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An Analysis of Contemporary Social Welfare Issues

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Contributors

Clare Cannon, Fred Buttell, Auxiliadora González Portillo, Germán Jaraíz Arroyo, Sylvia Kirchengast, Gabriele Berg-Beckhoff, Gabriel Gulis, Carsten Kronborg Bak, Pernille Tangaard Andersen, Rosario Laratta

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Meet the editor



Rosario Laratta is a faculty member at the School of Governance Studies and the School of Global Governance, Meiji University, Tokyo, and an adjunct faculty at the iCLA (Yamanashi Gakuin University), ICU (International Christian University), Sophia University, and Temple University. He earned an MA and a PhD in Sociology from Warwick University (UK) and a post-doctorate in social science from the University of Tokyo. He is the author of many books such as *Nonprofit Organizations in England and Japan* (2012) and *Empirical Policy Research* (2013) and editor of *Social Welfare* (2012) and *Social Enterprise* (2016). He has also published over hundred articles, most of which are peer-reviewed papers on leading international journals. He currently acts as a regular reviewer for fifteen peer-reviewed international journals and as advisory board member for some of those. He is also a member of a number of academic associations in Japan and abroad.

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Preface

This book offers a sharp critique and a detailed analysis of some pernicious social welfare problems and the wide-ranging causes and consequences of those complex social issues on individuals, families, and communities.

Unemployment, health-care disparities, teenage pregnancy, and intimate partner violence constitute the focus of this work. Based on empirical and historical analyses of primary and secondary data, the book provides a conceptual framework that facilitates the reader's understanding of how those social issues are interrelated.

Each chapter offers some clear policy recommendations directed to address those social problems. Written by well-published scholars, this work will be of great interest not only to students majoring in the social and political sciences but also to academics and practitioners active in the field of social welfare, social policy, and social work.

As the editor of this book, I am particularly grateful to all authors who contributed their precious time and work for this volume. I have been also very fortunate to work with Ms. Iva Simcic, a publishing process manager at InTech, who did an excellent work in assisting me during various stages. She helped to bring this volume to fruition.

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Introductory Chapter: An Overview of the Book

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Additional information is available at the end of the chapter

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Today, we feel the urgent need to understand the social problems that particular communities are facing and identify specific treatment interventions to address their unique needs both at macro- and at micro levels. The scope of this volume goes precisely toward this direction. Each chapter offers ways of intervention to address some of the most pressing social issues of our time.

The first chapter by Clare Cannon and Fred Buttell focuses on intimate partner violence in same-sex relationships in the USA and Canada, a real complex social problem if we think that violence in those relationships occur at a comparable or greater rate than opposite-sex relationships. Having demonstrated that the current traditional feminist theory sometimes inhibits an accurate view of the problem of same-sex intimate partner violence, the two authors reconceptualize the problem by deconstructing in a very sophisticated way the traditional gender-power argument. Their new approach is directed to understand who is violent in intimate relationships and why. The uniqueness of their approach is to look beyond the dichotomy 'same-sex/opposite-sex' and treat abusers and victims as whole people with power differences, which, in turn, create inequality. Based on empirical data analysis, the authors advocate for treatment options directed to work on both internal and external dimensions of those individual persons who use violence to mediate their intimate relationships.

The second chapter by Sylvia Kirchengast provides an interesting historical and contemporary analysis of teenage pregnancies and motherhood, a worldwide social and 'medical' problem. By looking specifically at the Austrian case, a number of strategies to decrease teenage pregnancy rates and improve teenage pregnancy outcome are discussed in this chapter. Although the author recognizes that Austria is still not among the lowest in terms of teenage motherhood among developed countries, she highlights the positive effects that mandatory sex education, legal abortions, and especially social programs have had in reducing teenage motherhood rates in this country. The author's description of the Viennese teenage pregnancy project is particularly informative. The results of this project made the author concluding that, even among early adolescent mothers aging below 15years, teenage pregnancies are not

associated with increased obstetrical risks and overall teenage pregnancies are mainly a social and not a medical problem.

The third chapter by Gabriele Berg-Beckhoff, Gabriel Gulis, Carsten Kronborg Bak, and Pernille Tanggaard Andersen examines other two very important and interrelated issues, namely unemployment related to healthcare disparities. Their study refers to the Danish 'welfare' and 'labor market' models. The first is famous worldwide for its principles of universalism, participation, and equity; the second is well known because of the 'flexicurity' (i.e., security in employment and income combined with flexibility in relation to the hiring and firing of workers). The latter model, as explained by the authors in their chapter, guarantees a high level of benefit security to workers with insurance if they become unemployed. These two models are often seen as the causal explanation of an overall association between unemployment and health outcomes in Denmark. The originality of this chapter consists in the fact that the authors, by analyzing the results of cross-sectional and longitudinal studies on the short-term association between unemployment and hospital admission in the municipality of Esbjerg, find out that an association between social welfare benefits and hospital admission exists, but the direction of such an association cannot be clearly defined yet.

