Health, disadvantage, and the welfare state

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Summary

In this dissertation, I study *how the organization of the welfare state shapes health outcomes of socio-economically disadvantaged people*. This is relevant, because people from the lowest income group live 8 years less long in general, and 21 years less long in good health, compared to people from the highest income group in the Netherlands. But the Netherlands is no exception. Socio-economic inequalities in health are highest in countries with a well-developed welfare state, like the Scandinavian countries. In the literature, this is referred to as the paradox of health inequality. That is why in this dissertation I analyse how such a well-developed welfare state shapes the health outcomes of this particular, disadvantaged, group. Does the welfare state promote the decrease of socio-economic health inequalities or does it increase them?

I divided the main research question into four subquestions. To answer the first – theoretical – subquestion, I bridge the two scholarly disciplines that form the foundation of this dissertation: welfare state scholarship on the one hand, and social epidemiology and social medicine on the other. In **chapter 2** I show what these disciplines can learn from each other: welfare state scholars could learn from the rich insights of the Social Determinants of Health framework to study health not only as outcome of healthcare policies, but of policies in all sectors of the welfare state. Social epidemiologists and social medicine scholars could learn from welfare state scholars how institutions shape societal – including health – outcomes.

In the following three empirical chapters, I peel off analytical layers starting from the micro- working to the meso- and macro-level.

In **chapter 3,** I study how socio-economic problems and health problems relate to each other in the lives of disadvantaged people in the context of the welfare state. For this study, I used the Biographic-Narrative-Interpretive Method. This interview method involves asking a single biographical question, followed by follow-up questions to elicit detailed life stories. Fifteen respondents were interviewed using this approach. The main findings of this chapter show that the life trajectories of disadvantaged people are very complex, as the socio-economic and health problems within these lives twist and turn, instead of developing in a linear way. Health problems cause socio-economic problems, and vice versa. At times, these issues escalate rapidly, while at other times they persist at a steady level for years. External factors, moreover, play a crucial role—whether as sources of misfortune or as avenues of support.

In **chapter 4,** I analyse perceptions of middle managers of welfare state organizations on the services they deliver to the recipient group of disadvantaged people with both socio-economic and health outcomes. For this study, I used a vignette interview method to interview twenty-five middle managers. Vignettes are small texts, in this case short summaries of the life stories that I collected in the previous interview study. I asked the middle managers to reflect on how their organizations would

work in these particular stories. Middle managers perceive a gap between policy goals and the practice of the services they deliver. The way that they articulate their ambiguous work in this gap indicates that the responsibility for bridging this gap is placed at the individual – either the professional working with the recipient, or the recipients themselves – and that there is a blind spot for structural changes in policy and systems that are necessary to adequately help this disadvantaged group.

In **chapter 5,** I move to the macro-level, studying the factors shaping the adoption of Health in All Policies (HiAP) in the Netherlands. HiAP is a collaborative policy approach advocating to include health considerations in all policy sectors. I studied both primary sources – mainly policy documents and reports – and secondary sources and compare the adoption process in the Netherlands to existing analyses of the adoption of HiAP in Finland and England. Both are well-known cases on which most of existing theoretical explanations of HiAP adoption are based, for this study they function as shadow cases. The findings show that policy learning is necessary but not sufficient for HiAP adoption. The political salience of health inequality was the key factor driving HiAP adoption in the Netherlands and played this decisive yet less visible role in the shadow cases as well.

Based on this thesis, I formulate three main concluding messages. First, *a holistic view on health entails a holistic view on the welfare state.* Not only the healthcare sector, but all domains of the welfare state, such as unemployment benefits or social support, are related to health outcomes. Second, *redistribution occurs also through service delivery, making it essential to ensure services are accessible to disadvantaged groups.* The organization of the welfare state makes a difference in how means are distributed across different groups of recipients. Health inequalities are an outcome of the political choices in the process of welfare state organization design, and not just an implementation flaw. Finally, *the individual's health stems from broader social determinants, but this does not necessitate medicalizing social policies to improve health.* Policies need not administratively be connected to the health policy domain to improve health. But health could be used as an argument to prioritize investment in social policies instead.

These findings raise the question if the (current) welfare state is capable of preventing or pivoting the complex twists and turns of socio-economic and health problems in the lives of disadvantaged people. The practical implication for policy-making is that, rather than customizing policies and services for this recipient group, universal policies that prioritize accessibility would benefit this group more and ultimately, hopefully, ameliorate health inequalities.