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Health, disadvantage, and the welfare state

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Chapter 1

General Introduction

I met Antoon on November 27th 2020. A generous man with an undeniable accent of the region in the Netherlands I grew up in. Immediately familiar, he told me that he had moved to Germany after a painful divorce. Being an electrician, he started his own company there. His life took a turn for the worse after a bad business investment heavily indebted him. He lived in poverty with his new family, leading to sleepless nights and a lot of stress. In the meantime, the extra administrative costs made the debt grow to more than double the initial amount. He moved back to the Netherlands because there he would at least have a right to social assistance. But also back in the Netherlands he felt himself often falling through the cracks between different policies: They either did not apply to his particular case of foreign debts, or were not upheld. He ended up paying off the debts for fifteen years of his life.

Aged 54, Antoon looked much older when he was sitting in front of me, telling me about his life. Due to all his financial problems, his health had suffered. In his own words, fifteen years of paying off his debts had made him feel thirty years older. Even if he felt sick, he would not skip work. He sometimes even went to work with pneumonia, because he had to make money. Multiple severe health conditions befell him. He survived a stroke, two heart attacks, and a tumour in his lungs. His teeth fell out due to an adverse drug reaction. This meant he could not work for some longer periods, but he always got back on the job. He told me he was scared of not making his retirement age with all these health conditions. Yet he was sitting there generously telling his story, smiling, comforting *me* by making jokes. Everything will be fine, he said, his debts were almost repaid.

Antoon's life and hardships are no anomaly. In the Dutch welfare state one in six people suffer a combination of problems in different life domains e.g. financial, health, labour market (SCP, 2023). This dissertation is about the link between socio-economic and health problems in the lives of people like Antoon, and how this relationship is influenced by the organization of the welfare state. It has been decades since modern social epidemiology found a link between poor health outcomes and a disadvantaged socio-economic position, resulting in the conclusion that there is a wide range of social determinants that influence health outcomes. By now this set of factors is famously known as the Social Determinants of Health (SDH) framework (Dahlgren & Whitehead, 1991; WHO, 2008). The SDH consists of determinants that are directly related to health - one may think of lifestyle, health behaviours, health technology and healthcare – but also determinants that are indirectly related to health outcomes, including institutions such as the education system and social services.

The paradox of health inequality

In a world in which resources are neither fairly nor justly distributed, social determinants of health lead to health inequalities. Although there are several types of health inequalities, I mean socio-economic disparities in health in this thesis when referring to this phenomenon. Health inequalities are measured in many different ways, depending on available data. For instance, health inequalities can

be measured by comparing health outcomes for groups with low and high income, or with low and high level of education. On average, across the OECD countries for which data are available, people with no high school diploma can expect to live about six years less than those with a tertiary education (a university degree or equivalent) (OECD, 2019: 66). The Covid-19 pandemic did not only make health inequalities more visible, it also highlighted that health inequalities are widening in Europe (European Commission, 2023).

Across the rich, industrialized democracies, health inequalities have persisted, and on some measures even widened, while welfare states were being built up (Mackenbach, 2012). One would expect that in generous welfare states health inequalities are the smallest. Yet research has shown that counterintuitively, health inequalities are actually among the largest in generous and inclusive welfare states (Beckfield & Krieger, 2009; Muntaner et al., 2011; Mackenbach, 2012). This puzzle is referred to as the 'paradox of health inequality'.

Although the paradox has not been empirically solved, two theoretical hypotheses have been formulated (Mackenbach, 2012). The first hypothesis suggests that groups from a disadvantaged socio-economic position have become more homogeneous in terms of personal characteristics that contribute to ill health, largely as a result of the expansion of higher education, which has facilitated greater intergenerational social mobility. The second hypothesis posits that advanced welfare states have progressed further in their epidemiological development, reaching a stage where health improvements now rely more on immaterial factors, such as cultural capital, which the welfare state has not addressed. In both cases, while the welfare state has improved the well-being of the middle classes, it may have paradoxically contributed to a widening of health inequalities between socio-economic groups (Mackenbach, 2012). In other words, in terms of *relative* health, the welfare state might have not been beneficial for the most disadvantaged groups.

