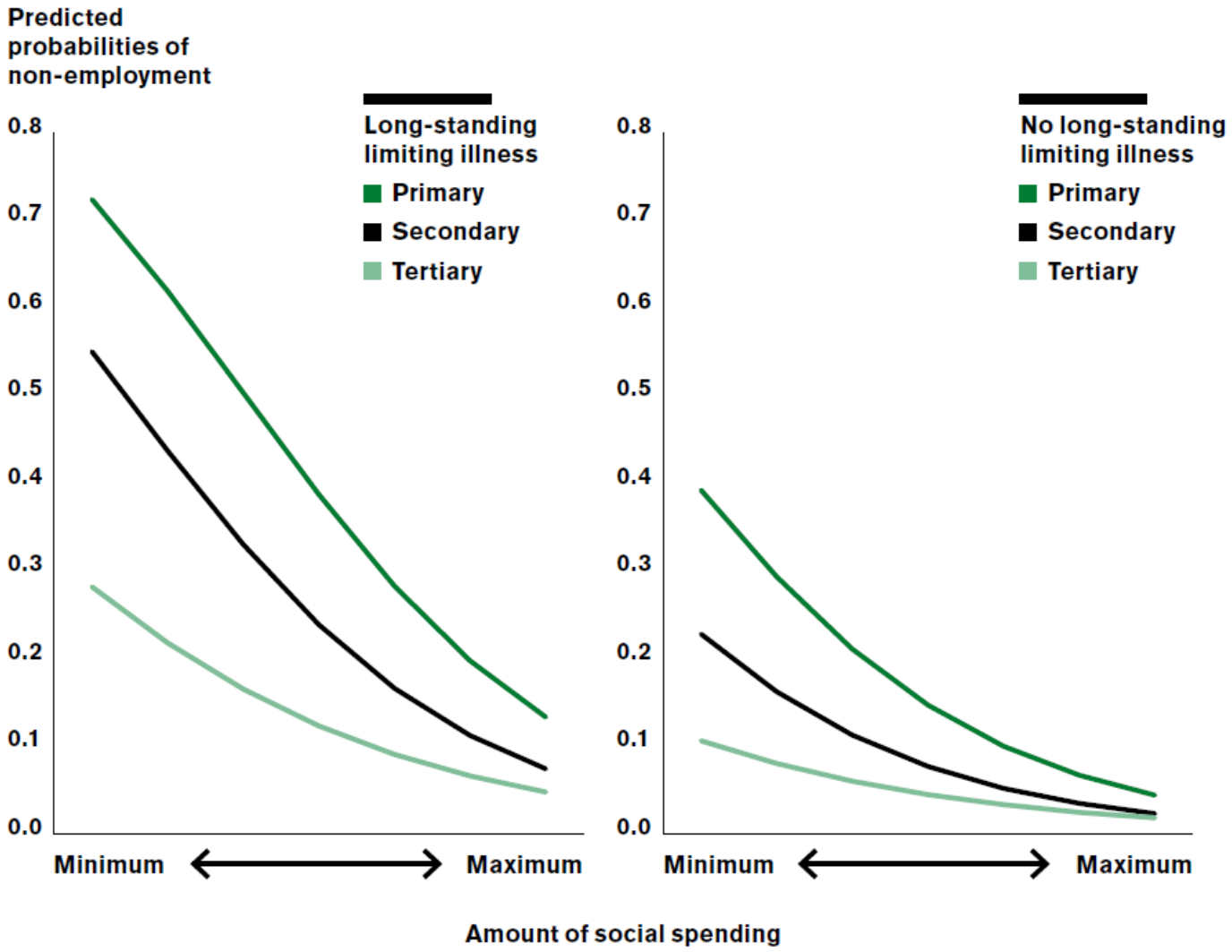
Social spending is also linked with employment



Source: van der Wel et al, Soc Sci Med 2011;73:1608-17

Unemployment benefits and health

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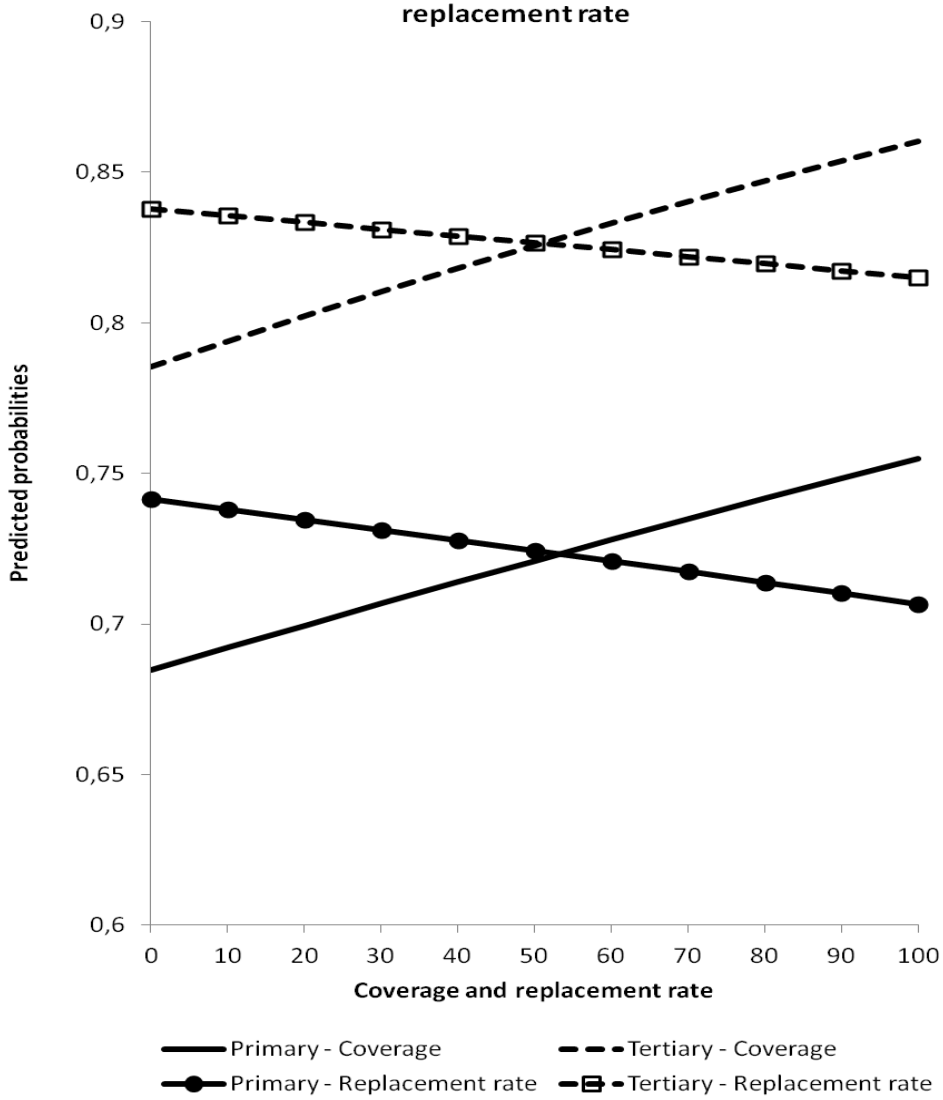
Two important dimensions: coverage and replacement rate.

