Health Affairs Scholar, 2025, **3**(3), qxae170
https://doi.org/10.1093/haschl/qxae170
Advance access publication: March 17, 2025
Commentary

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

The fundamental importance of social insurance for health equity

Seth A. Berkowitz*

Division of General Medicine and Clinical Epidemiology, Department of Medicine, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC 27599, United States

*Corresponding author: Division of General Medicine and Clinical Epidemiology, Department of Medicine, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC 27599, United States. Email: seth_berkowitz@med.unc.edu

Abstract

People need to consume goods and services that support health, such as nutritious food, medical care, and quality housing, throughout their lives. Many of these goods and services are allocated using markets, which means that people need income to provide purchasing power for these goods and services. However, everyone has times when supporting themselves through paid labor is not possible, so many individuals will not receive the income needed for a healthy life if income distribution is tied solely to economic production. Therefore, a key political economy of health goal is to put in place income-support policy that gets income to those unable to engage in paid labor. The 3 main forms of income-support policy—social assistance, social insurance, and guaranteed income—offer different strengths and limitations. I argue that social insurance, because of its focus on getting income to people in situations in which they cannot or should not engage in paid labor, is a fundamental part of a political economy that supports everyone's health.

Key words: income; social determinants of health; social insurance; socioeconomic status.

In their pathbreaking article, "Health and Political Economy: Building a New Common Sense in the United States," Roy et al[1] demonstrate how economic institutions contribute to poor health overall and the inequitable distribution of poor health. Moreover, they make clear the importance of reforming income-distributing institutions for better population health. In this commentary, I argue for the essential role of 1 set of distributive institutions—social insurance—in a political economy that promotes the health of everyone.

Income and health

The general relationship between income and health is that income provides purchasing power that allows individuals to consume goods and services necessary for health (eg, nutritious food, health care).[2-8] These health impacts accumulate over time, and financial security facilitates prioritizing health. Cash income, in particular, gives flexibility in addressing personal priorities. Moreover, income can affect social status and thus how people relate to each other. Indeed, the connection between income and health is one of the most robust in social epidemiology.[2-4,6,9] Of course, income is not all that matters for health, and income distribution is not the only explanation for health inequities. But income surely matters.

Income distribution

Income is of 2 types: factor income (received in exchange for goods and services, such as wages for paid labor or dividends for the use of assets) and transfer income (received without exchange of goods or services).[10] In market economies, the factor payment system, which distributes income under contractual terms for supplying "factors" of production (labor, land, or capital), is the primary income-distributing institution. However, this creates a problem. People engage in paid labor for, at most, part of their lives (and typically own little income-generating property), but have consumption needs throughout their lives. Thus, distributing income solely through the factor payment system would lead to many individuals not receiving the income needed for a healthy life.[11] From a political economy and health perspective, the factor payment system must be supplemented with additional income-distributing institutions. Broadly, these can take 3 forms: social assistance, social insurance, or guaranteed income.[12]

Social assistance provides income support based on need—that is, having insufficient income and assets (sometimes called "means-testing"). US social-assistance programs include the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

Social insurance provides income support based on risk—specifically, risk of insufficient income stemming from inability to engage in paid labor.[2] Viewed narrowly, social insurance is "contributory," covering only individuals who have "paid in," like with some unemployment insurance or retirement pension programs. However, I think we should view social insurance more broadly—encompassing all programs that provide income support to those with a "covered" reason for not engaging in paid labor. Using the term like this does expand its meaning,[13] but there is a similarity in the logic of such programs, providing income support during times in which engaging in paid labor is infeasible, which supports

Received: August 12, 2024; Revised: September 4, 2024; Accepted: December 9, 2024

thinking of them as forms of social insurance. Examples of social insurance programs are Social Security Administration Old-Age and Survivor's Insurance (OASI; commonly referred to as "social security checks") and Social Security Disability Income (SSDI).

Finally, guaranteed income provides income support to an entire population, regardless of need or risk. Guaranteed income programs are uncommon, but the Alaska Permanent Fund Dividend is one example.[14,15]

When is social insurance needed?

Social insurance protects against the risk of insufficient income for people in 6 important social "roles" that can occur across the life course: childhood (approximately to age 18 years), pursuit of higher education, caregiving, work-limiting disability, unemployment, and older age (approximately from age 65 years). About half of the US population is in one of these roles at any given time (Figure 1): 40% are under age 18 or over 65 and 10% are between 18 and 65 and are full-time students or caregivers (eg, for children or sick relatives), have a work-limiting disability, or face temporary unemployment.

The key distinction between social insurance and social assistance is the policy's logic. If a program is meant to provide income support during a time when a person cannot or should not be expected to primarily support themselves through paid labor, so as to prevent the risk of experiencing material deprivation (and the health harms that that brings), then I think it makes sense to think of it as a form of social insurance. If the intent is to provide relief only after a person's income drops below a certain level (for whatever reason), then I consider that a type of social assistance. The goals of social assistance and social insurance are both laudable, but the different intentions underlying them create substantive differences in program design and implementation that have important impacts on a policy's real-world effects.

Why social insurance?

Why should we structure income support as social insurance rather than social assistance or guaranteed income? In short, social insurance is effective, reaches those who are eligible, and minimizes macroeconomic costs.

