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Short communication

Social mobility and health in European countries: Does welfare regime type matter?

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ABSTRACT

Health inequalities pose an important public health challenge in European countries, for which increased social mobility has been suggested as a cause. We sought to describe how the relationship between health inequalities and social mobility varies among welfare regime types in the European region. Data from six rounds of the European Social Survey was analyzed using multilevel statistical techniques, stratified by welfare regime type, including 237,535 individuals from 136 countries. Social mobility among individuals was defined according to the discrepancy between parental and offspring educational attainment. For each welfare regime type, the association between social mobility and self-rated health was examined using odds ratios and risk differences, controlling for parental education. Upwardly mobile individuals had between 23 and 44% lower odds of reporting bad or very bad self-rated health when compared to those who remained stable. On an absolute scale, former USSR countries showed the biggest and only significant differences for upward movement, while Scandinavian countries showed the smallest. Downward social mobility tended to be associated with worse health, but the results were less consistent. Upward social mobility is associated with worse health in all European welfare regime types. However, in Scandinavian countries the association of upward mobility was smaller, suggesting that the Nordic model is more effective in mitigating the impact of social mobility on health and/or of health on mobility.

1. Introduction

Despite sustained efforts put in effect across European countries, health inequalities persist as an important public health challenge (Mackenbach, 2012). A range of policy solutions has been tried, but so far with relatively little impact. Social mobility has been identified as an important driver of health inequalities. Social mobility can occur either between generations (parents and children) as well as within the life-course of the individual. Truncated intergenerational social mobility is of particular concern because it can result in the crystallization of wealth inequality as well as health inequalities. Ill health is a potent cause of both intra-individual and inter-generational mobility restriction. For example, childhood illness has been shown to adversely affect educational attainment (Case and Paxson, 2008), which will subsequently affect an individual's success in the labor market. Ill health in midlife can affect labor force participation (reduced working hours, job loss), resulting in downward income mobility. Restricted social mobility can be manifest in multiple dimensions – educational achievement, occupational status or earnings and income. Furthermore health selection can be both direct (e.g. depressive illness directly resulting in truncated educational achievement) as well as indirect – e.g. depressive illness resulting in reduced social mobility via intermediary factors such as stigma and discrimination (West, 1991). Accordingly, social protections such as universal access to health care or anti-discrimination legislation represent important policies to promote both intra-individual and inter-generational social mobility.

An individual's socioeconomic position is a robust determinant of his/her health, both in terms of their current (or achieved) socioeconomic position, but also their lifetime trajectory (Marmot and Macmillan, 2004; Marmot and Wilkinson, 2005). This can reflect processes of accumulation or a direct impact of social mobility (Hallqvist et al., 2004). Studies on the effect of social mobility on health have not always produced clear-cut results, with

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some seeming to indicate that upward social mobility can be just as deleterious to health as downward social mobility (Hemmingsson et al., 1999; Liberatos et al., 1988). These mixed results might, however, be a consequence of the inconsistent ways in which social mobility has been operationalized in the empirical literature (Singhammer and Mittelmark, 2010). The use of different indicators to characterize social groups can also be of consequence, since different indicators, such as education, occupation or income, as well as the intergenerational movement between them, can have different meanings (Galobardes et al., 2006).

Overall, there are both theoretical and empirical grounds to suggest that the causal relationship between health and social mobility is bidirectional: individuals have more or less opportunities for social mobility depending on their health endowment and their health achievement is affected by transitions between social strata.

The extent of social mobility varies substantially between countries (Beller and Hout, 2006). Government actions, such as expanding access to schooling or investing in the health of children (e.g. via improved nutrition or vaccination programs) have the potential capacity to break the inter-generational transmission of social disadvantage. Considering the strong relationship between social mobility and health, these governmental actions, systematized in Fig. 1, can have an important impact on health inequalities. Welfare regime types, often used to categorize European countries, share common policies such as the ones outlined in Fig. 1.

In this cross national comparative study, we sought to examine the relation between social mobility and population health among different types of welfare regimes in the European region, in order to understand how the welfare state might moderate the link between mobility and health.