The paradox of health inequality raises the question how well the welfare state protects – in particular – the most disadvantaged societal groups from poor health outcomes. In this research I do not compare different societal populations, hence I am not directly studying health inequalities or aiming to solve the paradox. Instead, the paradox of health inequality highlights the relevance of studying the population of interest for this thesis, which represents the group that has poor health outcomes related to socio-economic disadvantage, in the context of a developed welfare state. Wolff and De-Shalit (2007) have shown that an important element of disadvantage is the clustering and accumulation of problems of different nature (debt, housing, relationships, health) throughout the life course. This is the perspective I take and when throughout the thesis I refer to *disadvantaged groups or individuals*, I mean specifically *those who experience a combination of socio-economic and health problems*. I provide more explanation on the operationalization of this combination of problems in chapter three.

Research question and aim of this study

In this dissertation, I trace the way in which the welfare state shapes the operation of socio-economic factors on health bottom-up from the lives of disadvantaged people, through the organization of the welfare state. The welfare state is related to health outcomes in different ways. Beckfield et al. (2015) theorized different mechanisms through which the welfare state as an assemblage of institutions distributes health. These mechanisms are: redistribution, compression, mediation, and imbrication. Whereas *redistribution* channels resources among the population, *compression* sets lower and upper bounds for the social determinants of health by for instance providing free access to healthcare for all or minimum income schemes. *Mediation* intervenes on the operation of the social determinants. Finally, institutional *imbrication* (overlap) represents reinforcing or cross-cutting policies. Whereas Beckfield et al. (2015) theorized how the welfare state affects health horizontally (pathways from institutions to health outcomes of the population), for this dissertation I open up the concept of the welfare state and gauge what happens at different analytical layers and different places vertically (pathways from institutions in which policies are created, via organizations that implement those policies, to health outcomes of individuals).

This dissertation takes a political economy perspective on health. The political economy account of health inequalities draws on materialist and psychosocial explanations but highlights that these social determinants of health are themselves shaped by macro-level determinants like the political system, the market economy, and the organization of the welfare state (Smith et al., 2016: 11). The scholarship on the political economy of health can be divided along the lines of political (i.e. regime types and government partisanship), structural (i.e. racism, sexism and capitalism) and policy (i.e. public health policy or economic policy) determinants of health (Lynch, 2023). All three inquiries within the political economy of health are characterized by a fairly high analytical level, often comparing population health indicators between countries grouped according to welfare state regimes (Øversveen et al., 2017: 108). Political scientists have been called upon to "analyze in a contextualized way the pathways and mechanisms through which power configurations cause illness and inequity" (Lynch, 2023: 389).

In the last decade, political economy of health scholarship has emphasized the importance of understanding the dynamics of health inequalities in an institutional context. The discussion in the literature has shifted from the question of *if* political economic institutions have an impact on health inequalities, to *how* this impact can be theorized, enabling the exploration of causal paths in empirical research guided by social theory (Beckfield et al., 2015; Øversveen et al., 2017). A call for new explorative research questions that focus on mechanisms and causal paths arose from the literature: "Moving forward, scholars must provide more detailed explanations of the mechanisms and pathways through which healthcare systems and other social policies affect health disparities" (Beckfield et al., 2013: 140). Most of these publications are at the stage of theorizing and have not taken the empirical

steps to explore these theorized causal paths, which I will do in this dissertation, ultimately answering the overarching question: *How does the organization of a developed welfare state shape the relationship between socio-economic disadvantage and poor health outcomes?*

This dissertation is an interdisciplinary effort insofar that it uses political science and public administration theory and methodology to speak to lacunas and puzzles in social medicine and epidemiology, and vice versa brings insights from the latter disciplines on the interconnectedness of social determinants and health to the study of social and health policies and politics. Each empirical chapter aims to understand outcomes relevant for a social medicine and epidemiology audience: health problems in the disadvantaged population and health policies, but intervening with insights and methodology from political science and public administration scholarship.

