Health, disadvantage, and the welfare state

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Chapter 6

General Discussion

The aim of this thesis is to understand how the organization of the welfare state shapes the interconnectedness of socio-economic and health problems in the lives of people like Antoon. In Antoon's life trajectory, which I presented in the introduction, his debts accumulated as well as his severe health conditions, ranging from pneumonia to life threatening heart attacks, partly because the welfare state did not provide adequate debt relief assistance. A case like Antoon's is part of the broader phenomenon of socio-economic inequalities in health. 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 (CBS, 2024). Socio-economic health differences in the Netherlands are just below the OECD average (OECD, 2019: 67). Given that socio-economic and health disadvantage are related, one would expect there to be less health inequalities in societies with a relatively generous welfare state. Curiously, health inequalities are relatively large in these societies (Mackenbach, 2012). This is why this thesis has tried to understand the relationship between the welfare state and health outcomes of socio-economically disadvantaged people in a well-developed welfare state, i.e. the Netherlands.

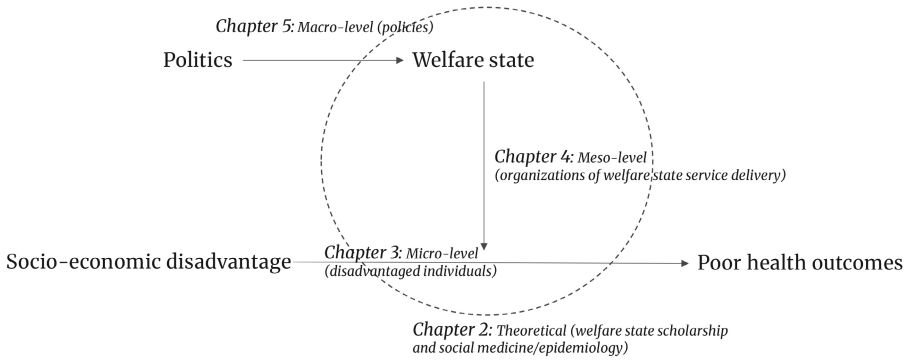

Figure 1: Thesis overview

The structure of the thesis has been as such that each chapter unpacks a separate part of the puzzle. This dissertation covers the continuum between the micro-foundations of health inequalities to the macro-level of the adoption of the Health in All Policies (HiAP) strategy, to answer different parts of the overarching question: *How does the organization of the welfare state shape the relationship between socio-economic disadvantage and poor health outcomes?* Figure 1, that I presented in the introduction, visualizes each step that was taken. Chapter two bridged the two relevant scholarships of this thesis, connecting social medicine and social epidemiology to welfare state literature in the social investment framework. In chapter three, I empirically studied the relationship between socio-economic and health disadvantage at the micro-level using life stories. I studied this relationship

in the context of the welfare state. In chapter four, I studied the perception of middle managers on the organization and implementation of service delivery for disadvantaged people at the meso-level. Social services are government provided services such as healthcare and social support services. Here, I studied how socio-economic disadvantage is related to health outcomes through the welfare state. Finally, in chapter five I studied the welfare state as outcome of political factors at the macro-level, specifically the role of policy learning and political salience, analysing how policies that should help decrease health inequalities are adopted in the first place.

Together these different pieces provide a detailed understanding of the role that the welfare state plays in the relationship between socio-economic and health disadvantage. This enhances the insights of existing scholarship. In short, the answer to the research question is as follows: This dissertation shows the complex, non-linear life trajectories of disadvantaged individuals, highlighting the ways in which their socio-economic and health challenges unfold at the micro-level. It argues that health outcomes for these individuals are shaped not only by the healthcare system but by the broader array of welfare state arrangements. At the meso-level, social services are supposed to work preventatively, tailored and complementary, but a gap exists between the intended goals and its actual implementation. At the macro-level, the adoption of the Health in All Policies strategy illustrates an ongoing struggle to implement the necessary policies to improve the wider social determinants of health for disadvantaged groups in society. As it stands, the organization of the welfare state does not have the capability to adequately support the complex life trajectories of these disadvantaged individuals.

In the remainder of the discussion I first recap the contributions of the individual chapters, before outlining the overarching empirical, theoretical, methodological and practical contributions. I finish by positing the three main messages of the dissertation.

