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Invited Commentary

Invited Commentary: Social Cohesion, Depression, and the Role of Welfare States

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In this issue of the *Journal*, Baranyi et al. (*Am J Epidemiol*. 2019;189(4):343–353) examine the longitudinal associations of perceived neighborhood disorder and social cohesion with depressive symptoms among persons aged 50 years or more in 16 different countries. An important contribution of their article is that they study how neighborhood-level social capital relates to depression in different welfare-state contexts. Although the authors provide empirical evidence for some significant differences between welfare states in the relationship between social capital and depression, they say little about potential explanations. In this commentary, I draw attention to welfare-state theory and how it could provide us with a greater understanding of Baranyi et al.'s findings. I also discuss the potential downsides of grouping countries into welfare regimes. I primarily focus on the associations between social cohesion and depression, as these associations were generally stronger than those for neighborhood disorder and depression. Finally, I provide some suggestions for future research within the field and discuss whether the findings could be used to guide policies aimed at increasing social cohesion and health.

depression; mental health; social capital; social cohesion; welfare regimes

In this issue of the *Journal*, Baranyi et al. (1) examine the longitudinal associations of perceived neighborhood disorder and social cohesion with depressive symptoms among persons aged 50 years or more in 16 different countries. They also explore how the associations are modified by welfare regime and by other macro-level social or environmental indicators within countries and neighborhoods. In a secondary analysis, they investigate the robustness of the findings for retired persons, for whom they assume stronger associations than in the general sample.

The findings showed that neighborhood disorder and lack of social cohesion were significantly associated with depression and that the risk of depression was even higher in retirement (1). Welfare regimes did not account for the associations, but the authors found stronger associations between neighborhood social cohesion and depression in egalitarian contexts, as well as rather large variations in associations between countries belonging to different welfare regime types.

In this commentary, I focus on the association between social cohesion and depression, as these associations were generally stronger than those for neighborhood disorder and depression. The authors group countries into different types of welfare regimes throughout their article, but they do not elaborate much on the theory of welfare-state typologies first introduced by Danish sociologist Gøsta Esping-Andersen (2) and its potential significance for the social cohesion–health association. I therefore start by discussing the theory of welfare typologies and then relate it to the findings presented by Baranyi et al.

WELFARE REGIMES

Baranyi et al. only briefly mention the theory of welfare-state typologies in their paper (1). A greater understanding of the theory is therefore needed in social epidemiology if we are to comprehend why and how welfare regimes and welfare-state characteristics matter for social cohesion and health. The welfare typologies introduced by Esping-Andersen (2, 3) clarify differences between various countries concerning welfare policy and its consequences. Esping-Andersen argues that welfare states have historically developed into systems with their own institutional logic, and that the relative importance of the market, family, and

the state for citizens' welfare varies from one country to another. Hence, the welfare regime concept stresses the various roles and importance of these institutions in the production of welfare.

For example, the ideal typical social-democratic regime's policy of emancipation addresses both the market and the traditional family; this regime includes the Scandinavian countries. These countries are characterized by the highest levels of social security, with mostly universal social benefits. The ideal is to maximize not dependence on the family but the capacity for individual independence. The result is a welfare state that, compared with other regimes, largely takes direct responsibility for caring for children, the aged, and the marginalized (2, 3). The consequence of such universalism is low levels of inequality and poverty (4). At the other extreme—the market-dominated liberal regime, including the Anglo-Saxon countries—means-tested assistance and modest social insurance plans predominate. The state mainly encourages the market—either passively, by guaranteeing only a minimum of benefits, or actively, by subsidizing private forms of the welfare provision. This type of regime entails independence from the state and forces citizens to rely on family and friends for help and aid in situations of personal crisis. The consequences of this type type of regime are high levels of income inequality and poverty compared with the social-democratic regime. Countries belonging to the conservative-corporatist or Bismarckian type of regime are found somewhere in between the social-democratic and liberal countries. However, 2 additional types of regimes were later added to the original ones: the Southern European and Eastern European types. The Southern European, "Mediterranean" regime aims to produce even more dependence on family and friends. Under this type of regime, a less developed system of social security exists, instead of an official level of security, accompanied by a very high degree of familialism—that is, dependence on the family for welfare and survival (5). In the postsocialist, Eastern European type of regime, social security benefits are very low, and this has resulted in high levels of income inequality and poverty. Moreover, the Eastern European countries are characterized by high coverage of social security systems but low levels of benefits; therefore, citizens still largely have to rely on family or the market for support (6).

Previous research has suggested that welfare states' features can have a significant impact on social cohesion and social capital (7, 8). Accordingly, empirical evidence has found significant variation between countries grouped into different welfare regimes in levels of social trust, participation in associations, social activity, and social support. The highest levels are generally found in the universal social-democratic Scandinavian countries, while the lowest levels are found in the Southern European and Eastern European countries, characterized by low levels of social security. Somewhere in between we find the Anglo-Saxon and Bismarckian countries. Previous findings also suggest that spending on social protection and welfare is positively associated with social capital (8). It has further been suggested that social capital accounts for some of the health inequalities that exist between welfare-state regimes (8–10). These studies have evaluated country-level social capital, but to my knowledge no previous study has examined how neighborhood-level social capital relates to health in different types of welfare states. This is an important contribution of Baranyi et al.'s study.

