



## Welfare states and population health: The role of minimum income benefits for mortality



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### ABSTRACT

The causes of cross-national differences in population health are subject for intense discussion, often focusing on the role of structural economic factors. Although population health is widely believed to reflect the living conditions in society, surprisingly few comparative studies systematically assess policy impacts of anti-poverty programs. In this paper we estimate the influence of minimum income benefits on mortality using international data on benefit levels in 18 countries 1990–2009. Included are all major non-contributory benefits that low-income households may receive. Our analyses, based on fixed effects pooled time-series regression, show that minimum income benefits improve mortality, measured in terms of age-standardized death rates and life expectancy. The results on country-level links between minimum income benefits and mortality are remarkably robust in terms of measured confounding effects.

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The causes of cross-national differences in population health are subject for intense discussion, often focusing on the role of structural economic factors. This study adds to this research agenda by bringing social protection into the theoretical and empirical frameworks. Although population health is widely believed to reflect the living conditions in society, surprisingly few comparative studies systematically assess policy impacts of anti-poverty programs. A few studies analyze health effects of social protection based on welfare state regime classifications (Bambra and Eikemo, 2009; Chung and Muntaner, 2007; Dahl et al., 2006; Eikemo et al., 2008), while others rely on social expenditure data (Dahl and van der Wel, 2013; Olsen and Dahl, 2007). Results from these studies have contributed with important insights, but in terms of possibilities for policy inference some analytical shortcomings are revealed. Whereas social expenditure usually is considered to be a very imprecise measure of policy design, welfare state regime classifications are often reluctant to change and obscure country differences within particular regimes (Ferrarini et al., 2014).

This study is based on a refined analytical approach where program level effects are in focus, thus moving research beyond the

black box of welfare state regimes and expenditure patterns (Bergqvist et al., 2013; Pega et al., 2013). Thus we agree with the conclusion offered by Mackenbach and McKee (2013), that it is what welfare states actually do, rather than how they are labeled, that matters for health. The purpose is to analyze determinants of population health in comparative perspective and to explore effects of minimum income benefits on mortality in affluent countries. These minimum income benefits are often exclusively designed to improve living conditions by providing income transfers to poor people who have no earned income and lack access to contributory benefits. The hypothesis is that minimum income benefits are positively related to population health and contribute to healthier societies in terms of lower death rates and improved longevity. In order to reduce influence from potential disturbing factors, the selection of countries in this study follows the most comparable cases approach (Lijphart, 1975). Countries are here similar in a large number of important characteristics to allow meaningful comparisons, while being different in terms of mortality and design of minimum income benefits. The period of observation is 1990–2009 and the following 18 OECD countries are included in the study: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. We use descriptive analysis and cross-sectional time-series

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regression to analyze the influence of minimum income benefits on population health in terms of mortality outcomes.

The paper is organized as follows. Next we briefly review research on economic development and mortality, subsequently outlining pathways that link minimum income benefits to population health. Thereafter we discuss various measurement issues and methods used to analyze data. In subsequent sections we present our results and discuss main findings.

## 1. Structural economic factors and population health

The role of structural economic factors for population health continues to be an issue of great concern, not least in connection with the international economic crisis that emerged in 2008 (Marmot and Bell, 2009). In analyses of prosperity and population health among affluent countries, the time dimension is often emphasized. Studies, surprisingly, show that mortality tends to decline during economic downturns, while shorter periods of prosperity seem to increase mortality (Catalano et al., 2011; Granados, 2005). Although pro-cyclical fluctuations in population health are stronger for causes of deaths that are closely related to behavioral responses, such as traffic and consumption induced mortality, perverse population health outcomes resulting from temporary economic upturns are often partially or even fully offset by long-lasting economic growth (Ruhm, 2000). Brenner (2005), for example, shows that economic growth over the medium and long-term is strongly inversely related to mortality in the United States.