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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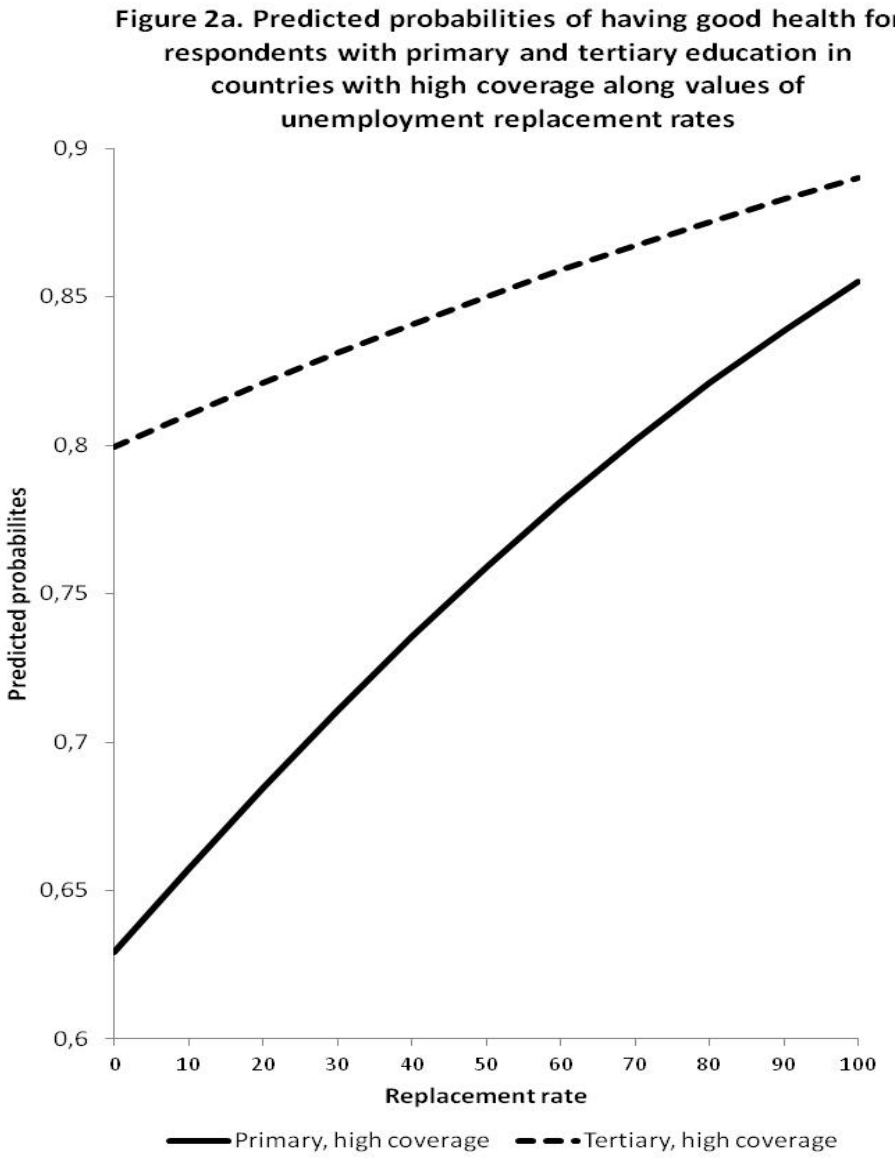
An interaction effect.

