Health and Illness in the Neoliberal Era in Europe

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INVESTOR IN PEOPLE

In memory of Gareth Williams, a greatly missed old friend and colleague.

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List of Contributors

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Chapter Two

Health Inequalities in Europe: Policy Matters in the Neoliberal Era[1]

Angela Genova and Simone Lombardini

1. Introduction

Inequality characterises Western societies in the neoliberal era. We refer to neoliberalism as 'a politically guided intensification of market rule and commodification' (Brenner, Peck, & Theodore, 2010). It has been marked by the promotion of competition in the provision of public services and the introduction of private sector management techniques to increase efficiency and to reduce costs (Harvey, 2007; Labonté & Stuckler, 2016; Saltman et al., 2013). This policy context has 'increased inequality' (Schrecker & Bambra, 2015) in economic, social and health conditions. Income inequality has been linked to higher infant mortality and lower life expectancy (Pickett & Wilkinson, 2015). Health inequality has been seen as one of the 'neoliberal epidemics' (Schrecker & Bambra, 2015). Moreover, recent studies have drawn attention to the long-term health implications of the economic crisis in 2008 and the related policy of austerity within the neoliberal policy framework dominating European countries (Bambra, 2019). Austerity measures (cuts to central and local governments and therefore to welfare services) have been linked to an increase in the mortality rate at older ages (Hiam, Harrison, McKee, & Dorling, 2018).

This chapter discusses health inequalities in European countries, focusing from a comparative perspective on healthy life years (HLY) for the older people as a specific contribution to the more general argument concerning health inequalities as 'neoliberal epidemics'. The first section outlines the theoretical framework on health inequalities found in the main literature, concentrating on the relationship between the health of the population and place. The second part investigates

[1]This chapter is a collaboration. However, Angela Genova is responsible for paragraphs 1, 2, 3; Simone Lombardini for paragraph 4. Paragraph 5 should be attributed to both authors.

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data on changes in HLY for the older people in European Union member states according to differences in income distribution (Gini Coefficient) and welfare regime. Based on these results, the last section makes some general comments on the issue of health inequalities in Europe in the neoliberal era according to place and welfare policies. By conducting a comparative analysis on changes in HLY for the older people in European countries, this chapter intends to contribute to the debate on health inequalities in the neoliberal era.

2. Theoretical Framework. Health Inequalities in Europe: Places Matter

Data from the WHO European region database include information not only on European Union member states but also on ex-Soviet Union countries. Comparative analysis shows that, in 2015, the lowest estimated life expectancy at birth was 62.2 for males in Turkmenistan, while the highest was 85.4 for females in Spain: a gap of 23.2 years. Within European member states, the gap for males was 12.6 years: between 68.1 in Lithuania and 80.7 in Sweden; while for females the gap was 7.5: between 78 in Bulgaria and 85.4 in Spain (Source: European Health for All database (WHO, 2019): https://dw.euro.who.int/api/v3/export?code=HFA_70).

Our health is inextricably linked to our geographies (Gatrell & Elliot, 2009): place is a 'milieu that exercises a mediating role on physical, social and economic processes and which effects how such process operate' (Agnew, 2011, p. 318). Nevertheless, places are nodes of social, economic and political networks (Cummins, Curtis, Diez-Roux, & Macintyre, 2007) and spatial inequalities in health are the final outcome of complex economic, social, environmental and political processes. As argued by Bambra (2016), places can be health promoting ('salutogenic') or health damaging (pathogenic).

Literature identifies two main explanations for geographical inequalities in health: compositional and contextual (Macintyre, Ellaway, & Cummins, 2002). According to the compositional approach, the health of a specific place is the result of the individual characteristics of the people living in that area; for the contextual explanation, health inequalities are related to the economic, social and physical environment of the area.

