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A model of how targeted and universal welfare entitlements impact on material, psycho-social and structural determinants of health in older adults

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Abstract

A growing body of research attests to the impact of welfare regimes on health and health equity. However, the mechanisms that link different kinds of welfare entitlement to health outcomes are less well understood. This study analysed the accounts of 29 older adults in England to delineate how the form of entitlement to welfare and other resources (specifically, whether this was understood as a universal entitlement or as targeted to those in need) impacts on the determinants of health. Mechanisms directly affecting access to material resources (through deterring uptake of benefits) have been well documented, but those that operate through psychosocial and more structural pathways less so, in part because they are more challenging to identify. Entitlement that was understood *collectively,* or as arising from financial or other contributions to a social body, had positive impacts on wellbeing beyond material gains, including facilitating access to important health determinants: social contact, recognition and integration. Entitlement understood as targeted in terms of *individualised* concepts of need or vulnerability deterred access to material resources, but also fostered debate about legitimacy, thus contributing to negative impacts on individual wellbeing and the public health through the erosion of social integration. This has important implications for both policy and evaluation. Calls to target welfare benefits at those in most need emphasise direct material pathways to health impact. We suggest a model for considering policy change and evaluation which also takes into account how psychosocial and structural pathways are affected by the nature of entitlement.

Keywords

England; older citizens; welfare; conditionality; social integration; public health; qualitative

Introduction

Welfare benefits and public amenities are of vital importance for health and wellbeing. In the context of policy reform in liberal welfare states, a growing body of research identifies the complex relationships that link entitlements to these resources with the determinants of health and health inequalities (Lundberg et al 2008, Lundberg et al 2010, Bambra 2011 Bambra 2013, O'Campo et al 2015, Peacock et al 2014, Mackenbach 2012). Much of this literature draws on international comparisons to assess whether different welfare regimes, at a structural level, are associated with outcomes such as life expectancy, excess mortality or inequalities in these. However, there are perhaps inevitable limits in how far these broad comparisons can determine which regimes do better in fostering health and health equity, in part because the mechanisms that link welfare policy at a national level with population health outcomes are complex and contested (Bambra 2011, Brennenstuhl, et al 2012, Mackenbach 2012). One illustration is the apparent paradox that the generosity of a welfare regime does not necessarily correlate positively with equality in health outcomes, reflected in debates around how far the Nordic states have better outcomes in terms of either mortality or social inequalities in mortality (Bambra 2011, Mackenbach 2012, Popham et al 2013). This is a challenge to arguments that the key mechanism through which welfare regimes impact on the determinants of health is through the State's role in provision or redistribution of resources (see for instance, Lundberg 2009). Given the complexity of the incentives and disincentives in any system, the coverage or relative generosity of any regime is not the only driver of health outcomes. Lundberg et al (2008) also suggest the 'style' of policy is important, as demonstrated with a comparison of how basic pension generosity is associated with lower mortality at older age in a cross-national study, whereas earnings -related pensions are not. The causal chains between welfare regimes and health outcomes involve multiple pathways linking policy, entitlement, uptake, resource distribution, health related behaviours and health outcomes at a number of levels. One important element of style, or what Spicker (2005) calls 'modes of operation', is the extent to which entitlement to material transfers or services is available to all in a population class (older adults, or parents, for instance), or only available to those who meet particular conditions as individuals; what is often termed 'universal' or 'targeted' provision, respectively. Targeting has not only implications for the reach of particular policies, but also how they are understood by potential recipients and the population in general. This paper focuses on how entitlement is understood by older adults in England to explore how the style, or mode of operation, of entitlement might operate as a mechanism linking welfare regimes and individual and public health outcomes.

To an extent, most entitlement to welfare within any regime is conditional: on criteria such as residence, nationality, payment of social insurance, or age, with only public amenities such as libraries or parks typically provided universally to the population (Spicker 2005). However, across many diverse welfare regimes and population groups, there have been shifts in conditionality, away from broader citizenship-based conditions of eligibility for population groups, towards more narrowly framed needs-based, means-tested or behavioural conditions (Weston 2012, van Lancker & van Mechelen 2015, Dwyer and Wright 2014). Older adults have been to an extent protected to date (McKee & Stuckler 2013), being typically perceived as the most 'deserving' welfare recipients (van Oorschot 2006). However, they are increasingly becoming the focus of debates around both the economic efficiency of targeting benefits to individuals in greatest financial need, and the fairness of current intergenerational distributions of resources (Higgs & Gilleard 2010). Where resources are constrained, the appeal of targeting resources more precisely at those who meet individualised conditions of need becomes "seductive"' (Carey & McLoughlin 2014) and debates around the financial efficiency of increasing conditionality emerge (McKee et al 2011, 2013). Ranged against economic arguments for introducing further elements targeting are a number of concerns about the broader health impacts of abandoning universal entitlements. First are the well-documented barriers to uptake when complex conditions on eligibility are introduced. The material resources provided by welfare benefits make a direct contribution to health and wellbeing for many older citizens on fixed low incomes (Moffatt and Scambler 2008), and both the complexity of access when recipients have to be assessed for eligibility and the stigma attached to claiming (van Oorschot 2002, de Wolfe 2012, Baumberg 2016) are likely to deter uptake for those who could benefit. These mechanisms are likely to be particularly salient for older adults, for whom 'claiming' may not be congruent with generational identities as, for instance, self-reliant citizens (Moffatt & Higgs 2007, Milton et al 2015). Second, eligibility dependent on individual needs may also have psychosocial impacts through what Peacock et al (2014) call the erosion of "legitimate discourses" of dependency, and the resulting internalisation of stigmatised concepts of need and shame (de Wolfe 2012, Chase & Walker 2013, Friedli & Stearn 2015). Third, reducing universal eligibility risks eroding public commitment to welfare, engendering a gradual withdrawal of the middle-class support needed for it to function (McKee & Stuckler 2011, Hills 2015). In short, the style of entitlement may be an important mechanism on psychosocial and structural pathways to health outcomes, as well as on those affecting access to the material resources needed for health.