2. Methods

2.1. Data sources and variables

Individual data was collected from six rounds of the European Social Survey (ESS), between 2002 and 2012, from thirty selected countries. The ESS is a repeated cross-sectional survey that collects comparable data on individual socioeconomic characteristics and health status of several European countries (ESS ERIC, 2014). Data is available online at www.europeansocialsurvey.org.

The outcome variable, self-rated health, was based on the survey participant's response to the question 'How is your health in general?', dichotomized so that 1 included 'bad' or 'very bad' (other possible answers were 'fair', 'good' or 'very good').

Social mobility was measured in relation to mother and father's achieved level of education according to the International Standard Classification of Education (ISCED) levels. Although social mobility is usually measured on the basis of the fathers' social standing, the increasing participation of women in the workforce and the importance of the mothers' characteristics on children's health behaviors (Favaro and Santonastaso, 1995) support the importance of considering mothers' status in social mobility studies; therefore, this analysis was done separately. Social mobility was classified in three possible categories: 'down', 'stable' and 'up', according to whether the respondent had reached, respectively, a lower, the same, or higher educational level than his or her parent. Our measure of mobility controlled for the parent's educational achievement when the respondent was 14 (the same variable used to assess mobility). Failing to take into account the 'social group of origin' has been a common pitfall in previous studies of intergenerational social mobility and health (Singhammer and Mittelmark, 2010). Controlling for parent's educational achievement yields mobility coefficients that can be interpreted as independent from social group of origin.

Other individual-level variables included age (restricted to 25 years and up), gender, marital status, belonging to an ethnic minority group, self-perceived income, domicile and main occupational activity. Respondents who were in full-time education were excluded, since not having completed education did not permit comparison to parents' achievement. For all these variables a base category with contrasting indicator variables was specified, except age, which was centered around it's grand mean.

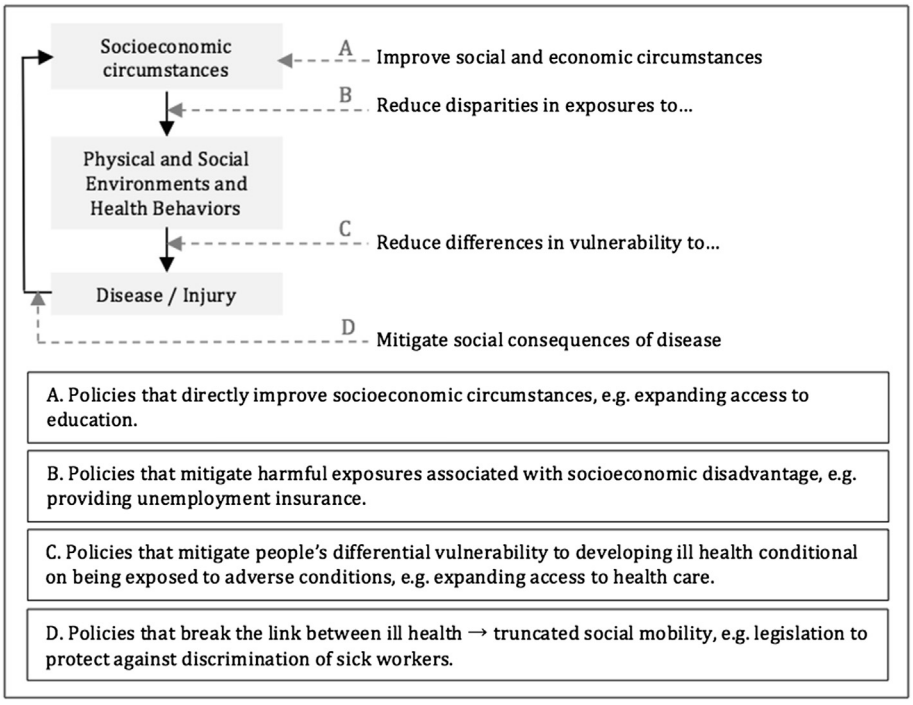

Fig. 1. Entry points for reducing and eliminating health disparities.