To be clear, social assistance programs are certainly better than no income support at all. For example, studies of SNAP; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the Earned Income Tax Credit (EITC) all show improvements in health when benefits reach individuals, compared with not receiving income support.[16-18] However, there are several reasons that building an income-support system around social assistance is a suboptimal choice for population health. First, because social assistance requires that people first experience low income before they can receive benefits, it is analogous to treating the problem after it occurs, rather than preventing it (the goal of social insurance). Experiencing low income can create health harms that subsequent income-support programs may not be able to undo. Second, because social assistance programs are focused on ensuring that only those in need receive benefits, they often have substantial administrative burdens related to eligibility determination and recertification.[19,20] These burdens can create stigma, adversarial program administration, and ultimately reduce take-up, such that many eligible individuals do not receive benefits.[19-21] Next, because social assistance programs are meant only for those in need, rather than as more universal benefits, it has empirically been difficult to fund benefits at levels that effectively alleviate poverty. Indeed, international comparative studies make clear that social assistance less effectively reduces poverty and material deprivation than social insurance.[22-29] Finally, phasing-out benefits as factor income increases creates high effective marginal tax rates, resulting in "poverty traps" that make it difficult to get ahead.[2,10,28] For all of these reasons, the overall population health impact of an income-support system that emphasizes social assistance is not as great as it could be. A policy regime that emphasized social insurance could get income support to people before a lack of income harmed health. Of course, having a more limited role for social assistance programs as a backup plan can be a good idea. But the more poverty can be effectively prevented by a country's social insurance system, the less social assistance would be needed.

Guaranteed income avoids many of the harms of social assistance but presents other issues. There is no clear mechanism for responding to large and unexpected expenses, and it likely would need to be structured as a complement, not a substitute for, other income-support programs. If there were to be a national guaranteed-income program, approximately half of individuals included would already be engaging in paid labor, and thus at lower risk for insufficient income in the absence of the program. Relative to a social insurance approach focused on individuals not engaging in paid labor, this could mean fewer health benefits for a given fiscal cost. Indeed, a recent randomized trial in which many participants were working observed few health impacts.[30] Another concern sometimes raised is the macroeconomic costs of such a program. Those costs could relate to "income" effects that may slightly discourage paid labor (among those who might otherwise work)—although empirical evidence suggests that such impacts are small[31,32]— and "substitution" effects that could discourage paid labor among those taxed to finance the program (if not financed through social wealth fund dividends, like the Alaska Permanent Fund).[31,33] However, empirical evidence also suggests that such substitution effects are likely not a large concern in the United States at present.[34,35] Of course, these concerns apply to social insurance as well, but since social insurance covers fewer people than guaranteed income (requiring less financing for a given benefit level) and covers people unlikely to engage in paid labor in the absence of the program, the macroeconomic costs of guaranteed income, if any, are likely to be larger than for social insurance. Overall, then, I think guaranteed income offers few marginal benefits over a system of social insurance.

Current social insurance and goals for improvement

The above-mentioned roles are part of the fabric of society, and each has existing income-support programs. However, these programs currently fall short, leading to preventable problems.

Older age

A mix of programs provide income support after retirement. The bedrock is OASI, which prevents poverty and improves health.[36-40] Additional programs are tax-advantaged accounts (eg, 401(k) plans), and enterprise benefits (eg, pensions offered

