Social policy and health

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Today

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- Defining the welfare state.

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- Defining institutions.

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- Identifying institutional mechanisms.

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- Identifying institutional mechanisms.
- Empirical examples from across the world.

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- More broadly: the institutional processes by which governments and people make, remake, or unmake human well-being (Dean, 2019).

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- Models of distinct "welfare state regimes" (more below).
- The welfare state as an institutional arrangement that distributes health (Beckfield et al., 2015).

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- Main idea: welfare states can be classified on the basis of the extent to which they decommodify human welfare via the political treatment of social inequality and the private-public mix of welfare provision.
- Threefold classification (Esping-Andersen, 1990): Liberal (e.g., UK, USA), Conservative (e.g., France, Germany), and Social Democratic (Scandinavia).

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4. Imbrication: combine multiple policy exposures and channel their overlapping effects to variable parts of the population (e.g., overall welfare regime with distinct configuration of housing, education, insurance, poverty, and healthcare policies).

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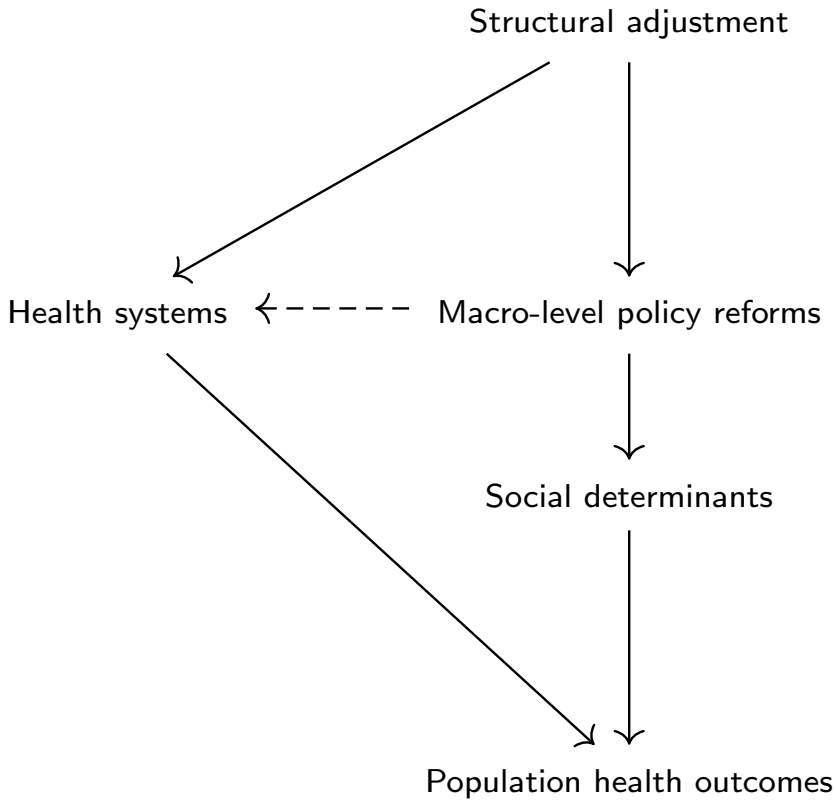
- Direct causal pathways (policies affecting health systems) and indirect pathways (via social determinants of health).

From structural adjustment to population health



Based on Kentikelenis (2017).

Example: structural adjustment and the Ebola crisis.

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The International Monetary Fund and the Ebola outbreak

Alexander Kentikelenis • Lawrence King • Martin McKee • David Stuckler

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Example: the US mortality disadvantage.

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Shorter lives in stingier states: Social policy shortcomings help explain the US mortality disadvantage

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ABSTRACT

The United States has a mortality disadvantage relative to its political and economic peer group of other *rich democracies*. Recently it has been suggested that there could be a role for social policy in explaining this disadvantage. In this paper, we test this "social policy hypothesis" by presenting a time-series cross-section analysis from 1970 to 2010 of the association between welfare state generosity (for unemployment insurance, sickness benefits, and pensions) and life expectancy, for the US and 17 other high-income countries. Fixed-effects estimation with autocorrelation-corrected standard errors (robust to unmeasured between-country differences and serial autocorrelation of repeated measures) found strong associations between welfare generosity and life expectancy. A unit increase in overall welfare generosity yields a 0.17 year increase in life expectancy at birth ($p < 0.001$), and a 0.07 year increase in life expectancy at age 65 ($p < 0.001$). The strongest effects of the welfare state are in the domain of pension benefits ($b = 0.439$ for life expectancy at birth, $p < 0.001$; $b = 0.199$ for life expectancy at age 65, $p < 0.001$). Models that lag the measures of social policy by ten years produce similar results, suggesting that the results are not driven by endogeneity bias. There is evidence that the US mortality disadvantage is, in part, a welfare-state disadvantage. We estimate that life expectancy in the US would be approximately 3.77 years longer, if it had just the average social policy generosity of the other 17 OECD nations.

See also Szreter, Simon. 2020. The Capacity to Surprise: On the Importance of History for Public Health Policy. *American Journal of Public Health*. 110(3): 337–338.

Example: institutionalised racism and infant mortality.

The Unique Impact of Abolition of Jim Crow Laws on Reducing Inequities in Infant Death Rates and Implications for Choice of Comparison Groups in Analyzing Societal Determinants of Health

Nancy Krieger, PhD, Jarvis T. Chen, ScD, Brent Coull, PhD, Pamela D. Waterman, MPH, and Jason Beckfield, PhD

Objectives. We explored associations between the abolition of Jim Crow laws (i.e., state laws legalizing racial discrimination overturned by the 1964 US Civil Rights Act) and birth cohort trends in infant death rates.