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

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



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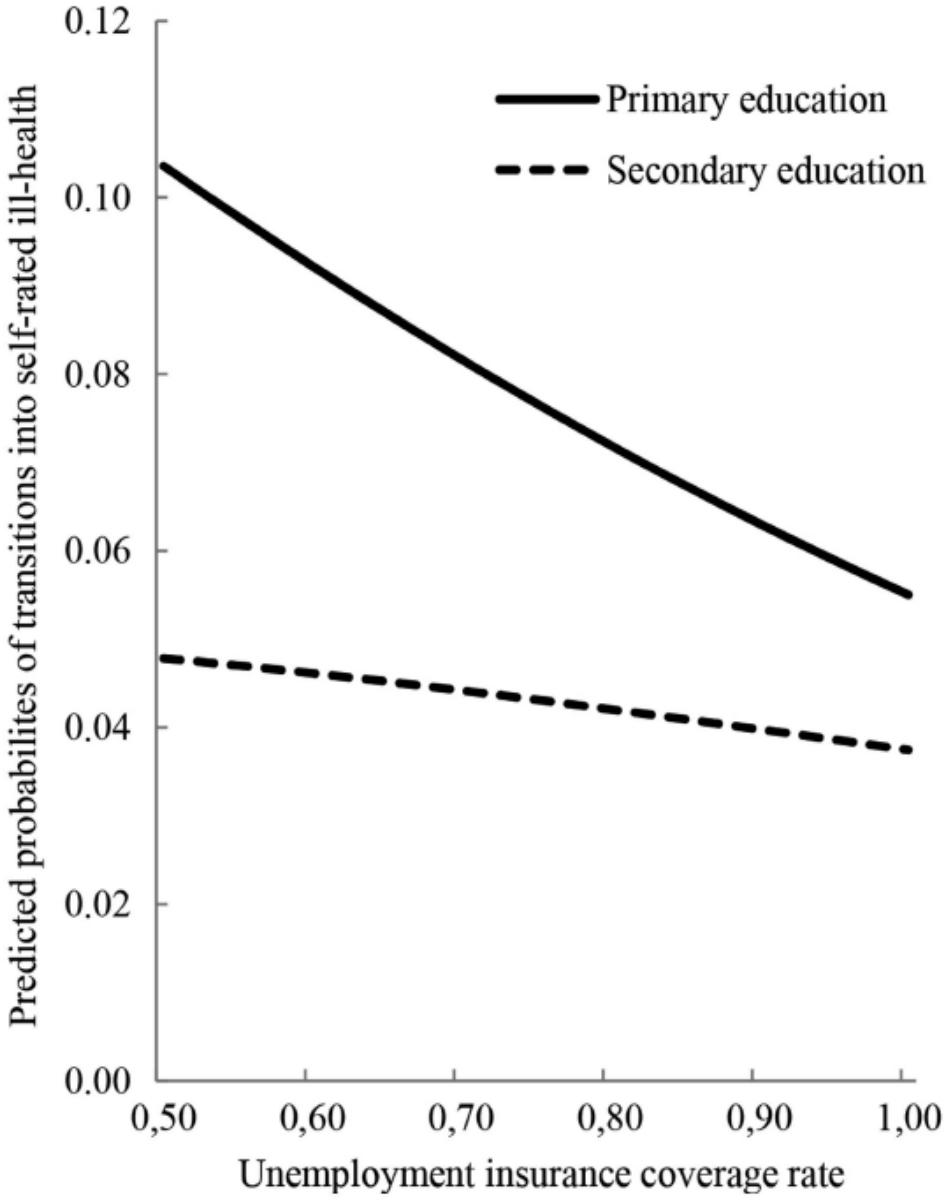
Coverage and deteriorating health

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



Source: Ferrarini, Nelson, Sjöberg (2014). Unemployment insurance and deteriorating self-rated health in 23 European countries, JECH

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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

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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!

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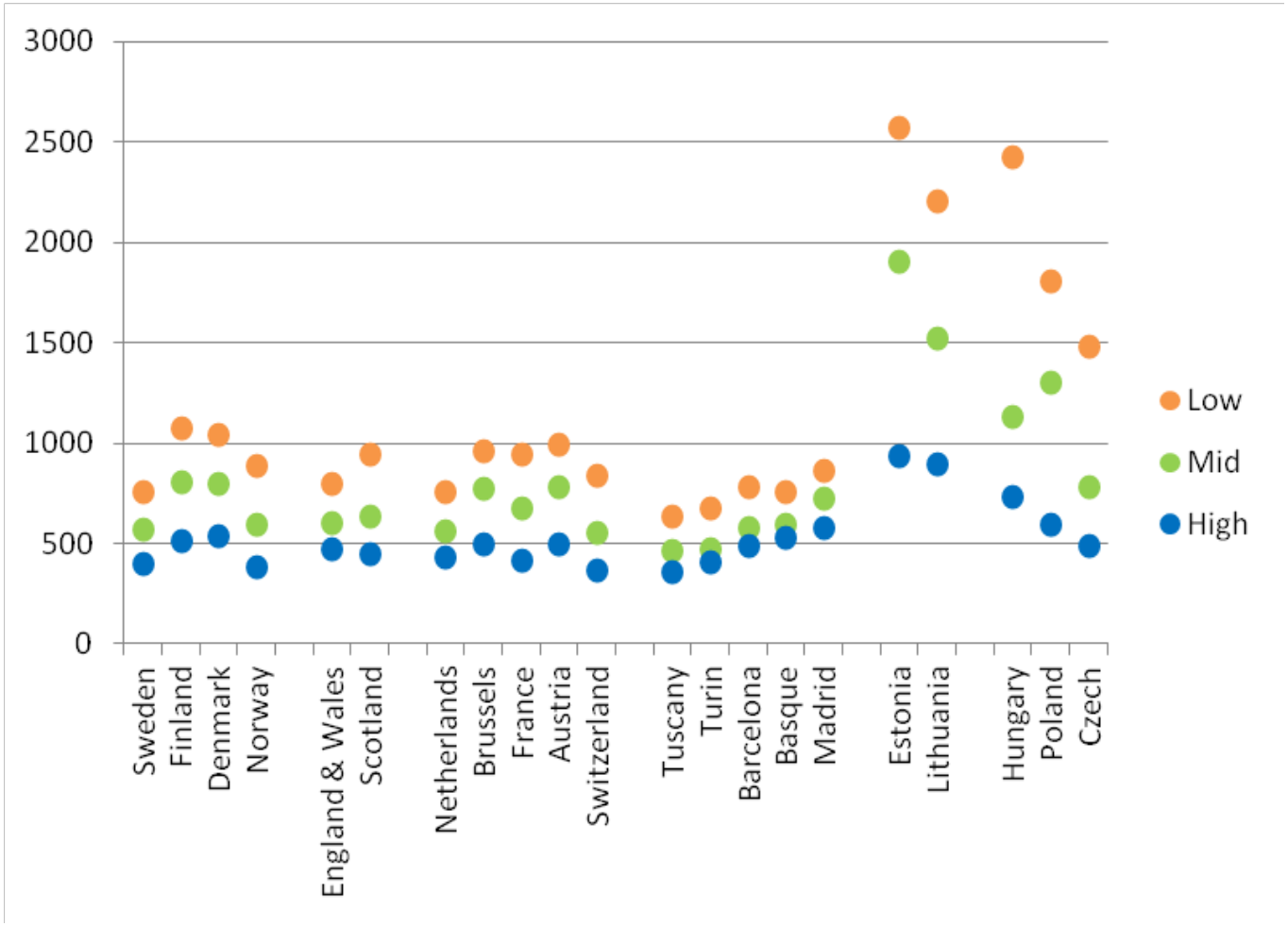
Mortality per 100 000 by education