SOCIAL COHESION AND DEPRESSION IN WELFARE STATES

Baranyi et al. do not thoroughly discuss why welfare-state characteristics could matter for the association between neighborhood social cohesion and depression. They found that in Southern European countries, lack of social cohesion did not increase the risk of depression, while in Eastern European and Anglo-Saxon countries, there were strong and significant associations (1). They also found a stronger risk of depression as a function of lack of social cohesion among people living in more equal countries.

A potential interpretation of the findings could be that the possibility of acquiring different types of support, including material support, within one's neighborhood might be relatively more important for older people's health in countries with less comprehensive welfare systems, such as the Eastern European and Anglo-Saxon welfare states (11). Social cohesion could hence be considered to increase the likelihood of accessing informal welfare in countries with low social security, low levels of welfare, high poverty rates, and high levels of inequality. The fact that social ties within the neighborhood might be the only way older people can obtain the necessary resources and support in these countries means that the absence of social cohesion could have important repercussions for the mental and physical health of older adults (11). Retired persons might receive many types of resources and support from their neighbors in areas with high social cohesion, including emotional support, practical help and support, feelings of safety, etc. In fact, the mere knowledge that a neighbor would support and help you if needed might promote mental health in older people.

Baranyi et al. also argue that as people age and then retire, the geographical extent of their mobility space tends to decrease, and they often become more reliant on their community and local services (1). This will make them more dependent on neighborhood characteristics, including social cohesion. In line with these arguments, it might be additionally detrimental, especially for retired persons, to live in a low-cohesion neighborhood in a country where the state offers limited welfare services, as that would make them even more reliant on their community. On the contrary, generous welfare states provide older citizens with better opportunities for equal social mobility through, for instance, higher-quality social infrastructure and public transport. This makes older adults less reliant on their community and, thus, the neighborhood's social cohesion will matter less for their health and well-being.

Somewhat unexpectedly, the authors do not find particularly strong associations in the Southern European countries, which, according to the welfare-regime theory, are characterized by low levels of social security. However, these countries are also highly family-oriented (2, 5), and it might be that family and relatives play a greater role in supporting the retired and aging in these countries. Thus, family

social capital and not neighborhood social cohesion could be the most important buffer against poor mental health in Southern European countries. Therefore, it would have been interesting if the authors had included additional measures of social relationships in their study, such as social support from family and relatives. This would have made it possible to distinguish between the associations of social cohesion and those of family social capital with mental health.

COUNTRY CLUSTERS OR SPECIFIC MEASURES?

Although Esping-Andersen's theory on welfare-state regimes has been frequently used, it is also a very crude reflection of reality. Although there are similarities among countries belonging to a given regime type, there are also differences, and the regime types should therefore be regarded merely as ideal types. Country clusters may be helpful for descriptive purposes, but they are much less useful if we really want to open the black box and analyze which aspects of the welfare state are important (12). Specific measures of welfare-state characteristics could more accurately capture aspects of welfare states, such as specific family policies, spending on various types of social protection, characteristics of pension systems, etc. The latter types of measures could be especially important in the subanalysis of retired persons in Baranyi et al.'s study. Hence, the lack of a significant contribution by welfare regimes to the association between social cohesion and depression in the article might reflect both the low number of countries in each category, as suggested by the authors, and the fact that the welfare regime categorization is too crude a measure to accurately capture welfare-state characteristics of significance for the social cohesion–depression relationship. The contradictory finding that the social cohesion–depression relationship is generally stronger in egalitarian countries, although strong associations are also found in some of the most unequal welfare regimes (i.e., the liberal and the Eastern European), indicates that specific welfare indicators might, in some instances, affect health in ways opposite of those we would expect.

CONCLUDING REMARKS

Needless to say, the study by Baranyi et al. (1) is complex, as it considers a number of variables at different levels of aggregation, such as the individual, neighborhood, and country levels. It is therefore also fairly difficult to draw any solid conclusions based on the findings, particularly regarding the mechanisms underlying associations; the study thus raises many questions that could be examined in more depth in future studies. In the future, researchers could more explicitly examine the mechanisms underlying the associations as well as examine neighborhood cohesion in relation to other prevalent health outcomes in older adults, such as dementia, cognitive and physical decline, and diabetes. It would also be interesting to consider other specific measures of welfare, because the welfare regime categorization might be too crude to capture specific welfare-state features of significance to the associations. The suggested policy implications also raise several questions and should be elaborated on further. The authors suggest that policies in countries with stronger links between neighborhood and depression should focus on improving the physical environment and supporting social ties in communities—efforts that could reduce depression and contribute to healthy aging. However, it is not clear how such policies should be designed and whether they should target only people aged $\geq$50 years or retired persons or should be universal and target all residents in a neighborhood with low social cohesion. The risk of universal policies for all residents in low-social-cohesion neighborhoods is that younger residents will gain more from such policies because they are healthier and more socially active and more easily adopt interventions. Examples of targeted interventions for the retired could focus on social cohesion and social activity in restricted contexts for older adults, such as retirement homes and voluntary associations and groups for the retired.

Baranyi et al. (1) have conducted an important, thought-provoking study that targets the "bigger" questions in epidemiology. It has great potential to inspire future studies that simultaneously consider upstream and downstream determinants of health (13) at different levels of aggregation.

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