Methods. We analyzed 1959 to 2006 US Black and White infant death rates within and across sets of states (polities) with and without Jim Crow laws.

Results. Between 1965 and 1969, a unique convergence of Black infant death rates occurred across polities; in 1960 to 1964, the Black infant death rate was 1.19 times higher (95% confidence interval [CI] = 1.18, 1.20) in the Jim Crow polity than in the non–Jim Crow polity, whereas in 1970 to 1974 the rate ratio shrank to and remained at approximately 1 (with the 95% CI including 1) until 2000, when it rose to 1.10 (95% CI = 1.08, 1.12). No such convergence occurred for Black–White differences in infant death rates or for White infants.

Conclusions. Our results suggest that abolition of Jim Crow laws affected US Black infant death rates and that valid analysis of societal determinants of health requires appropriate comparison groups. (*Am J Public Health.* 2013;103: 2234–2244. doi:10.2105/AJPH.2013.301350)

Surprisingly little research has quantified the health impact of the abolition of Jim Crow legislation, that is, state laws legalizing racial discrimination overturned by the 1964 US Civil Rights Act (78 Stat 241).[1–6] The 4 extant empirical population-based investigations, however, provide suggestive evidence of improvements in health among Black Americans and decreases in health inequities between Blacks and Whites.[7–10] Far from a matter of historical interest only, the contemporary significance of whether abolition of Jim Crow laws had any health impact is both substantive and methodological.

At issue is understanding not only determi-

Example: privatisation and the Russian mortality crisis.

Mass privatisation and the post-communist mortality crisis: a cross-national analysis

David Stuckler, Lawrence King, Martin McKee

Summary

Background During the early-1990s, adult mortality rates rose in most post-communist European countries. Substantial differences across countries and over time remain unexplained. Although previous studies have suggested that the pace of economic transition was a key driver of increased mortality rates, to our knowledge no study has empirically assessed the role of specific components of transition policies. We investigated whether mass privatisation can account for differences in adult mortality rates in such countries.

Methods We used multivariate longitudinal regression to analyse age-standardised mortality rates in working-age men (15–59 years) in post-communist countries of eastern Europe and the former Soviet Union from 1989 to 2002. We defined mass privatisation programmes as transferring at least 25% of large state-owned enterprises to the private sector within 2 years with the use of vouchers and give-aways to firm insiders. To isolate the effect of mass privatisation, we used models to control for price and trade liberalisation, income change, initial country conditions, structural predispositions to higher mortality, and other potential confounders.

Findings Mass privatisation programmes were associated with an increase in short-term adult male mortality rates of 12·8% (95% CI 7·9–17·7; p<0·0001), with similar results for the alternative privatisation indices from the European Bank for Reconstruction and Development (7·8% [95% CI 2·8–13·0]). One mediating factor could be male unemployment rates, which were increased substantially by mass privatisation (56·3% [28·3–84·3]; p<0·0001). Each 1% increase in the percentage of population who were members of at least one social organisation decreased the association of privatisation with mortality by 0·27%; when more than 45% of a population was a member of at least one social organisation, privatisation was no longer significantly associated with increased mortality rates (3·4% [95% CI –5·4 to 12·3]; p=0·44).

Interpretation Rapid mass privatisation as an economic transition strategy was a crucial determinant of differences in adult mortality trends in post-communist countries; the effect of privatisation was reduced if social capital was high. These findings might be relevant to other countries in which similar policies are being considered.

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Example: austerity and mental illness in the UK.

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Original Contribution

Reductions in the United Kingdom's Government Housing Benefit and Symptoms of Depression in Low-Income Households

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Housing security is an important determinant of mental ill health. We used a quasinatural experiment to evaluate this association, comparing the prevalence of mental ill health in the United Kingdom before and after the government's April 2011 reduction in financial support for low-income persons who rent private-sector housing (mean reduction of approximately £1,220 ($2,315) per year). Data came from the United Kingdom's Annual Population Survey, a repeated quarterly cross-sectional survey. We focused our analysis on renters in the private sector, disaggregating data between an intervention group receiving the government's Housing Benefit ($n = 36,859$) and a control group not receiving the Housing Benefit ($n = 142,205$). The main outcome was a binary measure of self-reported mental health problems. After controlling for preexisting time trends, we observed that between April 2011 and March 2013, the prevalence of depressive symptoms among private renters receiving the Housing Benefit increased by 1.8 percentage points (95% confidence interval: 1.0, 2.7) compared with those not receiving the Housing Benefit. Our models estimated that approximately 26,000 (95% confidence interval: 14,000, 38,000) people newly experienced depressive symptoms in association with the cuts to the Housing Benefit. We conclude that reducing housing support to low-income persons in the private rental sector increased the prevalence of depressive symptoms in the United Kingdom.

Who makes the rules? Examples from the United States.

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- Economic elites and organised groups representing business interests have substantial independent impacts on US government policy, while average citizens and mass-based interest groups have little or no independent influence. When income groups differ in their policy preferences, lower income groups have zero chance of winning. (Gilens and Page, 2014.)

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- Institutional arrangements can shape health directly (e.g., by designing healthcare systems) and (most often) indirectly by acting on various social determinants of health.
- The study of social power is part and parcel of studying population health.

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3. What are the mechanisms or pathways leading from an "upstream" policy decision to individual health?