According to the compositional approach, the behaviours and socioeconomic characteristics of people living in a particular area determine the health of the population in that place. The main risky health behaviours (smoking, alcohol, physical activity, diet and drugs) play a crucial role in health outcome. Smoking is related to cancer and cardiovascular disease, being the **more significant** preventable cause of mortality in European member states (Jarvis & Wardle, 2006). Socioeconomic status is the other key element in terms of occupational class, income or educational level (Bambra, 2011). Literature has extensively developed the concept of social gradient in health, according to which people in a higher social class have better health than those in the class below (Marmot, 2010; Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012).

While the compositional perspective focuses on people living in a specific place and considers their characteristics as influencing their health in that place,

for the contextual approach the starting point is the place itself which shapes the health of the people living there. Health, in fact, is strongly affected by the social, economic and physical environment, and 'place acts as a health ecosystem' (Bambra, 2019). In this analytical approach the focus is, therefore, not on the individual socioeconomic conditions, but on the area-economic factors, including employment conditions, poverty rates and income level. The socioeconomic characteristics of a place affect the health of the people living there according to several different mechanisms: the jobs people have access to, as well as the services available (e.g. poor food available in poor neighbourhoods; healthy food and physical activity opportunities absent in deprived areas). Poverty, as one of the main area-level economic factors, is a key predictor of health (Macintyre, 2007). Moreover, social elements, such as the possibility of accessing health care services and the quality of housing, have a significant impact on health conditions, as well as the possibility of implementing healthy or unhealthy behaviours. The absence of safe and walkable outside space as well as affordable fresh food are some of the elements contributing to an obesogenic environment (Pearce, Blakely, Witten, & Bartie, 2007). Places also shape the context of social capital, in terms of trust, norms and networks (Putnam, 1993) mediating between the socioeconomic conditions of people and health outcomes (Hawe & Shiell, 2000): higher social capital is linked to better health conditions. The quality of places as physical environment is another aspect strongly influencing the health of the population: the negative effect of air pollution, as well as contaminated land, is well documented in literature (Bambra, 2016; Walton et al., 2015; WHO, 2008), as is also the positive influence of natural and green space (Abraham, Sommerhalder, & Abel, 2010; Maas, Verheij, de Vries, Spreeuwenberg, & Groenewegen, 2005). Researchers have developed the concept of environmental deprivation associated with a higher mortality rate and the related concept of environmental justice (Pearce, Richardson, Mitchell, & Shortt, 2010).

Contextual and compositional theoretical approaches have to be seen as inextricably linked, with each one reinforcing the other in what is termed 'deprivation amplification'; this highlights the way individual deprivation is amplified by area deprivation (Macintyre et al., 2007). People and places have a marked reciprocal influence, creating a specific ecosystem affected by interrelated micro, meso and macro elements that produce geographical inequalities in health. Contextual and compositional explanations support the analysis at micro and meso levels; however, the macro level plays a crucial role in social, political and economic structures and, therefore, political choices. From this point of view, political choices, being outside the control of individuals or local areas, have been considered 'the causes of the causes of the causes of geographical inequalities' (Bambra, 2019, p. 8). Policy matters because levels of poverty and employment, and environmental conditions are determined by wider political actions at a national or supranational level: 'politics can make us sick or healthy' as mentioned in the title of a recent book (Schrecker & Bambra, 2015).

Economic recession is associated with increasing mental illness (Economou, Madianos, Theleritis, Peppou, & Stefanis, 2011; Gili, Roca, Basu, McKee, & Stuckler, 2013) and health inequalities (Bambra, 2019); despite this, studies of the

impact of the 'great recession' of 2008 on health inequalities have been limited, as its effects will be more evident in coming years. Comparatively, in Western countries previous economic downturns had different impacts on their populations; therefore, inequalities have increased, but not following the same path in all countries (Kondo, Subramanian, Kawachi, Takeda, & Yamagata, 2008; Valkonen et al., 2000).