Overview of contributions from the individual chapters

Chapter 2 theoretically linked insights from social epidemiology to welfare state research, proposing that the social investment framework has the most potential for the integration of both bodies of scholarship. Social investment is a framework which proposes that the welfare state should invest in human capital *ex ante,* as to activate people to participate in the workforce, instead of only compensating people *ex post*, in order to keep the welfare state sustainable. Social investment policies by design respond to people's complex life course transitions like losing a job or becoming a parent (Hemerijck, 2018). 'Stock' policies have the function of investing in human capital, such as childcare or education. 'Flow' policies have the function of assisting people in life course transitions, such as in and out of the workforce. 'Buffer' policies have the function of providing people with a safety net, such as social assistance. Social investment policies mirror the complex web of

interrelatedness of social determinants and health outcomes that is fundamental in the seminal Social Determinants of Health theory. Therefore, chapter two shows that social investment policies have the potential to affect the social determinants of health.

I showed how the stock, flow and buffer functions of social investment policies could be understood, when including insights from social epidemiology. The stock function could be extended to include health prevention programmes, especially for children. The flow function could be strengthened with the understanding that falling ill is an essential life-course transition, determining when people potentially exit and re-enter the labour market. The buffer function is crucial in a health perspective on the social investment framework, since social protection in itself is an investment in a healthy population. Especially the understanding of social protection as an investment in health returns in the empirical chapters of this dissertation.

In chapter two, I call for a research agenda on the intersection between welfare state scholarship and social epidemiology. First, the healthcare sector should be studied as an integrated part of the welfare state. Second, health outcomes should be added as outcome measures of all welfare state arrangements, not only for healthcare policy. Third, the health of the population should be viewed as necessary asset for the effectiveness of policies that aim to activate people on the labour market in the social investment state. Finally, 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 dissertation focuses on the final suggestion of this research agenda: unraveling the mechanisms linking social determinants and health across different analytical levels. But as the research agenda shows, the academic dialogue between welfare state scholarship and social epidemiology has further potential beyond this dissertation.

To start to empirically untangle the relations between macro-level welfare institutions and micro-level health outcomes, I used life stories drawn from biographic-narrative interviews in **chapter 3** to find how socio-economic and health problems are related in the lives of disadvantaged people. I distilled five patterns between socio-economic and health problems. The *ping-pong* pattern refers to a back-and-forth between socio-economic and health issues. The *snowball* pattern refers to smaller issues which build up over time. The *escalator* pattern is a conjunction of issues together in a short period of time setting off a critical situation. The *quicksand* pattern is defined by a longer period of time in which someone experiences a bad, yet not directly critical, situation. The *lever* triggers a sudden positive or negative change in the status quo. From these patterns, I deduct that the direction of the relationship between the socio-economic and health problems, the intensity of those problems, and external factors – be it luck, the social network or the organization of the welfare state – matter a great deal.

The contribution of chapter three is twofold. Theoretically, I provide a dynamic perspective on the pathway between socio-economic and health problems as outlined by Link and Phelan (1995). The authors argue that socio-economic factors are a fundamental cause of health outcomes, establishing a linear, unidirectional relationship. I build on existing critiques, showing that the assumption of linearity and unidirectionality does not hold when observing life stories in their welfare state context. Empirically, I observe that each life trajectory exists of patterns, together forming a sequence that leads towards poor health outcomes. These patterns portray the different twists and turns in the relationship between the socio-economic and health problems over the life course. In terms of policy relevance, this study shows among other things that throughout the life course there are different possible entry-points at which policies and services could pivot the life trajectory by providing help for disadvantaged recipients. This is where the empirical journey of this dissertation continued.

In **chapter 4** I continued peeling the analytical layers, this time studying the meso-level. I started from the finding in chapter two that service delivery is an important entry-point, by studying the perceptions of middle managers of service delivery to disadvantaged groups. Middle managers translate formal policies to actual services delivered by their frontline workers (Gassner & Gofen, 2018). I found that the middle managers perceive a discrepancy between service delivery goals and practice, and that they articulate their ambiguous work in this discrepancy in three different ways. First, middle managers *equate* prevention with early identification and accessibility of services. This makes prevention more tangible in daily practice as it comes to revolve around the mismatch of service supply and demand. Second, middle managers have *internalized* the discourse on customization to be a catch-all solution to improving service delivery. The success of service delivery depends, in perception of the middle managers, on the frontline professionals. And third, middle managers recognize the importance of complementarity, but do not often pursue this goal. In practice, middle managers *substitute* system-level and organizational-level complementarity with individual-level collaboration. This chapter thus demonstrates that middle managers lack the resources necessary to deliver services at the consistent level required by the goals set for them.