This book concludes intentionally with a chapter by Auxiliadora Gonzalez Portillo and German Jaraiz Arroyo. This chapter not only offers an accurate interpretation of the challenges currently faced by the public social services system in Spain, but also provides one of the most interesting conceptual and analytical frameworks with which the reader can more easily interpret the social issues discussed in the previous three chapters. In fact, according to the authors, we can distinguish three basic categorizations of social services:

1. *Personal social services.* Deeply rooted in the Anglo-Saxon realm, these are usually services directed to individuals and their families. Within this definition of social services, the authors recognize programs of intervention in families in conflict, especially highlighting intervention in situations of 'gender' violence. Therefore, it is evident that interventions targeting abusers and victims of intimate partner violence, discussed in the first chapter of this book, should be understood within this category.
2. *Community social services.* According to the authors, these services are intended to go beyond individual attention to needs and require the complement of individual intervention methodologies with other groups and community interventions. In this case, intervention programs are created for people with personal autonomy deficit. I think, the case of teenage pregnancy and motherhood, discussed in the second chapter, falls clearly into this category.
3. *Universal social services.* The authors argue that these are the services where the objective of social inclusion of disadvantaged social groups coexists with more universalistic objectives aimed at the needs of the whole population. The authors recognize that this understanding of universal social services is still vague for many nations. However, what is interesting to notice is that within this definition of services, we would have interventions directed to support population groups with social difficulties. This evidently recalls the case of Denmark and the issues of unemployment and health inequalities addressed in the third chapter of this book.

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Policy Discussions on LGBTQ Intimate Partner Violence in North America

Clare Cannon and Fred Buttell

Additional information is available at the end of the chapter

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Abstract

This chapter delves into social policy and welfare regarding intimate partner violence (IPV) across North America, specifically around research, policies, and treatment interventions for the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. In this chapter, we outline the problem of intimate partner violence, or IPV, in the USA; analyze IPV policies at the state and national levels; and advocate for more specific treatment interventions to address the unique needs of this community.

Keywords: social policy, LGBTQ, intimate partner violence, social justice

1. Introduction

Intimate partner violence (IPV), defined as emotional and/or physical abuse in an intimate relationship, is a pernicious social problem with wide-ranging causes and consequences for individuals, families, and communities. Although comparatively little scholarship has focused on IPV in same-sex relationships, relative to heterosexual couples, there is clear empirical evidence that IPV in lesbian, gay, bisexual, and transgender (LGBTQ) relationships occurs at comparable or greater rates than opposite sex relationships (see [1, 2]). For instance, Walters et al. [1] using the National Intimate Partner and Sexual Violence Survey (NISVS) found that 43.8% of self-identified lesbians reported having been physically victimized, stalked, or raped by an intimate partner in their lifetime, compared to 35.0% of heterosexual women, 29.0% of heterosexual men, and 26.0% of gay men. Bisexual women experienced the highest rates of IPV with 61.1% [2]. (For a more in-depth analysis of the breakdown in types of IPV perpetration by sexual orientation, see [1, 2].) It is important to note that the question of sexual orientation did not include trans* identified people, leaving information on this population uncollected and the

depth of the problem undefined. Recent studies have attempted to identify what resources if any are available for the treatment of LGBTQ perpetrators (see, for instance [3]).

In this chapter, we further develop these nascent discussions by providing an overview of recent IPV research and policy in the USA. We then delve into limited existing research on LGBTQ programming and views on policy standards and treatment interventions provided by batterer intervention programs (BIPs) across the USA and Canada. Since batterer intervention programs are a primary source of treatment intervention for IPV in North America, and since these programs reside at the nexus of research, policy, and treatment, our research provides insight into the problem of IPV as well as social policies and welfare in the USA.

