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Neoliberalism and the recommodification of health inequalities: a case study of the Swedish welfare state

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Abstract

Aims: This paper examines the effects of neoliberalism on health inequalities through an empirical examination of the recommodification of the social determinants of health - unemployment, healthcare, and pensions in Sweden.

Methods: Using time series data from the repeat cross-sectional Swedish Living Conditions Survey, it examines: (1) the effects of reductions in the replacement rate value of unemployment benefit on inequalities in self-reported general health between the employed and unemployed; (2) the effects of reductions in the replacement rate value of pensions on educational inequalities in self-reported general health amongst pensioners; and (3) the increase in user charges on inequalities in having visited a doctor in the past 3 months by educational level.

Results: The results suggest mixed effects of welfare state recommodification on health inequalities: inequalities increased between the Swedish employed and unemployed; yet they did not increase in the retired population; and inequalities in access to healthcare also remained steady during the study period.

Conclusions: The association between recommodification and health inequalities in Sweden is stronger regarding unemployment benefits than pensions or healthcare and that this may relate to the stigmatisation of the unemployed as well as the relatively higher levels of recommodification experienced in this domain.

Key words: social policy, health policy, social determinants of health, unemployment, access to healthcare, pensions

Word count 200

INTRODUCTION

There has been a surge of research into the effects of welfare states on public health and health inequalities¹. A sizeable amount of this has examined the relationship between different types of welfare state (welfare state regime) and population health outcomes. These studies consistently found that population health outcomes (most consistently in terms of infant mortality rates) are enhanced by the Scandinavian welfare state regime which offers universalism, comparatively generous replacement rates, and extensive welfare services¹. However, in terms of health inequalities the findings are less clear and the Nordic welfare states do not appear to have the smallest health inequalities - leading to the so-called 'Nordic public health puzzle'². Subsequently, there has been much debate and various explanations have been put forward to explain this puzzle including artefact³, health behaviours^{4,5}, relative deprivation^{6,7} and occupational risks⁵ (for an overview see Bambra, 2011²). This has also resulted in criticisms of the welfare state regime approach and the promotion of looking instead at the effects of specific single welfare state policies⁸.

In parallel, an extensive literature about the effects of neoliberalism on health and health inequalities has also developed (for an overview see Schrecker and Bambra, 2015⁹). This largely Anglo-Saxon focused research has found associations between various facets of neoliberalism (such as deregulation, reductions in the levels of social support and public services) and the magnitude of health inequalities both over time and between countries¹⁰. However, to date there has been little attempt to integrate the Nordic public health puzzle and the neoliberalism and health research agendas together. This paper is the first to do so and as such it advances, and fuses, these two key debates in public health and comparative sociology. It does so by examining the effects on health inequalities of the neoliberal

recommodification of the welfare state through a detailed case study of three specific welfare policy domains in Sweden - unemployment, healthcare, and pensions.

Decommodification, the Welfare State and the Social Determinants of Health

The welfare state affects health and health inequalities through decommodifying the social determinants of health. The social determinants of health are the material and psychosocial circumstances in which people live and work that affect their health and wellbeing¹¹⁻¹³. They can either protect and promote health, or influence health adversely: it is the social determinants of health that are the cause of health inequalities¹⁴. Those with higher socio-economic status (SES), whether this is measured by occupation, income, education, housing tenure, material possessions, or any other way of operationalising SES, tend to have lower rates of morbidity and mortality than those with lower SES¹⁵. This is because the latter tend to be more exposed to adverse social determinants, such as poor working and living conditions, and have less access to the protective social determinants, such as preventative healthcare¹⁴.

At its core, the welfare state comprises state-organised efforts to intervene in the market to ensure the welfare of its citizens¹⁶. As such, the welfare state is a key factor in the distribution of the social determinants of health and the exposure of citizens to key salutogenic and pathogenic factors¹⁷. Welfare states alter the distribution of resources in a society by providing cash and services to those in need¹⁸. This alters the social hierarchy, as well as the distribution of the social determinants of health¹⁹. More universal, generous, and extensive welfare states, mean that the key social determinants such as income, housing, and working conditions are more equally distributed.

