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From a conservative to a liberal welfare state: Decomposing changes in income-related health inequalities in Germany, 1994–2011

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ABSTRACT

Individual socio-economic status and the respective socio-economic and political contexts are both important determinants of health. Welfare regimes may be linked with health and health inequalities through two potential pathways: first, they may influence the associations between socio-economic status and health. Second, they may influence the income-related distributions of socio-economic determinants of health within a society. Using the Socio-Economic Panel (SOEP) for the years 1994–2011, we analyze how income-related health inequalities evolved in the context of the transformation from a conservative to a liberal welfare system in Germany. We use the concentration index to measure health inequalities, and the annual concentration indices are decomposed to reveal how the contributions of the explanatory variables age, sex, income, education, and occupation changed over time. The changes in the contributions are further decomposed to distinguish whether changes in health inequalities stem from redistributions of the explanatory variables, from changes in their associations with health, or from changes in their means. Income-related health inequalities to the disadvantage of the economically deprived roughly doubled over time, which can largely be explained by changes in the contributions of individual characteristics representing weaker labor market positions, particularly income and unemployment. The social and labor market reforms coincide with the observed changes in the distributions of these characteristics and, to a lesser extent, with changes of their associations with health.

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1. Introduction

A broad body of literature exploring social determinants of health and causes of health inequalities confirms that socio-economic deprivation is closely related to poor health. While extent and composition of inequalities in health may vary between different health and welfare systems, the association of socio-economic status and health holds true for most countries in the developed and developing world (Balia and Jones, 2008; van de Poel et al., 2008; Wagstaff et al., 2003; van Doorslaer and Jones, 2003; van Doorslaer and Koolman, 2004).

Although individual factors account for a large part of variations in health, welfare state arrangements have been identified as an important factor explaining variations between countries (Eikemo et al., 2008b). Welfare states are agreed to be important determinants for the formation and distribution of well-being and health in a society because they may mediate the associations between socio-economic position and health (Bambra and Eikemo, 2009; Bambra et al., 2009; Eikemo and Bambra, 2008; Eikemo et al., 2008b; Chung and Muntaner, 2007; Navarro and Shi, 2001; Coburn, 2004). Socio-economic insecurities in terms of job insecurity and the anticipation of unemployment have repeatedly been found to deteriorate health (Ferrie et al., 2001, 2002; Bartley et al., 1997), and the perceived socio-economic security depends to some extent on the underlying welfare state arrangements (Mau et al., 2012). Bambra and Eikemo (2009) argue that, although financial strain may have considerable adverse effects, income replacement alone may be insufficient to absorb the negative effects of unemployment on health. Strict entitlement criteria and means testing are often associated with stigmatization and a negative societal attitude towards benefit recipients (Rodriguez, 2001; Shaw et al., 2006; Esping-Andersen, 1990), which may affect mental and physical health through lower self-esteem and additional

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psychosocial stress (Coburn, 2004). One may thus agree that health outcomes and patterns of health inequalities may, to some extent, depend on the characteristics of the underlying social welfare regime, at least for subjective and mental health (Eikemo et al., 2008b, 2008c; Bambra, 2007).

Germany experienced a transformation from a conservative to a liberal welfare regime over the last two decades. Until the late 1990s, German welfare and labor market policies followed a conservative social insurance approach (see e.g. Esping-Andersen, 1990; Coburn, 2004). Entitlement criteria included the duration of former employment, and benefits were determined by wage-dependent contributions to unemployment insurance. Benefit recipients were allowed to reject job offers if either wage or field of occupation were inferior to their former employment. Those not meeting the entitlement criteria were eligible for means-tested social benefits (Seeleib-Kaiser and Fleckenstein, 2007; Viebrock and Clasen, 2009; Jacobi and Kluve, 2006). High unemployment rates and the anticipation of social and economic challenges owing to increasing globalization, however, evoked an urge for welfare state reforms and labor market deregulations (Seeleib-Kaiser and Fleckenstein, 2007; Viebrock and Clasen, 2009). The first reform in 1997/98 limited the definition of suitable employment to a wage threshold depending on the former salary and the duration of unemployment (Fleckenstein, 2008; Seeleib-Kaiser and Fleckenstein, 2007) and relaxed the regulations for fixed term contracts and minor employment. In the so-called Hartz reforms implemented between 2002 and 2004, labor market restrictions were further relaxed including the facilitation of minor, fixed term and precarious employment. In the end of 2004, the fourth and final Hartz reform reduced unemployment allowances and combined long term unemployment benefits with the former social benefits into a basic, means-tested benefit (Seeleib-Kaiser and Fleckenstein, 2007; Fleckenstein, 2008; Viebrock and Clasen, 2009; Jacobi and Kluve, 2006).