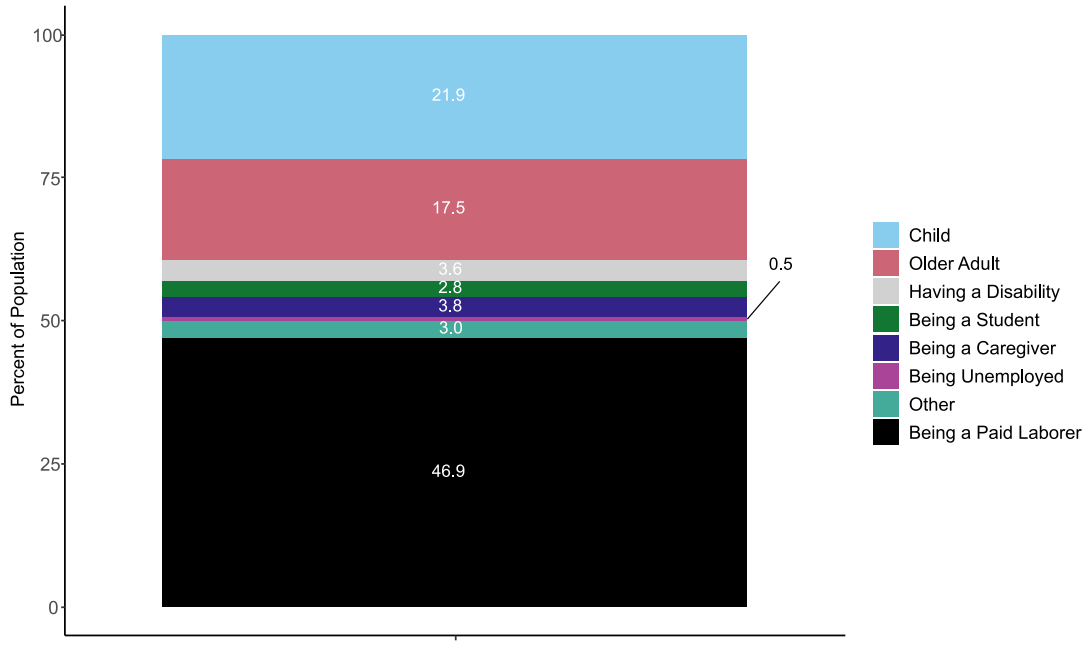

Figure 1. US population and "roles" relevant for social insurance. The figure depicts the distribution of the US population across social categories relevant for social insurance ("roles"). The numerals represent the percentage of the population in each category. Children are defined as those under 18 years of age; older adults are defined as those 65 years of age and older. The remaining "working-age" adults are categorized as having a disability if they report not working in the past year and a disability being the primary reason for that, being a student if they report not working in the past year and attending school as the primary reason for that, being a caregiver if they report not working in the past year and providing caregiving as the primary reason for that, being unemployed if they report not working in the past year but actively looking for work, being a paid worker if they report working for pay in the past year, and "other" if they report not working for pay in the past year but not for any of the other reasons. Source: Author's analysis of US Census Bureau Current Population Survey 2023 Annual Social and Economic Supplement, downloaded via IPUMS.

by former employers).[41,42] Because tax-advantaged accounts and enterprise benefits disproportionately favor individuals paid more highly during their working years, the current mix of income supports disadvantages those who faced educational and labor market discrimination earlier in life, particularly women and those who are racially minoritized.[43-45] For that reason, OASI should be emphasized. Moreover, if there truly are solvency issues in the benefit system for older individuals, it would be better to reduce tax expenditures on tax-advantaged accounts,[46,47] which primarily benefit the well-off, rather than cutting OASI benefits, the subject of recent congressional proposals.[48]

Children

Ensuring that children grow up with adequate income would be both health- promoting and a form of "investment" that has long-term social benefits.[49-52] Current children's benefits are mostly implemented through the tax code. Major programs include the Child Tax Credit (CTC), the child-related part of the EITC, head of household filing status, and dependent tax deductions. Tax code–based implementation has many problems, including not reaching non-filers (typically those with low income), lump sum payments that make income smoothing difficult, and lack of refundability for some benefits (meaning those with lower tax liabilities receive less support).[53-56] Moreover, the current EITC and CTC explicitly exclude those with the lowest income and intentionally provide less support for low-income families as the benefits "phase-in."[57,58] This means that children at greatest risk of poor health due to insufficient income receive the least support. A better approach would be a single program that issues monthly payments for each child (to a parent or guardian as payee). This could be partially financed through consolidation of the CTC, the child-related part of the EITC, and dependent deduction, and head of household tax expenditures. Moreover, greater social insurance spending may reduce the need for social assistance spending (eg, TANF, SNAP, and WIC).

Work-limiting disability

Work-limiting disabilities can reduce labor income and create additional expenses for medical care and adaptive strategies.[59-61] In thinking about disability income programs, it is helpful to separate short-term and long-term disability. At present, the Family and Medical Leave Act (FMLA) provides some short-term job protection but no income support (and excludes many workers).[62] A few state and local programs, along with enterprise benefits, offer short-term income support (such as paid sick leave), but there is no national program. Adding a national system of short-term disability income is likely to provide meaningful health benefits.[63-65] For long-term disability, SSDI is the main public program (Supplemental Security Income provides social assistance for those without an SSDI-qualifying work history). However, access is difficult, resulting in many eligible individuals not receiving benefits.[66,67] Further, benefit amounts are low, and limits on the amount of income that can be earned while still receiving benefits may prevent individuals from engaging in paid labor to the extent they are able.[68] One model for reform is the Veterans Affairs system of disability benefits, where benefits are set through an initial disability determination without subsequent earnings limits, avoiding labor disincentives.[69] There is strong evidence that this approach improves health.[70]

Students

Pursuing advanced education typically precludes full-time employment, and thus students need a source of income support during this time of their lives. Basing support on loans and family transfers likely discourages advanced education for those with less family support and contributes to high rates of food insecurity among students.[10,71] Thus, while perhaps not commonly thought of in this way, providing income support for those pursuing advanced education could fit well under the logic of social insurance. Given the clear connection between education and health, increasing the capability of individuals to pursue advanced education is likely to be health-promoting,[72-75] although this does not address other issues such as financing of advanced education, a topic separate from social insurance. Another approach that could be seen as a new area for social insurance is to provide income support during the years after compulsory education (approximately ages 18–24). Doing so addresses the risk of insufficient income that many face at this time (whether because they are pursuing advanced education or because they have had little time to accrue skills valued by the labor market), is neutral between those who do and do not pursue advanced education, and helps lessen pressure to forgo college so as not to burden one's family.

