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Public or private? The role of the state and civil society in health and health inequalities across nations☆

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ABSTRACT

Social scientists have long recognized that macro-level factors have the potential to shape the health of populations and individuals. Along these lines, they have theorized about the role of the welfare state in creating more equal opportunities and outcomes and how this intervention may benefit health. More recently, scholars and policymakers alike have pointed out how the involvement of civil society actors may replace or complement any state effort. Using data from the World Values Surveys and the European Values Study, combined with national-level indicators for welfare state and civil society involvement, we test the impact of each sector on health and health inequalities in 25 countries around the world. We find that both have a statistically significant effect on overall health, but the civil society sector may have a greater independent influence in societies with weaker welfare states. The health inequalities results are less conclusive, but suggest a strong civil society may be particularly beneficial to vulnerable populations, such as the low income and unemployed. Our paper represents an early step in providing empirical evidence for the impact of the welfare state and civil society on health and health inequalities.

Social scientists have long argued that broader institutional arrangements shape individual lives (Durkheim (1912)1951; Putnam, 1993). While earlier research often focused on life changes in terms of economic outcomes, recent decades have witnessed health and health inequalities as an increasingly important source of stratification in advanced, industrialized nations. Consequently, scholars have been interested in understanding how health inequalities are produced and reproduced within and across societies. New theoretical and empirical work highlights the potential role of institutional arrangements, cultural traditions, and historical trajectories as playing a role in determining such inequalities (Beckfield and Krieger, 2009; Olafsdottir, 2007; Olafsdottir and Beckfield, 2011). Much of the focus has been on theorizing if and how the social organization of the welfare state matters for individual health and health inequalities. Yet, societies across the globe have varied and complex configurations of social provision, that includes both the government and other agents.

The relationship between the government and civil society in shaping health and health inequalities has received increased attention from scholars and policymakers (Blas et al., 2008). It has been argued that both can impact health and health inequalities. For example, governments can affect health by protecting human rights, implementing health oriented policies, and monitoring the population's health status. A nation's civil society can impact health by engaging in various activities, including the provision of services, engagement in advocacy work, and by generating social capital. To be able to evaluate whether the government and civil society impact health and health inequalities, a systematic cross-national perspective is required. Such research provides an important lens to understand variation in the relationship between society and individuals and thus has the power to illustrate how different institutional configurations may lead to different health experiences (Olafsdottir and Beckfield, 2011). As all societies have some mixture of government provision and civil society involvement, it is important to consider these sectors together, rather than in isolation. This is especially true given the complex and interrelated relationship between providers of services within a society.

Although it can be argued that here has been an increased focus on the impact of the welfare state on health, a problematic missing link exists between the two. Scholars have argued that the relationship between the welfare state and health requires us to consider how the specific provision of health care in society translates into health outcomes and inequalities, but equally importantly, how the health care system is embedded within the

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larger social context of the welfare state (Olafsdottir and Beckfield, 2011). However, there are important cross-national variations in the provision of health care. For example, a large proportion of social services are provided through the state in strong welfare states, such as Sweden, whereas countries like Germany have traditionally relied more on the nonprofit sector to provide similar services (Esping-Andersen, 1990). This underscores the importance of considering the impact of the welfare state in general, the impact of the welfare state as a provider of health care, and the impact of civil society on health and health inequalities across nations.

Using data from the World Values Survey (WVS, 2009), the European Values Study (EVS, 2011), and national-level indicators from the Johns Hopkins Institute for Policy Studies, the World Bank, and the World Health Organization; we ask the broad research question: *Do the welfare state and civil society impact health and health inequalities across 25 nations?* By combining individual-level survey data and high quality national-level indicators for 25 countries as diverse as Argentina, France, India, Italy, Norway, Tanzania and the United States, we test the impact of the government and civil society on health and health inequalities, while taking into account important differences at the individual level (such as education, income, and gender).

Our paper proceeds in three steps. First we provide a theoretical overview for why the welfare state, civil society, and the interplay between the two should matter for health outcomes and health inequalities. Second, using hierarchical linear modeling, we evaluate the impact of national-level indicators of government and civil society involvement on health and health inequalities. Finally, we review our key findings, particularly considering how to proceed in building a research agenda that increases our understanding of the role of the welfare state and civil society in understanding health and health inequalities.