Empirical setting and research design

The empirical setting in this dissertation is – fitting to the paradox of health inequality – an affluent society with a well-developed welfare state exhibiting health inequalities: the Netherlands. Originally, the Dutch welfare state was characterized by generous benefits, similar to the Scandinavian countries. Social inequalities were considered as natural and the strong were expected to care for the weak (Vis et al., 2008). The Dutch welfare state also assigned the family unit a big role in social policy – instead of the state or the market (Goijaerts, 2022). Similar to other industrialized countries, the 1980s and 1990s saw a shift in the contents and character of the Dutch welfare state from a model of collective solidarity towards one of personal responsibility, accompanied by welfare cuts (Van Oorschot, 2006: 58). In the 21st century, as many other Western welfare states, the Netherlands has characteristics of the social investment state (Van Kersbergen & Hemerijck, 2012). This is one in which the priority is increasingly less on compensation of people's burdens (illness, old age, etc.), and more on investing through services such as childcare and education in people's abilities to cope with live course events (Hemerijck, 2018). Overall, the Dutch welfare state has been difficult to catch in the common typologies and consists of hybrid elements (Vis et al., 2008; Bokhorst & Goijaerts, forthcoming).

Since the new millennium several key reforms in the domains of social and health policy have been implemented. The 2006 Dutch healthcare act reform replaced the division between public and private insurance by one universal social health insurance and introduced managed competition (market competition regulated by the state) as a driving force in the healthcare system. The basic health insurance package and compensations for lower incomes protect citizens against catastrophic spending. Out-of-pocket payments are low from an international perspective (Kroneman et al., 2016). In 2007, social care was partly decentralized to municipalities. In the aftermath of the 2008 Financial Crisis, the Dutch government launched a fiscal austerity program and embarked on a new wave of reforms. In 2015, the Dutch universal long-term care system which had existed since 1968,

was changed into a centralized long-term care system, in combination with the decentralized social care system (Maarse & Jeurissen, 2016). The Participation Act of 2015 also decentralized key functions of implementation, activation, employment reintegration and poverty alleviation to the municipalities (Hemerijck & Van Kersbergen, 2019: 56).

Although the Netherlands is categorized as a comparatively generous welfare state with a well performing healthcare system, there are still large health inequalities to be found in this context. Socio-economic health differences in the Netherlands are just below the OECD average (OECD, 2019: 67). In the Netherlands, the difference in life expectancy between people from the lowest income group versus the highest income group is around 8 years. The difference in good perceived health expectancy between these groups is even higher, around 21 years (see Table 1). Whereas the life expectancy of women in the Netherlands is higher than of men, their years in good perceived health are in fact lower. Besides socio-economic position and sex, there are other important demographic determinants of health inequalities. Race and ethnicity have been found to be important determinants of health in other advanced democracies (Williams et al., 2019). In the Netherlands, non-Western immigrants spend 23% more years of their lives with disabilities than other citizens, which is mainly ascribed to the 26% higher prevalence of diabetes mellitus among these immigrants (Kroneman et al., 2016: 9). Although sex and ethnicity play an important role in the formation of health inequalities and should be acknowledged, this dissertation focuses on socio-economic position first and foremost.