Men, 30-74 yrs, early 2000s



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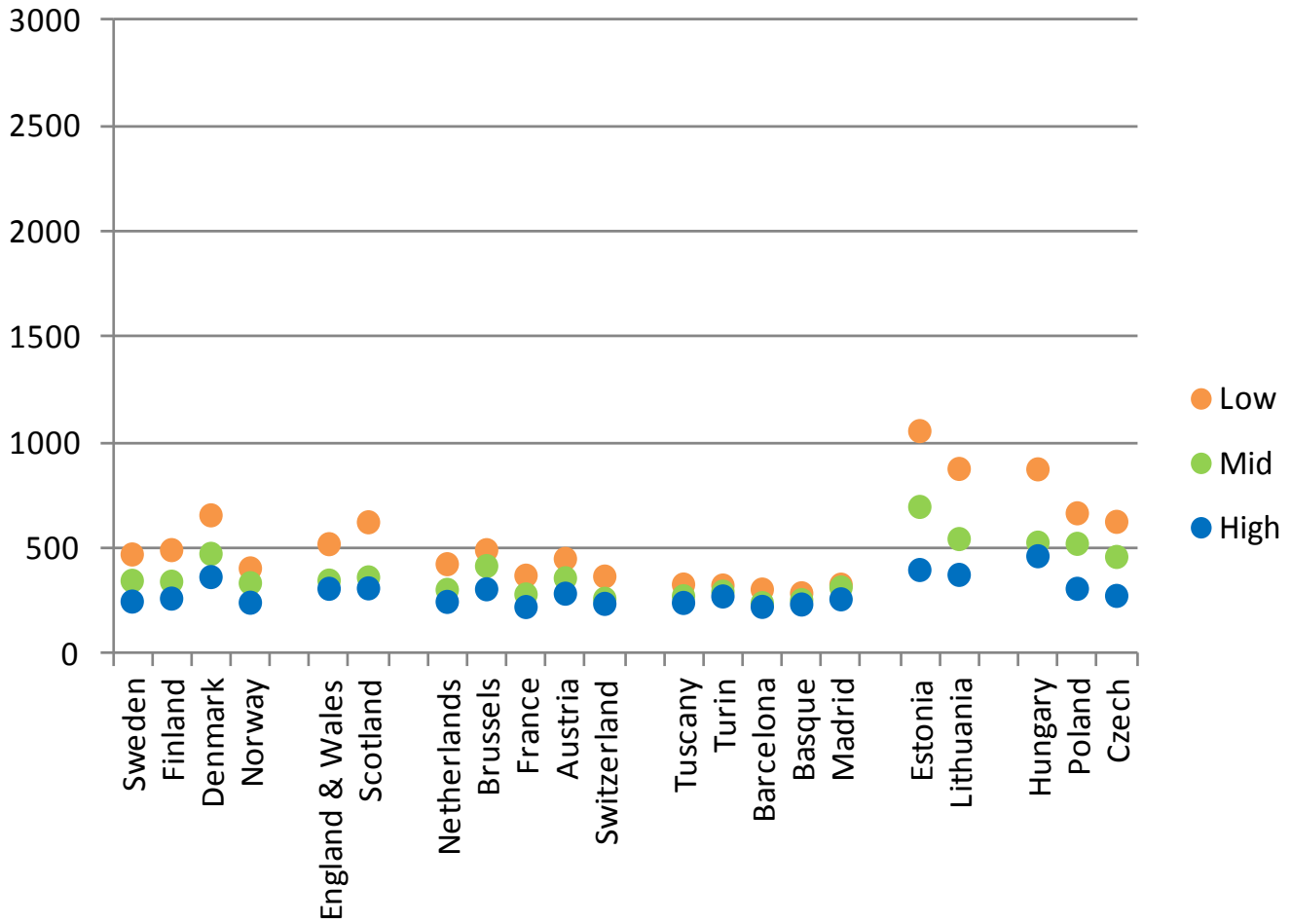
Mortality per 100 000 by education

