



A model of how targeted and universal welfare entitlements impact on material, psycho-social and structural determinants of health in older adults



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ABSTRACT

A growing body of research attests to the impact of welfare regimes on health and health equity. However, the mechanisms that link different kinds of welfare entitlement to health outcomes are less well understood. This study analysed the accounts of 29 older adults in England to delineate how the form of entitlement to welfare and other resources (specifically, whether this was understood as a universal entitlement or as targeted to those in need) impacts on the determinants of health. Mechanisms directly affecting access to material resources (through deterring uptake of benefits) have been well documented, but those that operate through psychosocial and more structural pathways less so, in part because they are more challenging to identify. Entitlement that was understood *collectively*, or as arising from financial or other contributions to a social body, had positive impacts on wellbeing beyond material gains, including facilitating access to important health determinants: social contact, recognition and integration. Entitlement understood as targeted in terms of *individualised* concepts of need or vulnerability deterred access to material resources, but also fostered debate about legitimacy, thus contributing to negative impacts on individual wellbeing and the public health through the erosion of social integration. This has important implications for both policy and evaluation. Calls to target welfare benefits at those in most need emphasise direct material pathways to health impact. We suggest a model for considering policy change and evaluation which also takes into account how psychosocial and structural pathways are affected by the nature of entitlement.

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1. Introduction

Welfare benefits and public amenities are of vital importance for health and wellbeing. In the context of policy reform in liberal welfare states, a growing body of research identifies the complex relationships that link entitlements to these resources with the determinants of health and health inequalities (Lundberg et al.,

2008; Lundberg, 2010; Bambra, 2011; Bambra, 2013; O'Campo et al., 2015; Peacock et al., 2014; Mackenbach, 2012). Much of this literature draws on international comparisons to assess whether different welfare regimes, at a structural level, are associated with outcomes such as life expectancy, excess mortality or inequalities in these. However, there are perhaps inevitable limits in how far these broad comparisons can determine which regimes do better in fostering health and health equity, in part because the mechanisms that link welfare policy at a national level with population health outcomes are complex and contested (Bambra, 2011; Brennenstuhl et al., 2012; Mackenbach, 2012). One illustration is the apparent paradox that the generosity of a welfare regime does not necessarily correlate positively with equality in health outcomes, reflected in debates around how far the Nordic states have better

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outcomes in terms of either mortality or social inequalities in mortality (Bambra, 2011; Mackenbach, 2012; Popham et al., 2013). This is a challenge to arguments that the key mechanism through which welfare regimes impact on the determinants of health is through the State's role in provision or redistribution of resources (see for instance, Lundberg, 2009). Given the complexity of the incentives and disincentives in any system, the coverage or relative generosity of any regime is not the only driver of health outcomes. Lundberg et al. (2008) also suggest the 'style' of policy is important, as demonstrated with a comparison of how basic pension generosity is associated with lower mortality at older age in a cross-national study, whereas earnings-related pensions are not. The causal chains between welfare regimes and health outcomes involve multiple pathways linking policy, entitlement, uptake, resource distribution, health related behaviours and health outcomes at a number of levels. One important element of style, or what Spicker (2005) calls 'modes of operation', is the extent to which entitlement to material transfers or services is available to all in a population class (older adults, or parents, for instance), or only available to those who meet particular conditions as individuals; what is often termed 'universal' or 'targeted' provision, respectively. Targeting has not only implications for the reach of particular policies, but also how they are understood by potential recipients and the population in general. This paper focuses on how entitlement is understood by older adults in England to explore how the style, or mode of operation, of entitlement might operate as a mechanism linking welfare regimes and individual and public health outcomes.