Table 1: Life expectancy in the Netherlands in the period 2019-2022 (CBS, 2024)

		Life expectancy	**Life expectancy in good perceived health**
Lowest income group	Men	74,1	52,1
	Women	78,3	50,7
Middle income group	Men	80,7	65,4
	Women	84,1	65,4
Highest income group	Men	82,9	72,9
	Women	85,4	72,4

Within this context, this dissertation aims to analyse vertical pathways in which the organization of the welfare state might impact poor health outcomes of socio-economically disadvantaged people. Rather than zooming out and comparing cases at a highly abstract level to provide a generalizable theory, I will zoom in on what happens in one of those affluent welfare states – the Netherlands – at different analytical levels, in order to gain a sense of the different political and policy mechanisms at work that result in poor health outcomes for disadvantaged groups. I contribute to existing scholarship by paying attention to micro-meso-macro

linkages, thereby giving empirical depth to theorized mechanisms and showing "how social policy is actually implemented in practice" (Øversveen et al., 2017: 108).

Figure 1 summarizes the contributions the different chapters of this thesis make to answer the overarching question. Chapter two is a theoretical exercise combining insights from socio-epidemiology with insights from welfare state scholarship. Chapter three looks at the micro-foundations of the relationship between socio-economic and health issues in the lives of disadvantaged people in the context of the welfare state. Chapter four studies the meso-level through analysing the perception of middle managers of street-level organizations on the service delivery to disadvantaged people with a combination of socio-economic and health issues. In chapter five, the outcome of interest is no longer the poor health outcomes of disadvantaged people, but the welfare state policies created to ameliorate health inequalities. I ask which factors contribute to the adoption of such policies.

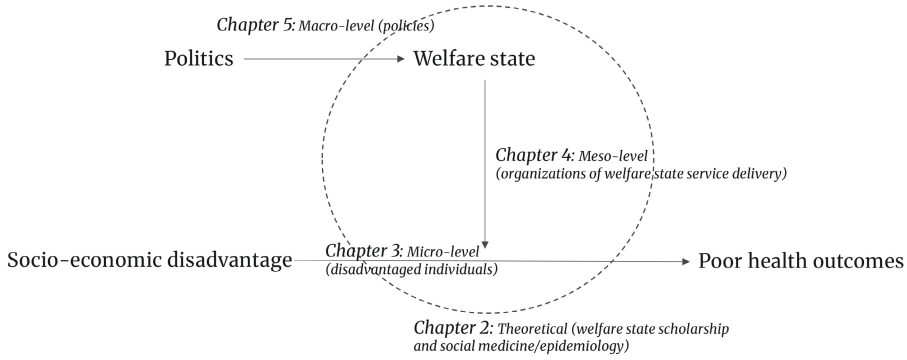

Figure 1: Thesis overview

I use different methodologies in each chapter to peel off the analytical layers of this thesis. In chapter three, I use the Biographic-Narrative-Interpretive Method to gather life stories of disadvantaged people (Wengraf, 2001). This is an interview method that is designed to elicit biographical information of respondents. In chapter four, I use vignettes (made from the life stories gathered in chapter three) to interview middle managers that deliver services to disadvantaged people (Wilks, 2004). Vignettes are small pieces of texts on the basis of which interview questions are asked. In chapter five, I study policy documents of one primary case (the Netherlands) and compare the outcomes to existing analyses of two shadow cases (Finland and England).

Note on epistemology

Critical realism as epistemological position fits well with the goal of this dissertation, which is to create more understanding of the ways in which the organization of the Dutch welfare state is related to poor health outcomes of disadvantaged people at

different analytical levels. Critical realists do not strive to make generalizable law-like claims, but to generate practical knowledge for social actors and contingent generalizations (Blatter & Haverland, 2012: 12). It is therefore opposed to a research approach based on variance and association, which deals with variables and the correlations among them (Maxwell, 2004: 248). Furthermore, critical realism offers the epistemological possibility to study the interaction of unobservable structural and observable agentic mechanisms that characterizes this research (Bhaskar, 1989: 16). Indeed, in this project such a 'broad' conception of causation that includes both idealist and materialist explanations is necessary as the analysis will take into account people's experiences, policy discourse and the connection between the two (Kurki, 2008: 218-230, in Blatter & Haverland, 2012: 13).