To contribute to delineating the ways in which the style, or mode, of welfare entitlement impacts on health, this paper draws on a study of older citizens (Milton et al 2015), which identified very different discourses in their accounts of ‘universal’ and ‘targeted’ benefits and amenities. In short, benefits understood as available to all were discussed in ways that fostered respect and solidarity across a generation, whereas targeted benefits were the subject of moral enquiry about legitimacy, and fostered discourses of division and distrust. This paper explores how these understandings shape access to (and the production of) key determinants of health including material resources, social contact and social integration.

Methods

Data are drawn from in-depth interviews with 29 adults aged 60 or over in England in 2014. Participants were purposively sampled from three different areas: inner London, Sheffield (a multi-cultural city in the north of England) and Cambridge and its rural and suburban outskirts, in south east England. These areas, and individuals within them, were purposively sampled to include a range of age, ethnic identity, income level and relative isolation (see Table 1 for a summary). This was not intended to be statistically representative of the population of England, or of the areas sampled, but to include a maximum variation sample of participants in order to facilitate analysis of how welfare was understood. Invitations to older citizens to take part in the study were made through a range of contacts, including those in in community groups and older people’s networks, who were asked to pass on (in writing and orally) project information, with contact details of the project team. To ensure we were including those less well connected, we also asked gatekeepers in voluntary organisations with a remit of helping older citizens to pass on invitations to participate. All of those who agreed to be interviewed were provided with information about the project and gave written consent to participation.

There are a number of methodological challenges in asking about welfare. First, financial circumstances can be sensitive to discuss. Second, asking directly about views of entitlement risks generating routine ‘public’ statements or tropes, rather than providing access to the more tacit knowledge which is likely to frame how conditionality is understood. To address both issues, we used interviews which began with prompts for participants to talk at length about their biographies, families, circumstances, lives, and how they ‘managed’. We then used a loosely structured topic guide to ask directly about access to specific welfare and amenities if these had not come up spontaneously in the biographical stories; this guide was developed in consultation with representatives from Patient & Public Involvement groups, and covered both uptake of benefits and views on current conditions of eligibility. Interviews were transcribed in full, translated if conducted in a language other than English (N=5) and analysed drawing on techniques from grounded theory (Strauss 1987) such as detailed coding of early data; iterative analysis and sampling; a cyclical process of induction and deduction to test emergent hypotheses; close attention to deviant cases and constant comparison. In practice, this entailed developing an initial coding frame which was informed both by the literature on forms of entitlement and by open coding the early data to generate insights into ‘what was going on’ and inform later sampling. Transcripts within each geographical site were analysed first, and we used comparisons of the site-specific analysis as well as thematic comparisons across the sites (such as between accounts of own uptake and that of others) to develop a mapping of the relationships between understandings of entitlement and dimensions of wellbeing. For instance, an early emergent hypothesis that ‘conditionality’ always led to disrespectful relationships between claimants and providers was challenged by the positive impacts reported from using a community centre, leading us to deliberatively sample community centre users in another site, and to identify ‘social contribution’ as a potential mechanism.. The final analysis therefore focused on how different understandings of entitlement relate to the determinants of health. The study was approved by LSHTM’s Ethics Committee.