This chapter discusses the impact of neoliberalism on the course of health inequalities in European member states, focusing on healthy life expectancy for people over 65 years (HLY65+) between 2004 and 2017. Studies into the causes of health inequalities (Beckfield et al., 2015) have demonstrated a complex relationship between welfare regimes (Bambra, 2007; Eikemo & Bambra, 2008) and the health of the population (Bambra & Eikemo, 2009). This work focuses on analysing healthy life expectancy for people over 65 years (HLY65+) according to income inequalities and welfare regimes in European member states using the concept of neoliberal epidemics of health inequality. Income inequality and welfare regimes are seen as macro-level variables and therefore influenced by the neoliberal political context. This study takes into account the literature that conceptualises the welfare state as an institutional arrangement for the distribution of health (Beckeld et al., 2015). The 'social determinants of health are real and they have real consequences' (Kelly & Doohan, 2012); they have to be considered in terms of the health of the population.

Adopting the life course perspective on the accumulation of disadvantages, this study can be framed within the critical case design methodological approach (Yin, 2018). For older people, the impact of recent economic changes is diluted by previous experiences. Thus, the older people seem to be the population with the lowest probability of seeing their health damaged by recent events (being the previous events more relevant). If we find an impact of crisis in this part of the population, we can assume that – a fortiori – it will be higher in other parts. In the following, our analysis shows the presence of severe inequalities in the healthy life expectancy for the older people in Europe. Taking into account the accumulation of disadvantages, the impact of neoliberal policies on the older people can be assumed to be mitigated by previous experiences, while it will be even more evident for the younger generation. More analytical generalisations are, therefore, discussed in the final part of the chapter.

3. Inequalities in Healthy Life Expectancy for the Older People in Europe

HLY (Eurostat), also called disability-free life expectancy, is defined as the number of years that a person is expected to continue to live in a healthy condition (Gold, Stevenson, & Fryback, 2002). According to the life course analytical perspective (Pearlin, Schieman, Fazio, & Meersman, 2005; Wadsworth, 1997; Willson, Shuey, & Elder, 2007), HLY for the older people (people over 65) reflects the accumulation of several health determinants at an individual as well as contextual level through the whole of life (Lundberg et al., 2008). As we discussed above, micro and meso levels are intertwined and both are linked to macro structural economic and social neoliberal features. The analysis investigates changes

in HLY65+ between 2004 and 2017 in the European member states. This time period has been selected to investigate the impact of the 2007 financial crisis and of subsequent neoliberal austerity policy up to 2017, the last data available. The relationship between European member states (places) and neoliberal policy is also analysed in relation to two variables: the Gini index, measuring income inequality and welfare regimes. European states have been classified according to five main welfare regime types (Arts & Gelissen, 2002; Bambra, 2007): Scandinavian (universalistic, strong interventionist states with generous social transfers), Bismarckian (welfare programmes linked to a labour market position and family support), Anglo-Saxon (minimal welfare state provision that is means-tested and has stigmatised social protection systems), Southern (fragmented, limited and partial coverage with a reliance on the family and voluntary sector) and Eastern (formerly Communist countries with limited welfare services). These ideal types represent a consolidated frame of analysis, even if the reality is more complex and such models have been questioned and are liable to change.

4. Data and Analysis

Data on HLY65+ are from Eurostat (Eurostat, 2019). Prevalence data were obtained by the following prompt from the annual European Statistics on Income and Living Conditions survey: PH 030: For at least the past six months, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been *severely limited*, *limited but not severely*, or *not limited?* Data were calculated by age categories of 5 years.