2. Addressing social policies: analysing LGBTQ IPV policy in the USA

Given the prevalence of the problem, scholars have begun to employ an array of theoretical frameworks and research methodologies to further understand the problem of IPV in LGBTQ relationships (e.g., [4, 5]) in order to better inform policymakers (e.g., [2, 3]) and to develop more acute treatment interventions (e.g., [2, 6]). For instance, Cannon et al. [4] apply a post-structural feminist approach to occurrences of IPV, to show that women cannot be understood as powerless and men cannot be depicted as having all the power as assumed in a US traditional feminist paradigm. Women can and do exercise power; sometimes in forms similar to how men use power (such as to perpetrate IPV) [4, 12]. However, because we live in a society that privileges men and heterosexual people, how we understand the use of this power is both important and different.

Therefore, scholars have begun to argue that policy proscriptions and treatment interventions should reflect these differences in order to better account for the various experiences, motivations, meanings, and contexts of perpetrators and victims (see [4, 7, 8, 5]). As Cannon and Buttell [8] argued, IPV policy in the US perpetuates an illusion of inclusion” through inclusive language that pays lip service to non-heterosexual relationships (e.g., the use of the term “partner”) but has the unintended consequence of serving to obfuscate key dynamics of IPV. In terms of treatment of IPV in the USA, scholars applying a post-structuralist feminist framework to IPV add to the growing chorus of scholars that argue that a one-size-fits-all treatment model for IPV perpetrators (e.g., the Duluth Model) should be replaced by culturally relevant and specific treatment options for different categories of perpetrators (e.g., heterosexual women, LGBTQ) (see [9, 7, 3]). The most compelling point these scholars advance is that all treatment interventions should address issues of sexism, homophobia, racism, and classism in order to address not only personal motivations of perpetrators but also the ways society materially disadvantages some while privileging others (e.g., [4]).

3. Methods and data

Much of what is known about batterer intervention programming nationally is derived from Price and Rosenbaum’s [10] analysis of 276 batterer intervention programs (BIPs) in 45 states.

They found that although 74% of programs reported that they served both male and female perpetrators, and 78% reported that they would serve LGBT clients, the percentage of female clients actually served was only 10% and LGBT clients 1% [10]. In order to further explore how policy affects LGBTQ clients in BIPs, we developed the first North American survey of its kind, distributing cover letters to 3256 BIPs across the USA and Canada. Our study employed a mixed-method design for the survey, the *North American Survey on Domestic Violence Intervention Programs* (NASDVIP), employing forced-answer choice questions (e.g., demographics, theories, and group length) and open-ended responses (e.g., what would you change if you could describe challenges facilitators face). The survey instrument was designed by the research team with certain aims in mind, most importantly, to ascertain what domestic violence BIPs were like across North America. To do this, the NADVIPS investigated facilitator demographics, client demographics, facilitator insights, and program logistics. We studied not only philosophy and structure of these programs but also the demographics of both facilitators and clients. Data were then analyzed using content analysis to better understand the needs and services of the LGBTQ community and to gauge the frontlines of IPV interventions across the USA and Canada.

The NASDVIP was sent to 3256 batterer intervention programs across North America for which we had hard and electronic addresses. Any member over the age of 18 was eligible to complete the survey. Programs were contacted using a recruitment letter asking whether they would like to participate by going online to complete the survey for which a link was provided. The survey was administered through the third party, Survey Monkey, in order to maintain anonymity of responses. Of these communications, 2710 were mailed and 546 were emailed. Given the high turnover in BIPs (roughly every 3 years) and the time it took to compile the list (3 years) in conjunction with using the standards employed by the American Association for Public Opinion Research (AAPOR), we calculated a conservative estimate of 65% non-contact rate (see AAPOR non-contact rate estimates). This means that we estimate 65% of BIPs for which we had hard addresses never received our mailed communications. There were 238 total responses. Thus, using AAPOR standards, we calculate a response rate of 20% for mailings. The response rate for email was 45% calculated by how many people completed the survey divided by the number of people who clicked on the email link.

4. Discussion of results

4.1. Program logistics

In order to analyze practitioners' views on policies and their effects on LGBTQ communities, we review program logistics. The average length of a BIP was 30 weeks ($SD = 12.12$), ranging from 8 to 78 weeks, with the mode for program duration was 26 weeks ($N = 178$). The average duration of each session was 103 minutes ($SD = 19.1$) with the mode for session duration being 120 minutes ($N = 184$). 96.7% ($N = 176$) of sessions met once a week. The average number of clients per session was 8 ($N = 166$). The number of clients per session ranged from 1 to 42, with the most frequent number of participants being 10. Nearly all of the programs in the sample

