Ill health and the risk of poverty in Europe: Individuals and welfare institutions

INVEST

Merita Jokela & Maria Vaalavuo
The relationship between health and socioeconomic status has been well established in research. Poor health can lead to lower income, education, and occupational status – “social selection.” Low socioeconomic status can negatively impact health through e.g. stress and anxiety, unhealthy/hazardous living and working conditions, worse access to health care or poorer health behaviour – “social causation.” Both selection and causation are probably at work leading to health inequalities. Institutions and societal factors can affect the relationship and the mechanism behind it. Who are poor, who have poor self-assessed health and how these two are related vary from country to country.
The role of institutions

• Welfare state institutions and level of economic development are important determinants of population health as well as poverty.
• However, health inequalities seem to persist also in egalitarian countries.
• The poverty/health association might be affected by welfare state institutions through composition of the poor and depth of poverty (e.g. to what extent social problems are accumulated).
• Social security mitigates the income risks related to ill health in various degrees in Europe.
• Health care systems affect general population health and also access to health care by the poor.
Research questions

• Variation in poverty penalties: How does the association between ill health and risk of poverty vary between countries?
  • Note: objective is not to examine causal direction between the two

• Has the association changed over time (2008-18)?

• Does welfare generosity moderate the association between poverty and ill health?

• Do the results change when we look at material deprivation instead of monetary poverty?
Research framework

Material deprivation, unmet needs, poverty gap

Poor

Socio-demographic factors (age, gender, family status and ethnicity)

Socio-economic factors (labour market status and education)

Social expenditure / social protection

Health care spending

GDP per capita

Ill health

Other institutional and cultural factors
Data and methods

- Cross-sectional EU-SILC data, 2008-2018 for 26 countries
- Working-age individuals 20-46 years old (n=2,661,634)
- **Outcome variable poverty** (dummy poor)
  - Poverty threshold 60% of country’s median equivalised disposable income
  - Material deprivation: identifies individuals who cannot afford at least three of the following nine items: 1) to pay their rent, mortgage or utility bills; 2) to keep their home adequately warm; 3) to face unexpected expenses; 4) to eat meat or proteins regularly; 5) to go on holiday; 6) a television set; 7) a washing machine; 8) a car; 8) a telephone.
- **Independent variable ill health** (dummy self-rated health)
- Control variables age, gender, education, migrant status, employment status, household type
- Logistic regression models and multilevel models
Proportion (%) of people with self-rated ill health by country in 2017/2018
Poverty penalties associated with poor self-rated health status
Poverty risk by self-rated health and health care expenditure

![Bar chart showing poverty risk by health and health care expenditure across different quartiles. The x-axis represents different quartiles: Lowest quartile, 2, 3, and Highest quartile. The y-axis represents the percentage of poverty risk. The chart shows a comparison between good health and ill health.]
Conclusions

• In all countries, individuals with ill health face a poverty penalty
• Penalty differences are surprisingly small when various individual factors are controlled for
• Differences between countries are bigger when material deprivation is analysed; in Nordic welfare states the penalty is the highest
• This “Nordic deprivation paradox” could reflect accumulation of social problems; material deprivation in these countries is something else than just lack of income