Welfare states differ in their arrangements towards both service and cash provision – differing levels of decommodification. Decommodification describes the extent to which individuals and families are able to maintain an acceptable standard of living, regardless of market position²⁰. For Esping-Andersen, decommodification was measured in terms of the replacement rates and duration of key welfare benefits (unemployment, pensions and sickness absence). Later work has extended the concept to healthcare access²¹. Decommodification is also influenced by the extent to which prices of market goods such as housing, food, energy etc. are subsidised or regulated, allowing people access to goods and services even when they cannot afford them through the market²².

Decommodification can act as a social determinant of health in its own right – *all* the citizens of a country with higher levels of decommodification are likely to have higher living standards and less financial stress than those in less decommodifying welfare states as even those with a weak labour market position are able to maintain an acceptable standard of living²³. However, decommodification can also be a property of other social determinants: the extent to which people's access to or exposure to a particular determinant is independent of their market position can be characterised as the extent to which the said determinant is decommodified.

Neoliberalism and the Recommodification of the Social Determinants of Health

Since the rise of neoliberalism (in the 1980s and 1990s), there has been a process of significant restructuring of post-war welfare states - characterised by the privatisation and marketisation of welfare services; entitlement restrictions and increased qualifying conditions for benefits,

and a shift towards targeting and means testing; cuts or limited increases to the actual cash values of benefits; modified funding arrangements (with a shift away from business taxation); and an increased emphasis on an active rather than a passive welfare system²⁴. It is argued that this has resulted in a process of the *recommodification* of the social determinants of health - whereby market position has become once more of increasing importance as a determinant of health⁹.

Sweden underwent a severe economic crisis in the 1990s, with the interest rates suddenly increased to 500% and unemployment rose from 2% in 1991 to 12.5% in 1993^{25,26}. The response of all political parties was to seek out cuts to the state finances and social welfare²⁷. Some, but not all, of these cuts were reversed once the crisis was over, and the public funds were again in surplus^{28,29}. This had an important effect on the three key policy domains of decommodification: unemployment benefits, the healthcare service and pensions.

The percentage of the previous salary paid by the unemployment insurance was lowered during the 1990s, from 90% to 80%. However, since the maximum payable amount was not updated in line with earnings, by 2002, less than half of the unemployed received 80% of their previous salary in compensation, undercutting the earnings-relatedness of the benefits and making them more flat-rate^{30,31}. The proportion of unemployed at below the European poverty threshold increased from just over 5% to over 30% in Sweden between 1995 and 2013³². There was also a greater increase in absolute poverty levels among the non-employed than employed during both the 1991-96 and 2007-8 economic crises in Sweden³³.

User charges in Swedish healthcare were introduced in 1970. They were initially set at SEK 7, and are now substantially higher, ranging from SEK 100 to SEK 350 for a primary care physician. Charges may be up to 450 SEK for visits to specialists^{34,35}. Alongside user charges and a system reorganisation, patient choice in primary care was introduced in many country councils through the 1990s and 2000s³⁶⁻³⁸. The changes to the Swedish healthcare system can be thought of in terms of recommodification, both in the sense of increased market involvement in healthcare and in the sense that a person's market position determines his or her access to healthcare. However, the share of healthcare costs paid for by user charges is still fairly low³⁹, and the cost for primary care is just below the median hourly salary⁴⁰.

Sweden underwent a radical pension reform in the 1990s, despite the political risks that such an act carries⁴¹. One of the main changes was that instead of guaranteeing a set pension level, pensions would be paid out on the basis of how much had been contributed and how well the pension fund had done on the stock market. Furthermore, a mandatory Premium Pension was introduced, wherein people make their own choices of funds to invest their pension in, and the amount received by the Premium Pension depends entirely on how well the chosen funds have performed on the market^{41,42}. In the short term, Sweden's reform improved the situation for many low-income pensioners: the value of the minimum guaranteed pension was increased and surplus funds from the pension system were used in the transition period to cover individuals who had not made enough contributions to get adequate pension benefits under the new system..However, it was also a recommodifying reform, tying pension income more closely to the market and over the longer term, elderly poverty rates have increased and are projected to continue to increase into the future ⁴³.