Taking the stance of the critical realist epistemology also means a clear departure from both a positivist and interpretivist epistemology. In contrast to interpretivists, critical realists assume that there is an objective social reality that plays a role in the process of scientific knowledge generation (Blatter & Haverland, 2012: 12). But in contrast to positivists, critical realists believe that this objective reality is not directly observable. Instead, it is necessary to have a closer look at the underlying mechanisms and conditionalizing contexts that constitute social entities to uncover causal effects in the social world (Blatter & Haverland, 2012: 12).

Throughout the thesis I often refer to mechanisms. I define them broadly as chains or aggregations through which cause and effect relationships in the social world come about (Gross, 2009: 375). This is also the way in which I want to define the verb 'shape' in the research question of this thesis. First, an important characteristic of mechanisms is that meso- and macro-level social phenomena are to be explained by reference to the actions of the individuals involved (Hedström & Swedberg, 1998: 24). Second, the mechanisms that I try to uncover are more abstract than directly observable mechanisms. In the more abstract sense of the term, mechanisms uphold both singular causality of the case under research and analytical generality (Pouliot, 2014: 238). I use mechanisms close to the meaning of Pouliot (2014) who argues that mechanisms are "analytical constructs that help organize empirics; they make sense of history, but do not drive it" (ibid.: 251). The value of the mechanisms is not that they are either true or false, but that they are useful in making sense of a complex social world (ibid.: 239). As explained, in this thesis I peel back the different micro-meso-macro layers to come to theoretical abstractions that can help explain the social world. In the discussion I will reflect on how these different layers match each other, and how policies and service implementation match the complexity of issues of people in disadvantaged groups.

The abovementioned paints a picture of the general context of the dissertation. Yet each chapter gives answer to a specific piece of the overall puzzle. Below, I explain the content of the individual chapters and how they relate to each other.

Structure and outline of the dissertation

After the general introduction, the thesis starts in **chapter 2** with a theoretical exercise to bring core insights from social epidemiology into conversation with welfare state research. There is a lacuna in welfare state scholarship as it has mainly focused social policies such as labour, income and pensions, and on healthcare policies in the case of special interest in the health sector, but not on health as outcome of social policies broadly considered. Contributions in the field of social epidemiology help connect welfare state scholarship to health outcomes.

In chapter two, I introduce the *social investment framework* as the welfare state framework that has the most potential for the integration of welfare state research and social epidemiology. Social investment is an analytical framework for social policy. The objective of social investment policies is to keep modern welfare states sustainable through high employment and strong human capital. This requires not only a large and well-educated workforce, but also a *healthy* one (Diderichsen, 2016). Hemerijck (2018) distinguishes between three social investment policy functions: stock policies for creating human capital, flow policies for adapting policies to life course events, but also buffer policies which pertain to social protection. In this chapter, I integrate health into the social investment framework, by showing how the stock, flow and buffer functions could be understood, when including health.

Chapter two ends with a research agenda in which I argue, among other things, that the complex mechanisms between macro-level welfare institutions and micro-level health outcomes should be untangled, considering the complex ways in which different policies intersect and/or overlap. This is the empirical starting point of the remainder of this dissertation. In chapter three I start to untangle these mechanisms from the micro-foundations: The experiences of disadvantaged people with socio-economic and health problems.

Chapter 3 is the first empirical chapter of this dissertation and analyses the experiences of Antoon and fourteen other disadvantaged individuals with health problems. Using a biographic interview method, I asked these fifteen individuals to tell me about the problems they have faced in life and the help they received from government to better understand how socio-economics and health are linked in people's everyday lives. The question the first empirical chapter answers is the following: *What are important patterns in which health and socio-economic problems develop in the life trajectories of people, observed within their welfare state context?* I observe that each life trajectory exists of patterns, together forming a chain that leads towards health inequalities over the life course. The patterns I found portray the different twists and turns in the relationship between the socio-economic and health problems over the life course. This means that welfare state services are an important tool to pivot someone's life in a positive direction, but at the same time that it is unpredictable in which moments and in what ways services and other welfare state provisions are necessary. This is where the empirical journey of this dissertation continues in chapter three.