Theoretically, I contribute to the existing scholarship that studies the ambiguous work of middle managers in street-level organizations from which services are delivered (Gassner & Gofen, 2018; Klemsdal et al., 2022). I explored how these middle managers bridge the discrepancies between goals and practice for the recipient group of disadvantaged people. Empirically, I contribute to welfare state scholarship by further opening the black box of street-level organizations who deliver services (Brodkin, 2013a). The results also contribute to policy practice. Having observed the three articulations described above, I argue they might be prone to a self-reinforcing effect leading to an individualization of responsibility both for recipients and frontline workers, instead of also discussing the structural

changes in the organization of service delivery that are necessary for the type of policy ambitions described in the policy goals.

In the final chapter, the focus shifts from the organization of the welfare state to the political factors shaping the adoption of Health in All Policies (HiAP) as a policy strategy to tackle health inequalities. HiAP is a collaborative approach to policy making in which health considerations are included in policy making in these other policy sectors. In **chapter 5**, I studied the adoption of Health in All Policies (HiAP) in the Netherlands and compared the outcomes to two shadow cases: Finland and England. Specifically, I looked at the factors that explain what happens in the time between knowledge dissemination of HiAP and actual policy adoption.

Together the three cases show that knowledge is a necessary basis, but the stage of 'knowing' can last as long as there is no political salience of health inequality. In Finland and England, health inequalities became salient through the publication of reports on data of health inequalities in the respective countries. In Finland, both centre-right and centre-left political parties in combination with corporatist bodies advocated for HiAP. In England, political parties were the most influential actors. New Labour campaigned with the promise of decreasing health inequalities and implemented HiAP. In the Netherlands, health inequalities became salient following a government scandal related to childcare allowances, which sparked a political discourse around livelihood precarity. In the Netherlands political parties have not propagated HiAP. Instead, corporatist bodies, like the Socio-Economic Council, and civil servants have been the decisive policy agents. The Dutch case shows that adoption of HiAP was not partisan, yet still political.

The fifth chapter closed the circle of this dissertation. HiAP is considered by some scholars and in some policy practice circles as a social investment strategy (Lynch, 2020a). Hence, the dissertation concludes by revisiting the framework it proposed in the second chapter, through understanding what factors lead to the adoption of these type of policies and nuancing the potential of the framework with the insights of practical implications.

In what follows, I will analyse the findings of the four articles in tandem from different perspectives, namely empirical contributions, theoretical contributions, methodological contributions and practical contributions.

Empirical contributions

This dissertation is an empirical study of how the organization of the welfare state shapes health outcomes of socio-economically disadvantaged groups at different analytical levels. I empirically studied the diverse ways in which the relationship between socio-economic disadvantage and health problems is *moderated* by the welfare state as context at the micro-level (chapter three), in which this relationship

is *mediated* by the organization of service delivery at the meso-level (chapter four), and in which this relation is indirectly affected by the adoption of health inequality policies at the macro-level (chapter five).

To study these analytical layers, I zoomed in on them and tackled different aspects of their complexity. Chapter three and four, which form the empirical core of the thesis, provide a very detailed picture of how the organization of the welfare state shapes health outcomes in practice – in everyday life and on the work floor. I have shed light on the micro-foundations of health inequality in the Dutch welfare state, using life stories of disadvantaged individuals (chapter three), as well as the meso-level of service delivery, drawing from interviews with middle managers (chapter four). Taken together, the central section of my thesis enables me to trace health inequalities back to the experience of poor health outcomes by disadvantaged people and the organization of the welfare state in the perception of middle managers of service delivery. In chapter five, instead, I zoom out to the macro-level by conducting a case study of the adoption of the HiAP policy approach at the Dutch national level, based on an analysis of policy documents and secondary sources.

Overall, the dissertation makes three empirical contributions. First, it describes how health and socio-economic issues intertwine and give shape to life trajectories. For instance, chapter three proposes five patterns (snowball, ping-pong, escalator, quicksand, and lever) on the connections between socio-economic and health problems in lives of disadvantaged people. Against this backdrop, the chapter also shows how external factors affect at once socio-economic and health issues, intensifying this strife. These findings point out that life trajectories are not predictable, and that disadvantage accumulates through bad luck and individual responsibility (Wolff & De-Shalit, 2007).

