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Do welfare regimes influence the association between disability and self-perceived health? A multilevel analysis of 57 countries

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ABSTRACT

Disability is usually associated with poorer self-rated health. However, as many people with disabilities do not consider themselves unhealthy, the association may not be as straightforward as it appears. This study examines whether the relationship between disability and self-rated health is dependent on a country's welfare regime. Welfare regimes can play a significant role in securing the needs of disabled people and lessening their social exclusion. However, welfare regimes also label disabled people accordingly, before they become entitled to specific provisions and services. Being given a low status label and being dependent on welfare provisions might trigger a negative self-evaluation of health. Using data from 57 countries of the World Health Survey of 2002–2004, the multilevel regression analyses show that people with a disability tend to rate their health worse than people without any disability. Moreover, the strength of this negative association varies significantly across countries and is affected by a country's welfare regime. The association is the strongest in the various Welfare State regimes (mostly European countries) and the weakest in Informal-Security regimes (Latin-American and Asian countries) and in Insecurity regimes (African countries). Disabled people living in Welfare States regimes tend to rate their health worse than people in other regimes. These findings confirm that welfare regimes play a role in shaping the health perception of disabled people and that processes of labeling may result in unintended and negative consequences of welfare programs. Research on the nexus between disability and self-rated health that neglects this macro-social context of welfare regimes may lead to undifferentiated and even incorrect conclusions.

1. Introduction

Although impairments and disability are risk factors for a poorer self-rated health and well-being, many people with a disability report a good quality of life (Albrecht and Devlieger, 1999). Previous articles have focused on psychological resources and social support to explain these findings (Albrecht and Devlieger, 1999; Cott et al., 1999). In this article, we examine the impact of a country's welfare regime on the association between disability and self-rated health based on data from the World Health Survey (2002–2004). We argue that welfare arrangements are not only determinants of population health (see e.g. Eikemo and Bambra, 2008), but also influence the relationship between disability and self-rated health. On the one hand, welfare regimes might have policies for people with disabilities to attain an acceptable and healthy standard of living. On the other hand, the implementation of such policies and an individual's entitlement to provisions and services depend on prior labeling as 'disabled'. A better understanding of the link between disability and self-rated health may lead to better informed health promotion strategies for people with disabilities and the population in general (Cott et al., 1999).

In the following sections we review existing literature on disability and self-rated health and elaborate on why welfare regimes might affect their interrelation. Two hypotheses are outlined. After the description of the analyses, the findings are discussed.

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2. Background

2.1. Disability and self-rated health

Almost everybody will experience difficulties in functioning at some point in their life (WHO and WorldBank, 2011; Zola, 1989). In 2011, the World Report on Disability estimated that about 15 percent of the world's population, approximately one billion people, have a moderate or severe disability (WHO and WorldBank, 2011).

According to the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001), disability refers to difficulties encountered in human functioning. It arises from the interaction of a person's health condition with contextual factors, such as the built environment, but also social relationships and policies (Fellinghauer et al., 2012; WHO, 2001) and refers to problems in body functions or structures, difficulties in performing activities such as walking or eating, or problems with involvement in any area of life, for example discrimination in the labor market.

A number of studies found that disability is associated with poorer self-rated health (Cott et al., 1999; Debpuur et al., 2010; C. Drum, 2008). The latter has been identified as an important predictor of mortality (Idler and Benyamini, 1997; Jylha, 2009), morbidity (Latham and Peek, 2013) and health care use (Miilunpalo et al., 1997). It is an inclusive concept, not linked to a specific medical condition, and covers physical, mental and social aspects of health (Idler et al., 1999). It can be seen as summary statement, in which various aspects of health are combined (Jylha, 2009; Tissue, 1972). Nevertheless, disabled people do not always tend to see themselves as unhealthy (Cott et al., 1999). The Australian National Health Survey of 2007–2008, for example, concluded that approximately 40 percent of people with a severe impairment perceived their health as being good, very good, or excellent (Australian Bureau of Statistics, 2009). This is in accordance with the *disability paradox*, or the finding that many people with profound disabilities report a high quality of life, while observers think they live an undesirable daily existence (Albrecht and Devlieger, 1999).

