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Health inequalities and welfare state regimes. A research note

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Abstract

Aim: Comparative research on health and health inequalities has recently begun implementing a welfare regime perspective. The aim of the study was to review the existing evidence for identifying the determinants of health and health inequalities in highly developed welfare states and to develop a theoretical model for future research approaches.

Subject: A welfare state regime typology is applied to comparatively analyse a) the relationship between the level of economic prosperity in a society and its respective level of overall population health and b) the nature of the corresponding relationship between economic inequalities and health inequalities in different groups of countries.

Results: Although the Social Democratic welfare states have a relatively equal distribution of material wealth as well as the highest levels of population health, they are not characterised by the smallest levels of health inequality. Rather, with respect to health equality, conservative countries seem to perform better than social democracies. We propose a comprehensive theoretical model which takes into account different factors on the structural (macro), organisational (meso) and individual (micro) level in order to contribute to a better understanding of this important challenge for public health policy and practice.

Conclusion: Future research will require an appropriate theoretical model with the potential to explain health and health inequalities in different types of welfare states. On the basis of this model, future research should test the hypothesis that in highly developed countries not only economic, but also social, cultural, and life-style factors are important in determining health outcomes in different segments of the population.

Keywords

Welfare state, health inequalities, economic inequalities, social determinants of health, Scandinavian paradox, health sensitive public policy

Introduction

Social inequalities in health remain a strong and impressive issue on the scientific and policy agenda (Mackenbach 2006; Marmot and Wilkinson 2006; CSDH 2008). Although developed countries have achieved unprecedented levels of wealth, social inequalities continue to have a profound influence on health and longevity. In the past decades, several cross-national studies have shown that health inequalities exist not only between socioeconomic groups within a society, but also across societies themselves. Simultaneously, there exists a growing body of evidence that structural determinants such as political and economic factors are strongly associated with health and health inequalities at population level (Chung and Muntaner 2007; Eikemo et al. 2008a, b, c; Navarro and Muntaner 2004; Navarro et al. 2003; Navarro and Shi 2001). These finding show that the Social Democratic, Scandinavian countries rank better than their developed country peers on various population health measures (Navarro et al. 2006; Borrell et al. 2007). In contrast, the Anglo-Saxon countries – Great Britain, USA, Australia and New Zealand – with their relatively high level of average income but large income inequalities have relatively poorer levels of average population health. The central European countries of Austria, Germany, the Netherlands, France, Switzerland and Italy rank in the middle on both measures (Chung and Muntaner 2007; Coburn 2000; Conley and Springer 2001).

Several authors have concluded that these cross-country differences could be caused by public policy traditions with an established profile of strategies (Borrell et al. 2007; Navarro 2002; Navarro et al. 2006; Navarro and Shi 2001). In particular, the welfare typology framework has been applied to the field of public health and health policy research as an attempt to identify links between policy strategies and health (Chung and Muntaner 2007; Coburn 2004; Dahl et al. 2007; Ross et al. 2000). Several studies underscore the fact that population health differs substantially across welfare state regimes (Bambra in progress; Chung and Muntaner 2007 ; Coburn 2004; Dahl et al. 2006; Eikemo et al. 2008a, b, c; Dahl et al. 2006; Navarro 2002; Navarro and Shi 2001; Navarro et al. 2003). These findings suggest that in addition to other important determinants of health, political systems must also be considered.

Recently a welfare state regime perspective has also been introduced to the analyses of cross-national differences in the magnitude of social inequalities in health (Bambra in progress; Eikemo and Bambra 2008). Interestingly, almost all studies have shown that the Social Democratic welfare states do not have the smallest health inequalities, although they show the highest level of overall population health. In general, the conservative, central European countries perform better and are characterised by the smallest inequalities in health. The Anglo-Saxon countries, however, still hold the last position. This unexpected ranking represents an important challenge for public health (Bambra in progress; Dahl et al. 2006; Lahelma and Lundberg 2009). It is already been troubling to explain how education and income find their way into the human body. But figuring out how the welfare state gets under our skin is an even stronger theoretical and empirical challenge. The aim of the present paper is to trace and reconcile some of the growing evidence on the relationship between welfare state regime, health and health inequalities and suggest directions for future research.

The welfare regime perspective: an emerging topic in public health

The welfare state has been a subject of academic interest for several years and across a range of disciplines (Esping-Andersen 1990, 1999; Titmuss 1974). Researchers have suggested various classifications which categorize the provision of welfare into different 'regime types' (Bambra 2005, 2006; Eikemo and Bambra 2008). Esping-Andersen is among the early pioneers of comparative analyses of welfare state policies and introduced the term "welfare state regime" to denote the institutional arrangements, rules and understandings that guide and shape social policy. Although Esping-Andersen's 'three worlds of welfare' typology has been criticized by many scholars (Arts and Gelissen 2002; Bambra, 2005, 2006; Castles and Mitchel 1993; Ferrera 1996), it still is highly influential and continues to stimulate academic discourse and shape research in various disciplines.