Initially, HLY65+ data from 2004 to 2017 were studied by carrying out the Dickey–Fuller (D–F) test (Dickey & Fuller, 1979) in order to skim countries that have experienced a significant trend (both positive and negative) from those that have remained stable. The D–F test checks the null hypothesis that an autoregressive model follows an increasing or decreasing trend (unit root). The alternative hypothesis is that the autoregressive model moves around its fixed mean (stationarity) or around a trend (trend-stationarity) (Eurostat, 2019). The tests were conducted differentiating between men and women. For p-values greater than 0.1, the time series should be considered non-stationary. Subsequently, linear regressions were conducted to study the slope of the eventual trend in HLY65+ and its statistical significance. Moreover, a delta analysis was run to perform variance analysis between European minimum and maximum data.[2]

4.1. Changes in HLY65+ within Each Member State and Welfare Regimes

A comparative analysis between European member states shows differences in changes in HLY65+. Observing the female and male values, no series of HLY65+

[2]We consider the spread between maximum and minimum level of HLY65+ in absolute (i.e. among all countries) and in the same year, both for 2004 and for 2017. Then, we compute their difference.

for any country is stationary, with the exception of Spain, Portugal, Greece and Italy (Yes = p-value > 0.1, significant trend; No = p-value < 0.1, non-significant trend). Nevertheless, Greece and Italy appear stationary according to the D–F test since they dropped dramatically in the first years (and before 2004) and then remained stable.

Comparative analysis of the relationship between changes in HLY65+ and welfare regime shows that there is no common trend for the four main welfare regimes. They have been differently affected by changes in HLY65+, but for the Southern welfare regime the negative trend is more evident. The European average for HLY65+ remained stable in the period 2004–2017. The trend is minimal (0.008) and not statistically significant, both in females (slightly decreasing) and in males (slightly increasing). Nevertheless, many countries exhibit large variations; 11 countries have worsened their HLY65+ in the last 12 years – 5 of them in a statistically significant way, among them in descending order of severity are Bulgaria, Italy and Greece. This trend has also affected Denmark, a Scandinavian welfare regime, and the Netherlands, a Bismarckian welfare regime.

On the other hand, 17 countries have improved their HLY65+ and 13 of them in a statistically significant way (95% and 99%). Scandinavian welfare regime countries (Sweden, Norway and Finland) mainly present a positive and statistically significant trend. Finally, seven countries did not present a statistically significant trend.

In all countries, both the female and male trends are consistent; however, where it is positive, it is less positive for women (except for Sweden, Cyprus, Czech Republic and Estonia), and where it is negative, it is worse for women (except for Denmark). Finally, while at the European level the maximum values per year have grown at a statistically significant rate, the minimum values have not experienced a statistically significant trend.

The chart shows the countries ordered from the higher variation in terms of improvement of the trend in HLY65+. The first glance at the table reveals immediately the high heterogeneity among EU countries: 8 nations have worsened their HLY65+; 8 nations have not exhibited any significant trend and 13 countries have improved their HLY65+. This outcome reflects the absence of a common health policy in the EU; each country competes with the others and the final outcome, as usual, is that there are winners and losers. Countries with the worst deterioration in their HLY65+ are Bulgaria, Romania, Italy and Greece. Their trends are showed in the following chart, in comparison with the EU country which has performed best in term of HLY65+ over the period analysed: Sweden. Data are considered from 2004 to 2017.

In 2005, the HLY65+ for female and male in Italy, Greece and Sweden was very close. In 2017, the HLY65+ for a Swedish female was 15.8, for a Greek female 7.8; for a Swedish male 15.4, for a Greek male 8.1. As the chart shows (FIGURE 2.1), the worst countries in Europe, for HLY65+, saw their index deteriorate between 2004 and 2010; after that, they remain approximately steady. At the opposite end, Sweden's trend increased over the whole period except for a brief pause between 2010 and 2013 when it suspended its growth. This general trend between the worse countries and the better ones applies to both males and females.

Table 2.1. European Member States According to Welfare Regime, Presence of HLY65+ Trend, Linear Regression of HLY65+ Trend, Sex Aggregated and Disaggregated Data – 2004–2017.