Previous research has explained this finding by means of balance theory framework, pointing to the importance of an equilibrium between body, mind, and spirit (Albrecht and Devlieger, 1999) and psychological factors such as self-esteem (Cott et al., 1999) for a good self-rated health. The strength of social support should also not be neglected in preventing poor self-rated health for impaired people (Albrecht and Devlieger, 1999; Fellinghauer et al., 2012).

Although we acknowledge the strengths of these explanations, in this paper we focus on the broader socio-political context of the welfare regime. Many studies show that country characteristics and welfare policies, in addition to personal characteristics and intrapersonal relationships, explain a substantial part of the variations in socio-economic inequality in health and disability across countries (Beckfield and Krieger, 2009; Bergqvist et al., 2013; Chung and Muntaner, 2006; Coburn, 2004; Levecque et al., 2011; Witvliet et al., 2011, 2013, 2012). With regard to welfare regimes, the underlying assumption is that these not only affect socio-economic positions, but also health, as they mediate the health effects of socio-economic positions by providing sufficient and affordable (health) services and cash benefits (Bergqvist et al., 2013; Levecque et al., 2011).

Welfare regimes may affect the association between disability and self-rated health through two competing mechanisms. The first concerns the role of welfare policies for people with disabilities in helping them attain an acceptable and healthy standard of living. The other concerns the consequences of labeling people as 'disabled' before they become entitled to various provisions and services.

2.2. Welfare provision and services

People with disabilities are more likely to experience worse educational and labor market outcomes and to be poorer than people without disabilities (WHO, 2011). Through a range of programs and services, countries can buffer the detrimental outcomes for people with disabilities and thereby improve their quality of life. Historically, disability was one of the first risks covered by social insurance (Van Oorschot and Hvinden, 2000) and by the mid-1990's, 163 countries had statutory disability social security programs (Dixon and Hyde, 2000). The comparative assessment of design features of these programs published by Dixon and Hyde (2000) showed that Australia and Western European countries had the best designed social security program. Brazil and Nicaragua also performed well, while Ireland, the UK and Slovenia performed rather poorly. Although social insurance and supplementary cash transfers are important means to improve the standard of living of disabled people, other significant tools are found in health care services, as well as in labor market and anti-discrimination policies. Independent living programs and personal assistance with care are other examples through which welfare regimes can enhance disabled people's participation in society. However, many variations exist in national disability policies (Dixon and Hyde, 2000; OECD, 2010). One way of taking this diversity into account is by looking at welfare regimes, as programs and services dealing with disability tend to map onto the broader socio-political context of the welfare regime (van Santvoort, 2009).

Although most existing welfare regime studies tend to be restricted to Western states, in this study we expand the focus to countries in other continents by applying the typology of Wood and Gough (2006). Because the state and markets in non-Western countries prove inadequate to realize an acceptable standard of living, citizens rely to a greater extent on informal, and most likely hierarchical and even clientelist relations. Therefore, Wood and Gough complemented the 'de-commodification' axis put forward in the welfare state typology of Esping-Andersen (1990) with the axis of 'de-clientalization'. While de-commodification refers to the degree to which a person can maintain an acceptable standard of living without participation in the market, de-clientalization refers to the extent to which informal relationships are characterized by unequal patron-clientelism and the need to establish more formal and universal rights to welfare and security.

Wood & Gough specified three main types of welfare regimes. The first main one is the Welfare State regime. Based on Esping-Andersen (1990), Wood and Gough (2006) distinguish three subtypes: *Social-Democratic*, *Conservative*, and *Liberal* welfare states. In these countries a more secure climate prevails, as welfare arrangements are provided by the state. Social-Democratic countries are characterized by a relatively generous benefits and coverage, broad (labor market) integration policies and legislation based on citizenship (van Santvoort, 2009). Conservative welfare states have relatively accessible and generous benefits, and quite developed employment programs, but not at the level of the Social-Democratic states. In the Liberal countries, the labor market plays a key role in securing the needs of disabled people, as securing an acceptable standard of living is assumed to be accomplished through paid work (Harris et al., 2012).

In our study, we follow others (e.g. Ferrera, 1996; Levecque et al., 2011) by distinguishing *Bismarckian* and *Southern European* welfare states within the subgroup of Conservative countries. The welfare policy of Southern European countries is characterized by an emphasis on (highly fragmented) income maintenance programs and a central role for the family in the provision of support (Ferrera, 1996; Pinto, 2011). With regard to disability in particular, there seems to be a heavy workload for family members, as the formal