Identifying three regime types

Esping-Andersen`s (1990) typology is based on an analysis of three dimensions of welfare. First, social rights as measured by a “decommodification index” that captures the extent and generosity of key social security programmes (pensions, health and unemployment insurance, etc.); second, the social stratification effects of welfare; and third, the public-private family welfare mix in the delivery of individual welfare services. The term “welfare state regime” was introduced to denote the institutional arrangements, rules and understandings that guide and shape social policy. Using historical analysis, Esping-Andersen distinguishes three welfare state prototypes: “liberal”, “conservative” and “social democratic” welfare state regimes (figure 1).

-----Table 1 about here-----

According to his typology, Liberal welfare state regimes (e.g. UK, USA, Ireland and Canada) are characterized by a strong emphasis on market-based mechanisms to support the needy – where recipients of welfare provision are usually means-tested and stigmatised. In the Conservative regime type (e.g. Germany, France, Austria, Belgium, Italy and, to a lesser extent, the Netherlands), reliance on work-based insurance contributions results in status-dependant welfare benefits. This reflects a hierarchical social order with differing “decommodification” effects. The Social Democratic welfare regime (including the Scandanavian countries of Norway, Sweden, Denmark and Finland) displays the highest amount of relative social transfers. Under this regime type, social policy targets the entire organisation of the societal infrastructure and all individuals within it.

This typology strongly emphasizes that each of the three different welfare state regimes are deeply anchored in their respective political histories, which in turn are strongly associated with specific political traditions, each based on a different philosophy regarding the relationship between society and the individual. Navarro et al. (2006) demonstrate that the three regimes can be characterised by different policies. The programmes of social-democratic parties prove to be specifically oriented towards policies of distributive equality. According to their schemes,

the resources that are important for securing quality of life should be distributed as equally as possible among different population groups. Conservative parties, however, emphasise policies of distributional equality much less. Instead, they focus on securing the traditional provision and care structures of families and family-like social networks, associations and organisations. Liberal parties, as counterpoint, assume that citizens' financial endowments and material resources are linked directly to their productive capacity and their readiness to take part in gainful employment. It follows, then, that the liberal government's implicit role in guaranteeing the health quality of their citizenry is limited to those members of the society who are unable to work: the sick, the poor and the physically and mentally disadvantaged.

Navarro et al.'s study also shows that the political traditions and ideologies of parties governing over long time periods on a stable power basis affect crucial indicators of population health. Thus, policies explicitly aimed at reducing social and economic inequalities, such as welfare state and active labour market policies, have a salutary effect on health indicators like infant mortality and life expectancy at birth. "Cumulative years of pro-redistributive governance were statistically correlated with policies promoting full employment, highly regarded labour markets, and public health expenditure, as well as universal health and generous social benefits coverage" (Navarro et al. 2006, 1036). The social democratic parties in the Scandinavian countries, for example, have historically been committed to redistributive policies. They provide universal health care coverage and social benefits to all citizens, are characterised by a high rate of public health care expenditure, a high proportion of adult labor force participation for men and women, and generous social transfers and services, including family-oriented services such as paid maternal leave, early child education and home care services for the elderly.

Welfare regimes, economic inequality and health

Many other studies have shown that population health differs substantially across welfare state regimes (Chung and Muntaner 2007; Eikemo et al. 2008a, b, c). Most of these studies focus on mortality (especially infant mortality), life expectancy and low birth weight. In almost all analyses, social democratic countries rank higher on various population health indicators than the

other regimes, especially those characterized as being liberal. These findings have been consistent for different welfare regime typologies – irrespective of whether they are based on Esping-Andersen's ideal type classification or following the Navarro et al. (2006) tradition on typologies of political traditions (for example Borrell et al. 2007). Other empirical analyses focusing on the connection between economic welfare, income inequality, and health status also support these results (Coburn 2000, 2004, 2006; Chung and Muntaner 2007).

Although Esping-Andersen's classification was not developed specifically for the analysis of health and health inequality, it is useful for a better understanding of their interrelation, as it also calls attention to the differences that exist across different types of welfare states in their endeavours to deal with economic inequality. In his analyses of the 1980s, Esping-Andersen (1990, 1999) comes to the conclusion that the Scandinavian ("social-democratic") model of realising a welfare state leads to a relatively higher degree of economic equality than the two other models. These findings have been subsequently confirmed on the basis of newer empirical data (Dahl et al. 2006; Fritzell and Lundberg 2005; Raphael, Bryant and Rioux 2006). The Anglo-Saxon states, with their "liberal" conception of welfare policy, exhibit the greatest economic inequalities within their populations while the central European "conservative" states rank in the middle (Coburn 2000, 2004).