Second, the dissertation highlights that social stratification takes place at the stage of service delivery. While this finding is valid in the Dutch welfare state, it could potentially be relevant in other contexts. Evidence gathered in this thesis shows that services benefit certain groups to the disadvantage of others, mainly because services work less optimal when the issues of a person are multiple and interrelated. In social investment scholarship this is also referred to as the 'Matthew Effect' – the advantaged accumulate advantage and vice-versa (Cantillon, 2011). Through their unique applicability, services are supposed to aid people in their different life course transitions, for instance back to the workforce after a period outside of it (Hemerijck, 2017). Yet, life trajectories move in more complicated ways than services have the capacity to be adapted to, and service delivery goals are not aligned with service delivery practice – especially for the most disadvantaged recipients who are exposed to a combination of socio-economic and health problems. As it stands, Dutch services are not able to cater to the needs of this recipient group. As my dissertation does not compare outcomes for disadvantaged groups with non-disadvantaged groups, future research in this direction could study a potential Matthew Effect in health outcomes.

Finally, the dissertation illustrates the process behind the adoption of policies aimed at the mitigation of health inequalities and how this process differs per country. Chapter five mirrors on the macro-level what chapter three and four show at the micro- and meso-level, namely that an intersectoral collaborative approach to decreasing health inequalities in practice is difficult to achieve. The country-case descriptions of chapter five provide insight in the process of adoption of the HiAP strategy. I show that public health researchers have done a lot of work to promote insights in disseminate knowledge of the Social Determinants of Health framework, but that HiAP has been adopted in cases in which health inequalities also became politically salient. In the process between knowing and doing, politics happens. This chapter shows that it is not necessarily partisan politics that matters, but a politicized process of story construction.

Theoretical contributions

Taken together, the different chapters first and foremost contribute to *political economy of health* – the scholarship studying the relationship between political and economic institutions and health outcomes (Lynch, 2023). As I stated in the introduction, I consider this the main perspective of this dissertation. Political economy of health generally inspects relations between institutions and health outcomes (e.g. Navarro et al., 2006; Muntaner et al., 2011; Barnes et al., 2023). An important starting point for this thesis has been the theory of institutional mechanisms of health inequality as described by Beckfield et al. (2015). Their theory connects the welfare state as overarching institution to health inequality as general outcome. Whereas the institutional theory by Beckfield et al. (2015) takes the welfare state as overarching institution, in this dissertation I analyse separately services and policies and zoom in on what happens when they are delivered to socio-economically disadvantaged people with health issues. I show what happens when social policy is implemented in practice (Øversveen et al., 2017: 108).

Another stream of literature that this thesis contributes to is *welfare state scholarship*, more specifically *social investment scholarship*. Some important starting points in this thesis derive from social investment literature: (1) service delivery is increasing in importance in the organization of developed welfare states to tackle new social risks such as temporary unemployment or care responsibilities (Bonoli, 2007; Ferragina, 2022); (2) the Netherlands is one of those welfare states[16] (Van Kersbergen & Hemerijck, 2012); and (3) social investment policies in theory have the potential to incorporate health outcomes in social policy functions (chapter two). But health inequalities are largest in exactly these developed welfare states that could be labelled as social investment states (the paradox of health inequality, see Mackenbach, 2012). The findings of this dissertation question the practical possibility of the concept of the life course multiplier in social investment literature, which entails that if policies and

16 Although it has always had hybrid elements (Bokhorst & Goijaerts, forthcoming).

services are intimately aligned, they create synergy effects to the benefit of the recipient and effectiveness of the use of policies and services (Hemerijck, 2017: 22-29). A vicious downward cycle (snowball or ping-pong effect) might happen instead (see chapter three). This dissertation shows the complexity of creating in practice the theoretically formulated synergy effects.

This dissertation also contributes to *social medicine* and *social epidemiology*. In this field of research it is common to either study individual or aggregated quantitative data relating for instance health outcomes to demographic data (e.g. Kist et al., 2023), or individual qualitative data at the micro-level showing for instance how care is provided to and received by certain groups of patients (e.g. Van Heteren et al., 2025). Both of these approaches are very valuable and have created important insights, yet they are also difficult to relate to the workings of institutions, even though the welfare state – beyond the healthcare sector – is known to have an impact on health outcomes (see chapter two). Even though the Social Determinants of Health framework specifically states the importance of institutions, there has been a lack of analysis of the workings of institutions in this broader framework (of course, there are exceptions, such as Whitehead et al., 2000). My research is an attempt to bridge these larger bodies of scholarship, as explained above. It offers entry-points to expand insights from social medicine and social epidemiology. It also formulates patterns in lives of disadvantaged people that unpack the linear fundamental cause relationship between socio-economic disadvantage and health (Link & Phelan, 1995). Other frameworks like Population Health Management and Syndemics – although they have their own important benefits and contributions (e.g. Slagboom et al., 2022; Van Ede et al., 2023; Van Ede, 2025) – are more specific in the requirements for their application and were therefore less useful to address the research question of this dissertation. In my attempt to create bridging theoretical contributions, I have found that the more general Social Determinants of Health framework holds space for a theoretical connection to welfare state scholarship (Dahlgren & Whitehead, 1991).