This paper examines a neglected element of the Nordic public health puzzle - the effects of neoliberalism on health inequalities. It does so through an empirical examination of the recommodification of the social determinants of health in Sweden via a detailed case study of financial changes to three specific welfare policy domains: unemployment, healthcare, and pensions.

METHODS

Data

The data comes from the Swedish Living Conditions Survey (ULF) for the years 1991-2011, or 1980-2005 for access to healthcare. For the studies on unemployment and pensions, the outcome variable was self-rated health adjusted for age, dichotomised into *Good* (Very good or Good) and *Not good* (Something in between, Fair, Poor or Very poor). For healthcare, the outcome variable was whether the respondent had seen a doctor during the past three months.

Education was used to indicate SES, due to a lack of adequate income measurement in the data. This was categorised into three levels – those with low education (primary education [up to 9 years of schooling] or no qualifications), intermediate education (secondary school qualifications [9-12 years of education]), and higher education (university level qualifications or above [more than 12 years of education]). Employed persons included both full-time and part-time employees. Unemployed persons were defined as currently not in employment but seeking employment or claiming benefits aimed at job-seekers.

Commodification was measured by the net single adult replacement rate in unemployment insurance and in pensions using data from Scruggs et al., 2014⁴⁴ Comparative Welfare Entitlement's Database. Net replacement rate is calculated as the percentage of an average production worker's salary that is replaced by social insurance/pensions during the first 6 months, net of any taxes or transfers²⁰. This means that it is a relative measure of commodification that can be compared over time. Healthcare commodification was measured as the average user fee in primary care using information provided by the Swedish Association of Local Authorities and Regions. The average user fees were converted to their 1991 values in order to make them comparable and to remove the effects of inflation, using the Consumer Price Index, available at Statistics Sweden. This was not done for net replacement rates, as they are relative measures of wages.

Analyses

Similar procedures were followed for all analyses. In the first stage, logistic regression models were fitted to estimate the magnitude of health inequalities as odds ratios between socio-economic statuses. The magnitudes of health inequalities were estimated per year because of the lack of a constant relationship between self-rated health and time. In the second stage, the estimated magnitudes of health inequalities were correlated to measures of recommodification using linear regression models: user charges for healthcare and net replacement rates in the unemployment insurance and pensions. This allowed us to estimate changes in health inequalities due to a unit change in recommodification. More detailed description of the methods used in each policy domain are available in Farrants et al., 2016⁴⁵, Farrants et al., in press⁴⁶, and Farrants (manuscript submitted for publication). The results for

healthcare access were stratified by health status (*Good vs Not good*), since health status is an important link in the relationship between social position and healthcare usage.

RESULTS

Figure 1 shows the trends in net replacement rates in unemployment insurance and pensions 1991-2005. Figure 2 shows user charges for healthcare visits in Sweden 1991-2005. This shows clear evidence of recommodification in all three policy areas: net replacement rates of pensions and the unemployment insurance decreased, while user charges for healthcare increased. There was a slight increase in the net unemployment replacement rates from 2001, when the maximum amount was raised, but this was reversed in 2003 and continued to decline. The pension net replacement rate decreased fairly steadily from 1995. User charges for healthcare increased dramatically from 1991 to 1995, after which they were fairly steady and even declined slightly until 2002, after which they increased again.

Figure 1: Net replacement rates in the unemployment insurance and pensions

Figure 2: Mean User Charge of a Primary Care Visit in 1991 value SEK

Figures 3-5 show the trends for health inequalities from stage 1 of the analysis. Health inequalities between the employed and unemployed increased during the time period studied (Figure 3), whereas health inequalities between the highest and lowest educated pensioners remained fairly steady over the time period (Figure 4). Figure 5 shows the results for visiting a doctor in the past three months: in those with *Good health*, there were no major

differences by education but amongst those with *Not Good health*, the less educated were less likely to visit than their higher educated counterparts. However the difference decreased over time, and by the end of the study period had all but disappeared.