Although they do not follow a distinct welfare regime perspective, Wilkinson and Pickett (2009) provide further evidence for a strong relationship between population health and determinants associated with welfare regimes. They clearly demonstrate that the Anglo-Saxon countries show the highest levels of economic inequality of any of the developed OECD countries. These inequalities are significantly associated with a wide range of negative health outcomes such as lower life expectancy, a higher prevalence of mental health problems, drug use with the risk of addiction, obesity, teenage pregnancy and violent experiences which end in death among young people. On all of these counts, the Scandinavian countries do considerably better while the central European countries rank in the middle. Several other analyses support these results and show a clear relationship between economic inequalities and overall levels of population

health (Bambra 2005; Coburn 2006; Muntaner et al. 2002, 2006; Navarro and Muntaner 2004; Navarro and Shi 2001; Ross et al. 2000).

On the basis of their empirical analysis, Navarro et al. (2006) develop a heuristic model of the relationship between politics, labour market and welfare state policies, economic inequality and health outcomes (figure 1).

-----Figure 1 about here-----

This model differentiates between a macro level of political traditions, power structures, and social and welfare policy features, a meso level of life conditions and economic inequality, and a micro level of individual health outcomes. The model gives much credit to politics and policy's institutional relations with society and the market, and links health directly to economic inequality. As such, it is an important tool for structuring the research results reviewed. The model, however, suggests a direct interplay between economic inequality and health outcomes and does not attempt to introduce intervening variables. We think it would be helpful to develop a more comprehensive theoretical model that takes additional factors into account, particularly given the fact that recent research has shown that the picture is more complex.

Welfare regimes and health inequalities: The "Scandinavian Welfare Paradox of Health"

Given the studies reviewed thus far, one might assume that economic inequalities would have an impact on health inequalities and, as a corollary, that the divide between the health status of the richest and poorest groups would be narrowest in the Scandinavian states and widest in the liberal welfare states. An early research review of Mackenbach et al. (1997), however, offers some of the earliest counter-intuitive empirical evidence. This evidence was rarely discussed until subsequent, recent studies confirmed the surprising result that although Scandinavian countries have relatively low levels of economic inequality, they do not have commensurately low levels of health inequality (Dahl et al. 2006; Lahelma and Lundberg 2009). Huits and Eikemo (2009), for example, find that the Nordic countries perform only intermediately relative to

other highly developed European countries when relative inequalities in health are considered. According to these studies, some of which go beyond the three welfare regimes mentioned to include “Latin Rim/Southern” (e.g. Spain, Portugal, Greece) and “East European” (e.g. Poland, The Czech Republic) countries, the countries in the conservative group (e.g. Germany, France, Italy) show the lowest socioeconomic differences in both mortality rates and self-reported and other measures of health (Bambra 2007).

These studies make it clear that, although economic inequalities are reflected in overall population health, their relationship with health inequalities is more complex (Eikemo et al. 2008a). The conservative states, with their moderate level of economic inequality, are those that achieve the lowest level of health inequalities. The greatest inequalities are found in the liberal welfare states, while only average levels of health inequality are observed within the Social Democratic regime (Eikemo 2008a, b; Espelt et al. 2008; Mackenbach et al. 2002).

How can these surprising results of the “Scandinavian Welfare Paradox of Health” be explained? Wilkinson and Pickett (2009) elaborate on the limited effect of economic growth on the improvement of the health of a population. They emphasise the importance of differentiating between the average level of population health and differences in health levels across socioeconomic groups (Wilkinson 1996, 2005). According to the analysis, if the most important material demands of the population in developed countries are fulfilled – i.e. access to good-quality shelter, clean water, sanitation, and a nutritious diet – the quality of health has reached a saturation level. “As living standards rise and countries get richer and richer, the relationship between economic growth and life expectancy weakens. Eventually it disappears entirely and the rising curve … becomes horizontal – showing that for rich countries to get richer adds nothing further to their life expectancy” (Wikinson and Pickett 2009, 6).

Several studies confirm the phenomenon described above. Further increases in wealth, whether in the form of income or assets, only have a very limited effect on the health of a country’s population. Higher national income (as measured by GDP per capita) is generally associated with

higher life expectancy at birth, although the relationship is less pronounced at higher levels of national income (OECD 2009, 16). Above a certain threshold, gains in life expectancy are not related to higher levels of average income (Lynch and Kaplan 1997, 299). As figure 2 illustrates, there are also notable differences in life expectancy between OECD countries with similar levels of per capita income: Japan and Spain have higher life expectancies and the United States, Denmark and Hungary have lower life expectancies than their GDP per capita alone would predict (OECD 2009, 16). A similar picture emerges when one looks at health expenditures per capita across OECD countries. Thus, other factors, beyond national income and total health spending must affect variations in life expectancy as well as health inequalities across countries.