A final theoretical contribution speaks to the scholarship on *health policy and politics*. Important contributions in this field critically assess not only how change in health policy happens (e.g. Immergut, 1992; Tuohy, 2018b; Greer, Fonseca, et al., 2022), but also what these changes entail and whose interests are reflected (e.g. Godziewski, 2020; Godziewski, 2021). Chapter five provides context for the latter, using insights of the former. Scholars have found that HiAP changes shape between its initial idea and implementation, and argue this is caused by the influence of neoliberal ideas, such as individualizing responsibility and market liberalization (Lynch, 2020a; Godziewski, 2022; for an overview of the neoliberal turn in the Netherlands see Woltring, 2024). Chapter five shows that knowledge is only translated in policy when triggered by political salience, and thereby provides context to this neoliberal influence. Political salience and the time of policy adoption may determine the shape that policies take, more so than the knowledge on which the policies are initially based.

Methodological contributions and limitations

Throughout the introduction and discussion of this thesis, I have put a lot of emphasis on the research design enabling me to study different analytical layers (micro, meso, macro). To answer this specific research question (*How does the organization of the welfare state shape the relationship between socio-economic disadvantage and poor health outcomes?*), it was necessary for the design to move through these different layers and peel them off. I have had to develop a practice of zooming in and out between these analytical layers. For instance, I used the individual-level data gathered in the interviews not only to reflect on the individual level, but also to relate the micro-level to the welfare state context (chapter three) and inspect the meso-level of organizations (chapter four). In this way, I have been able to untangle the relations between macro-level welfare institutions and micro-level health outcomes, as I formulated in the research agenda in chapter one.

To address the research question, I have used diverse qualitative methods. Chapter three and four are interview studies, but the type of interview method differs. Chapter five is based on a qualitative case study using document analysis of primary and secondary sources. I compared the Dutch case to Finland and England as shadow cases. The most common method to study the role of institutions on social outcomes is top-down – particularly in welfare state scholarship. Essential to the research design of this thesis is that I have started from the bottom-up, from the experiences of disadvantaged individuals. Especially chapter three and four are grounded in these experiences, which makes the findings very detailed, but also very encompassing.

One important methodological aspect of this thesis is that chapter three and four are empirically directly connected. For chapter three I used the Biographic-Narrative-Interpretive Method (Wengraf, 2001). This is a rather surprising method of interviewing as initially the interviewer is only allowed to ask one question, and essentially further only to prompt on the answer to that one question. Having been sceptical at first, I was surprised how well this method worked. It allowed me to gather data in form of stories that I would never have, had I conducted the interview with a detailed interview guide. For chapter four, I used a vignette interview method (Wilks, 2004). Sometimes vignettes are used to make interviews quasi-experimental, which makes for a very interesting research design (Harrits & Møller, 2021). I used the real-life summarized life stories gathered through the interview study of chapter three to create the vignettes that were then used to interview the middle managers for chapter four. This layered set-up is beneficial in two ways. First, it empirically links the findings of chapter three and four, which makes the findings directly comparable. Second, the benefit of using real-life vignettes in relation to studies of work, is that they have the potential to allow for the elicitation of rich, detailed and frank comments because of the ways in which the real-life vignettes allow researchers, by association, to temporarily attain the status of an 'insider' within a group (Sampson & Johannsessen, 2020: 70).