Unemployment

US unemployment insurance has federal standards but is administered by each state. This creates wide variability in rules and benefits, along with underinvestment in system infrastructure.[76-79] Many workers remain uncovered, income replacement rates are low, and benefits are hard to access.[80] Key goals for reform include federalization of administration, expanding eligibility (including adoption of a "job-seeker" approach without work history requirements), and increasing replacement rate and benefit duration. Since better unemployment insurance helps individuals meet basic needs and improves mental health, such reforms would bring important health benefits.[81-87]

Caregiving

Caregiving benefits are health-promoting,[88-91] but there is no national program, only the FMLA (unpaid job protection) and some state and job-based programs.[62,92] Social insurance for caregivers is often presented as paid "leave," meaning benefits for someone stepping away from paid work. However, since caregiving precludes paid work even if not previously employed, it would be better to envision universal caregiving benefits, without work history or earnings requirements. Such eligibility criteria are hallmarks of most current proposals[93] but would exclude many.[94]

Improving factor income distribution

Social insurance is principally for those with barriers to paid labor. For this reason, efforts to improve the distribution of factor income, also a key part of a political economy of health agenda,[1] are complementary to, rather than substitutes for, efforts to improve social insurance. Such efforts include facilitation of collective bargaining (eg, unionization and sectoral bargaining) to work against employers' monopsony power,[95-99] minimum wage laws,[100,101] and full employment macroeconomic policy.[102,103] These efforts will improve population health,[96,97,103,104] but individuals not directly attached to the factor payment system—those for whom social insurance is meant—would benefit only indirectly. For example, despite recent full employment conditions that cut by one-third 40 years of wage-inequality growth,[105] food insecurity and poverty increased substantially when COVID-19–related social-insurance programs ended.[106,107] Efforts to improve factor income distribution are clearly important but are no substitute for social insurance.

Achieving social insurance reform

Social insurance reform will require an organized political coalition.[108,109] Potential beneficiaries are a natural constituency, but because social insurance protects against risk from situations that occur commonly across the life course, it can help organize those who do not immediately stand to benefit. For instance, those who are not currently caregivers or parents can still rally around the fact that they may need to care for a loved one eventually, or the desirability of smoothing the costs of raising young children over longer time frames. The broader applicability of social insurance programs may be an important political asset.[20] A key trade-off emphasized in policy debates over social assistance vs social insurance is that social insurance tends to have greater fiscal costs than a similar social assistance program restricted only to those with low income.[28] This greater fiscal cost could be seen as a political liability as it may require greater taxation to finance it. However, empirical work has demonstrated that it is often easier to generate political support for more inclusive social insurance programs, even with their larger budgets.[22,28] Whereas those with middle-range incomes might see little benefit from supporting social assistance for those with low incomes, a social insurance program they can benefit from, along with those with lower incomes, may be more feasible. Indeed, this has been the trajectory of older-age pensions in many countries, starting as poverty relief but growing to encompass virtually the entire older population.[27,110]

Conclusion

People have consumption needs throughout their lives, but they can engage in paid labor during, at most, part of it. If income distribution is related solely to economic production, many individuals will not receive the income needed for a healthy life. Tackling this cause of poor population health requires reforming our income-distributing institutions: we must get income to those unable to engage in paid labor. Social insurance is the mechanism for this, and is thus a fundamental part of a political economy that supports everyone's health.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Funding

No specific funding was received for this work.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