To an extent, most entitlement to welfare within any regime is conditional: on criteria such as residence, nationality, payment of social insurance, or age, with only public amenities such as libraries or parks typically provided universally to the population (Spicker, 2005). However, across many diverse welfare regimes and population groups, there have been shifts in conditionality, away from broader citizenship-based conditions of eligibility for population groups, towards more narrowly framed needs-based, means-tested or behavioural conditions (Weston, 2012; Van Lancker and van Mechelen, 2015; Dwyer and Wright, 2014). Older adults have been to an extent protected to date (McKee and Stuckler, 2013), being typically perceived as the most 'deserving' welfare recipients (Van Oorschot, 2006). However, they are increasingly becoming the focus of debates around both the economic efficiency of targeting benefits to individuals in greatest financial need, and the fairness of current intergenerational distributions of resources (Higgs and Gilleard, 2010). Where resources are constrained, the appeal of targeting resources more precisely at those who meet individualised conditions of need becomes "seductive" (Carey and McLoughlin, 2014) and debates around the financial efficiency of increasing conditionality emerge (McKee and Stuckler, 2011; 2013). Ranged against economic arguments for introducing further elements targeting are a number of concerns about the broader health impacts of abandoning universal entitlements. First are the well-documented barriers to uptake when complex conditions on eligibility are introduced. The material resources provided by welfare benefits make a direct contribution to health and wellbeing for many older citizens on fixed low incomes (Moffatt and Scambler, 2008), and both the complexity of access when recipients have to be assessed for eligibility and the stigma attached to claiming (Van Oorschot, 2002; de Wolfe, 2012; Baumberg, 2016) are likely to deter uptake for those who could benefit. These mechanisms are likely to be particularly salient for older adults, for whom 'claiming' may not be congruent with generational identities as, for instance, self-reliant citizens (Moffatt and Higgs, 2007; Milton et al., 2015). Second, eligibility dependent on individual needs may also have

psychosocial impacts through what Peacock et al. (2014) call the erosion of "legitimate discourses" of dependency, and the resulting internalisation of stigmatised concepts of need and shame (de Wolfe, 2012; Chase and Walker, 2013; Friedli and Stearn, 2015). Third, reducing universal eligibility risks eroding public commitment to welfare, engendering a gradual withdrawal of the middle-class support needed for it to function (McKee and Stuckler, 2011; Hills, 2015). In short, the style of entitlement may be an important mechanism on psychosocial and structural pathways to health outcomes, as well as on those affecting access to the material resources needed for health.

To contribute to delineating the ways in which the style, or mode, of welfare entitlement impacts on health, this paper draws on a study of older citizens (Milton et al., 2015), which identified very different discourses in their accounts of 'universal' and 'targeted' benefits and amenities. In short, benefits understood as available to all were discussed in ways that fostered respect and solidarity across a generation, whereas targeted benefits were the subject of moral enquiry about legitimacy, and fostered discourses of division and distrust. This paper explores how these understandings shape access to (and the production of) key determinants of health including material resources, social contact and social integration.

2. Methods

Data are drawn from in-depth interviews with 29 adults aged 60 or over in England in 2014. Participants were purposively sampled from three different areas: inner London, Sheffield (a multi-cultural city in the north of England) and Cambridge and its rural and suburban outskirts, in south east England. These areas, and individuals within them, were purposively sampled to include a range of age, ethnic identity, income level and relative isolation (see Table 1 for a summary). This was not intended to be statistically representative of the population of England, or of the areas sampled, but to include a maximum variation sample of participants in order to facilitate analysis of how welfare was understood. Invitations to older citizens to take part in the study were made through a range of contacts, including those in community groups and older people's networks, who were asked to pass on (in writing and orally) project information, with contact details of the project team. To ensure we were including those less well connected, we also asked gatekeepers in voluntary organisations with a remit of helping older citizens to pass on invitations to participate. All of those who agreed to be interviewed were provided with information about the project and gave written consent to participation.

There are a number of methodological challenges in asking about welfare. First, financial circumstances can be sensitive to discuss. Second, asking directly about views of entitlement risks generating routine 'public' statements or tropes, rather than providing access to the more tacit knowledge which is likely to frame how conditionality is understood. To address both issues, we used interviews which began with prompts for participants to talk at length about their biographies, families, circumstances, lives, and how they 'managed'. We then used a loosely structured topic guide to ask directly about access to specific welfare and amenities if these had not come up spontaneously in the biographical stories; this guide was developed in consultation with representatives from Patient & Public Involvement groups, and covered both uptake of benefits and views on current conditions of eligibility. Interviews were transcribed in full, translated if conducted in a language other than English (N = 5) and analysed drawing on techniques from grounded theory (Strauss, 1987) such as detailed coding of early data; iterative analysis and sampling; a cyclical process of induction

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