These research design and methodological choices also come with drawbacks. I am aware that this thesis aims to understand a big question on the basis of empirical material that is relatively small in breadth and scope. To understand the complexity of the interconnected layers between socio-economic and health problems and the welfare state, I have opted to zoom in very deeply and then abstract to develop theory. This also means that the empirical findings of this thesis are specific to the Dutch welfare state context (except for the comparison with Finland and England in chapter five) and have limited external validity. At the same time, I theoretically abstract from this context and substantiate the case selection in a larger world of cases – namely well-developed welfare states in which we find the paradox of health inequality (see the introduction, chapter one) and social investment states (see chapter two). In the case selection logic that I applied, the Netherlands functions as a least likely case: if in a well-developed welfare state such as the Netherlands (health) policies and service delivery cannot create better health outcomes for socio-economically disadvantaged people, the same will happen in less well-developed welfare states too. Furthermore, I have aimed to study stories rather than numbers. For instance, rather than measuring the influence of middle managers' work on welfare state outcomes, I have studied the perceptions they have of their work. The reason I have chosen to do so, is that the link to health outcomes is in many cases indirect, and thus difficult to measure. Yet to further this field of research, I believe it is necessary to analyse these exact phenomena that are hard to measure. At the end of the day, politics and policies is the work of (wo)men and stories provide as valuable insights as numbers.

Reflections on conducting interdisciplinary research

I would like to briefly touch upon what has potentially been the biggest challenge in writing this dissertation: conducting interdisciplinary research. It took me five years of trial and error to really understand that different disciplines have their own theoretical jargon. Each different analytical level that I studied in this dissertation, contributes to a different scholarship. For each part of the overarching puzzle, I had to speak to different (journal) audiences. Essentially, it means I had to use a different vocabulary each time.[17]

Similar to the different theoretical vocabularies I have had to learn, working as a political scientist in a health department has known its challenges in communicating on research design and methodology. Although mixed-methods are becoming more common in public health, and the Health Campus in the Hague is in many ways a front-runner on this trend, studying policies and institutions is not yet well-integrated in public health (De Leeuw et al., 2014; Fafard & Cassola, 2020). This is unfortunate, because social medicine and social epidemiology could greatly benefit from the insights of political science (Lynch, 2023), particularly in recognizing

17 I thank Irene Slootweg for a conversation that helped me gain this insight.

that health determinants are often not natural factors, but human-made causes. Likewise, as I have argued throughout the dissertation, political science should take health and health inequalities more seriously, shedding light on the political determinants of what is perhaps the ultimate 'outcome variable': people's health. Overall, conducting research at a public health department taught me not to think in policy sectors or siloes. Political scientists and public administration scholars are trained to think in these siloes because this is how institutions shaped, with the risk of forgetting that siloes do not exist in the lives of normal people.

These epistemological differences necessarily have implications on the approach towards the research subject, the methodology the analysis developed, and the conclusions reached. I believe that research efforts come to fruition when researchers are *literate* in each other's vocabulary – one does not have to be fluent in the other language, but should able to understand it at least. While this process has undoubtedly been tough, I hope to have paid sufficient respect to each of the disciplines I contributed to, tried to bridge disciplinary divides in an ever more specialized research environment.

Practical contributions and policy implications

This thesis does not only respond to a research puzzle, but also a policy puzzle. Despite the accumulation of knowledge on health inequalities, research has not translated into effective policies that help ameliorate health inequality. Scholars of public health have lobbied for decades both in journal publications and in policy reports for the adoption of policies backed by research to decrease health inequalities, showing that not only healthcare policies but also policies in other domains such as the labour market, housing and social assistance have an impact on health (e.g. Dahlgren & Whitehead, 1991; Marmot, 2005). But the success rate of even the most substantial HiAP policy programmes (the one the New Labour government implemented in England, see chapter five) to reduce health inequalities is low (Mackenbach 2010).

The conundrum of the current approach of health inequality is as such that it is very difficult to implement the policies that are necessary to improve the wider social determinants of health for the disadvantaged groups in society; both administratively/practically and politically/ideologically. On the one hand, policies targeted at the wider social determinants of health are difficult to implement administratively (Exworthy et al., 2003; Ollila, 2011; Lynch, 2020a). On the other hand, in the process of implementation these policies often slip from tackling structural determinants of health towards behavioural health promotion interventions (Baum & Fisher, 2014; Lynch, 2020a). Another option, apart from the integration of the social determinants of health in services and policies, is to focus on universal redistributive social policies, to make a society more equal in general (not necessarily focusing on health) (Lynch, 2017: 658). As I suggest in chapter two, social policies are an investment in health in themselves. These policy tools are relatively straightforward and within the range of technical feasibility for policy-

makers. Yet these policies have since the 1990s not been politically viable. The current political decision-making in the Netherlands is a case in point. Livelihood precarity has been the number one priority of the parliamentary elections of 2023. The cabinet Schoof I that has been formed as result of these elections has adopted a Health in All Policies agenda in 2024 (although it was in development by the previous cabinet already) as explained in chapter five, but as of yet there are little concrete plans to improve livelihood precarity.