Findings

Targeted and universal eligibility

Participants received a range of welfare benefits, including state pensions (paid for through national insurance contributions), Pension Credits, Disability Living Allowance (DLA), Attendance Allowance, free travel passes, free prescriptions, the National Health Service (NHS), Winter Fuel Allowance, council tax rebates and free television licenses, as well as local public amenities such as libraries, parks and community centres. Participants reported that these provided a number of direct material benefits for accessing determinants of health such as housing, food, goods and services and warmth. The Winter Fuel Allowance helped in managing heating bills, and travel passes facilitated access to social activities and hospital appointments, for instance. For benefits that were provided (at the time of the study) to all older adults irrespective of financial or other need, such as free travel passes and the Winter Fuel Allowance, participants' accounts initially suggested that universal entitlement was understood by many as wasteful. That is, that the more affluent (those participants who were not in receipt of financial-means tested benefits) often acknowledged that receipt of universal benefits played little role in meeting their own immediate health or social needs. One participant, for instance, described the Winter Fuel Allowance as an unneeded "*two hundred pounds dropped in my account*" (Sheffield 04, male, 60s, White British). In the context of a life in which he did not have to forgo luxuries, let alone the basic determinants of health, this payment clearly did not make much material difference to his circumstances. The Winter Fuel Allowance was introduced to reduce excess winter mortality in the UK, by ensuring poorer citizens could afford to pay fuel bills, yet is paid to all. If wealthier recipients acknowledge not needing the payments, this does suggest that introducing elements of targeting would be understood as just and fair by those who would lose out, as well as being economically efficient. However, a closer examination of how older adults discussed universal entitlements illustrates the importance of more symbolic meanings that attach to eligibility. Another participant, for instance, who described herself as "*comfortably off*", also mentioned the appeal of targeting the Winter Fuel Allowance at those in greatest financial need. However, she swiftly went on to unpack eloquently the positive symbolic meanings of the current (age-based) rationale for eligibility, and its importance for feelings of wellbeing:

> [I thought] they perhaps should keep [the Winter Fuel Allowance] for people who are very poor and then I thought well, no, it gives me a nice feeling that I'm being looked after, even though I'm more comfortably off than perhaps lots of people. If they took it away from us, it's like you get a feeling, they didn't have to care about you. (Cambridge 02, female, 70s, White British)

She concludes by suggesting something of the stigma that might attach to needs-based rather than universal entitlement: "*because everyone gets it, you can feel good about it ... you're not part of a minority group*" whereas "*if you were in a minority group ... you might think everybody knows I can't afford to do my heating*" (Cambridge 02, female, 70s, White British). There are two distinct pathways evoked by her contrast of the potential impacts of (imagined) targeted entitlement and her (current) universal entitlement. The latter she described as fostering feelings of being cared for and included: being recognised. The former, however, she associated with the risk of stigma and disrespect. Her prediction about the potential consequences of more targeted entitlement as signalling stigmatised need was borne out by accounts of those who had applied for welfare benefits that were currently understood as conditional on individual financial needs or vulnerabilities.

The material and psychosocial implications of targeted entitlement

Discussions of targeted benefits in interviews were typically suffused with moral comment, reflections on the legitimacy of others' entitlement, and the challenges of continually demonstrating the legitimacy of one's own claims. Disability related allowances, for instance, for which eligibility was based on need, were a common topic which opened up a space for questioning the legitimacy of others' entitlement. One man (in receipt of disability related benefits himself), felt that all older citizens should be entitled to universal benefits such as travel passes, whatever their financial circumstances. However, as he went on to discuss conditional benefits, his focus turned to the illegitimacy of many claims, made by those whose health problems were not sufficiently severe:

> So many people are on it [disability benefit] now who shouldn't be on it it's, it's affecting the people that should be on it. It's going to affect them and all like […] it's the government's fault really because, they give it to people who've got a bad back [suggesting malingering]. "Oh, let's go on Disability", you know, and it's wrong. It's immoral. (London 07, male, 60s, White British)

Across the data set, needs-based entitlements such as disability related benefits, housing benefits and unemployment benefits were widely discussed in similar terms, with the illegitimate claims of general or specific 'others' frequently cited. A common trope of complaints about illegitimate claims was that the claimant typically utilised the benefit for health-damaging rather than health-promoting purchases: "*they're getting too much money…buying cigarettes and booze*" (London 02, male, 60s, White British)

Despite widespread comment on the legitimacy of the claims of others, there were (perhaps unsurprisingly) no participants who claimed that their own uptake of conditional benefits was illegitimate, or their use of an amenity inappropriate. Given that targeted entitlement generated these discourses of moral censure, those who were claiming conditional benefits often had to engage in considerable moral work within the interviews to defend their own legitimacy. Need in itself was something that 'others' had, and was shameful; neediness in one's own, current, circumstances was therefore often explicitly disavowed:

> We don't receive any benefits, no, except state pension of course, we haven't applied and nor do receive any of the other assistance benefits [...] we don't feel we have to ask for help. (Cambridge 04, male, 70s, White British)

> People feel shy when asking about the benefits. When you are asking it makes you feel that you are begging so people feel ashamed, even if they are eligible. People are not used to do that. (Sheffield 05, female, 70s, Black/Black British)

Introducing elements of needs-based conditionality does not, then, just remove access to 'unnecessary' benefits for the more affluent. Stigmatised discourses of claiming and need also create barriers for those who do meet conditions of eligibility. This was evident in people's accounts of their own encounters with claims systems, and in accounts of being deterred by 'what is known' about the challenges:

> We once tried a means tested test and it was so humiliating we tore it up. (Cambridge 06, female, 80s, White British)

> People have told me that if you don't fill this that and the other criteria, if you can walk so many yards; you don't need a mobility payment, you don't need help with having a bath. (Sheffield 03, female, 60s, White British)