1. Roy V, Hamilton D, Chokshi DA. Health and political economy: building a new common sense in the United States. *Health Aff Sch*. 2024;2(5):qxae041. https://doi.org/10.1093/haschl/qxae041
2. Berkowitz SA. *Equal Care: Health Equity, Social Democracy, and the Egalitarian State*. Johns Hopkins University Press; 2024.
3. Marmot M, Bell R. Fair society, healthy lives. *Public Health*. 2012;126(Suppl 1):S4-S10. https://doi.org/10.1016/j.puhe.2012.05.014
4. Pickett KE, Wilkinson RG. Income inequality and health: a causal review. *Soc Sci Med 1982*. 2015;128:316-326. https://doi.org/10.1016/j.socscimed.2014.12.031
5. Sen A. *Development as Freedom*. Reprint ed. Anchor; 2000.
6. Wagstaff A, van Doorslaer E. Income inequality and health: what does the literature tell us? *Annu Rev Public Health*. 2000;21(1):543-567. https://doi.org/10.1146/annurev.publhealth.21.1.543
7. Agarwal SD, Cook BL, Liebman JB. Effect of cash benefits on health care utilization and health: a randomized study. *JAMA*. 2024;332(17):1455-1463. https://doi.org/10.1001/jama.2024.13004
8. Rizvi A, Kearns M, Dignam M, et al. Effects of guaranteed basic income interventions on poverty-related outcomes in high-income countries: a systematic review and meta-analysis. *Campbell Syst Rev*. 2024;20(2):e1414. https://doi.org/10.1002/cl2.1414
9. World Health Organization. Social Determinants of Health. Accessed May 10, 2021. https://www.who.int/westernpacific/health-topics/social-determinants-of-health
10. Barr N. *Economics of the Welfare State*. Annotated ed. Oxford University Press; 2020.
11. Bruenig M. The best way to eradicate poverty: welfare not jobs. Accessed March 12, 2021. https://www.peoplespolicyproject.org/2018/09/18/the-best-way-to-eradicate-poverty-welfare-not-jobs/
12. Berkowitz SA. The logic of policies to address income-related health inequity: a problem-oriented approach. *Milbank Q*. 2022;100(2):370-392. https://doi.org/10.1111/1468-0009.12558
13. Wendt C. Social health insurance in Europe: basic concepts and new principles. *J Health Polit Policy Law*. 2019;44(4):665-677. https://doi.org/10.1215/03616878-7530837
14. Alaska Department of Revenue. Permanent Fund Dividend. Accessed April 1, 2022. https://pfd.alaska.gov/
15. Jones D, Marinescu I. The labor market impacts of universal and permanent cash transfers: evidence from the Alaska Permanent Fund. *Am Econ J Econ Policy*. 2022;14(2):315-340. https://doi.org/10.1257/pol.20190299
16. Hamad R, Rehkopf DH. Poverty, pregnancy, and birth outcomes: a study of the earned income tax credit. *Paediatr Perinat Epidemiol*. 2015;29(5):444-452. https://doi.org/10.1111/ppe.12211
17. Berkowitz SA, Palakshappa D, Rigdon J, Seligman HK, Basu S. Supplemental Nutrition Assistance Program participation and health care use in older adults: a cohort study. *Ann Intern Med*. 2021;174(12):1674-1682. https://doi.org/10.7326/M21-1588
18. Food and Nutrition Service. About WIC—How WIC helps. Accessed August 2, 2018. https://www.fns.usda.gov/wic/about-wic-how-wic-helps
19. Herd P, Moynihan DP. *Administrative Burden: Policymaking by Other Means*. 1st ed. Russell Sage Foundation; 2019.
20. Rothstein B. *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Illustrated ed. Cambridge University Press; 1998.
21. Ko W, Moffitt RA. Take-up of social benefits. Published online June 2022. https://doi.org/10.3386/w30148
22. Jacques O, Noël A. Targeting within universalism. *J Eur Soc Policy*. 2021;31(1):15-29. https://doi.org/10.1177/0958928720918973
23. Brady D, Bostic A. Paradoxes of social policy: welfare transfers, relative poverty, and redistribution preferences. *Am Sociol Rev*. 2015;80(2):268-298. https://doi.org/10.1177/0003122415573049
24. Brady D. *Rich Democracies, Poor People: How Politics Explain Poverty*. Illustrated ed. Oxford University Press; 2009.