(97.7%; $N = 166$) were outpatient focused. Only 2.9% ($n = 5$) were inpatient and 1.2% ($N = 2$) were located in prisons. Programs provided additional services to domestic violence perpetrators. Most commonly, programs provided crisis management (60.7%; $N = 91$), parenting classes (53.3%; $N = 80$), substance abuse counseling (50.7%; $N = 76$), educational resources (38.0%; $N = 57$), and community advocacy (24.7%; $N = 37$). Roughly 8–12% of programs offered associated services such as mentoring, food, transportation, career services, housing, police/safety, and job training. These programs, sometimes in conjunction with sister agencies, also offered services for victims. For instance, 73.8% ($N = 90$) of programs that responded offered mental health treatment; 62.3% ($N = 76$) offered peer support groups; 52.5% ($N = 64$) offered social service assistance (e.g., getting food stamps, child care, etc.); 47.5% ($N = 58$) offered some sort of legal assistance (e.g., obtaining restraining orders); 42.6% ($N = 52$) offered shelter beds; 33.6% ($N = 41$) offered transitional housing.

4.2. Program demographics

Respondents were asked to provide percentages of the demographics of clients participating in their programs. Of all the programs that responded, 14% ($N = 122$) of clients were identified as female and 83% ($N = 130$) as male. In terms of sexual orientation 3% ($N = 104$) of clients were identified as lesbian, 4% ($N = 98$) as gay, 1% ($N = 77$) as bisexual, 0% of trans M to F, Trans F to M, and other sexuality, and 90% ($N = 112$) of clients were identified as heterosexual.

Respondents, on average, estimated that 75.7% ($SD = 17.68$) ($N = 110$) of clients completed the program after intake assessment. Respondents, on average, estimated that 10.6% ($SD = 9.15$) ($N = 85$) of clients were arrested for domestic violence within 1 year of completion of the program.

4.3. Respondents' views of treatment

Results are reported in **Table 1** and discussed here. Of those who responded, 86.1% ($N = 93$) indicated that treatment interventions were delivered according to a written curriculum; 63.9% ($N = 69$) of programs reported using treatment interventions adapted to fit the specific and various needs of their clients. Of these respondents, 41.7% ($N = 45$) responded that treatment interventions were the same for all clients regardless of ethnicity, race, gender, class, sexual orientation and identity, disability, religion, age, or religious status. While the same percentage (41.7%; $N = 45$) reported that treatment interventions were developed specifically for various client needs and contexts. Of these respondents, 18.5% ($N = 20$) responded that treatment interventions were not written but are used according to the agency's philosophy of treatment and expectations.

When asked "Do you provide any LGBTQ specific services? Please describe" ($N = 91$) most respondents said no ($N = 80$). Several programs would treat LGBTQ people in individual sessions, otherwise LGBTQ people would be in the gender-segregated groups. Several respondents reported their programs adapted their curriculum to the LGBTQ population. Two programs were specially trained for LGBTQ populations.

In terms of perpetration, 46.6% ($N = 34$) of respondents indicated that state standards provided effective intervention for female perpetrators, whereas 32.88% said they strongly disagree or disagree with state standards' ability to provide effective treatment intervention. 31.5% ($N = 23$) of respondents strongly agree or agree that state standards adequately provided effective treatment intervention for same-sex perpetrators, whereas 30.1% ($N = 22$) strongly disagree or disagree that same-sex perpetrators were adequately provided treatment interventions. For males, 82.8% ($N = 63$) of programs strongly agree or agree that state standards provided adequate intervention for male perpetrators, while only 11.8% ($N = 9$) strongly disagree or disagree with this assessment. When asked how faithfully respondents adhere to state standards, 59.6% ($N = 62$) reported they always adhere to these standards; 33.66% ($N = 35$) reported they often adhere to state standards.

Key findings	Percentage of respondents (NN)
Treatment interventions were delivered according to a written curriculum;	86.1% (93)
Programs reported using treatment interventions adapted to fit the specific and various needs of their clients	63.9% (69)
Treatment interventions were the same for all clients regardless of ethnicity, race, gender, class, sexual orientation and identity, disability, religion, age, or religious status	41.7% (45)
Treatment interventions were developed specifically for various client needs and contexts	41.7% (45)
Treatment interventions were not written but are used according to the agency's philosophy of treatment and expectations	18.5% (20)
<ul style="list-style-type: none"> • 80 respondents said they do not provide any LGBTQ specific services. • Several programs opted to treat LGBTQ people in individual sessions • A few respondents reported their programs adapted their curriculum for the LGBTQ populations 	(91)
Indicated that state standards provided effective intervention for female perpetrators	46.6% (34)
Strongly disagree or disagree with state standards' ability to provide effective treatment intervention	32.88% (24)
Strongly agree or agree that state standards adequately provided effective treatment intervention for same-sex perpetrators	31.5% (23)
Strongly disagree or disagree that same-sex perpetrators were adequately provided treatment interventions	30.1% (22)
Strongly agree or agree that state standards provided adequate intervention for male perpetrators	82.8% (63)
Strongly disagree or disagree with the assessment that state standards provide adequate intervention for male perpetrators	11.8% (9)
When asked how faithfully respondents adhere to state standards, reported they always adhere to these standards	59.6% (62)
Reported they often adhere to state standards	33.66% (35)