An important element of the deterrent effect of targeting is the way in which 'need', in practice, is complex and contingent, rather than simply a binary category. Like the wider population of older adults, in which multiple morbidities are common (Barnett et al 2012), many of those interviewed had an entangled range of social and health needs, which changed over time, and in often unpredictable ways. One London participant, for instance, described: a stroke, partial eyesight and arthritis as problems which entitled him to disability benefits; unemployment just before retirement age; and difficulties in keeping his house tidy without help (for which he paid directly). Accessing the necessities for health and wellbeing were challenging: different needs were provided by different agencies, and information was difficult to access without professional help. With little understanding of, or access to, computers, he faced a system that was hard to navigate. In contrast to the ease of access to the Winter Fuel Allowance which simply 'drops' into a bank account, conditional entitlements typically posed administrative, as well as cultural, challenges to access. As this man explains, he required considerable help to both find out about and apply for entitlements:

> Well I, I actually went to Citizens Advice [organisation providing free advice] first of all […] then I went to Age UK [organisation providing free advice to those over 50]. And they went through the paperwork with me, and it's all gobbledegook [impossible to understand], it's not black and white. It's not basic. The form for my benefits, it took nearly an hour. And that's with somebody who can actually see the thing. (London 02, male, 60s, White British)

Forms of entitlement and access to social contact.

The processes of demonstrating eligibility for conditional benefits, and the inevitable complexity of rules for categorising 'need', therefore create well-documented barriers to accessing basic material determinants of health such as income. This kind of targeting also deterred access to another crucial determinant of health: social contact. Social contact was clearly important to our participants. Although difficult to admit to directly, the potential for social isolation was widely hinted at in our interviews, even for those not living alone. Amenities such as libraries and parks were utilised as important points of access to public life that were clearly missed when they could not be accessed:

> Presently it has become very difficult because my wife is ill so I have to be at home all the time. [...] After every two weeks I try to join this lunch club. The rest of time I don't go out, just go for grocery shopping from local shops.
> I: What do you do at home?
> Nothing, I look after my wife all the time; sometimes I watch television (Sheffield 02, Male, 70s, Asian)

In the context of what were sometimes relatively isolated lives, television was reported as a lifeline for some, with free licences for those over 75 facilitating access. One man who reported no longer going out noted "*I do rely on the television a lot… I would be bereft if I didn't have the television*" (London 06, male, 80s, White British). For those who did leave the house, the free travel pass was frequently cited as vital in both facilitating access to social interaction directly, by providing travel to social events, but also indirectly, simply by being a public space that could be used to interact with other passengers in passing. One woman, who made twice weekly outings with a friend, said without her travel pass: *"we wouldn't go anywhere"* (London 04, female, 70s, White British).

Membership of community centres, which were typically funded by a mix of local authority and other funding, were also reported as providing important benefits for health. These offered not just direct health benefits (such as hot meals, or exercise classes), but also access to services such as welfare advice. Importantly, however, what interviewees focused on in their accounts was the vital role community centres played in mitigating what could otherwise be potentially isolating circumstances. These centres were described as providing an important place of belonging, with convivial company, with benefits that clearly went beyond those of providing nutritious meals:

> I like it here, I've made a lot of friends […] if I wasn't coming I'd be sitting indoors. Because my family don't come down that often, so I've got no one to talk to (London 03, female, 70s, White British)

> I like to come and sit down and talk with people you know, have a bit of conversation. It's just because the food, not the food alone but to associate with people. (Sheffield 09, female, 80s, Black/Black British)

At the time of the study, eligibility for these amenities and benefits was based on age (in the case of travel passes), local residence (in the case of libraries) or a mix of local residence and age in the case of community centres. Given the difficulties in admitting to loneliness, what is crucial about these provisions is that they can be utilised with no shame. Taking up free television licences, using the library or catching a bus can all provide social contact or interaction, but utilising them does not imply that the user has a *need* for social contact.

Accounts of using community centres are interesting in this regard. These were typically 'targeted' to some extent, in that participants occasionally talked about being referred to them by health or social workers. But using them apparently had none of the stigma or implicit disrespect suggested in accounts of utilisation of benefits conditional on disability or financial circumstances. What was striking in accounts was how interviewees stressed the reciprocal nature of their use of community centres. Despite recognising the centres as playing an important role in mitigating their isolation, participants spoke of the them as 'clubs', of which one was a 'member' rather than a 'user' or client. The benefits accrued were therefore those of a contributor to the social body, rather than a needy supplicant, as this woman suggests:

> [Since I retired] I've been very depressed, I didn't know what to do with my days you know ... [now] they're supporting me and I'm supporting them. There's nothing I wouldn't do for this club. As long as I'm able to do something I would, I would do it. (Sheffield 06, female, 70s, White British)

If resources offering social interaction had to be applied for, and eligibility relied on demonstrating need, it would be extremely difficult for many to identify as 'needy' in the way this woman suggests. Uptake of benefits and amenities therefore has a direct impact on determinants of health not simply through providing the good or service itself, but by facilitating the kind of interaction which offsets social isolation, a key determinant of health (Valtorta et al 2016). We suggest that they do this because, largely, eligibility does not require conditions of need or vulnerability to be met. Further, they are understood as being provided on the basis of eligibility conditions which carry pride rather than shame, such as age (for travel passes); local residence (libraries) or willingness to contribute to the social body by participating in community activities (the community centre).