25. Kenworthy L. *Social Democratic Capitalism*. Illustrated ed. Oxford University Press; 2019.
26. Lindert PH. *Making Social Spending Work*. Cambridge University Press; 2021.
27. Wilensky HL. *Rich Democracies: Political Economy, Public Policy, and Performance*. University of California Press; 2002.
28. Korpi W, Palme J. The paradox of redistribution and strategies of equality: welfare state institutions, inequality, and poverty in the Western countries. *Am Sociol Rev*. 1998;63(5):661-687. https://doi.org/10.2307/2657333
29. Ben-Shalom Y, Moffitt R, Scholz JK. An assessment of the effectiveness of antipoverty programs in the United States. In: Jefferson Philip N, ed. *The Oxford Handbook of the Economics of Poverty*. Oxford University Press; 2012:709–749. https://doi.org/10.1093/oxfordhb/9780195393781.013.0023
30. Miller S, Rhodes E, Bartik AW, Broockman DE, Krause PK, Vivalt E. Does income affect health? Evidence from a randomized controlled trial of a guaranteed income. Published online July 2024. Accessed September 17, 2024. https://doi.org/10.3386/w32711
31. JFI Research. *Model behavior: a critical review of macroeconomic models for guaranteed income and the Child Tax Credit*. Jain Family Institute; 2021. Accessed December 28, 2021. https://www.jainfamilyinstitute.org/projects/parts/a-critical-review-of-macroeconomic-models-for-guaranteed-income-and-the-child-tax-credit/
32. Vivalt E, Rhodes E, Bartik AW, Broockman DE, Miller S. The employment effects of a guaranteed income: experimental evidence from two U.S. states. Published online July 2024. Accessed Sept 17, 2024. https://doi.org/10.3386/w32719
33. Hoynes H, Rothstein J. Universal basic income in the United States and advanced countries. *Annu Rev Econ*. 2019;11(1):929-958. https://doi.org/10.1146/annurev-economics-080218-030237
34. Saez E, Slemrod J, Giertz SH. The elasticity of taxable income with respect to marginal tax rates: a critical review. *J Econ Lit*. 2012;50(1):3-50. https://doi.org/10.1257/jel.50.1.3
35. Diamond P, Saez E. The case for a progressive tax: from basic research to policy recommendations. *J Econ Perspect*. 2011;25(4):165-190. https://doi.org/10.1257/jep.25.4.165
36. Arno PS, House JS, Viola D, Schechter C. Social security and mortality: the role of income support policies and population health in the United States. *J Public Health Policy*. 2011;32(2):234-250. https://doi.org/10.1057/jphp.2011.2
37. Brucker DL, Jajtner K, Mitra S. Does social security promote food security? Evidence for older households. *Appl Econ Perspect Policy*. 2022;44(2):671-686. https://doi.org/10.1002/aepp.13218
38. Reeves A, McKee M, Mackenbach J, Whitehead M, Stuckler D. Public pensions and unmet medical need among older people: cross-national analysis of 16 European countries, 2004–2010. *J Epidemiol Community Health*. 2017;71(2):174-180. https://doi.org/10.1136/jech-2015-206257
39. Romig K. Social Security Lifts More People Above the Poverty Line Than Any Other Program. Center on Budget and Policy Priorities. October 25, 2013. Accessed August 28, 2024. https://www.cbpp.org/research/social-security/social-security-lifts-more-people-above-the-poverty-line-than-any-other
40. Ayyagari P. Evaluating the impact of social security benefits on health outcomes among the elderly. *SSRN Electronic J*. 2015. https://doi.org/10.2139/ssrn.2669699
41. Diamond PA. *Taxation, Incomplete Markets, and Social Security*. MIT Press; 2002.
42. Barr N, Diamond P. The economics of pensions. *Oxf Rev Econ Policy*. 2006;22(1):15-39.
43. Goldin C, Pekkala Kerr S, Olivetti C. When the kids grow up: women's employment and earnings across the family cycle. Published online August 2022. Accessed September 17, 2024. https://doi.org/10.3386/w30323