Women, 30-74 yrs, early 2000s



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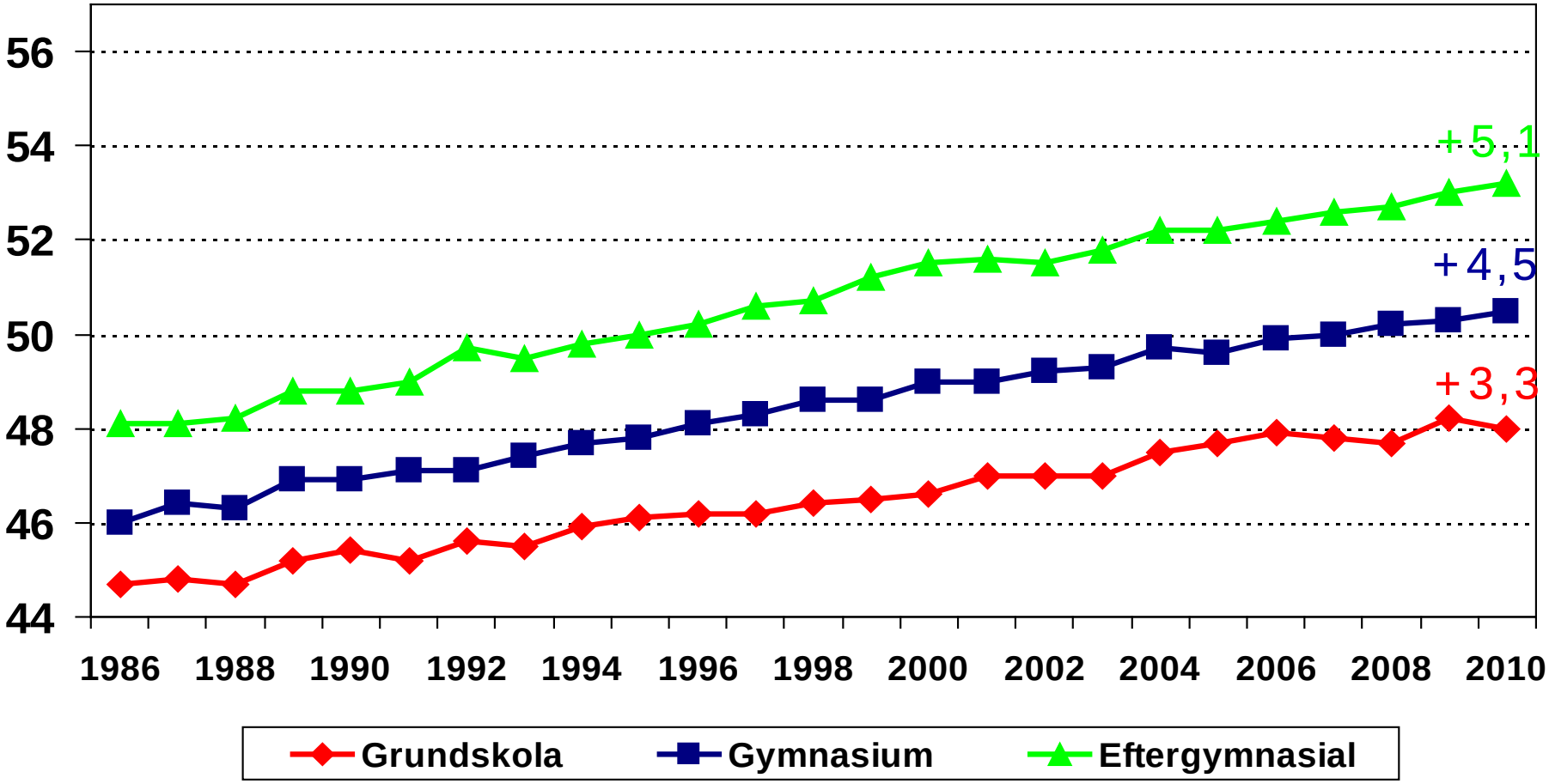
Remaining life expectancy at 30

Men, Sweden 1986-2010



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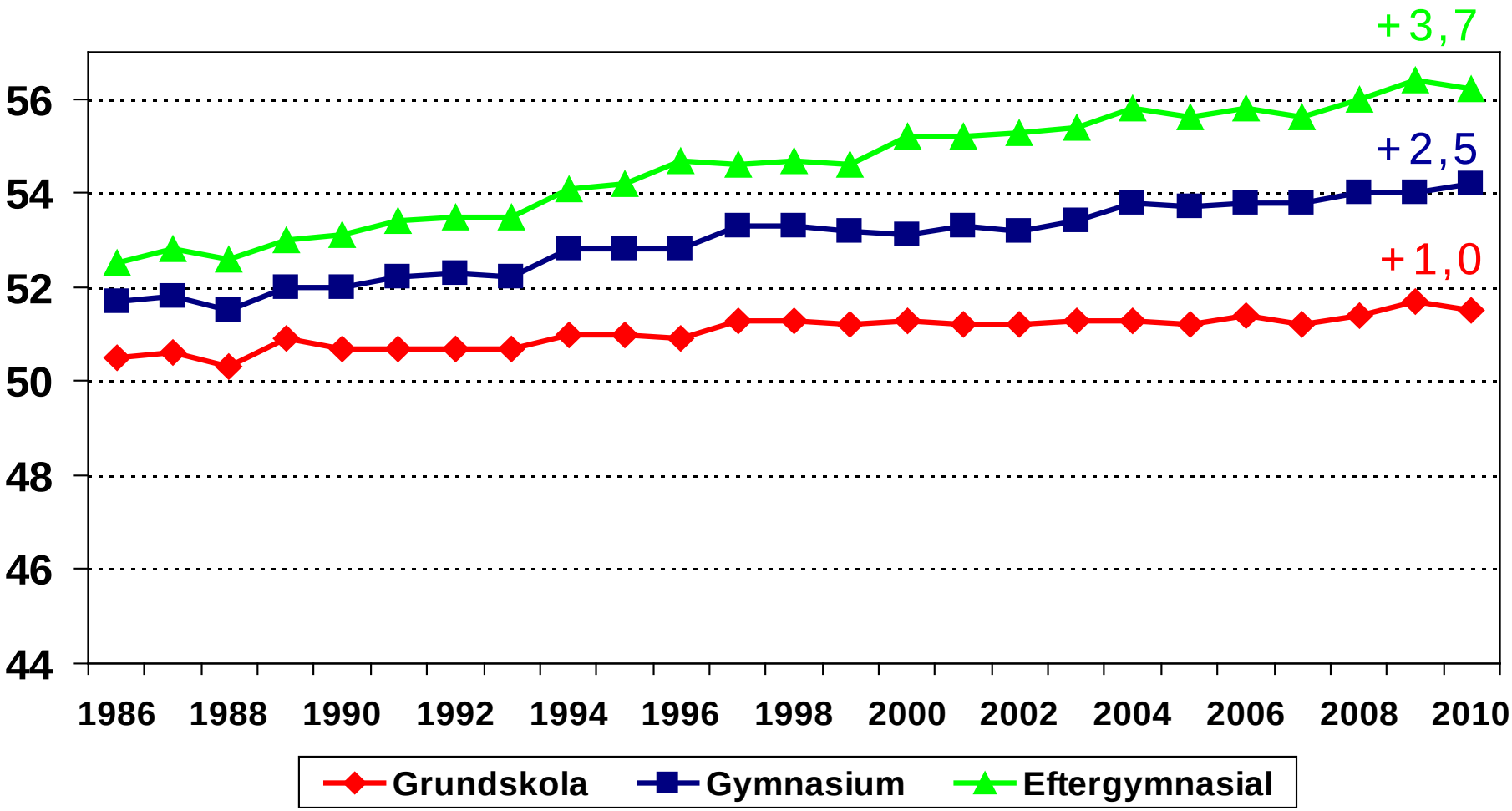