1. Theoretical background

1.1. The relationship between the welfare State and health

The welfare state shapes and reflects the economic, political, and cultural landscape that contextualizes and creates proximate causes of health and illness across nations. Specifically, there are various mechanisms that potentially link the welfare state to health and health inequalities (Olafsdottir and Beckfield, 2011). The WHO Commission on the Social Determinants of Health has suggested three mechanisms that link what governments do to health inequalities. First, they can protect human rights (e.g. require certain conditions for employees) and provide essential services, both in the health domain (e.g. access to health services) and more generally (e.g. access to quality childcare or education). Second, they can provide policies that decrease the likelihood of health inequalities to emerge within a society, for example setting rules about how global companies can treat individuals within the society or put forward specific policies to encourage gender equality. Finally, governments can monitor the health status of the population, particularly across major social fault lines, as high quality data are a fundamental step to allow us to understand health and health inequalities (CSDH, 2008).

Even though health care is one of the largest, if not the largest, spending categories in most advanced, industrialized nations, a serious consideration of the relationship between the welfare state and the health care system has been missing (Olafsdottir and Beckfield, 2011). We argue that it is critical to consider the specific domain of health care provision in the attempt to understand issues of health and health inequalities across countries. However, it is equally important to consider how health care systems are embedded in the larger context of the welfare state, given that previous work has shown that merely providing health care does little to decrease health inequalities if interventions do not address the fundamental relationship between social conditions and such inequalities (Link and Phelan, 1995). The concept of the welfare state is broad and welfare state scholars have relied on multiple measures to capture it, including spending, welfare regimes, and specific configurations of policy. Here, we rely on government expenditure in general and public spending in the health domain. While not perfect, these two measures capture the overall size of the welfare sector and correspond closely to what would be expected from a regime approach (e.g. Sweden would have higher spending levels than the U.S.).

Based on previous theorizing and somewhat limited empirical work, we expect that government involvement in health should positively impact health and reduce health inequalities. More specifically, our ***Welfare State and Health Hypothesis*** (H1a) *suggests that greater levels of government expenditure and/or public spending on health are associated with better overall self-rated health*, and our ***Welfare State and Health Inequalities Hypothesis*** (H1b) *expects that greater levels of government expenditure and/or public spending on health are associated with less health inequalities across social fault lines.*

1.2. Why should civil society matter for health?

Often viewed as replacing or complementing the welfare state, civil society long has been recognized to have positive effects for the political and economic dimensions of a community's social welfare (Tocqueville (1835)1966; Almond and Verba, 1963; Putnam, 1993). Civil society, also called the third, voluntary, or nonprofit sector, is typically understood as a societal space alongside the government and the market. This paper employs a "structural-operational" definition of civil society, which emphasizes the distinct presence of organized, private, non-profit distributing, self-governing, and voluntary organizations in this third space, including NGOs, community-based organizations, religious groups, and labor unions, among others (Frumkin, 2002). This tripartite view of society as composed of the government, market, and civil society overlooks the intersections and interdependencies between these three spaces, but it allows us to contribute to a growing body of literature that examines the relative role of the government, civil society, and the market in effecting positive social outcomes (Evans and Heller Forthcoming).

Specifically, scholars have investigated how civil society has a beneficial influence on health and health care. The capacity of civil society to address health inequities forms the basis for policy recommendations by the World Health Organization's Commission on the Social Determinants of Heath, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and other global actors to encourage members of the third sector to participate in new governance structures (CSDH, 2008; Doyle and Patel, 2008). It also underlies the growing earmarking of funds by states, private actors, and multilateral entities to civil society actors in developing countries, rather than local governments, to coordinate and provide health programs (Craig and Porter, 2006).

Civil society can affect health, either negatively or positively, through three mechanisms (Anheier, 2009). First, nongovernmental organizations can provide needed services to individuals, either distinct from the state or as a conduit for government-funded programs (Crook et al., 2005; Wilson et al., 2012). Second, actors in the third sector also can affect a community's health for the better by ensuring government accountability, advocating for government programs that address the health needs of disadvantaged populations, and by working for inclusion of those groups' voice in public policy, particularly in developing countries (Turiano