44. Glover A, Mustre-del-Rio J, Pollard E. Lifetime earnings differences across black and white individuals: years worked matter. *Econ Rev*. 2022;108(1).
45. Bayer P, Charles KK. Divergent paths: a new perspective on earnings differences between Black and White men since 1940. *Q J Econ*. 2018;133(3):1459-1501. https://doi.org/10.1093/qje/qjy003
46. Urban-Brookings Tax Policy Center. How large are the tax expenditures for retirement saving? Tax Policy Center. Accessed August 28, 2024. https://www.taxpolicycenter.org/briefing-book/how-large-are-tax-expenditures-retirement-saving
47. Toder E, Khitatrakun S, Boddupalli A. Tax incentives for retirement savings. Tax Policy Center. May 11, 2020. Accessed August 28, 2024. https://www.taxpolicycenter.org/publications/tax-incentives-retirement-savings
48. Congressional Budget Office. Raising the full retirement age for social security. Accessed October 29, 2024. https://www.cbo.gov/publication/60516
49. Pascoe JM, Wood DL, Duffee JH, Kuo A. Committee on Psychosocial Aspects of Child and Family Health; Council on Community. Pediatrics mediators and adverse effects of child poverty in the United States. *Pediatrics*. 2016;137(4):e20160340. https://doi.org/10.1542/peds.2016-0340
50. Pilkauskas N. Child poverty and health: the role of income support policies. *Milbank Q*. 2023:101;379-395.
51. Hoynes H, Schanzenbach DW, Almond D. Long-run impacts of childhood access to the safety net. *Am Econ Rev*. 2016;106(4):903-934. https://doi.org/10.1257/aer.20130375
52. Aizer A, Hoynes HW, Lleras-Muney A. *Children and the US Social Safety Net: Balancing Disincentives for Adults and Benefits for Children*. National Bureau of Economic Research; 2022.
53. Berkowitz SA, Orr CJ, Palakshappa D. The public health case for a universalist child tax credit. *JAMA Pediatr*. 2022;176(9):843-844. https://doi.org/10.1001/jamapediatrics.2022.2503
54. Jones MR, Ziliak JP. *The Antipoverty Impact of the EITC: New Estimates from Survey and Administrative Tax Records*. Center for Economic Studies, US Census Bureau; 2019. Accessed December 29, 2021. https://ideas.repec.org/p/cen/wpaper/19-14.html
55. Linos E, Prohofsky A, Ramesh A, Rothstein J, Unrath M. Can nudges increase take-up of the EITC? Evidence from multiple field experiments. *Am Econ J Econ Policy*. 2022:14(4);432-452. https://doi.org/10.1257/pol.20200603
56. Berkowitz SA, Dave G, Venkataramani AS. Potential gaps in income support policies for those in poor health: the case of the Earned Income Tax Credit—a cross sectional analysis. *SSM—Popul Health*. 2023;23:101429. https://doi.org/10.1016/j.ssmph.2023.101429
57. Internal Revenue Service. Earned Income and Earned Income Tax Credit (EITC) tables. Accessed April 13, 2022. https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit/earned-income-and-earned-income-tax-credit-eitc-tables
58. Internal Revenue Service. Child tax credit. Accessed August 28, 2024. https://www.irs.gov/credits-deductions/individuals/child-tax-credit
59. Sen A. *Inequality Reexamined*. Oxford University Press; 1995.
60. Brucker DL, Garrison VH. Health disparities among social security disability insurance and supplemental security income beneficiaries who participate in federal rental housing assistance programs. *Disabil Health J*. 2021;14(3):101098. https://doi.org/10.1016/j.dhjo.2021.101098
61. Heflin CM, Altman CE, Rodriguez LL. Food insecurity and disability in the United States. *Disabil Health J*. 2019;12(2):220-226. https://doi.org/10.1016/j.dhjo.2018.09.006
62. Arora K, Wolf DA. Paid leave mandates and care for older parents. *Milbank Q*. 2024;102(3):732-2764. https://doi.org/10.1111/1468-0009.12708
63. Ogunbameru A, Gebretekle GB, Perryman A, et al. Health and non-health benefits and equity impacts of individual-level economic relief programs during epidemics/pandemics in high income settings: a scoping review. *BMC Public Health*. 2024;24(1):2106. https://doi.org/10.1186/s12889-024-19493-8
64. Maclean JC, Golberstein E, Stein B. State paid sick leave mandates associated with increased mental health disorder prescriptions among Medicaid enrollees. *Health Aff Sch*. 2024;2(5):qxae045. https://doi.org/10.1093/haschl/qxae045
65. Lamsal R, Napit K, Rosen AB, Wilson FA. Paid sick leave and healthcare utilization in adults: a systematic review and meta-analysis. *Am J Prev Med*. 2021;60(6):856-865. https://doi.org/10.1016/j.amepre.2021.01.009
66. Schweitzer J, DiMatteo E, Buffie N, Ives-Rublee M. How dehumanizing administrative burdens harm disabled people. Center for American Progress. December 5, 2022. Accessed August 28, 2024. https://www.americanprogress.org/article/how-dehumanizing-administrative-burdens-harm-disabled-people/
67. Rein L. Lawmakers decry massive backlog in Social Security disability claims. *Washington Post*. December 7, 2022. Accessed August 28, 2024. https://www.washingtonpost.com/politics/2022/12/07/social-security-claims-backlog-lawmakers-response/
68. Social Security Administration. Supplemental Security Income (SSI). August 4, 2023. Accessed August 28, 2024. https://www.ssa.gov/ssi
69. Raderman W. Op-ed: America's oldest and best disability benefit system—Niskanen Center. Niskanen Center—Improving Policy, Advancing Moderation. July 1, 2023. Accessed August 28, 2024. https://www.niskanencenter.org/op-ed-americas-oldest-and-best-disability-benefit-system/
70. Silver D, Zhang J. *Impacts of Basic Income on Health and Economic Well-Being: Evidence from the VA's Disability Compensation Program*. National Bureau of Economic Research; 2022.
71. McCoy M, Martinelli S, Reddy S, et al. Food insecurity on college campuses: The invisible epidemic. *Health Affairs Forefront*. 2022. https://doi.org/10.1377/forefront.20220127.264905
72. Feinstein L, Sabates R, Anderson TM, Sorhaindo A, Hammond C. *What Are the Effects of Education on Health*. Organization for Economic Co-operation and Development; 2006. Accessed October 27, 2021. https://www.oecd.org/education/innovation-education/37425753.pdf
73. Hayward MD, Farina MP. Dynamic changes in the association between education and health in the United States. *Milbank Q*. 2023;101(S1):396-418.
74. Zajacova A, Lawrence EM. The relationship between education and health: reducing disparities through a contextual approach. *Annu Rev Public Health*. 2018;39(1):273-289. https://doi.org/10.1146/annurev-publhealth-031816-044628
75. Zimmerman E, Woolf SH. Understanding the relationship between education and health. *NAM Perspect*. 2014:4. https://doi.org/10.31478/201406a
76. Dube A. *A Plan to Reform the Unemployment Insurance System in the United States*. Brookings; 2021. Accessed April 14, 2022. https://www.brookings.edu/research/a-plan-to-reform-the-unemployment-insurance-system-in-the-united-states/
77. Advisory Council on Unemployment Compensation. Collected findings and recommendations: 1994-1996. 1996. Accessed August 4, 2020. https://oui.doleta.gov/dmstree/misc_papers/advisory/acuc/collected_findings/adv_council_94-96.pdf
78. Konczal M. Unemployment insurance is a vital part of economic freedom. Published online May 29, 2020. Accessed June 24, 2020. https://www.thenation.com/article/economy/cares-act-unemployment/
79. Wandner SA. Four decades of declining federal leadership in the federal-state unemployment insurance program. *SSRN*. 2019. https://doi.org/10.2139/ssrn.3477213
80. East CN, Simon D. The safety net and job loss: how much insurance do public programs provide? *J Public Econ*. 2024;238:105171. https://doi.org/10.1016/j.jpubeco.2024.105171
81. Berkowitz SA, Basu S. Unmet social needs and worse mental health after expiration of COVID-19 federal pandemic unemployment

