How do welfare policies contribute to the reduction of health inequalities?

Olle Lundberg

Summary: While the provision of health care is important for public health, public health policies are much more than health care policies. Since a range of social factors and living conditions throughout the life course are of importance for health and survival, welfare policies that aim at improving such conditions and tackling social problems are of importance for health as well. It is important to consider both macro- and micro-level policies when we try to assess what works; the fact that micro level interventions are easier to evaluate should not stop us from trying to understand the health impacts of macro level welfare policies.

Key words: welfare policy, health inequalities, social protection

Welfare policies and public health

One may ask why we should be interested in welfare policies as a way to improve public health and reduce health inequalities. A fundamental reason is that while the provision of health care is important for public health, public health policies are much more than health care policies. Since a range of social factors and living conditions throughout the life course are of importance for health and survival, policies that aim at improving such conditions and tackling social problems are of importance for health as well.

One can also observe that many welfare policies and programmes are in fact motivated by health problems, disabilities and their economic consequences. Pensions, sickness insurance or work injuries insurance schemes are basically implemented to reduce or eliminate the risk of poverty associated with illnesses due to the loss of opportunity to generate a market income. In addition, it is important that we consider both macro- and micro-level policies when we try to assess what works; the fact that micro-level interventions are

REFERENCES

easier to evaluate should not stop us from trying to understand the health impacts of macro-level welfare policies.

**Welfare states, welfare resources and social determinants of health**

A very fruitful approach is to define welfare as “the resources ... by which the individual can control and consciously direct her conditions of life.”¹ These resources include economic resources, working conditions, housing conditions, education and knowledge. In short therefore, the welfare resources necessary to lead a good life also constitute the key social determinants of health.

Many welfare resources are generated within families or in the market. In addition to such individual resources there are also collective resources generated through welfare state institutions. These resources are intended to assist citizens with “the collective matters that arise from the demands and possibilities that all individuals in all societies are facing during the life cycle.”² In other words, in all societies individuals will be faced with the challenge of getting an education and the means to support themselves, to find a job and somewhere to live, to raise and support a family, to care for their children and older relatives and so on.

The collective resources can thus be divided in two major groups, ‘cash’ and ‘care’, where the former include social insurance covering income loss, for example due to illness, unemployment and old age. More recent programmes also include family policies. The latter category comprises welfare services provided free of charge or heavily subsidised, for example child care, health care and care for older people or those with disabilities.

From a public health point of view it is reasonable to believe that the supply and quality of collective resources provided through welfare policies is important in helping individuals sustain their health and wellbeing. Moreover, these resources are likely to be more important for people with lower incomes and more unfavourable living conditions. The less you have in terms of individual resources, the more important it will be that you are able to draw on collective resources, and that means that welfare policies that provide more generous transfers and better quality services are likely to improve public health and reduce health inequalities. But is there any evidence supporting this logical argument?

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**Figure 1: Family policy generosity and child poverty**

![Graph showing the relationship between family policy generosity and child poverty](Image)

**Figure 2a: Family policy generosity and infant mortality**

![Graph showing the relationship between family policy generosity and infant mortality](Image)

**Figure 2b: Family policy generosity and child injury mortality**

![Graph showing the relationship between family policy generosity and child injury mortality](Image)

*Source Figures 1, 2a and 2b: Adapted from Ferrarini and Sjöberg, forthcoming.⁶*
Welfare policies and public health – the case of family policies

Childhood and the child rearing years are traditionally periods of high poverty risks, as for instance identified by Seehoorn Rowntree in his famous poverty cycles. Welfare policies aiming to provide children and their families with a decent standard of living and schools of good quality, among other things, should contribute to child health and wellbeing. Our knowledge on the importance of the early years for health throughout the life course suggests that such welfare policies could also have health beneficial consequences in the longer term.

As a part of the NEWS-project, analyses of family policy generosity and infant mortality across eighteen OECD countries were performed. The basis for the analysis is that not only might family policy generosity be of importance, but also the institutional characteristics of family policies. These characteristics include the type of family behaviours that different policies tend to sustain, such as more traditional family types with a male breadwinner as opposed to dual-earner families. The measure of family policy generosity used refers to the legal entitlement to benefits, calculated for different family types, expressed as a percentage of the average production worker’s wage.

A simple plot of family policy generosity against the child poverty rate (Figure 1) shows a clear relationship: countries with more generous family policies tend to have substantially lower child poverty rates. This association is mainly due to policies that support dual earner families. The relationship is partly caused by a direct contribution through the amount of benefits paid, but also indirectly because policies that support two earners will increase families’ market incomes.

We also find clear relationships between family policy generosity and infant mortality (Figure 2a) and child injuries (Figure 2b), despite the fact that the graphs neither take into account institutional arrangements, nor the design of family policies.

When separating dual earner support and more traditional (or general) types of family policies (Table 1) we find that it is the generosity in dual earner types of family policies that is linked to lower infant mortality, even when controlled for differences in Gross Domestic Product (GDP). The general finding from the analysis (performed by means of pooled cross-sectional times-series analysis for the period 1970–2000 in eighteen OECD countries) are robust for changes in model specifications – the analysis presented is based on de-trended series where change rather than levels in independent and dependent time-series are analysed.

But what about health inequalities?