Universal entitlement fosters social recognition and integration

Where eligibility was understood as universal (such as to the NHS), entitlement to benefits and amenities were largely taken for granted, and uptake did not incur any of the kind of disquiet that attached to conditional benefits. Such entitlements were, in most accounts, not referred to as a benefit: indeed they were often explicitly distinguished from 'benefits':

> No, I certainly wasn't in receipt of any benefits... largely free of the state, other than pensions and the health service, of course (Cambridge 01, male, 60s, White British)

The points in interviews where these more universal provisions like the NHS were recognised as 'benefits' are instructive. They occur when reflections on alternatives (from other countries, for those born elsewhere, or from early lives, for the older participants who had experiences from before 1948, when the NHS was established) bring taken for granted entitlements into focus for the interviewee. One participant, for instance, discussed the advice a friend had given to "*pay yourself*" for health care, which prompted her to see the NHS as a benefit "*if you think about it*" (Cambridge 02, female, 70s, White British). She followed up this consideration of a (theoretical at least) financial possibility to pay privately for health care by commenting that using the NHS, rather than alternatives, became a social obligation: she was happy to "*wait my turn like everybody else*". Uptake can be presented, then, as evidence of her commitment to the welfare state, rather than evidence of need, in rather similar ways to the accounts provided of being members of community centres. This is telling: receipt of universal health care provided not just the direct health gain, but also (at least where it was understood as ‘entitlement’ rather than simply a taken for granted feature of the world) the potential symbolism of signalling one’s commitment to the social contract, through willingness to be part of that collective through (in this case) collectively ‘waiting’. Indeed, both eligibility for, and uptake of, universal provisions were often framed positively in interviews, as signally the respect and reward of a nation for a lifetime of contribution:

> I’m 78, I’ve worked since I was 16, I’ve paid my dues and everything, and it’s my country and I want my country to look after me ... I suppose I feel I’ve made my contribution (Cambridge 02, female, 75-79, White British)

Entitlement understood as rooted in collective conditionalities of age or citizenship therefore orientated participants to what people have in common, rather than what divides them. Entitlement understood as conditional on prior financial contribution was in addition framed essentially as part of a reciprocal exchange of obligations, responsibilities and rights.   One participant (London 06, White British), who was over 95 years, was unsure about her own financial circumstances or what benefits she did receive (“*you’d have to look in my bank account*”) but her opinion on welfare in general perhaps reflected this collectivist attitude: “*everybody in a welfare state receives benefit merely by living in that State*”. For individuals, then, conditionality that rested on financial contribution, or on national citizenship, did not undermine positive conceptions of the self. Uptake of such benefits fostered a sense of belonging and membership of the social body, and evoked a reciprocity inherent in a more broadly understood welfare state. That is, recipients understood their gain to result from their belonging to a generation which had ‘given’ itself through both material contributions (taxes, national insurance) and more symbolically, through contributing as part of the citizenry of the country, rather than because of individual need, vulnerability or inadequacy.

These psychosocial pathways are potentially important contributors to health. Entitlement that was understood as universal did not simply operate through the absence of those barriers that are evoked by more targeted benefits; it appeared to positively evoke health-promoting subjective feelings in and of itself. Feeling cared for by the State, or the local community, fosters social recognition, and generates discourses that stress sources of social collectivity, self-worth, legitimacy, and belonging rather than division. At a social level, these therefore produce elements of social capital, in strengthening social bonds.

Changing understandings of forms of entitlement

An understanding of entitlement as accruing from being part of a social collective had been undermined to some extent by policy reforms and recent public debate. The free travel pass, for instance, had recently undergone changes to age-related entitlement to bring it into line with gender equality legislation, and had been the subject of media coverage of the 'fairness' of offering it universally, regardless of financial need. Participants noted these debates, sometimes with anxiety: "*they said they're going to do away with it [bus pass], I thought surely they can't do that?*" (London 03, female, 70s, White British). They also used interviews as an opportunity to rehearse the competing rationales for entitlement, how these might change, and how such change might impact on the meanings of welfare and amenities for them. In a similar way to the woman from Sheffield reflecting on the Winter Fuel Allowance (above), a participant from Cambridge (01) also initially offered the view that benefits and resources should be means-tested. Again, though, he anticipated negative effects of targeting, in predicting that he would feel "*miserable*" if his entitlement to a free travel pass was revoked. This would, he suggested, have significant impacts on his mobility: "*a consequence will be that I won't make as many journeys by bus, because it's going into the wallet every time, and it's giving the driver a fiver* [five pounds]" (Cambridge 01). Accepting that he could afford to pay for bus fares, he nonetheless anticipated reduced journeys, and the replacement of some journeys by car travel, if bus travel were no longer free. Here, the individual impact on health might be minimal; yet in population terms, these effects are potentially significant, given the evidence for public health benefits of older people's use of public transport (Webb et al 2012, Green et al 2014). For some, a collectivist framing of entitlement to free travel was explicitly drawn on to justify universal entitlement, and (on occasion) explicitly flag up direct public health benefits:

> You'll be better off having all the incompetent old people off the road and let them go on the buses, they're not going to do anyone any damage that way! [I feel I am] doing the right thing because [I] shouldn't be driving, and they're looking after you by giving you a bus pass (Cambridge 02, female, 70s, White British)

Thus, although several participants recognised the arguments that "*there is only so much money in the pot*" and that travel passes might become means tested, they also noted that having a travel pass made significant differences to their lives, and meant that they could "*leave the car behind more often*" (Cambridge 04). More typically, however, when asked about benefits that were currently universal, participants rejected the view that such benefits ought to be means tested, on the grounds that "*it would be so difficult to differentiate*" (London 08, female, 70s, White British)

For welfare benefits where the basis of entitlement had become more ambivalent, or where public debate had fractured any easy equation of entitlement and a reciprocal relation to the State, participants often made other claims for reciprocities that accrued from their uptake of benefits or a service. These were on occasion explicit, such as examples from those who donated unneeded benefits (such as Winter Fuel Allowances) to charity (Cambridge 01, male, 60s, White British), thus generating a literal material reciprocity. More common, though, were examples of social reciprocity, which were included in many stories to illustrate how the recipient used benefits or amenities to make a contribution to their family:

> The Freedom [free travel] Pass is such an important thing in London… and especially when you're taking out children that just need to spend time outdoors. I would think twice if I was paying for that. (London 08, female, 70s, White British)

These claims for reciprocity suggest the imperative of a social contract for off-setting the potentially negative impacts of benefit uptake for the self. Moral discourses of illegitimacy, stigmatised understandings of being in need, and uncertainty that any claim for targeted benefit uptake will be read as legitimate, all entail a real risk to the self from disrespect.

Where benefits could be understood as collective entitlements, they fostered public discourses of belonging, reciprocity and solidarity (however limited to nationalised or age-bound cohorts), and uptake of such benefits provided opportunities for social recognition (Honneth 2005) and social integration. In contrast, where entitlement was understood as based on individualised needs and vulnerabilities, this fostered discourses of disintegration and division. We therefore propose two rather different pathways that tended to characterise collectively understood entitlement and individually understood entitlement in our data, which are summarised in Figure 1.

[Figure 1 about here]

Entitlement that was understood as 'universal' was typically also understood as being conditional on collective criteria, whereas benefits that were currently more tightly targeted were understood as based on individual criteria of conditionality. These two pathways are not simply mirror images: understanding entitlement as being conditional on collective criteria did not just imply the absence of barriers to targeted welfare, it also produced health promoting discourses of pride, belonging, and integration.

Discussion

We have used older citizens' accounts of benefits and amenities to show how health and wellbeing outcomes are likely to be influenced by not only the generosity or coverage of entitlement, but also by how its mode of operation is understood. The pathways linking understandings of entitlement to public health outcomes operate at individual levels (through, for instance, influencing likelihood of claiming) but also at structural levels, through fostering discourses of social belonging or social difference. These discourses shape the general stock of 'what is known' about both entitlement and the proper relations between individuals, co-citizens and the State, and thus feed back into individuals' willingness to apply for welfare benefits, and their views about others who do make claims.

More collectivist framings – particularly those relating to feeling part of a welfare state - could be presented as reciprocal exchange, and some benefits were understood to be part of that exchange. Broadly, collectivist framings evoke criteria that carry (at least in part, and at least for those eligible) positive moral meanings, such as contribution (whether characterised in terms of citizenship, financial, or in kind, contributions). More individualised framings of conditionality, such as those based on financial needs or physical vulnerabilities, were more problematic, and engendered discourses of division and stigma.

Application processes for individualised benefits generate the potential for disrespect in the processes of applying, even for those who are successful (de Wolfe 2012). Disrespect can have real public health consequences, with evidence of links between experienced discrimination and mortality at older age (Barnes et al 2008), and between levels of disrespect and mortality at population levels (Wilkinson et al 1998). At a social level, the moral discourses about deservingness that are generated by individualised conditionality are potentially corrosive (Chase & Walker 2013). These discourses were evident for all benefits conditional on specific vulnerabilities, such as those of income or disability, but not those where conditionality depended on citizenship, financial or other contributions. Collectivist rationales for entitlement were most often cited in our interviews in relation to benefits such as NHS services, or pensions, and often understood as a return on 'saving' through paying national insurance or taxes through a lifetime (Milton et al 2015). This rationale carried over to other benefits understood as currently provided on the basis of age-related criteria, such as free travel passes. Uptake of these benefits conferred wellbeing advantages not just through ensuring access to material resources, but also by facilitating access to social interaction, a vital determinant of health given the evidence on the health risks of isolation (Valtorta et al 2016). At a more social level, entitlement to these benefits evoked respect for the user, and demonstrated participation in the social body, and (for some) a commitment to that social body. Given that the travel pass was still available to all, it could still be framed as a reward marking respect for a valued life, rather than as compensation for vulnerability or need. Entitlement therefore brought a sense of pride, rather than shame (Jones et el 2013).