Figure 3: Odds ratios of Not good health for the lowest educated pensioners compared to the highest educated pensioners, controlling for age

Figure 4: Odds ratios of Not good health for the unemployed compared to the employed, controlling for age

Figure 5: Odds ratios of having visited a doctor in the past three months for the lowest educated compared to the highest educated, stratified by self-rated health, controlling for age

The linear regression model (Table 1) confirmed that the correlation between health inequality and net replacement rate, as measured by the β value (a measure of the strength of the correlation between two variables), was stronger for unemployment insurance ($\beta=-2.194$) than in pensions ($\beta=-0.817$) or healthcare ($\beta=0.006$ *Good health*, $\beta=-0.002$ *Not good health*). The r^2 value was also higher for unemployment insurance ($r^2=0.438$) than pensions ($r^2=0.034$) or healthcare ($r^2=0.095$ *Good health*, $r^2=0.411$ *Not good health*). This means that net replacement rates explain over 40% of the variation in health inequalities for the unemployed. Partial correlation tests controlling for time were used to de-trend both health inequality and net replacement rates. Regarding unemployment, the de-trended r^2 increased to 0.518. This means that the decreased net replacement rates explain approximately half of

the increased health inequalities between the employed and the unemployed in Sweden, when adjusted for year. For pensions, de-trending had little effect on the r^2 of the model, which suggests that pension generosity is unrelated to health inequalities in older age even when time is controlled for, as was the case for healthcare in those with *Good health*. In those with *Not good health*, on the other hand, the r^2 greatly increased in value, indicating that the magnitude of inequalities in access to healthcare in that group is associated with the price of healthcare.

Table 1: The association between measures of recommodification (net replacement rates in the unemployment insurance, pensions, and user charges for healthcare) and health inequalities between the employed and unemployed, the lowest and highest educated pensioners, and inequalities in access to healthcare between the highest and lowest educated (stratified by health status)

DISCUSSION

Our study has found mixed effects on health inequalities of neoliberal processes of recommodification. Health inequalities increased between the Swedish employed and unemployed, yet they did not increase in the retired population, and inequalities in access to healthcare also remained steady during this period.

There was substantial recommodification of unemployment in Sweden. Net replacement rates were decreased from nearly 90% of salary, to just over 60%. In addition to the decline in net replacement rates, work tests have increased in Swedish labour market policies, and

there are concerns that the activation measures are bordering on workfare^{47,48}. This may have affected the health of the unemployed, as stigma is reduced and self-esteem is increased by activation measures, but less so by workfare⁴⁹. Rodriguez ⁵⁰ suggests that means-tested benefits are more stigmatised than contributory benefits, which may also have implications for the health of the unemployed. The increased use of means-testing rather than contributions may have increased the stigma of unemployment, and brought back the notion of the “deserving” and “undeserving” ^{51,52}. The increased use of sanctions may thus also have contributed to the increase in health inequalities between the employed and unemployed in Sweden. The net replacement rate in the Swedish unemployment insurance was well above the threshold for people at risk of poverty (60% of the average salary) in the 1990s, but it had fallen to hover around this threshold by 2011. This is an average measure, and thus many more unemployed people were in poverty in 2011 than in 1991, and this might be one cause of the rise in health inequalities between the employed and the unemployed in Sweden, since the link between poverty and ill health is very well documented^{53,54}.

Health inequalities between pensioners with the highest and lowest levels of education remained steady, despite decreased replacement rates. Furthermore, this was accompanied by decreased levels of self-reported Not good health by people of all educational levels. It is not surprising that health inequalities in old age are less sensitive to policy changes. A life course perspective of health inequalities states that health is a product of accumulated advantage and disadvantage: the retired population has had longer to experience influences on health, and its health is thus less susceptible to policy changes¹. This may explain why we found decreasing rates of Not good health in the Swedish pensioners, despite the recommodification of pensions.