Table 1. Key findings and percentage of respondents for North American Domestic Violence Batterer Intervention Program Survey.

As indicated in the results here, many BIPS offer a range of services besides group therapy in an effort that recognizes and supports the multiple dimensions that affect one's use of violence. In this way, BIPs have shown their effectiveness in addressing a host of co-factors (e.g., offering parenting classes, transportation, substance abuse counseling, community advocacy, etc.). In doing so, BIPs have proven their ability to work with other services and community partners in order to holistically address the range of issues faced by perpetrators. However, no respondent indicated work with specifically LGBTQ organizations to identify and address the needs of this community. Research has shown that IPV occurs in the LGBTQ relationships at similar or greater rates than heterosexual couples (see, for instance, [1, 2]) but BIPs surveyed here have yet to make inroads into well-established community organizations to work to address these disparities.

Although policy language has mostly shifted to discuss domestic violence between "partners," as Cannon and Buttell [8] note, this language has papered over the need for policy to adequately legislate treatment options that directly address the needs of the underserved LGBTQ populations. For instance, 69% of respondents did not agree that state standards adequately legislate treatment options for LGBTQ populations. Given the pervasiveness of the problem of LGBTQ IPV and the perniciousness of the personal and social effects of this, it is necessary for policymakers to use evidence-based practices to generate policies that adequately protect and regulate treatment options for all perpetrators and victims of IPV. To this end, respondents offered several key recommendations for better addressing treatment interventions for LGBTQ people. Furthermore, it was clear from the survey that practitioners thought that the state standards adequately legislated treatment for male batterers. This finding lends support to scholars who have argued that most policies do a good job of helping male batterers but that there is a gap in policy that does not explicitly and directly support female batterers or LGBTQ batterers. Specifically, policy that directly structures culturally relevant treatments now being called for by leading scholars (see, e.g., [7, 11, 3, 2, 12, 5]).

5. Conclusions

Practitioners on the frontlines of IPV intervention across the USA and Canada proposed several recommendations for addressing the lack of treatment options for LGBTQ perpetrators of IPV. These recommendations are important for creating equal access and opportunity for all people afflicted by IPV. First, outreach to LGBTQ communities is necessary to alert people to the kinds of services available for them. Second, policy must, at best, set the tone for culturally relevant curriculum and training for practitioners of BIPs and, at worst, provide a flexible framework to allow individual programs to better address the problems faced by the LGBTQ community. Additionally, as this research shows BIPs have been able to provide similar types of services (e.g., parenting classes, substance abuse counseling, education classes). Along similar lines, culturally relevant curricula must be developed to address the particular experiences LGBTQ have (e.g., encounters with homophobia) that may impact how they mediate interpersonal relationships. Furthermore, LGBTQ facilitators would be helpful in addressing group instances of homophobia as well as being better equipped to create a safe space for clients.

Providing equal access to treatment services to such a widespread problem as IPV in LGBTQ relationships is part of a larger push for equality. These insights coupled with the fight for social justice have widespread implications across the field of social work, not just for those who research and treat perpetrators and victims of IPV. All of these recommendations begin with socially responsible scholars and practitioners—utilizing multiple theoretical frameworks with which to develop culturally relevant curricula, community outreach skills, and coalition building, as well as how to identify and address instances of homophobia, racism, and sexism. Such an approach benefits not just LGBTQ clients nor perpetrators of IPV but all clients.

Current policy is limiting in that it simply privileges a certain kind of relationship over others (e.g., heteronormativity). Broadening our thinking about who is violent in intimate relationships and why it helps us to better understand the complexities of IPV itself (see [5]). Following the recommendations elaborated above would improve treatment services for this population. Given the Supreme Court's ruling for marriage equality in *USA v. Windsor* (2015) and President Obama's latest extension of protection for transgendered employees of the Federal government (2016), there is a reason to hope that more policies will be put into place that provide greater resources and treatment for the LGBTQ community with respect to IPV. Expanding our ideas about how and why different groups of people initiate IPV in their relationships allows us to treat abusers and victims as whole people and takes seriously the notion that our society is rife with inequalities and power differentials.