		Presence of Trend in HLY65+	Linear Regression of Trend in HLY65+		
Country	**Welfare Regime**	***p*-value D–F test (Male + Female)[b]**	**OLS Female + Male**	**OLS Female**	**OLS Male**
			Positive trend statistically significant[a]		
1. Sweden	Scandinavian	YES	0.342***	0.359***	0.343***
2. Norway (no EU)[c]	Scandinavian	YES	0.282***	0.248***	0.289***
3. Ireland	Bismarckian	YES	0.278***	0.278***	0.278***
4. Malta	Hybrid[e]	YES	0.271***	0.288***	0.300***
5. Cyprus	Southern Europe	YES	0.217**	0.222**	0.137*
6. Finland	Scandinavian	YES	0.187***	0.162***	0.210***
7. Estonia	Eastern Europe	YES	0.167***	0.195***	0.139***
8. Portugal	Southern Europe	NO	0.165*	0.168*	0.163**
9. Belgium	Bismarckian	YES	0.140***	0.165***	0.115***
10. Czech Republic	Eastern Europe	YES	0.128***	0.126***	0.095**
11. Hungary	Eastern Europe	YES	0.108***	0.080***	0.127***
12. Austria	Bismarckian	YES	0.068	0.044*	0.092**
13. France	Bismarckian	YES	0.010***	0.091***	0.108***

Table 2.1. *(Continued)*

Country	Welfare Regime	Presence of Trend in HLY65+	Linear Regression of Trend in HLY65+		
		p-value D–F test (Male + Female)[b]	OLS Female + Male	OLS Female	OLS Male
			Trend statistically not significant		
14. Luxemburg	Bismarckian	YES	0.013	–0.07	0.096
15. Germany[d]	Bismarckian	YES	0.0259	0.012	–0.036
16. Lithuania	Eastern Europe	YES	0.043	0.032	−0.003
17. Spain	Southern Europe	NO	0.082	0.092	0.071
18. Poland	Eastern Europe	YES	−0.017	0.004	−0.060
19. UK	Liberal	YES	−0.038	−0.019	−0.020
20. Slovakia	Eastern Europe	YES	−0.04	−0.015	0.011
21. Slovenia	Eastern Europe	YES	−0.095	−0.177**	−0.066
			Negative trend statistically significant		
22. Latvia	Eastern Europe	YES	−0.071**	−0.070	−0.071**
23. Netherlands	Bismarckian	YES	−0.093**	−0.154***	−0.036
24. Denmark	Scandinavian	YES	−0.163***	−0.151***	−0.176***
25. Greece	Southern Europe	NO	−0.191***	−0.215***	−0.166***
26. Romania	Eastern Europe	YES	–0.196**	−0.232**	−0.160**
27. Italy	Southern Europe	NO	−0.287***	−0.332**	−0.237***
28. Bulgaria	Eastern Europe	YES	−0.292***	−0.295**	−0.192**
29. Croatia	Eastern Europe	YES	–0.386**	−0.407**	−0.365**
European Union	–	NO	0.047*	0.013	0.033**

Source: Eurostat (2017).

[a]Significant level: *** 99%; ** 95%; *90%; [b]Results used for testing the stationarity are in the appendix; [c]We added Norway (a non-EU country) in order to consider all Scandinavian countries; [d]Germany is considered until 2014 and Italy until 2015 since data after are uncertain; [e]Briguglio and Bugeja (2011).