-----Figure 2 about here-----

It is almost exclusively already-privileged population groups that profit from increases in wealth; the health of disadvantaged groups is barely affected. If large subgroups of the population have only limited access to additional economic resources, their quality of life and their health status does not improve significantly (Bartley 2004; Borrell et al. 2007; Lynch et al. 2000; Raphael 2006; Scambler 2002) – even when per capita levels are increasing.

A comprehensive theoretical model for future research

The research reviewed demonstrates that, while there is strong association between welfare state regimes and health, there is no clear evidence of the interconnectedness of specific policy strategies or mixtures of policies and health inequality. Thus there is a need for a comprehensive theoretical model that takes into account the bothersome findings described above. The model by Navarro et al. (2006) is a very good starting point, but it implicitly forces a linear model on the relationship between economic conditions and the overall health status of the population and does not include determinants of individuals health and health inequalities within a popula-

tion. In particular, existing models cannot explain why in the Scandinavian countries the "social democratic" regime that ensures a relatively high level of economic and social equality does not directly translate into health equality.

If governments and welfare states want to improve the health status of their population and reduce health inequalities between segments of the population, they need a convincing model of the interdependence of policy strategies and health outcomes. The welfare state typology of Esping-Andersen only includes distal variables on a high level of aggregation. The typology does not contain proximal variables, which might explain the pathways leading from welfare policy traditions to health. The Navarro model thus represents the first step in extending the typology and introducing the translation of policy traditions into (social, labour and health) politics. It is restricting, however, in that only economic factors can determine health outcomes. Inspired by these approaches, we suggest a theoretical model which overcomes these restrictions (figure 3).

The model combines factors on the structural (macro), organisational (meso) and individual (micro) level. On the macro level, the model contains structural variables describing the welfare state architecture; on the meso level, it takes into account variables describing the life conditions of the population; on the micro level, it includes variables describing the health status of individuals and groups of the population. As "intermediate" factors, a group of variables is included in the model, which expresses a combination of health policy and public policy. These intermediate factors are interrelated with variables on the macro, meso, and micro levels:

-----Figure 3 about here-----

1. Continuing with the notion of welfare state typologies, our framework takes the *"Architecture of Welfare Policy"* as an important independent structural factor. The organisation of the societal infrastructure is mainly characterised by policy decisions related to the extent of market power and dominance, civil vs. state networks, the acceptance of egalitarianism in civil and human

rights, and the degree of generosity of social security benefits for unemployment, sickness and old age – the so-called "level of decommodification" in the Esping-Andersen terminology. These structural determinants can be clustered into types of welfare state regimes, as we have seen. The factor "Architecture of Welfare Policy" subsumes both the historical determinants giving rise to a path dependence of policy strategies, as well as the variety of institutional arrangements and political values implied by each welfare state type. The individual architecture of welfare policy thus constraints which distinct institutional factors are imposed on both public and private as well as collective and individual actors and determine the resulting consequences for state-society relations.

2. The specific architecture of welfare policy directly impacts the *"Conditions of Life of the Population"*. We consider this at the meso level in our model, constituting the main link between the structural and the individual variables. The quality of life conditions is first described by the level of economic equality in terms of income and wealth, the level of employment of all age groups and of the relative poverty of the whole population. Additional indicators – and here we extend the Navarro et al. model – are the levels and availability of educational and occupational training, the level of social integration and cohesion, the degree of political participation, trust in governmental agencies, availability of social networks, reliance on police and legal system, cultural integration of migrants, religious tolerance, criminality and antisocial behaviour, sense of control of social environment, availability of good food and water, and shelter from environmental contaminants.

3. The dependent variable in this framework is the *"Health Status of the Population"* as indicated by a) the quality of objective and subjective wellbeing, b) quality of health of disadvantaged groups and c) the difference in these measures between wealthy and poor segments of the population ("health inequality").

4. The model also includes a factor categorized as the *"Combination of Health and Public Policy"* as an intermediate entity. Policy variables are considered to have a direct and indirect in-

fluence on the dependent factor “Health Status of the Population”. Following the approaches of Esping-Andersen and Navarro et al., we consider the specific features of a) the general welfare state policy (“public policy”) and b) the specific nature of health care policy (“public health policy”) as well as the combination and overlay of the two (“intersectoral public policy”) as indirect influences. The type of welfare regime sets the stage for the specific features of health and public policy. The degree of “health sensitivity” of public policy influences health outcomes via two paths: First, indirectly, in influencing the overall living conditions of the population and, second, directly, by shaping the institutions and organizations which are responsible for health.