From the micro-level of the individuals in chapter three, I unpack the meso-organizational level by studying the perceptions of middle managers on the functioning of their service delivery in **chapter 4**. Service delivery is where an increasingly large part of the welfare state 'happens', yet at the same time rather invisible and often overlooked in welfare state scholarship (Brodkin, 2013a). Middle managers have to translate formal policies to actual services delivered by their workers (Gassner & Gofen, 2018). Hence this chapter focuses on what we earlier described as 'how social policy is actually implemented in practice'.

Social investment scholarship prescribes preconditions to service delivery so that they work in a preventative, tailored, and complementary way (e.g. Scalise & Hemerijck, 2022). However, several scholars have found these goals to be lacking in practice (Klenk & Reiter, 2023a). Managers can influence this discrepancy, by either alleviating or further enhancing it. Middle managers find themselves in this grey zone of translating policy on paper to their employees at the street-level (Gassner & Gofen, 2018; Klemsdal et al., 2022). This chapter thus answers the question: *How do middle managers perceive and articulate the discrepancy between service delivery goals and practice?* I explore how these middle managers bridge the discrepancies between goals and practice for a the recipient group of disadvantaged people, using a vignette interview study.

In the perception of the middle managers there is a discrepancy between policy goals and service delivery practice. I find that these middle managers have different articulations of this discrepancy – I differentiate three types. Based on those articulations, I argue they might be prone to a self-reinforcing effect leading to a certain individualization of responsibility, concerning both the client and frontline worker. But individual policy implementation is at least partly the result of political choices of policy design. In the last empirical chapter of the dissertation I study the political factors shaping policies aimed to reduce health inequalities at the macro-level.

Chapter 5 brings national politics and policy in, analysing the political dynamics of the adoption of Health in All Policies (HiAP) in the Netherlands. HiAP is a widely acknowledged policy strategy or approach to improve population health and decrease health inequalities. In its core, it recognizes that population health is not merely a product of healthcare sector policies, but also of other policy sectors, such as housing, social assistance and security, and labour market policy (Ollila, 2011). It therefore proposes a collaborative approach to policy-making in which health considerations are included in policy-making in these other policy sectors. Over the past decades there has been a growing literature on technical implementation of HiAP, but little work has delved into the political dynamics of HiAP adoption and implementation (Godziewski, 2020: 1307).

Most research on HiAP adoption focuses on a few well-known cases, highlighting the importance of policy learning and partisan politics. These two different existing explanations raise the question how we can best explain the adoption of HiAP. This

chapter aims to answer that question by raising insights from a relatively little studied case – asking *which factors shape the adoption of HiAP in the Netherlands* – and comparing the findings to two well known cases of HiAP adoption (Finland and England). I show that policy learning is necessary, but not sufficient for HiAP adoption. Instead, health inequalities need to become salient before HiAP is adopted.

I finish the dissertation with a discussion of the findings of the abovementioned chapters. In the general discussion I spell out the empirical, theoretical, methodological and practical contributions of the chapters taken together. I answer the research question and present the limitations and suggestions for future research. And finally, I formulate three main messages of this dissertation. Table 2 summarizes the structure of the thesis.

Table 2: Structure of the dissertation

Chapter	**Aim**	**Research question**
Chapter 1	General introduction	-
Chapter 2	Create a theoretical bridge between disciplines	How can contributions in the field of social epidemiology help connect welfare state scholarship to health outcomes?
Chapter 3	Study the micro-level	What are important patterns in which health and socio-economic problems develop in the life trajectories of people, observed within their welfare state context?
Chapter 4	Study the meso-level	How do middle managers perceive and articulate the discrepancy between service delivery goals and practice?
Chapter 5	Study the macro-level	Which factors shape the adoption of HiAP in the Netherlands?
Chapter 6	General discussion	-