Furthermore, a tension exists between the potential and the risk of policies designed to ameliorate health inequalities. Health inequalities are intricately linked with socio-economic inequalities, that is what we know from social epidemiologists. Yet the focus on health inequalities might risk medicalizing social problems and the welfare state, instead of treating the social causes of health problems (Reibling & Ariaans, 2023). Reibling and Ariaans (2023: 2) give the example of the European Commission promoting access to quality healthcare as a strategy for achieving social and economic goals regarding employment. The tension can also be found in what is the central policy framework of this thesis, the social investment framework. Social investment has the most potential as a policy perspective to align social policies, health policies, socio-economic outcomes, and health outcomes (as explained in chapter two). The Health in All Policies (HiAP) approach shares the same ideological political background as social investment (chapter five). Yet this dissertation shows that the theory of social investment policies does not always hold in practice. Chapter two shows the potential of the social investment framework. But analysing the implementation of service delivery in chapter four and the political dynamics of arriving at HiAP policies in chapter five show that these services and policies might not work in practice as they have been thought out in theory, with the implication of not serving the disadvantaged recipient group and not decreasing health inequalities.

Based on the findings of this dissertation, I conclude on two policy implications related to the policy discussions presented above. (1) Instead of the medicalization of social and public policies, it is better to use health as argument for prioritization of social policies that *also* improve health outcomes, while keeping the implementation of social and public policies within their own policy domain. Instead of prioritizing the level of integration of services and policies to mimic the interconnectedness of socio-economic and health problems in disadvantaged peoples' lives, the structural conditions of services and policies themselves need to be prioritized. In other words, health outcomes are a bonus gained from designing effective social policies and services. For example, instead of an opaque HiAP programme in which social policies need to fit under the umbrella of HiAP, the government might want to invest in building good and affordable housing. As a result, when disadvantaged people live in good insulated houses, this will also be to the advantage of their health, and ameliorate health inequalities. (2) This thesis shows that policies and services, as any welfare state arrangement, stratify. They benefit certain groups of people to the disadvantage of others. Yet it is much less transparent in service delivery than for instance in taxation. Research has shown that universal welfare state arrangements

enjoy more public support compared to those targeted at specific groups, especially when these groups are seen as undeserving (Van der Veen, 2025). Additionally, universal arrangements reduce complexity in implementation because they are not subject to means testing (Roosma, 2024). Since this thesis shows the difficulty of designing and implementing services and policies that benefit disadvantaged people, the – potentially counterintuitive – solution might not be to design them to fit the 'twists and turns' of these complex lives, but rather to design them to be universal and accessible. If we want to truly invest in decreasing health inequalities, this should be the priority.

Research agenda

In recent years, interesting works have been published on the political economy and political determinants of health, showing the field is in lively development. Of course, the Covid-19 crisis drew many scholar's attention to health. Most notably, Bambra et al. (2021) showed the pluriform mechanisms in which the virus did not strike people equally, due to amongst others institutional constellations. Meulman et al. (2024) demonstrated that the same holds true for the Netherlands. But there have been plenty developments beyond the Covid-19 crisis too. Based on quantitative data, Barnes et al. (2023) used social epidemiological theories to develop hypotheses linking social determinants of health with institutional explanators at the macro-level. Brooks et al. (2024) have published a special issue with a collection of articles promoting the political determinants of health framework. Recent research also highlights the importance of the reverse relationship: the impact of health on democracy (Kavanagh et al., 2021). In a world of increasing threats to health and democracy, this field of research is more important than ever.

This dissertation has drawn attention to several elements that warrant further research. As mentioned in the research agenda of chapter two, more research is needed analysing (1) health not only as outcome of healthcare policy, but of different welfare state arrangements, and (2) a healthy population as necessary asset for the effectiveness of active labour market policies in the social investment state. Chapter four scratches the surface of the politics of service delivery in street-level organizations, but there is still much to study here. It would be valuable to further explore the interest representation of middle managers and, more broadly, the workers in social services, as Perera (2025) hints at this as a determining factor in the establishment of mental healthcare service provision. Potentially, managers and workers of welfare state organizations can make a difference for the quality of the services they deliver not only through their day-to-day performance on the job, but through collective action.