This comprehensive theoretical model takes the welfare state architecture as the starting point for a long chain of subsequent parameters and conditions. Together, they form a complex pattern of multi-dimensional determinants of health, including both the concrete living circumstances of the population as well as the format of public policy in infrastructure sectors such as economy, agriculture, labor, energy, environment and education and the fundaments of (public) health policy. Our model assumes neither a one-way path from policy to life conditions (including economic inequality and its relationship to health) nor from life conditions to health outcomes. Rather, our model proposes recursive, interdependent associations between the factors included and takes into account feedback loops between factors at the meso and the micro levels as well as between both these factors and intermediate policy variables.

Future research approaches

We suggest that future research approaches take conceptual and empirical proof of the proposed theoretical model as a starting point. The most important variable omitted from previous models seems to be the inclusion of non-economic factors in explanatory approaches. The literature reviewed above has emphasized the fact that in rich welfare states that have reached material saturation, non-material social factors are important determinants of whether or not poten-

tial health factors are incentivised in all groups of the population. Once material demands are satisfied, the social determinants of health appear to be determined independently of the economic determinants of health; when a country's domestic financial situation is relatively satisfying for its citizens, the subjective concept of being able to manage a meaningful life becomes increasingly important (Bonoli 1997; Castles and Mitchell 1993; Kovacs 2002; Mackenbach et al. 2002).

In our model, we try to take these interrelations into account by combining economic and non-economic variables under the heading "Life Conditions of the Population". We are convinced that alongside material determinants of health status, social, cultural, and psychological variables will gain in importance in future research. In rich countries, the availability of supporting social networks, the demand for experiencing a sense of control, occupying a productive social role involving public responsibility, and the feeling of self-efficacy are among the most influential determinants of individual health once material necessities are satisfied. We assume that the "Scandinavian Welfare Paradox" can only be explained if these determinants are taken into account. This presents the possibility that the "Social Democratic" societies – with a low degree of economic inequality – fail to provide the social infrastructure necessary for their disadvantaged populations to cope with everyday problems. The explanations for this phenomenon are likely multi-causal, with several potentially important factors:

Fading of primary social networks

The relatively egalitarian distribution of material and immaterial resources in the Scandinavian countries is facilitated to a large extent by universal and comprehensive social programmes with state responsibility. In this way, all relevant social obligations become increasingly communal, and no longer the responsibility of informal groups such as family and kinship systems, or the individuals themselves. As our review has shown, the type of welfare system in place determines whether the structural and cultural conditions for a thriving and pluralist civil society are present. If public social expenditures are accompanied by decreased responsibility and influence of private actors and informal corporate institutions, then the social system disincentivises and de-

valuates the social activities of closely-knit social networks and diminishes individual's perception that they can help themselves. In economic terms, this is tantamount to a "crowding out" of informal health institutions. As a consequence, health promoting strategies within the family, leisure and work settings may be neglected or deemphasised in the Social Democratic countries. In this respect, Conservative countries with their somewhat stronger reliance on informal social networks may have an advantage vis-a-vis the Scandinavian countries.

In Esping-Andersen's theoretical approach (Esping-Andersen 1999), the degree to which a society can depend on the government for financial support, and the degree of universality in the availability of social services for citizens are requisites for modern states. These features, however, do not necessarily strengthen the social fabric of a society, which, in turn, is important for ensuring self confidence as a basis for health development in all sub-groups. Even if the social welfare policy of a country does guarantee civil rights – and in particular the accessibility of arrangements for safeguarding against disease, unemployment and retirement – this does not necessarily affect the social determinants of health, which influence the capacity for self-regulation and self-efficacy.

In a similar line of argument, Hudson and Kühner (2009) raise doubts that, in times of economic globalisation, the Scandinavian, Social Democratic policy can successfully narrow the health gap between socioeconomic groups because it embodies a protective, socio-political approach. This type of welfare policy, they argue, discourages the creative and entrepreneurial potential of its citizens, which is a prerequisite for a thriving economically competitive country. Room (2002) also makes a case for redirecting welfare policy so that it strengthens the individual potential of citizens through investments in their own education and social competence in a knowledge-based service economy, as prevails today.

As it is the conservative states that rank better with respect to health inequalities, we consider this persistent fact as preliminary evidence for the significance of flexible, supportive social networks in welfare states. Central European countries have applied notably more intensive social

and health-sensitive infrastructure policies which emphasise the importance of networks – in particular as compared to the Scandinavian and liberal countries.