There is no need to deny that economic development is important for population health. Long-lasting economic growth can certainly improve living conditions and produce positive health effects. Yet, long-term prosperity seems to be no more than a necessary, but not sufficient, condition for improvements in population health, indicated by reduced health returns of economic growth at higher levels of prosperity (Kangas, 2010). The relationship between economic development and mortality at single cross-sections also disappears among affluent countries when we move into the 21st century (Kawachi and Kennedy, 2002; Wilkinson and Pickett, 2009). Still, however, population health differs extensively across affluent countries, something that calls for explanation (OECD, 2013). Social protection may be a key to this endeavor, allowing economic growth to trickle down and benefit the poor, or as Friel and Marmot (2011: 225) states it in a recent review of the social determinants of health, "... economic and social policy, if done well, can improve health and health equity".

## 2. Minimum income benefits and mortality

Several welfare state programs are likely targets of a policy oriented mortality analysis. The influential WHO commission on macroeconomics and health stressed the importance of investments in health care to improve both economic growth and population health (Sachs, 2001). Certainly, accessibility and quality of health care are central components in the overall battle against ill-health. However, social protection in terms of cash benefits may equally be essential in government strategies to improve population health.

Social protection may impact health in a variety of ways, but two interrelated individual level pathways are often emphasized (Lundberg et al., 2010). The first pathway recognizes the significance of economic resources for living conditions more generally. It stresses the role of consumption patterns, where income is linked to health by strengthened purchasing capacity of individuals. Increased material living conditions are here expected to affect health directly, for example, by allowing poor people to purchase better and more nutritious food, acquire more adequate housing

and afford staying in areas that are safer and less polluted. This consumption effect is expected to occur even after basic material needs have been fulfilled (Lynch et al., 2004), although health impacts are lower at higher income levels (Kawachi, 2000; Rodgers, 1979). The generosity of minimum income benefits should here affect health by providing poor people economic resources that can be invested in products and activities that are beneficial for health.

The second pathway is less direct and recognizes the role of status differentials and other psycho-social processes of health. Social protection operates here mainly through redistribution of economic resources as income differences in society affect health through mechanisms that go beyond material living conditions at individual level (Wilkinson, 1992). Although the role of income inequality has become prominent in discussions on the social determinants of health, as illustrated by two major reviews on the topic (Lynch et al., 2004; Wilkinson and Pickett, 2006), it is beyond this study to assess in greater detail the theoretical underpinnings of the argument or existing empirical evidence. Here it suffices to acknowledge that social protection should be relevant for health because the distribution of income in society affects stress levels among individuals, for example, when people compare their living conditions with those of others (Åberg Yngwe et al., 2003).

It is difficult to separate empirically the two pathways above. As Fritzell and Lundberg (2007) notes, command over resources includes both the material and the intangible, and lack of material resources may often lead to psycho-social processes. Experiences of poverty therefore involve both direct and indirect pathways, where lack of possibilities to consume may lead to feelings of shame (Smith, 1776). Social protection may thus influence health through a combined consumption and status effect (Lundberg et al., 2008a). One example is people who cannot participate in society because lack of purchasing power.

Theories about processes affecting health at individual level cannot straightforwardly be deduced to circumstances affecting health at population level. Notwithstanding this problem of aggregation, a curvilinear association between income and health at individual level is sufficient to produce effects of both poverty (Fritzell et al., 2013) and income inequality (Lundberg et al., 2010) on population health. Here we expect minimum income benefits to affect mortality primarily as a result of the poor being less poor and therefore healthier. One reason why the second pathway – the one that goes through income inequality and feelings of individual stress caused by relative deprivation – is expected to be of less importance in analyses of minimum income benefits is that the lion share of social benefit expenditure in affluent countries is spent on first-tier programs. In fact, cross-country differences in redistribution and income inequality seem largely to be accounted for by the structure of contributory social insurance programs, not primarily by the ways in which countries have organized minimum income benefits (Nelson, 2004). Empirical evidence even show that countries with less targeting towards the poor in redistributive processes in fact have lower income inequality (Fritzell, 2001), something that also is the essence of the so-called paradox of redistribution (Korpi and Palme, 1998).

It should be acknowledged that the relationship between minimum income benefits and income inequality has changed lately as targeted benefits now seem to account for a greater share of cross-country differences in redistribution (Kenworthy, 2011). These more recent results on income redistribution indicate that the second pathway above perhaps will become more important in terms of assessing links between minimum income benefits and population health. In this study, however, we find it is reasonable to assume that it is primarily the material mechanisms that are at work when focus is on minimum income benefits. One reason is that the generosity of minimum income benefits is an important

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