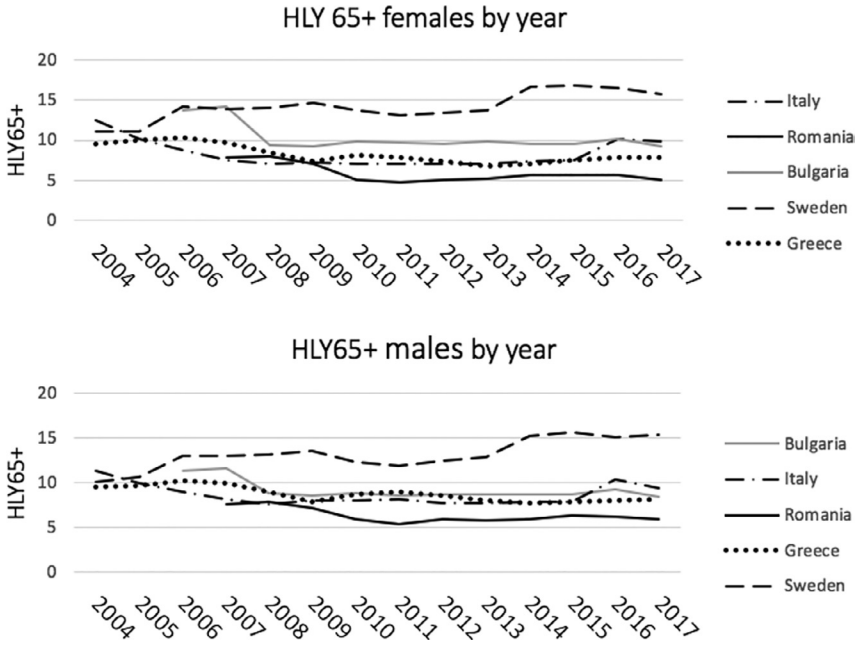

Fig. 2.1. HLY65+ Trend in the Worst Countries and the Best One, 2004–2017. *Source*: Eurostat.

Table 2.2 shows that, on the one hand, the maximum value increased for both the female (from 13.7 to 16.8) and male population (from 13.3 to 15.7); on the other hand, the minimum value decreased for males (from 4.6 to 4.1) and it is stationary for females (3.8). Nevertheless, the male minimum data are still above the female level, showing that part of the female European population has worsened

Table 2.2. Maximum and Minimum HLY65+, Sex Disaggregated Data, 2004 and 2017 and Delta.

	HLY65+			
	2004	**2017**	**Delta Absolute Value**	**Delta %**
Male Max	13.3 (Denmark)	15.4 (Sweden)		
Male Min	4.6 (Estonia)	4.1 (Latvia)		
Male Gap	8.7	11.6	2.9	33
Female Max	13.5 (Denmark)	15.8 (Sweden)		
Female Min	3.8 (Portugal)	4.1 (Slovakia)		
Female Gap	9.9	13	3.1	31

in HLY65+ compared to the male one. Moreover, the gap between maximum and minimum values in Europe (Delta%) increased for both the male (33%) and female populations (31%), and it is wider for females (13 years against 11.6 for males). The absolute difference (delta absolute value) between male and female gap increased too, by 2.9 and 3.1, respectively.

4.2. Correlation between Income Inequality and HLY65+

In this section, we link the trend in HLY65+ of the EU countries with an index of income inequality. Economic inequality is a typical characteristic of the neoliberal era and it is linked, as literature has already stated, to health inequalities (Wilkinson, 1996). The huge inequality in health conditions among the countries studied in the previous section is also reflected in income distribution.

To investigate this relationship, we adopt the familiar Gini index as a proxy for income distribution. The Gini index varies from 0 to 1 (0 perfect distribution; 1 a single person earns all the income of the country) so that the higher the index, the greater the income inequality. The idea is to compare the Gini index average trend (from 2004 to 2017) with the average trend of HLY65+ (from 2004 to 2017), for all of the 28 EU countries (plus Norway). In this way, we will not simply compare HLY65+/Gini index for a single year; rather, we are comparing how a long-term trend (positive or negative) in the Gini Index is associated with a long-term trend (positive or negative) in HLY65+. We estimated the average trend in Gini index with a simple OLS model. Income inequality was measured with the Gini index provided from the Standardised World Income Inequality Database (SWIID). The SWIID is based on the Luxembourg Income Study and offers comparable high-quality data.