Thus the countries with a conservative welfare policy tradition seem to have found the best balance between overstressing and under-stressing public versus private responsibilities and obligations in this regard. The citizens of these countries rely on primary social networks for securing basic needs. Since the state only intervenes when these networks are overtaxed, these countries embody the idea of the “enabling welfare state”, which is interested in strengthening voluntary family, communal and interpersonal ties. This political framework assigns value to private obligations and strengthens the individual’s competences for self-organisation with respect to the demands of everyday life. This may have an impact on the health of every individual in that it stimulates self-support capabilities.

Neglecting individual determinants of health

Theoretical approaches to health underscore the importance of the social factors in determining health outcomes. The “salutogenesis” theory develops the concept of the individual’s “sense of coherence” as an expression of a positive state of self-regulation of physiological, psychological, cultural, social and ecological conditions of daily living (Antonovsky 1987). This theory focuses on one’s sense of self-worth and confidence with regard to one’s ability to take action and manage life’s internal and external challenges and considers these capabilities to be the essential prerequisite for health. “Self-responsible behaviour and self-regulation are regarded as essential factors in the development of a healthy personality. Thus, health-conscious and health-promoting lifestyles can only be expected when the prerequisites for such factors are available. Health is therefore both, a personal and a collective variable (Hurrelmann 1989, 5).

Cockerham (2005) seconds this approach with his “health lifestyle theory”. He stresses the structural dimensions of living conditions for the development of a healthy personal lifestyle and achieving high health status (Abel, Cockerham and Niemann 2000). “Social structures influence the thoughts, decisions, and actions of individuals” and influence their dispositions to act, lead-

ing to health promoting or to health detrimental practices (Cockerham 2005, 64). Socially disadvantaged groups develop a susceptibility to developmental challenges, and become vulnerable to various health risks. They exhibit a high level of cigarette and drug consumption and a low level of physical activity and weight control relative to their socially privileged counterparts. These risk factors, in turn, lead to cardiovascular diseases and psychosomatic complaints. The vulnerability of socially disadvantaged individuals can be attributed to weak social networks, which would normally provide them with the resources necessary to avoid health risks. Without external support from public and private networks and lacking internal coping mechanisms that stem from feelings of self confidence, stressful situations can induce health problems (Mechanic and Tanner 2007).

Epidemiological life course research and socialisation theory reveal the cumulative effects of material deprivation, low social integration and weak networks, combined with social isolation and minimal education (Blane, Netulevi and Stone 2007; Elder and Giele 2009; Kuh and Ben Shlomo 2005). As they age, disadvantaged children and adolescents are gradually pushed ever further away from the protective sphere of society and into outsider roles as various risk factors accumulate and fewer opportunities become available to them (Lynch and Davey Smith 2005). If social welfare policy in these societies does not strengthen individuals' self-management capacities, economical inequalities will increasingly translate into health inequalities.

Subtle discrimination of disadvantaged segments of the population

The degree to which this infrastructure policy is sensitive to the social determinants of health in all socioeconomic groups of the population also plays a decisive role. Advantaged groups seem to have the capacity to maintain autonomous and self-regulated life styles, because individuals feel valued in their contribution to society and economy. This, in turn, stimulates positive health behaviours which ultimately improves health. Disadvantaged groups – such as migrants, school dropouts and homeless people – in contrast, experience a loss of autonomy and have the impression that their contributions to society and the economy are of little real value. This discour-

ages investment in physiological and psychological health and instead gives way to detrimental behaviours that jeopardize individuals' health.

In the Scandinavian countries which are characterised by broad state coverage of social obligations, these differences between advantaged and disadvantaged groups appear more extreme than in the conservative countries. In the conservative countries, whose societies are organised around close social networks and primary institutions, the accessibility of common goods to the relatively impoverished segments of the population is relatively high. We theorize that these societies achieve a relatively low level of health inequalities because their disadvantaged subgroups feel better-integrated and supported through active political participation. In contrast, the Scandinavian welfare architecture does not foster feelings of self-worth among disadvantaged population groups, lowering the level of self-efficacy among the individual members of these groups.

If this holds, then it implies that the Scandinavian countries would benefit from a more health-sensitive infrastructure policy that promotes social and health empowerment for disadvantaged groups and individuals. While increasing the level of health in all socioeconomic groups, health improvement measures would be applied simultaneously to every level of society (Graham and Kelly 2004; Richter and Hurrelmann 2009). The comprehensive goal here is not only to narrow the gap in socioeconomic inequalities in health, but also to achieve health gains for individual population groups from an early age so that individuals do not begin their lives at a disadvantage. This kind of strategy would do more to target the actual causes of health inequalities, including those that stem from the inability of certain groups to achieve autonomy and self-control inherent in a social hierarchy.