In the light of public debate about the affordability of continuing to pay for universal entitlements, many older citizens were willing to countenance some kind of means tested eligibility criteria. However, in their accounts of the effects of benefits and amenities were suggestions that such conditionality would potentially erode public health, as well as individual wellbeing. For our participants, recent public debate had opened up questions around some, currently universal, entitlements, such that they were attuned to both economic and 'generational fairness' arguments about entitlement. As Williams (1976) noted, the meanings of 'welfare' change over time, and our analysis suggests that older citizens' contemporary understandings are framed by specific geographic, political and cultural contexts: in this case (at least for the older members of our sample) of a national generational habitus often characterised as self-reliant and having contributed to a country over a lifetime, and a current political context in which talk about financial constraint is more possible, and generous talk about others' dependency less so (see for instance, Peacock et al 2014). We cannot claim, then, that the specific issues raised here would be found in other welfare regimes, or in other samples from England. However, our general finding - that how entitlement is understood and constructed has profound implications for the wellbeing effects of benefits and amenities – is likely to be generalisable.

The meanings that attach to particular kinds of conditionality are not fixed, and indeed our participants at times rehearsed the different and changing rationalities that might inform eligibility assessments. Conditionality does not, then, *necessarily* entail a degradation of respect or negative impacts on health. Use of community centres was to some extent targeted at those who needed support, for instance, yet users widely discussed such provision in positive terms, for its contribution to social interaction particularly. Here, the potential negative effects of needs-based targeting (through disrespect and stigma) appear to be off-set because uptake can be framed as reciprocal engagement: that is, beneficiaries also see themselves as contributors in these contexts. For the more equivocal benefits in this study, where entitlement could not be assumed to be understood as a collective right, participants often had to engage in some moral work within the interview to demonstrate how the benefit enabled them to make a contribution. Thus, on a small scale, these are reproducing the reciprocity entailed in the concept of a welfare state, in which membership involves sets of rights and responsibilities which accrue from membership of the social body, rather than any individual characteristics.

Whilst targeting may have intuitive appeal as an evidence-based measure to increase the effectiveness of welfare spending (Carey & McLoughlin 2014, McLaren & McIntyre 2015) the model in Figure 1 suggests that any evaluation of the health impacts of welfare changes should address all pathways, as the effects on public health and health equity are likely to emerge through psychosocial and structural pathways, as well as the direct and immediately measurable ones of access to material resources.

Conclusion

Current erosion of the foundations of the welfare state in the UK and other countries has been ideologically driven, in an economic context where 'targeting' has a plausible appeal. However, the implicit logic model by which such targeting impacts on health is untested. Given the complex pathways we have demonstrated that link styles of entitlement to wellbeing and the public health, policy makers cannot assume that restricting access to welfare benefits or public amenities to those in most need will necessarily have the intended effects, even if it appears economically efficient. However, we also need to avoid romanticism, and a nostalgic argument for simply reviving post-war understandings of the welfare state. In increasingly globalised societies, conditionality reliant on national citizenship, for instance, may no longer have the resonances it had for our older participants. As our data suggest, understandings of welfare (and the bases of entitlement) are contingent, and they are malleable: following Williams (1976), the meanings of 'welfare' are likely to change further. Paying attention to the pathways through which the framing of entitlement impacts on the determinants of health, as well as direct access to resources, might better enable policy makers and practitioners to assess potential impacts, and to identify points for mitigating negative consequences for public as well as individual health.

