



Healthcare system and the wealth–health gradient: A comparative study of older populations in six countries



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ARTICLE INFO

Article history:

Received 29 May 2013

Received in revised form

31 July 2014

Accepted 13 August 2014

Available online 14 August 2014

Keywords:

Healthcare systems

Health inequality

Physical health

Wealth–health gradient

Older population

Cross-national comparative analysis

ABSTRACT

The present study provides a comparative analysis of the association between wealth and health in six healthcare systems (Sweden, the United Kingdom, Germany, the Czech Republic, Israel, the United States). National samples of individuals fifty years and over reveal considerable cross-country variations in health outcomes. In all six countries wealth and health are positively associated. The findings also show that state-based healthcare systems produce better population health outcomes than private-based healthcare systems. The results indicate that in five out of the six countries studied, the wealth–health gradients were remarkably similar, despite significant variations in healthcare system type. Only in the United States was the association between wealth and health substantially different from, and much greater than that in the other five countries. The findings suggest that private-based healthcare system in the U.S. is likely to promote stronger positive associations between wealth and health.

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1. Introduction

Social scientists have long demonstrated that wealthy people tend to be healthier and live longer than poor persons (Kawachi et al., 1997; Wilkinson and Pickett, 2006). The positive association between economic resources and health (usually referred to as “health gradient”) can be attributed to two reasons. First, economic resources can be used to purchase better healthcare services (e.g., Van Doorslaer et al., 2006). Second, poor health may lead to a depletion of economic resources (e.g., Smith, 2005). While both approaches are logical and quite convincing, they are by no means contradictory.

To date most cross-national studies have focused on the association between economic well-being and health, showing that the average health of a population is likely to rise with economic growth (e.g., Hurd and Kapteyn, 2003) and to decline with higher inequality (e.g., Pickett and Wilkinson, 2007). However, only few studies have systematically investigated the extent to which the wealth–health gradient differs across countries (e.g., Avendano et al., 2009; Semyonov et al., 2013) and none have examined whether the wealth–health gradient varies in magnitude across different types of healthcare systems using individual-level data. The data for this study consist of six national samples of populations

fifty years of age and over. The comparative analysis enables to delineate the relationship between wealth and health and to better understand whether healthcare system types affect the association between wealth and health.

The contribution of this research is twofold. First, it provides a cross-national comparative study of the link between different healthcare system types and overall population health. Second, it examines, for the first time, the extent to which the association between wealth and health among older adults differs across countries, and ascertains whether the type of a nation’s healthcare system is tied to this association. Thus, this research not only advances theoretical knowledge in the fields of health and gerontology, but also gives initial insights into the ways in which health policies affect wealth–health inequality.

2. Theoretical background

2.1. Wealth–health gradient

A plethora of research on health gradient has examined the association between socioeconomic well-being of individuals and various indicators of health within specific countries. These studies have repeatedly found that individual socioeconomic status—measured either by income, occupational status or education—is positively associated with health—measured by various health indicators, including self-reported health, measures of physical and

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mental illness, long-term disabilities, functionality and longevity even after controlling for individual socio-demographic characteristics (Huisman et al., 2003; Deaton, 2008).

The other body of literature includes comparative studies that focus on the relationship between structural characteristics of ecological units (i.e., nations, regions, counties etc.) and indicators of population health and mortality (Kawachi et al., 1997; Pickett and Wilkinson, 2007). In general, all cross-national ecological studies provide repeated support for the argument that a country's population, on average, benefits from greater availability of economic resources and from a more equal distribution of these resources (Kawachi et al., 1997; Eikemo et al., 2008c). That is, the population's health tends to rise and mortality rates tend to decline, with increased economic resources (measured by gross domestic product) and income equality (measured by the Gini index). The negative association between income inequality and population health is often interpreted to be the result of limited access of large segments of the population (usually the poor) to medical services and medical resources in non-egalitarian social systems (see Wilkinson, 2006 for a detailed discussion).

2.2. Framework for analyzing wealth–health gradient

Recently, welfare regime theory has gained epidemiological attention for its relevance in evaluating cross-national differences in population health and health inequality (Brennenstuhl et al., 2012). Comparative studies of health inequality have shown that countries exhibit substantial variation in population health and the health gradient, and that welfare states play an influential role in these public health outcomes (e.g., Bambra, 2006). Furthermore, countries with similar welfare and healthcare policies are likely to achieve, on average, similar population health outcomes (e.g., Chung and Muntaner, 2006). Studies have unanimously agreed that countries with social-democratic welfare regimes enhance average population health, compared to other regime types, due to their extensive social protections programs and universalism. For example, classifying 19 wealthy countries into four types of welfare regimes, Chung and Muntaner (2007) found that over a 39-year period social-democratic countries exhibit significantly better health outcomes, compared to other countries. Similarly, Eikemo et al. (2008a) reported that populations in countries with Scandinavian and Anglo-Saxon welfare regimes tend to have better health in comparison to Southern and East-European welfare regimes. Overall, this literature suggests that social-democratic welfare state regimes provide a combination of different policies (e.g., higher levels of employment and decommodification, universal access to welfare services including public health insurance etc.) which leads to better health outcomes (e.g., Chung and Muntaner, 2007).