The chart shows evidence of a negative link between the Gini index and HLY65+. Indeed, in those countries where the income distribution has been most concentrated over the period observed, the HLY65+ has followed (on average) a declining trend. An outlier is Sweden: it is the first country in Europe for HLY65+ increment while exhibiting one of the highest Gini index increments: from 0.23 in 2004 to 0.27 in 2017 (+17%). Other countries which do not perfectly fit the general trend are Slovakia and Poland, where inequalities have strongly reduced while HLY65+ has remained quite stable (a slight decline). The remaining countries, however, respect the general trend. According to the graph, the countries which perform best (i.e. high HLY65+ increase plus high Gini index decrease) are Finland, Belgium, Portugal, Estonia and Czech Republic. On the other hand, the countries which perform worst (i.e. high HLY65+ decrease plus high Gini index increase) are Bulgaria, Denmark, Slovenia, Italy, Greece and Romania.

5. Conclusion: Policy Matters in the Neoliberal Era

The comparative analysis of HLY65+ represents a key indicator in investigating health inequalities (Robine, Michel, & Branch, 1992; Salomon, Wang, & Freeman, 2013; Stiefel, Perla, & Zell, 2010). This study extends, and updates some of the main results in health inequalities literature (Beckfield, Morris, & Bambra,

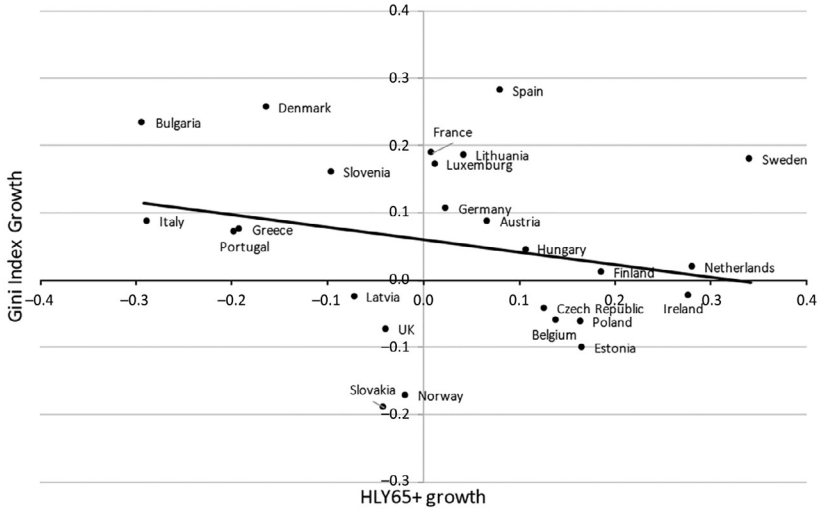

Fig. 2.2. HLY65+ Average Growth vs. Gini Index Average Growth, 2004–2017. *Source*: Eurostat. *Notes*: Malta and Cyprus are excluded since their two systems are too small and are not comparable with the others. Adding them to the chart would distort the general trend; Croatia is excluded since data on HLY65+ and Gini index for this country are only available from 2010, therefore the estimated parameters for these two trends are too uncertain; On the gap in HLY65+ data for Italy (2010) and Sweden (2012), as well as for other European countries, Eurostat reported as 'not available' the values for HLY, due to limitations in data collection procedures.

2018; Mackenbach, 2006), adding more evidence on the HLY65+ trend between 2004 and 2017. HLY65+ within each European state exhibited no consistent trend: in some countries it increased, while in others manifesting severe health inequalities it decreased. Findings highlight a positive performance in most of the Scandinavian (Sweden, Norway and Finland), Bismarckian (Germany, Belgium, Austria, France) and Eastern Europe (Czech Republic, Estonia Hungary) welfare regime countries, and a negative trend for Southern welfare regimes (Italy and Greece). Nevertheless, the negative trend in HLY65+ also affected a Scandinavian country (Denmark), a Bismarckian (the Netherlands) and four Eastern Europe countries (Bulgaria, Latvia, Romania, Croatia), highlighting that none of the welfare regimes has been immune to this neoliberal epidemic, though the Southern regime has been more vulnerable.