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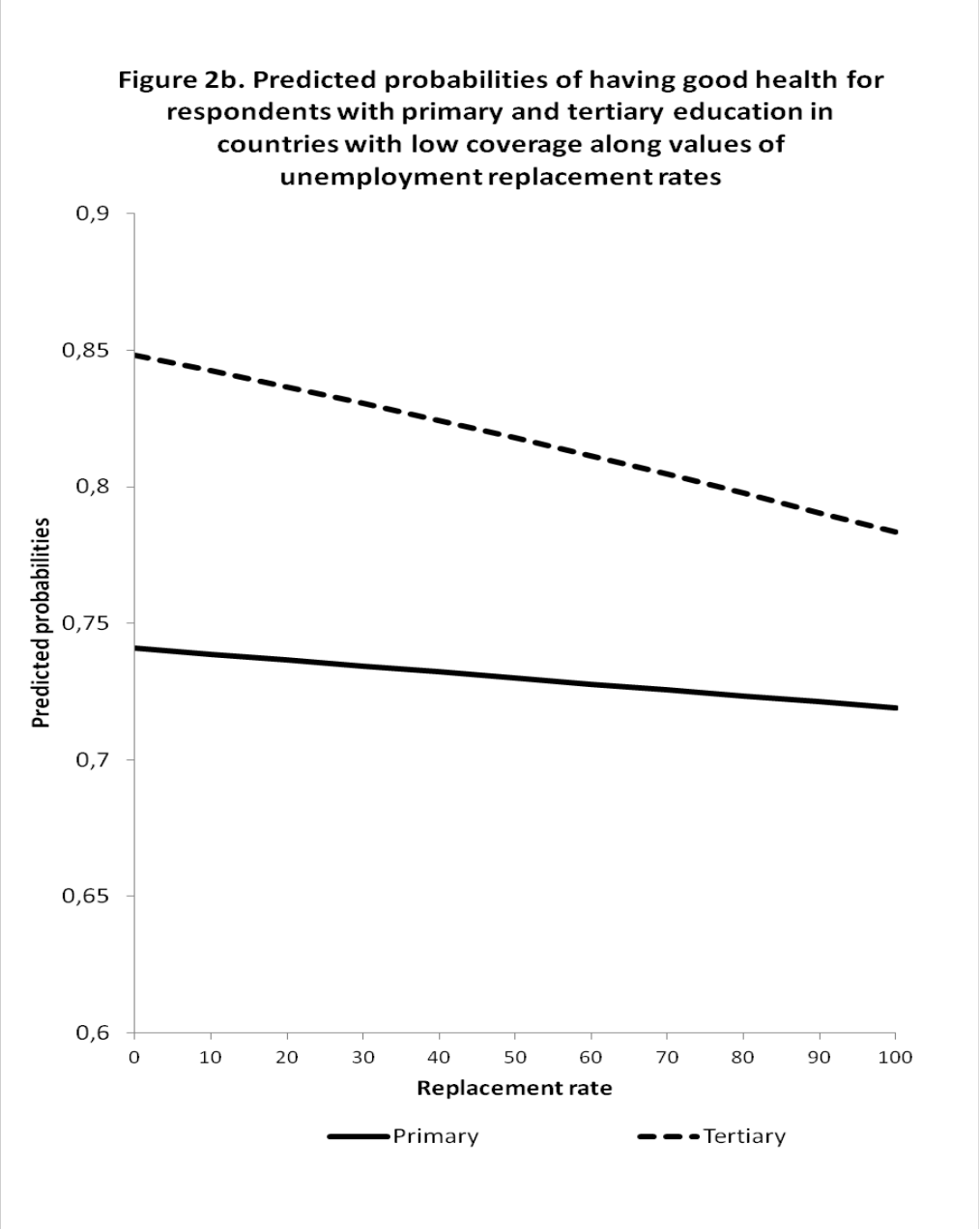

Source: Sjöberg, Nelson, Ferrarini (2014) Decomposing the effect of social policies on population health and inequalities. DRIVERS working paper