Yet, in contrast to the consistent evidence in terms of *overall health*, the research on welfare state regimes and the *magnitude* of health inequalities show quite ambiguous results. Specifically, the findings reveal that social-democratic welfare state regimes do not systematically exhibit the smallest health inequalities compared to conservative and liberal countries (e.g., Beckfield and Krieger, 2009). For instance, Eikemo et al. (2008b) found that the Anglo-Saxon welfare state regime had the highest income-related inequalities in health, while contrary to expectations health inequalities in Scandinavian welfare regimes were found to be significantly higher than those in the Bismarckian. Another study by Mackenbach et al. (2008) revealed significant differences among 22 European countries, in terms of the magnitude of inequalities in mortality and self-assessed health. For instance, inequalities in mortality from cardiovascular disease were higher in social-democratic countries compared to other countries.

A series of recent critical reviews of empirical studies that apply welfare regime typology in comparative health research have identified issues still to be addressed in this field. Beckfield and Krieger (2009) conclude that there is no clear evidence on the relations between political systems and the magnitude of health inequities. That is, while social-democratic policies are likely to positively affect population health, the transition to capitalist economies and neoliberal reforms tend to expand health disparities. Additionally, Brennenstuhl et al. (2012) present a critical review of 33 empirical studies. They suggest that findings of significantly better health outcomes in social-democratic welfare regime are more likely to focus on overall population health, rather than on socioeconomic inequalities in health. In general, these studies have concluded that health differences by regime are not always consistent with welfare regime theory and that a broad categorization of countries according to welfare regime types is not sufficient for tackling the health inequality issue (Beckfield and Krieger, 2009; Brennenstuhl et al., 2012). The authors argue that it is important for comparative investigations on health inequality to implement healthcare system typologies that identify how healthcare systems affect not only average population health, but also the steepness of the health gradient (e.g., Brennenstuhl et al., 2012). Thus, classifying countries according to healthcare system type, as opposed to welfare regime, provides a better framework for understanding the effect of the healthcare context on the association between economic well-being and health (e.g., Wendt et al., 2009).

To date, only few studies focused on the effect of the health system itself on health inequities, and those conducted revealed contradictory results (Beckfield and Krieger, 2009). Some studies provided evidence that enhanced welfare-state provisions reduce relative health disparities. For instance, the establishment of Canada's national health insurance plan led to a decline in income-based inequality in mortality due to conditions amenable to medical treatment (e.g., Kunitz and Pesis-Katz, 2005). Other studies reported that the development of welfare-state health systems provisions did not translate into reduced health inequities (e.g., Arntzen et al., 1996). For example, the establishment of Australia's national health care system was associated with increased socioeconomic inequalities in avoidable mortality (Korda et al., 2007). It should be noted that most studies examine aggregated health indicators (e.g., infant mortality, cause-specific mortality etc.) without the use of individual-level health measures (Brennenstuhl et al., 2012). Studies that utilized individual-level indicators relied on self-assessed general health or limiting illness (see for example the studies by Bambra et al. (2009) across 13 European welfare states and by Burstrom et al. (2010) in Italy, Sweden and Britain).

Furthermore, past research has not systematically examined the aforesaid issue in older populations, which are particularly vulnerable to health problems. Whereas several studies show that socioeconomic disparities in health increase throughout the life span, as individuals endure the cumulative effects on their health of earlier-life behavioral, environmental and psychosocial risk factors (e.g., Berkman and Gurland, 1998), other studies find that health differences by socioeconomic status are likely to diminish at older age (e.g., House et al., 1994). With regard to inconsistencies in these findings, more and more researchers acknowledge that studies should include socioeconomic measures such as wealth or home ownership that reflect the cumulative and dynamic nature of economic well-being as well as potential consumption which is especially relevant for the older population (e.g., Semyonov et al., 2013). Despite the evidence that wealth-based indicators are preferable to other commonly used measures, the number of studies that focus on the relationship between wealth and health is very limited, mostly due to lack of high quality data on wealth

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