We found that in the complete population those with lower education were more likely to have visited a doctor than those with higher education in Sweden, while the opposite was the case for those who had self-reported Not good health. This suggests that access to healthcare is unequal, and that the increased probability of having made a visit among those with lower education was due to the greater prevalence of need in that group. However, the inequalities in access among those with Not good health were greater in 1980 than in the 1990s and 2000s, despite an increase in user charges. User charges were fairly stable relative to inflation during the 1990s and 2000s, which may explain why inequalities were stable during that period. User charges increased, however, between 1980 and 1991, and we expected to see this reflected in an increased inequality of access, as the people with lower SES are more likely to be price-sensitive⁵⁵. There are inequalities in access to healthcare in Sweden, but they cannot be directly linked to the presence of user charges, since inequalities in access did not increase when user charges did. However, it is probable that user charges did contribute somewhat to, or at least did nothing to reduce, inequalities in access. It may be that the comparatively low level of the charges or the presence of a maximum limit prevented the user charges from having a large effect.

The results presented here show that cash benefits were more recommodified than healthcare in Sweden during the 1990s and 2000s. There is often a difference between a country's cash and service provision^{21,56}. Recommodification is not a uniform process, and developments may sometimes be contradictory. However, similar developments have been studied in other countries. One example is New Zealand, which underwent large structural changes, including the introduction of a less redistributive tax system, targeted social

benefits, and a regressive tax on consumption. Further, major utilities and public housing were privatised, user charges for welfare services were introduced, and the labour market was deregulated⁵⁷⁻⁵⁹. In the UK, Thatcherism (1979-1990) was characterised by the deregulation of the labour and financial markets, the privatisation of utilities and state enterprises, reductions in social housing, curtailed trade union rights, a marketised public sector, and significant cuts to the social wage via welfare state retrenchment, alongside large tax cuts for the business sector and the most affluent. In this period, whilst life expectancy increased and mortality rates decreased for all social groups, the increases were greater and more rapid amongst the highest social groups so that inequalities increased. The Nordic countries also underwent such structural changes during the 1990s: replacement rates were cut, waiting days were introduced, and schools and primary care clinics were opened to private ownership and consumer choice. These changes were more sudden and severe in New Zealand and the UK than in the Nordic countries as the latter did not include the privatisation of utilities and housing⁵⁹..

Despite its long tradition of left-wing governments, Sweden recommodified extensively during the period studied, even when the Social Democrats were in government. This is especially noticeable in the unemployment benefit. Healthcare was recommodified to a lesser extent, at least when user fees are used to measure recommodification, as were pensions. This may be due to the different political popularities of the domains in question: healthcare and pensions are very popular among the public, while unemployment benefits are more contentious: it is easier to introduce a notion of the “undeserving” among the unemployed, especially among the unemployed who depend on social assistance benefits, even in Sweden^{60,61}.

Limitations

ULF is a repeated cross-sectional study and so individuals were not linked over time. ULF was discontinued in 2005, replaced by SILC. However, the questions used in this study remained unchanged. In 2006, the data collection method was changed from face-to-face interviews to telephone interviews, which may have affected how respondents answered certain questions. Our measure of commodification, net replacement rate, captures only one aspect of decommodification. Decommodification includes other aspects, such as population coverage, duration of benefits, and own contributions towards benefits, as well as state subsidies and regulation of the market. Using self-rated health as an indicator is also subject to certain limitations. For example, there is some evidence that the relationship between self-rated health and mortality is stronger in higher educated groups than lower⁶². Relating to the analysis, it is possible that some residual confounding remains from other time-varying factors that we missed by controlling for time. Further, we have not made any adjustments for gender in our analyses, and there may be some confounding due to gender differences in the relationship between recommodification and health inequalities. This deserves further study.

CONCLUSION

In conclusion, the association between recommodification health inequalities in Sweden is stronger regarding unemployment benefits than pensions or healthcare. This may be due to the relatively higher level of recommodification experienced in regards to unemployment. With regards to healthcare and pensions in Sweden, there was a smaller degree of recommodification, and this was not accompanied by greater health inequalities - it may be

that the level of recommodification has not yet reached a tipping point in terms of health.

Future research, ideally using cohort data is required to continue to monitor the trends.

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