The sex differences in HLY65+ confirmed in this study have been observed in other studies (Baerlocher, 2007; Crimmins & Saito, 2001; Jagger et al., 2008) showing that on average, women tend to live longer than men and in better health. Nevertheless, health inequality in HLY65+ is higher for the female than for the male population, showing that females are impacted more severely by this trend.

Sex disaggregated data usually show both similar trends and small differences by gender. The female population usually presents better HLY65+, but this was not observable in all countries. The female population, more than the male population, has been more exposed to the inequality epidemic, paying the price of a decrease in HLY65+. In Italy (Gennaro, Ghirga, & Corradi, 2012) and in Greece, compared to the average of European countries, females present worse HLY65+ especially after the year 2006. Despite the decrease in HLY65+ in Denmark, the female population has been less affected by this trend, while in Sweden, the increase has been greater than for the male population, showing an advantageous position for the female population in Scandinavian countries.

Analysis on the correlation between differences in income inequalities and HLY65+ move forward the debate on the role of macro elements on the health of the population. From a sociological point of view, these findings are in line with previous studies on the role of welfare policy on the health of the population (O'Campo et al., 2015). The analysis has confirmed that the Scandinavian welfare regime presents the best outcome in term of HLY65+. Nevertheless, the decreasing trend in Denmark and in the Netherlands seems to show that the dominant neoliberal policy context has deteriorated the protective capacity of the European welfare regime and thereby reduced the capacity of welfare policy to combat health inequalities.

Compositional and contextual analytical perspectives in explaining geographical health inequalities are strongly intertwined: individual (micro) and area (meso) deprivations are summed and affected by the political–neoliberal (macro) level. This study highlights the fact that the health inequalities epidemic is impacting on all welfare regimes (Bambra, 2007); however, the severe decrease in HLY65+ in Greece and Italy, as well as the stable trend in Spain and Portugal, seem to suggest that Southern European countries have been more vulnerable to neoliberalism. Furthermore, the female population has been more exposed to such 'neoliberal epidemics', confirming the presence of a greater structural disadvantage for women in Europe, with interesting differences that call for further study. Structural gender differentiation characterises the pension systems in European member states (Leitner, 2001), and the gender pay gap is one of the most evident indicators of disadvantage (Eurostat, 2019). Moreover, 'austerity represents a major challenge for gender equality' (Karamessini & Rubery, 2013, p. 4), influencing demand for female labour but also access to services that support women as carers and therefore increasing the risk of pushing women back into unpaid domestic labour. The neoliberal policy context increases women's vulnerability in society with regard to gender segregation in the labour market and in the family care role and, taking a life course approach, this is affecting female healthy life expectancy for those over 65 in Europe.

As has been shown in this study in considering the wider mechanisms in health inequities (Kriznik, Kinmonth, Ling, & Kelly, 2018), place matters because policy matters: 'social welfare matters' (O'Campo et al., 2015), confirming the main literature on neoliberal welfare policy and health inequalities (Farrants, 2017; Högberg, Strandh, Baranowska-Rataj, & Sevä, 2017; Kriznik et al., 2018; Kwarteng, Schulz, Mentz, Zenk, & Opperman, 2013).

Inequalities in HLY65+, as results of micro, meso, but above all macro political factors, are socially produced and, therefore, are potentially avoidable and widely considered unacceptable in a civilised society (Lynch, 2017). 'Such inequalities, being unfair and stemming from some form of injustice' (Whitehead, 2007) 'could be avoided by reasonable means' (Kawachi, Subramanian, & Almeida-Filho, 2002).

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