Any effort to right such inequalities begins by acknowledging they exist and that they create *differences* that matter; that need to be addressed in policies that affect both perpetrators and victims. Treatment options, then, must be available that deal with different people's social contexts and opportunities (or lack thereof) as well as their identities, since both these macro and micro issues affect *how* and *why* people use violence to mediate their intimate relationships (e.g., [9, 3, 7]).

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Teenage Pregnancies: A Worldwide Social and Medical Problem

Sylvia Kirchengast

Additional information is available at the end of the chapter

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Abstract

Teenage pregnancies and teenage motherhood are a cause for concern worldwide. From a historical point of view, teenage pregnancies are nothing new. For much of human history, it was absolutely common that girls married during their late adolescence and experienced first birth during their second decade of life. This kind of reproductive behavior was socially desired and considered as normal. Nowadays, however, the prevention of teenage pregnancies and teenage motherhood is a priority for public health in nearly all developed and increasingly in developing countries. For a long time, teenage pregnancies were associated with severe medical problems; however, most of data supporting this viewpoint have been collected some decades ago and reflect mainly the situation of per se socially disadvantaged teenage mothers. According to more recent studies, teenage pregnancies are not per se risky ones. A clear risk group are extremely young teenage mothers (younger than 15 years) who are confronted with various medical risks, such as preeclampsia, preterm labor, and small for gestational age newborns but also marked social disadvantage, such as poverty, unemployment, low educational level, and single parenting. In the present study, the prevalence and outcome of teenage pregnancies in Austria are focused on.

Keywords: teenage pregnancies, adolescent mothers, social and medical problems, teenage pregnancy in Austria

1. Introduction

Teenage pregnancies and teenage motherhood are a cause for concern worldwide. According to the World Health Organization (WHO), about 16 million girls aging between 15 and 19 years

and about one million girls younger than 15 years give birth every year [1]. Nowadays, the vast majority of teenage pregnancies occur in low- and middle-income countries characterized by poor health-care services; therefore, complications during pregnancy, birth, and postpartum phase (e.g., 42 days after birth) are the second cause of death among girls aging between 15 and 19 years worldwide. Additionally, it is estimated that some three million teenage girls undergo unsafe abortions, which may result in consecutive reproductive problems or even death [1]. Fifteen years ago, The United Nations International Children's Emergency Fund (UNICEF) reported that worldwide every fifth child is born by an adolescent mother and 80% of these so-called teenage pregnancies occur in third-world countries [2]. Although in traditional societies the majority of these pregnancies are socially desired, several studies have pointed out the enormous risks which are associated with teenage pregnancies [3, 4], such as anemia, preterm labor, urinary tract infections, preeclampsia, high rate of cesarean sections, preterm birth, and low birth weight infants and even maternal and newborn mortality. Teenage pregnancies, however, still also occur in high-income countries and despite much better medical care teenage pregnancies are also considered as risky and policy tries to avoid too early motherhood [1]. This is not only due to medical problems, but first of all the social consequences of teenage motherhood. Therefore, the analyses of causes and consequences of teenage pregnancies have been the topic of much research and debate [5–7]. The present paper focuses on the biological, medical, and social aspects of teenage pregnancies with special respect to the situation of Austria, a country with exceptionally high standards in medical and social care.

2. Biological basis of teenage pregnancy

A girl can conceive from sexual intercourse as early as she started to ovulate. Usually, the first ovulation takes place after the first menstrual bleeding, the menarche [8]. Girls experience menarche at very different ages and it is quite difficult to estimate the mean age at menarche worldwide, because significant differences between individual countries, but also between subpopulations within a country, are observable [9]. Commonly, the mean age at menarche is considered as 13 years, the median, however, as 14 years [9]. Consequently today menarche occurs mainly in the first half of the second decade of life. From the viewpoint of human life history theory, this stage of life is called adolescence: Adolescence starts with pubertal hormonal changes such as the activation of the hypothalamus-pituitary-gonad-axis and can be divided into early and late adolescence. Early adolescence is defined as an age of 15 years and below, late adolescence means an age of 16–19 years. From the viewpoint of evolutionary biology, adolescence seems to be a very recent phenomenon [10]. It is not found before *Homo sapiens* and may lead to a fitness advantage because it is a phase of socio-sexual maturation and of acquisition of social and economic skills which may increase reproductive success during later life. During early adolescence, successful reproduction was and is rare. The years following menarche are often characterized by anovulation and consequently the likelihood of successful conception is quite low [11]. Furthermore, a mean age of menarche of 13 years is a quite recent phenomenon. Although the reliability of data concerning age at menarche in historical times has to be questioned, it can be assumed that over the past 180 years the age of