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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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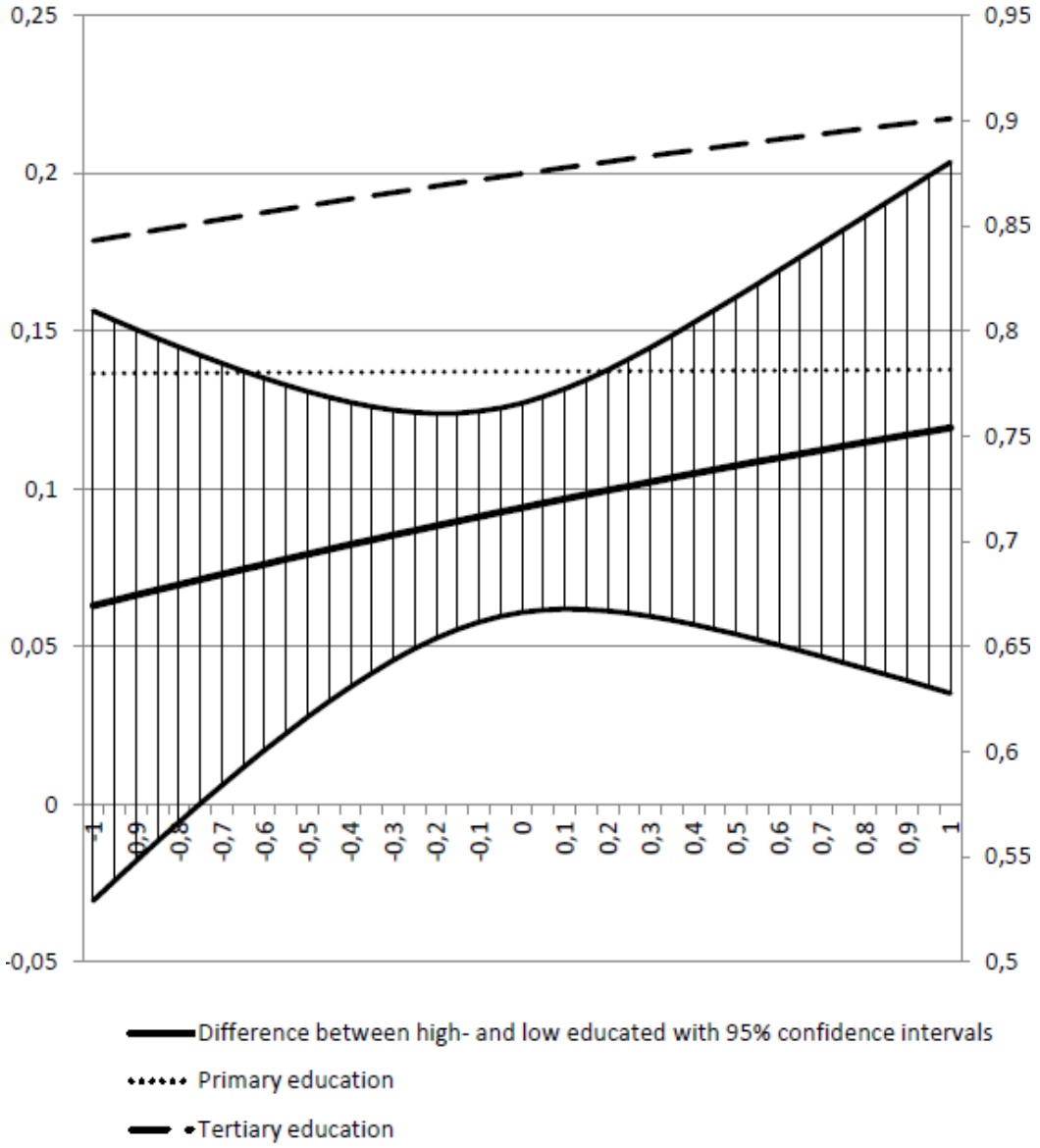
Figure 3a. Unemployment benefits. Predicted values on self-assessed health (right y-axis) and difference between youths with primary and tertiary education with 95% C.I. (left y-axis)



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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

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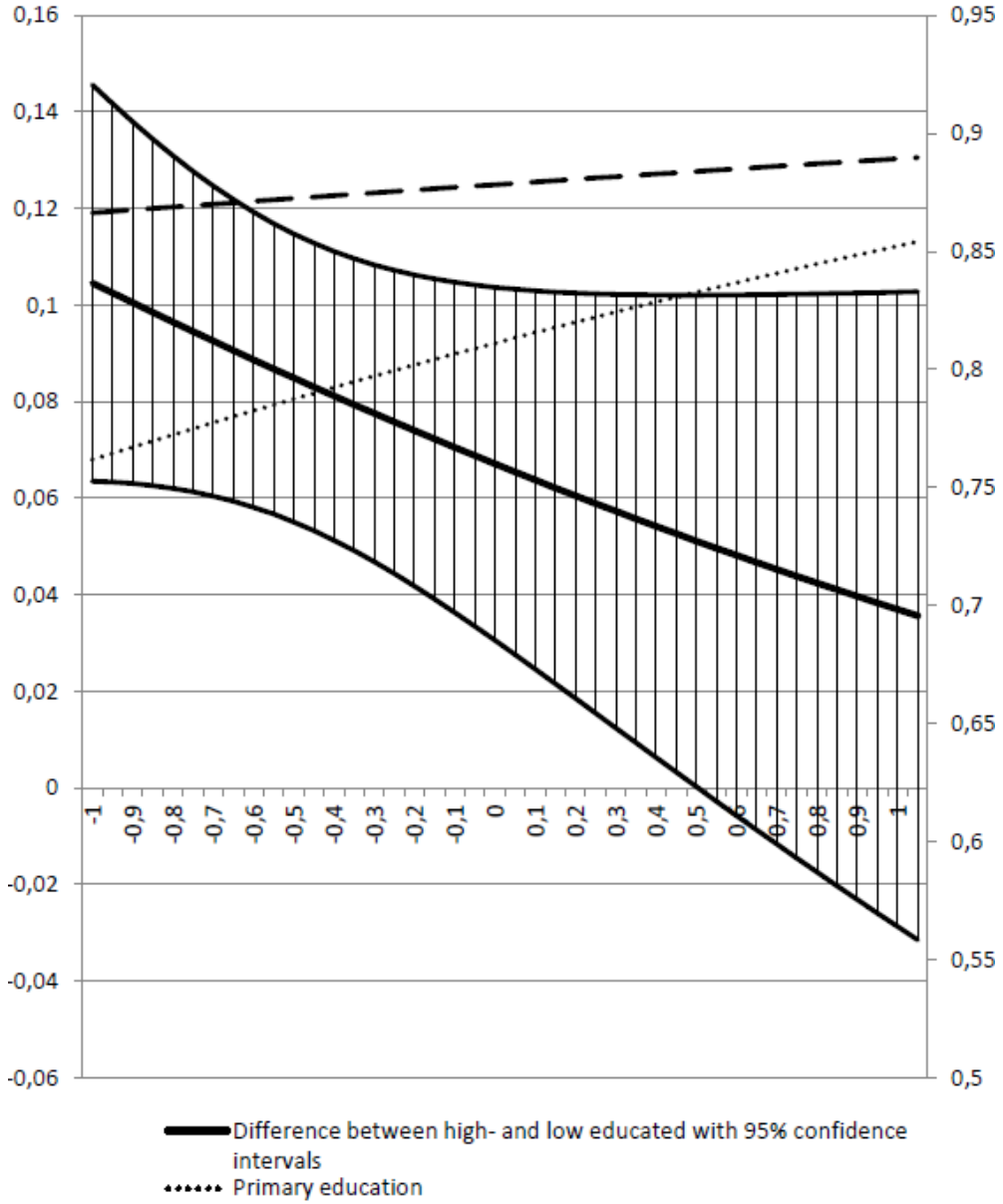
Figure 3b. Unemployment benefits for youths. Predicted values on self-assessed health (right y-axis) and difference between youths with primary and tertiary education with 95% C.I. (left y-axis)