It has been argued that welfare state retrenchments decrease population health and increase health inequalities (Eikemo and Bambra, 2008; Acheson, 1998). As the welfare state is thought to mediate the associations between socio-economic position and health (Eikemo and Bambra, 2008; Bambra and Eikemo, 2009; Eikemo et al., 2008b; Bambra et al., 2009; Chung and Muntaner, 2007; Bambra, 2007; Coburn, 2004), we postulate that welfare state arrangements and policy measures may be linked with health and health inequalities through their potential influence on the associations of individual socio-economic status variables with health, and these variables' distributions within a society. While the literature provides a broad theoretical basis for this assumption, evidence from cross-country comparisons of welfare state regimes is somewhat inconsistent (see e.g. Brennenstuhl et al., 2012; Mackenbach et al., 2008; Muntaner et al., 2011). In their systematic reviews, Muntaner et al. (2011) and Brennenstuhl et al. (2012) found no consistent association between welfare state regimes and health inequalities. However, Muntaner et al. (2011) have shown that countries with an egalitarian welfare policy tradition, on average, have higher levels of population health, and Brennenstuhl et al. (2012) suggest that welfare policies defined by universalism and generosity seem to foster population health. Alike Pega et al. (2013), Brennenstuhl et al. (2012) argue that comparisons of individual policy measures in light of the respective political and economic contexts may be a more promising approach than "simply comparing health across the 'black box' of welfare typologies" (Brennenstuhl et al., 2012, p. 399).

This paper investigates how the extent of income-related health inequalities evolved in the context of the described reforms, and how the contributions of individual socio-economic characteristics changed with the changes in labor market and welfare policy measures. Using data from the German Socio-Economic Panel (SOEP) for the years 1994–2011, we employ the concentration index (Wagstaff et al., 1991) to measure income-related inequality in the prevalence of unsatisfactory health. The regression-based decomposition of the yearly indices into the contributions of age, sex, income, education, and occupation allows us to infer how income-related inequality would differ if these variables were not associated with health or were distributed equally with respect to income. Further decomposition of the changes of these factor contributions allows us to distinguish whether changes of health inequalities stem from changes in the variables' income-related distributions, from changes in their associations with health, or from changes in the means of the variables (Wagstaff et al., 2003).

2. Data

We use 18 cross-sectional surveys taken from the German Socio-Economic Panel (SOEP v28) covering the years 1994–2011. The SOEP is a representative annual survey of individuals living in private households all over Germany, and the data are regularly included in the European Community Household Panel (ECHP). Individuals were sampled by multistage sampling methods in West Germany and by probability sampling in East Germany. Response rates exceeded 60%, and the SOEP is generally agreed to be satisfactorily representative (Nolte and McKee, 2004). Pre-computed cross-sectional sample weights are provided with the data. Wagner et al. (2007) and the online documentation at http://www.diw.de/en/soep provide detailed descriptions of the data and sample methods.

The data comprise a total of 30,870 individuals (15,782 female and 15,088 male) between the ages of 25 and 60 in 18,595 households. The total number of observations in all 18 surveys is 210,904 (109,124 female and 101,780 male). Excluding observations with any missing information (12,634 total, 5.8% on average per year) and adjusting sample weights leaves us with 198,270 observations from 29,090 individuals (14,869 female and 14,221 male) in 17,704 households. See Table 1 for annual information on available data and excluded observations.

We use a subjective measure of health for our analysis. Individuals were asked the question "How would you describe your current health", and could rate their health status on a five point Lickert scale with answers "very good", "good", "satisfactory", "poor" or "bad". We distinguish individuals who are at least satisfied with their current health situation from those who are not, thus generate a binary variable indicating what we denote as unsatisfactory health, that is poor or bad health. Age in years and sex are included as control variables in all analyses.

We use income as our socio-economic status indicator and as an explanatory variable in the regression analysis. Income is widely agreed to be associated with health, and income growth as well as changes in its distribution may affect the extent of income-related health inequalities (van Ourti et al., 2009). The net household income variable in the SOEP is the sum of all incomes available to an individual's household per month and is not restricted to a particular source. We compute the equivalent household income by dividing the net income through the square root of the household size. The current net equivalent household incomes are rescaled to the price level of 2011 using the consumer price indices for each year provided by the German Statistical Office (data are available from destatis.de), allowing us to compare income and its association with health throughout the observation period.

One may agree that higher levels of qualification are associated with more job and employment security for an individual, and this may have a protective effect on health (Ferrie et al., 2002). We measure education as the total years of schooling and training.

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