menarche has fallen substantially across all developed countries [9]. In the 1840s, the average age at menarche was 16.5 years in Europe; today, menarcheal onset occurs at the age of 12.5 on the average in Europe [12]. This decline of menarcheal age is the consequence of the so-called secular acceleration trend, which was induced by improved living conditions, infection control, and an improvement of nutrition [13]. In the 1990s, the secular trend in menarcheal age had slowed down or ended in many European countries and the United States [14]. Better living conditions and sufficient food supply, however, resulted not only in earlier sexual maturation but also in an increase in the rate of ovulatory cycles soon after menarche. In other words, the risk of becoming pregnant shortly after menarche increased too. The secular trend, however, affected not only sexual maturation, on the other hand peak height velocity and the development of secondary sexual characteristics such as breast development take place much earlier and most adolescent girls often look like young ladies, long before they reach mental maturity [15, 16]. Consequently, these girls may feel that they are old enough to start with sexual activity. Although sexual freedom and activity patterns among adolescent girls differ markedly according to cultural and religious background, we have to be aware that today nearly half of the global population is less than 25 years old. Even the generation of adolescents, that is, individuals between 10 and 19 years [1], is the largest in our history. Worldwide, an increasing number of adolescents tend to develop increased interest in sexual activities and consequently we are faced with increasing rates of sexually transmitted diseases including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) but also of unintended pregnancies and all associated social and medical risks of early childbearing among adolescent girls.

3. Teenage motherhood from a historical viewpoint

From a historical point of view, teenage pregnancies are nothing new. Teenage pregnancies and teenage motherhood were considered as normal and often socially accepted in previous centuries and even during the twentieth century in Europe. It was absolutely common that first births took place during adolescence for much of human evolution and history. Girls married during adolescence and gave birth during their second decade of life. This kind of reproductive behavior was socially desired and considered as normal [17]. It is documented that Hildegard of Vinzgouw, the second wife of Charlemagne, was about 14 years old when she delivered her first son in 772 AD. Another prominent example is Margaret Beauford, who was only 13 years old when she gave birth to Henry VII of England in 1457. Margaret Beauford's granddaughter Margaret Tudor gave birth to her first three children before her 19th birthday. These are only few historical examples; childbirth during the second decade of life is quite common even today. In 2008, there was much debate concerning the teenage motherhood of Bristol Palin, the daughter of Sarah Palin, the Governor of Alaska and vice presidential candidate of the United States.

Pregnancies during early adolescence (girls under the age of 15), however, have always been rare. This was mainly due to the biological fact that menarche and reproductive maturity were experienced much later in historical times than today. Furthermore, sexual activity of girls and

young women was mainly related to marriage until the second half of the twentieth century [9]. Today, the first sexual activity is initiated at a much younger age, and the use rate of contraception among this age group, however, is rather low [18, 19]. Therefore, the probability of pregnancies during teenage age increased worldwide during the second half of the twentieth century.

4. Teenage pregnancies as a worldwide phenomenon

Today, teenage pregnancies are a worldwide phenomenon. About 11% of all births worldwide are still girls aged 15–19 years old. According to the World Health Statistics 2014, the average global birth rate among 15–19 year olds is 49 per 1000 girls, whereas country rates range from 1 to 299 births per 1000 girls. Rates were highest in Sub-Saharan Africa [20]. The 10 highest-risk countries for teenage motherhood are still Niger, Liberia, Mali, Chad, Afghanistan, Uganda, Malawi, Guinea, Mozambique, and the Central African Republic. In these countries, teenage birth rate (births per 1000 women aged 15–19) ranges from 233 in Niger to 132 in the Central African Republic. In Niger, more than 50% of teenage girls (15–19 years) are married. Approximately 25% of teenage girls gave birth between 15 and 19 years [21]. This is mainly due to the fact that childbearing among teenagers is socially desired in some traditional societies and in developing countries [22]. Therefore, a substantial proportion of teenage pregnancies and births are therefore intended in developing countries.