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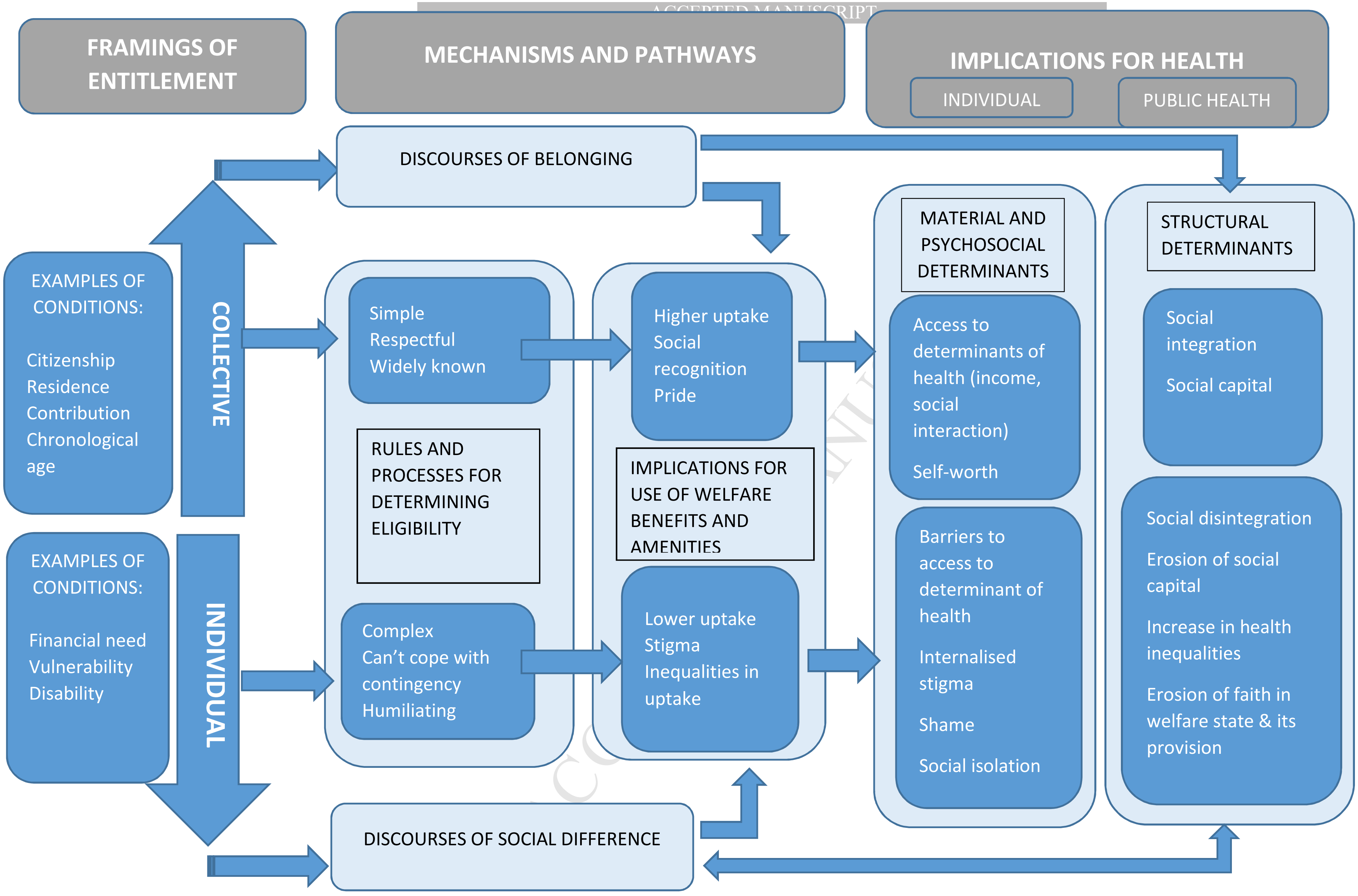
Table 1 Participants: summary

	Site			
	London	Cambridge	Sheffield	Total
Gender				
Female	5	4	5	14
Male	4	4	7	15
Age range				
60-69	2	2	3	7
70-79	4	3	6	13
80 or over	3	3	3	9
Ethnicity*				
White British	7	7	4	18
White Other	2	0	0	2
Black or Black British	0	0	5	5
Asian	0	0	3	3
Total	**9**	**8**	**12**	**29**

*categorised from self-identified census categories

Figure1 Pathways linking forms of entitlement to implications for health and wellbeing


FRAMINGS OF ENTITLEMENT
MECHANISMS AND PATHWAYS
IMPLICATIONS FOR HEALTH
INDIVIDUAL
PUBLIC HEALTH
DISCOURSES OF BELONGING
COLLECTIVE
EXAMPLES OF CONDITIONS:
Citizenship
Residence
Contribution
Chronological age
Simple
Respectful
Widely known
Higher uptake
Social recognition
Pride
MATERIAL AND PSYCHOSOCIAL DETERMINANTS
Access to determinants of health (income, social interaction)
Self-worth
STRUCTURAL DETERMINANTS
Social integration
Social capital
RULES AND PROCESSES FOR DETERMINING ELIGIBILITY
IMPLICATIONS FOR USE OF WELFARE BENEFITS AND AMENITIES
INDIVIDUAL
EXAMPLES OF CONDITIONS:
Financial need
Vulnerability
Disability
Complex
Can't cope with contingency
Humiliating
Lower uptake
Stigma
Inequalities in uptake
Barriers to access to determinant of health
Internalised stigma
Shame
Social isolation
Social disintegration
Erosion of social capital
Increase in health inequalities
Erosion of faith in welfare state & its provision
DISCOURSES OF SOCIAL DIFFERENCE

Highlights

Welfare impacts on health through material, psycho-social and structural pathways

Older adults' understandings of the form of entitlement affect wellbeing outcomes

Universal entitlement facilitates access to resources, sociality and respect

Targeted entitlement deters uptake and fosters discourses of disrespect and division

Evaluations of welfare change need to focus on structural pathways to health outcomes

SSM Welfare Additional material needed for submission

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Disclaimer

The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health

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