The analyses presented here suggest that the institutional design of welfare policies (whether to have support that stimulates dual-earner families or more traditional families), as well as the levels of generosity, may be related to public health outcomes also in rich western countries post 1970. But what about health inequalities – will countries with more generous welfare policies, like Sweden and Norway for example, also have smaller inequalities in health and mortality?

While that question has attracted some interest from the Black report and onwards, it has not often been systematically addressed, albeit with some exceptions. Comparative research on health inequalities has so far to a large extent been limited to cross-sectional data and therefore has been unable to disentangle the direct effect of welfare policies from other factors, such as economic conditions.

Table 1. Family policy and infant mortality

<table>
<thead>
<tr>
<th></th>
<th>Crude</th>
<th>Adjusted</th>
<th>Adjusted</th>
<th>Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Domestic Product (GDP)</td>
<td>0.345 (0.272)</td>
<td>-0.008 (0.306)</td>
<td>-0.105 (0.298)</td>
<td>0.064 (0.300)</td>
</tr>
<tr>
<td>Total family policy generosity</td>
<td>2.840 (1.705)</td>
<td>2.573 (1.441)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dual earner support</td>
<td>-4.256** (1.811)</td>
<td>-3.772* (1.865)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General family support</td>
<td>-0.129 (2.755)</td>
<td>-0.106 (2.366)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of observations</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>R squared</td>
<td>0.31</td>
<td>0.32</td>
<td>0.30</td>
<td></td>
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Table 2: Relative inequalities, absolute inequalities and levels of mortality among blue collar workers (men 45–65, in the 1980s)

<table>
<thead>
<tr>
<th>Panel A</th>
<th>Panel B</th>
<th>Panel C</th>
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<tbody>
<tr>
<td>Country</td>
<td>Relative</td>
<td>Country</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>1.33</td>
<td>Norway</td>
</tr>
<tr>
<td>Norway</td>
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<td>Sweden</td>
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<td>1.33</td>
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<tr>
<td>Portugal</td>
<td>1.37</td>
<td>Italy</td>
</tr>
<tr>
<td>Spain</td>
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<tr>
<td>Sweden</td>
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<td>England &amp; Wales</td>
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<tr>
<td>England &amp; Wales</td>
<td>1.45</td>
<td>Ireland</td>
</tr>
<tr>
<td>Finland</td>
<td>1.52</td>
<td>Finland</td>
</tr>
<tr>
<td>France</td>
<td>1.70</td>
<td>France</td>
</tr>
</tbody>
</table>

extent been highly descriptive, basically because of the fundamental lack of even descriptive data on inequalities in health and mortality. What we do know, however, is that relative health inequalities appear to persist irrespective of social policies or welfare state regimes (although they are probably much larger in Eastern Europe\(^8\)). However, absolute inequalities, and in particular the levels of mortality among the lower strata (blue collar workers) may be linked to the type of welfare policies adopted, or at least follow the pattern one would expect on the basis of theoretical reasoning and the results presented above.

An illustration of this point is given in Table 2, where countries have been ranked on the basis of relative mortality inequalities, absolute inequalities and finally by the levels of mortality experienced by blue collar workers. The cases of Sweden and Ireland are of particular interest. While they come out very similar in terms of relative inequalities (men who are blue collar workers have a 40% higher risk of dying between 45 and 65), the absolute differences between white and blue collar men are clearly larger in Ireland. Most strikingly, the mortality risk among blue collar workers is 50% higher in Ireland than in Sweden! If one were presented with the choice to be born in Sweden or Ireland one would clearly choose Sweden, despite the fact that the relative inequalities are equally large in the two countries.

The remaining inequalities in Sweden are driven by the exceptionally low mortality risks among white collar employees, a fact that is hardly a public health problem. If Swedish welfare policies have contributed to lower mortality risks among blue collar workers (which we don’t really know, however) they must be regarded as a success, despite the fact that there are still health inequalities that need our attention. If we judge welfare policies or welfare regimes on basis of relative inequalities alone we clearly run the risk of throwing out the baby with the bathwater.

**Concluding remarks**

Do welfare policies contribute to the reduction of health inequalities? It is a good question that needs more scientific attention. However, it is safe to say that the sum of welfare policies is highly likely to affect both average public health and health inequalities – simply imagine the poverty and poor health conditions we would have in Europe without any social protection. Furthermore, the recently conducted NEWS-project\(^3,4\) suggested that universal welfare policies are linked to better public health. Whether that conclusion is valid for inequalities in health as well is still unclear; welfare policy and health inequality is an area in great need of more systematic empirical analysis. However, our conclusions will be highly dependent on how we define health inequalities and their consequences in terms of survival and health among different social groups and measures of relative inequalities are likely to be of little relevance for conclusions regarding welfare policies. But while welfare policies have the potential of being important for health inequalities there are also many other factors that affect health and inequalities. Hence there are also different roads to success in improving public health and combating health inequalities.

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**Czech Republic: Health System Review**

**November 2009**

Lucie Bryndová
Kateřina Pavloková
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Martina Rokosová
Matthew Gaskins

Many of the recent reforms to the Czech health system have attempted to address the chronic financial instability that has marked the system since its inception. Others have focused on the issue of hospital ownership and management structures, or on improving purchaser–provider relationships, compliance with EU law, and coordination between the systems of health and social care.

The key challenge in the coming decades will be to keep high-quality care accessible to all inhabitants while taking into account economic development, demographic ageing and the capacity of the social health insurance system.