Finally, I want to highlight one avenue for future research beyond this dissertation that is particularly promising. This dissertation has had a blind spot on the influence of the private organizations. The relatively new field of commercial determinants of health examines the economic relations and actors that influence health on a large scale, such as food producers and their marketing efforts (Hagenaars et al., 2024).

It is vital to raise more scholarly understanding on the mechanisms at play here. Again, communication between disciplines is called for, because health researchers could draw on the work of welfare state scholars who have studied the influence of the market in for instance healthcare, elderly care and education (Gingrich, 2011).

Main messages of the dissertation

To conclude the discussion, I filter the different contributions of this dissertation down to three main takeaways.

(1) A holistic view on health entails a holistic view on the welfare state. The first main message of this dissertation is not a unique one, as other scholars have also drawn attention to this message (e.g. Dahlgren & Whitehead, 1991; Marmot, 2005; Bambra et al., 2021; Lynch, 2023). Yet it remains too often unacknowledged both in research and in policy practice – which is why it is worth reiterating. The Social Determinants of Health framework shows that both downstream or direct determinants influence health, and also upstream or indirect determinants, of which an important part are the institutions that redistribute, compress, mediate and imbricate social determinants of health in society (Beckfield et al., 2015). Therefore not only the healthcare sector, but all other domains of the welfare state should be studied in relation to health outcomes, certainly if the goal is to improve or equalize these outcomes. Within this dissertation, this point is made theoretically and most strongly in chapter two. Chapter three and four show empirically how welfare state domains including but also beyond the healthcare sector are related to health.

(2) Redistribution occurs also through service delivery, making it essential to ensure services are accessible to disadvantaged groups. Services make up an increasingly important part of Western welfare states instead of redistributive measures (Ferragina, 2022). This does not mean, however, that services are not redistributive in their own right. Chapter three, four and five of this dissertation show that the design of the organization of the welfare state makes a difference in how means are distributed across different groups of recipients of the welfare state. In other words, health inequalities are an outcome of political choices in the process of welfare state organization design, and not just an implementation flaw. Therefore I call for more political science in health research. Rudolf Virchow famously stated "Medicine is a social science, and politics nothing but medicine at a larger scale" (Mackenbach, 2009). Scholars interested in health outcomes – from all disciplinary backgrounds – should understand what that entails (Bussemaker, 2019). Beyond using policy research to make policy interventions more effective, it also entails understanding the power relations and interests behind those policies.

(3) The individual's health stems from broader social determinants, but this does not necessitate medicalizing social policies to improve health. This statement is borne out of a combining the insights from chapter two and five of the dissertation.

Chapter two shows how health outcomes are actually related to many different policies such as social policies and housing policies. Chapter five, instead, shows the complexity and intricacy of translating this insight into Health in All Policies. For example, to design labour market policies with the intention of bringing about positive health outcomes might blur the main goal of the those policies which is for instance stable and safe work. Even though stable and safe work is already good for health in the first place. Policies need not administratively be connected to the health domain to improve health. Instead, health could be used as an argument to invest in social policies (chapter two). It is the duty of health scholars, welfare state scholars, and policy makers to find the right balance between acknowledging the health outcome whilst not medicalizing other societal issues.

Afterthought

One of the results of finishing this dissertation is not only the bundle of work in front of you. Throughout the process one develops their own view of science and their own sense of the type of scholar they are or want to be. For me, research is not only about the search for knowledge, it is also about societal improvement. A former colleague told me that she saw her dissertation not as a stepping stone in academia, but as a stepping stone to practice and using her knowledge to improve that practice.[18] Throughout writing this thesis I have first worked with and then for the Council for Public Health and Society (Raad voor Volksgezondheid en Samenleving, RVS) and it has been a great privilege to see the research that I have done come to life in amongst others the book 'Faces of Precarity' (Gezichten van een onzeker bestaan) and to see the impact it has had in the Dutch policy arena.

What social science is and should aim for then, is described by Gross (2009: 376), in a more succinct way than I could have written: "*Sociology can then mark its progress by whether, for any social outcome of interest to us, we are able to identify reasonably well the often hidden social mechanisms responsible for it; gain some insight into how those mechanisms, or related ones, might play out under different circumstances; and, as a result, intervene effectively to bring society into greater conformity with our values and ideals.*" Research takes place according to standards of scientific method and integrity. What comes next is to make sure the effort was not in vain.

18 I thank Willemijn van der Zwaard for sharing this thought with me.