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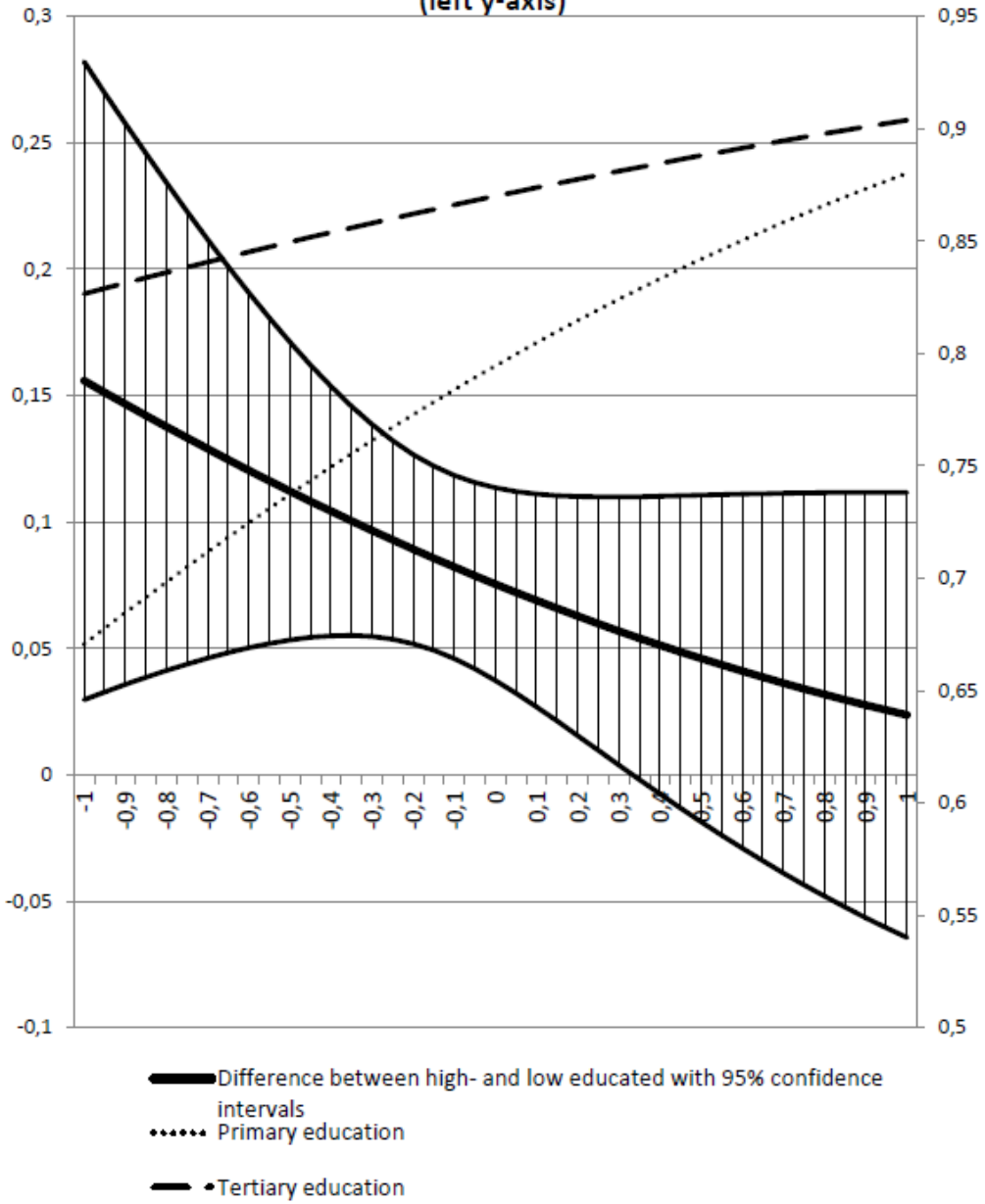
Health improves with larger efforts in terms of ALMPs generally, but more so among low educated youth

Figure 3c. Active labour market policy. Predicted values on self-assessed health (right y-axis) and difference between youths with primary and tertiary education with 95% C.I. (left y-axis)



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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