The underlying problem is typical of rich countries: in societies with a "post-materialistic" mentality, certain commodities (education, nutrition, water, freely available time, prestige etc.) are considered essential for well-being. These conditions are visible and ostensibly "within reach" for any member of society. However, if these resources are not actually tangible for defined sec-

tions of the population, disadvantaged groups interpret this as a sign that they are being deprived of the wealth and resources available to all other members of the society. They feel purposefully excluded from the opportunities for social mobility and individual development that seem so easily accessible to large segments of the population. This phenomenon also inhibits the capacity of disadvantaged groups to feel valued and motivated to invest in subjective activities to maintain or improve their own health or that of others. As these groups loose self confidence and the competence for self management, they become more susceptible to engage in adverse health behaviours such as higher cigarette and alcohol consumption, poor diet, and reduced physical activities. The result is health deterioration of the economically disadvantaged population in comparison to more privileged groups, which have no reason to feel excluded from economic and social progress.

Conclusion

As discussed, theory still lacks a convincing explanation for the observed relationship between economic and health inequalities in developed countries. What is needed is an appropriate model with the potential to explain divergent health outcomes in different welfare states. Highly developed countries are facing new challenges in safeguarding the quality of health of all segments of their population. Moving forward, these countries will have to develop a modern version of “health sensitive public policy”, a brand of social policy which includes not only health care but labour policy, social security, social networking, education policy, unemployment insurance, etc. as constitutional elements of welfare policy. In this framework, fighting health inequalities becomes not only a matter of addressing the negative health consequences and unleashing the positive potential of other policy areas but also of fine tuning welfare state policies to effectively promote the health of vulnerable populations.

A modern health-sensitive public policy recognises that welfare and health policy follow historical traditions, fixed power structures and strong path dependencies which acknowledges the

need for pragmatic policy mixes. Looking at the three ideal regime types discussed above, each necessitates different prerequisites and starting points for policy implementation:

a) In the Social Democratic regime type, the state controls all health care and public health budgets. The resources needed for a health sensitive public policy can therefore be structurally activated without any change in the system. As discussed above, the welfare state policy mix of the Social Democratic type has produced the most egalitarian societies, but recent research presents disturbing evidence of persistent health inequalities nonetheless. To generalise broadly, this may suggest that while a high degree of universalism in the provision of welfare support has benefited the society as a whole, more differentiated policy mixes with regard to the social determinants of health may be needed to close the existing socioeconomic health gap. After all, an equal distribution of monetary flows resulting in a decommodified labour force does not seem to guarantee health equity. If further research undermines existing studies this would clearly indicate that achieving health equality is a task that goes beyond economic considerations. Moreover policy makers have to approach additional causes and determinants of inequality, such as living and working conditions. Should the conclusions above be confirmed, a policy recommendation to the Scandinavian countries would likely include measures to strengthen social network infrastructure in order to boost social determinants of health that grow and maintain the self-management capabilities of disadvantaged members of the population.

b) By contrast, in the Conservative regime type, financial and power structures are divided. The health insurance administration mostly based on the Bismarckian paradigm is responsible for the provision of health care on an individual level, and the state administers public health and prevention programs on a collective level. However, recent reforms blur these clear distinctions. This has reduced the focus of the system on the employment status that Esping-Andersen's ideal typology predicts. If the studies that find the lowest level of health inequality for this type of welfare regime are correct, then the general fear that such a scheme freezes social mobility might be misleading. Nevertheless, it is within reason to expect that focussing on securing and maintaining a certain living standard enjoyed by active members of workforce, while also pro-

tecting employment status will maintain existing socioeconomic differences in health. Thus, decision-makers must find the right policy mix between individual insurance against disease and other life challenges on the one hand and general health care provision to guarantee social penetration on the other.

c) In the Liberal regime type, the state only provides very low levels of health care services, whereas additional services are bought privately on the market (typically via privately purchased or employer-sponsored health insurance). As previously discussed, while it is still debated whether Social Democratic or Conservative welfare regimes perform better in terms of health inequalities, it seems fairly certain that the Liberal regime always performs the worst. Since public expenditures are paid out of tax revenues there are no structural barriers to implementing a more health sensitive public policy. Nevertheless, given the government's low capacity to support individuals in the context of powerful market actors, the effects of policy action are limited. Positive outcomes from an equality perspective would require a non-trivial rearranging of the power basis. When profit motives constitute more convincing incentive structures than the social value of health equality, it is difficult to see how a health-sensitive public policy regime can be implemented, especially when service provision is spread out over a broad range of actors.

Conflict of Interest

The authors declare that they do not have a conflict of interest.