compensation. *Health Aff Proj Hope*. 2021;40(3):426-434. https://doi.org/10.1377/hlthaff.2020.01990
82. Berkowitz SA, Basu S. Unemployment insurance, health-related social needs, health care access, and mental health during the COVID-19 pandemic. *JAMA Intern Med*. 2021;181(5):699-702. https://doi.org/10.1001/jamainternmed.2020.7048
83. Ferrarini T, Nelson K, Sjöberg O. Unemployment insurance and deteriorating self-rated health in 23 European countries. *J Epidemiol Community Health*. 2014;68(7):657-662. https://doi.org/10.1136/jech-2013-203721
84. O'Campo P, Molnar A, Ng E, et al. Social welfare matters: a realist review of when, how, and why unemployment insurance impacts poverty and health. *Soc Sci Med 1982*. 2015;132:88-94. https://doi.org/10.1016/j.socscimed.2015.03.025
85. Cylus J, Glymour MM, Avendano M. Do generous unemployment benefit programs reduce suicide rates? A state fixed-effect analysis covering 1968-2008. *Am J Epidemiol*. 2014;180(1):45-52. https://doi.org/10.1093/aje/kwu106
86. Cylus J, Glymour MM, Avendano M. Health effects of unemployment benefit program generosity. *Am J Public Health*. 2015;105(2):317-323. https://doi.org/10.2105/AJPH.2014.302253
87. Cylus J, Avendano M. Receiving unemployment benefits may have positive effects on the health of the unemployed. *Health Aff Proj Hope*. 2017;36(2):289-296. https://doi.org/10.1377/hlthaff.2016.1040
88. Irish AM, White JS, Modrek S, Hamad R. Paid family leave and mental health in the U.S.: a quasi-experimental study of state policies. *Am J Prev Med*. 2021;61(2):182-191. https://doi.org/10.1016/j.amepre.2021.03.018
89. Lee BC, Modrek S, White JS, Batra A, Collin DF, Hamad R. The effect of California's paid family leave policy on parent health: a quasi-experimental study. *Soc Sci Med 1982*. 2020;251:112915. https://doi.org/10.1016/j.socscimed.2020.112915
90. Nandi A, Jahagirdar D, Dimitris MC, et al. The impact of parental and medical leave policies on socioeconomic and health outcomes in OECD countries: a systematic review of the empirical literature. *Milbank Q*. 2018;96(3):434-471. https://doi.org/10.1111/1468-0009.12340
91. Ahrens KA, Janevic T, Strumpf EC, Nandi A, Ortiz JR, Hutcheon JA. Paid family leave and prevention of acute respiratory infections in young infants. *JAMA Pediatr*. 2024:178;1057-1065. https://doi.org/10.1001/jamapediatrics.2024.3184
92. Center for American Progress. The state of paid family and medical leave in the U.S. in 2024. January 17, 2024. Accessed August 28, 2024. https://www.americanprogress.org/article/the-state-of-paid-family-and-medical-leave-in-the-u-s-in-2024/
93. The White House. Fact Sheet: The President's Budget for Fiscal Year 2025. March 11, 2024. Accessed August 28, 2024. https://www.whitehouse.gov/briefing-room/statements-releases/2024/03/11/fact-sheet-the-presidents-budget-for-fiscal-year-2025/
94. People's Policy Project. The case for making parental leave actually universal. October 26, 2021. Accessed August 28, 2024. https://www.peoplespolicyproject.org/2021/10/26/the-case-for-making-parental-leave-actually-universal/
95. Freeman RB. *What Do Unions Do?* Basic Books; 1985.
96. Leigh JP, Chakalov B. Labor unions and health: a literature review of pathways and outcomes in the workplace. *Prev Med Rep*. 2021;24:101502. https://doi.org/10.1016/j.pmedr.2021.101502
97. Muller J, Raphael D. Does unionization and working under collective agreements promote health? *Health Promot Int*. 2021:38;daab181. https://doi.org/10.1093/heapro/daab181
98. VanHeuvelen T, Brady D. Labor unions and American poverty. *ILR Rev*. 2022;75(4):891-917. https://doi.org/10.1177/00197939211014855
99. Western B, Rosenfeld J. Unions, norms, and the rise in U.S. wage inequality. *Am Sociol Rev*. 2011;76(4):513-537. https://doi.org/10.1177/0003122411414817
100. Cengiz D, Dube A, Lindner A, Zipperer B. The effect of minimum wages on low-wage jobs. *Q J Econ*. 2019;134(3):1405-1454. https://doi.org/10.1093/qje/qjz014
101. Kaufman BE. Institutional economics and the minimum wage: broadening the theoretical and policy debate. *Ind Labor Relat Rev*. 2010;63(3):427-453.
102. Kalecki M. Political aspects of full employment. *Polit Q*. 1943;14(4):322-330. https://doi.org/10.1111/j.1467-923X.1943.tb01016.x
103. Berkowitz SA. Health Keynesianism: why full employment policy matters for population health. *J Gen Intern Med*. 2024;39(10):1914-1916. https://doi.org/10.1007/s11606-024-08756-0
104. Rokicki S, Reichman NE, McGovern ME. Association of increasing the minimum wage in the US with experiences of maternal stressful life events. *JAMA Netw Open*. 2023;6(7):e2324018. https://doi.org/10.1001/jamanetworkopen.2023.24018
105. Autor D, Dube A, McGrew A. The unexpected compression: competition at work in the low wage labor market. Published online March 2023. Accessed September 17, 2024. https://doi.org/10.3386/w31010
106. Rabbitt MP, Hales LJ, Burke MP, Coleman-Jensen A. Household food security in the United States in 2022. Accessed March 8, 2024. http://www.ers.usda.gov/publications/pub-details/? pubic=107702
107. Shrider EA, Creamer J. Poverty in the United States: 2022. Census.gov. Accessed August 28, 2024. https://www.census.gov/library/publications/2023/demo/p60-280.html
108. McAlevey JF. *No Shortcuts: Organizing for Power in the New Gilded Age*. Reprint ed. Oxford University Press; 2018.
109. Michener J. Racism, power, and health equity: the case of tenant organizing. *Health Aff (Millwood)*. 2023;42(10):1318-1324. https://doi.org/10.1377/hlthaff.2023.00509
110. Vanhuysse P, Medgyesi M, Gal RI. Welfare states as lifecycle redistribution machines: decomposing the roles of age and socio-economic status shows that European tax-and-benefit systems primarily redistribute across age groups. *PLoS One*. 2021;16(8):e0255760. https://doi.org/10.1371/journal.pone.0255760