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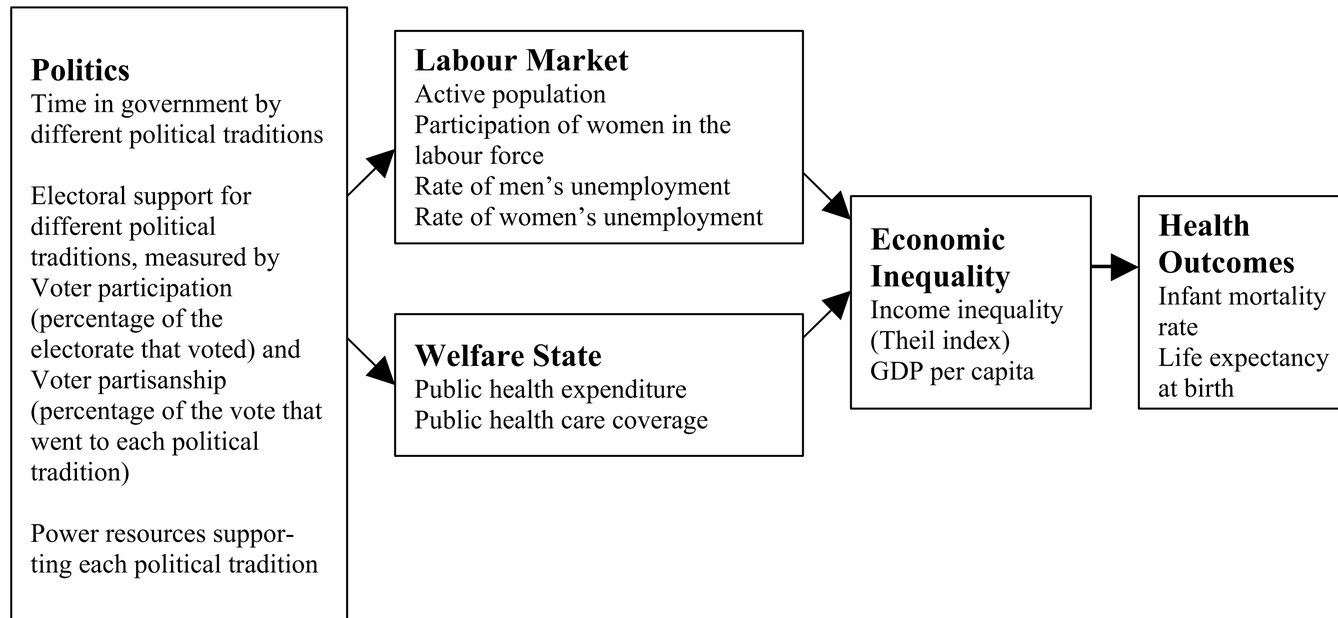
Table 1: Esping-Andersen's Welfare State Typology

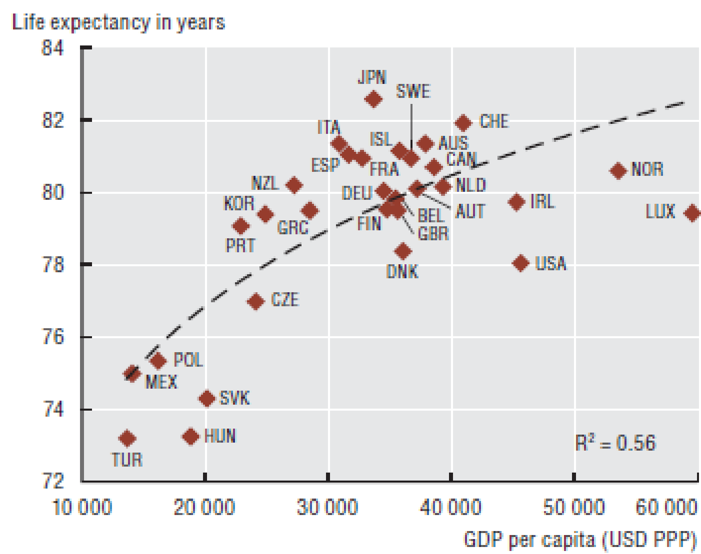
	Social Democratic	Conservative	Liberal
De-Commodification	Maximal	Medium	Minimal
Target Group	Entire Society	Working Population	Low Income House-holds
Transfers	Highest possible	Status-dependent	Modest
Rights based on	Universalism	Employment Status	Means-tests
State-Market Relation	Primary Focus on State	Market with State Support	Primary Focus on Market
Welfare Tradition	Beveridge	Bismarck	Beveridge
Real Types	Scandinavia	Continental Europe	Anglo Saxony

Figure 1: Relation between Politics, Economic Inequality and Health Indicators



Source: Navarro et al. 2006, 1036

Figure 2: Life expectancy at birth and gross domestic product (GDP) per capita



Source: OECD 2009, 17

Figure 3: Structural and Political Factors Influencing the Health Status of the Population