In developed countries, by contrast, teenage birth rates are quite low and teenage motherhood is discouraged, debated as a public health problem and considered as a societal challenge. Nevertheless, there are considerable differences in teenage pregnancy rates between the different developed nations. The majority of teenage mothers (60%) are accounted for by the United States [20]. The teenage birth rate of the United States is about four times that of the European Union (EU) average [23]. Within the European Union, the highest teenage birth rates are found for UK with 27% and the new European Union members Bulgaria (33%), Romania (34%), and the Baltic States (21–23%) [20]. Extraordinary high levels are also reported for Ukraine (38%), Macedonia (34%), Russia (31%), and Belarus (27%). By contrast, extremely low rates of teenage births are reported for Japan and Korea (less than 5%), for Switzerland (4%), Netherlands (5%), and Sweden (6%). Less than 15% were reported for Italy, Spain, Denmark, Finland, France, Luxembourg, Belgium, Greece, Norway, Germany, and Austria [23].

However, we have to be aware that contained in all of these data sources the teenage birth rate focused on girls aged between 15 and 19 only. The extremely vulnerable group of teenage mothers younger than 15 years is not accounted for in the majority of statistics quoted. Singh [24] reported that 8–15% of girls in Cameroon, Liberia, Malawi, Niger, and Nigeria and 11% of the girls in Bangladesh had given birth before their 15th birthday. Pregnancy and birth among girls younger than 15 years are extremely risky; nevertheless, in some societies it is still common that girls marry in their teens and reproduce as early as possible mainly because

early reproduction may enhance the girls' low status in their new family [25]. This social pressure to reproduce as early as possible increases the mortality rate among early adolescent girls such as in Bangladesh where the risk of maternal mortality may increase fivefold among mothers aging between 10 and 14 years in comparison to adult women [21].

5. Adverse effects of teenage pregnancies

Female reproduction has always been risky and doubtless pregnancies and births are, independent of maternal age, critical phases in the life of mother and fetus. Teenage pregnancies were seen as a special problem because adverse health consequences of teenage pregnancies were solely attributed to the young maternal age for a long time. The REPRO-STAT project of the European Union declared teenage pregnancy rates as one of 18 core indicators for monitoring and describing reproductive health in the European Union [26, 27]. Teenage pregnancy is labeled alongside obesity, diabetes, cardiovascular disease, and cancer rates as a major public health problem [5, 7, 28]; the classification of teenage pregnancies as a high-risk category and a major public health concern, however, is debated controversial today. Adverse medical effects of teenage pregnancies have been reported mainly in quite old studies dated back to the 1950s. At this time, teenage pregnancies were seen as obstetric problems per se, which are associated with an increased risk of anemia, preterm labor, urinary tract infections, hypertension, preeclampsia, a high rate of cesarean sections but also preterm birth, low birth weight, and intrauterine growth restriction [5, 15, 29–35]. These observations, however, are based on studies among social-deprived subpopulations and from third-world countries with very poor medical conditions [30, 36–38]. During the 1970s, this viewpoint of teenage pregnancies changed markedly. Studies from more economically advantaged clinics in developed countries yielded no increased obstetrical problems among teenage mothers compared with older mothers [32, 33, 39–42]. A recent study from Austria showed clearly that the obstetric outcome of adolescent pregnancies has remained favorable over the last 18 years. Cesarean section rate remained the same in the adolescents during the last 18 years, and the incidence of abnormally adherent or incomplete placentas decreased. The authors concluded that teenage motherhood is a social problem and not an obstetrical or a clinical one [43, 44]. Adverse health consequences and poor pregnancy outcome among teenage mothers seem not to be associated with low gynecological or chronological age of the mothers but with adverse life circumstances [4, 45] because the highest proportions of teenage pregnancies occur in most socioeconomically disadvantaged subpopulations or in developing countries. Therefore, in developed countries teenage pregnancies and teenage motherhood were no longer seen as medical risk but as a social problem because teenage motherhood has numerous deleterious social consequences for mother and child. Teenage motherhood is significantly associated with dropping out of school, low educational level, low income, poverty and single parenting, and/or belonging to ethnic minority groups [6, 34, 46]. What remains unknown is the extent to which these poor outcomes result from teenage pregnancies or from per se social disadvantages which affect the teenage mother already before pregnancy.

It is really a chicken-egg debate because it remains unclear if social disadvantage is the reason or the result of teenage motherhood [47].

6. Strategies to decrease teenage pregnancy rates and improve teenage pregnancy outcome

Some recent studies have demonstrated that a well-acting social welfare system including appropriate psychosocial support and prenatal care improves the obstetric outcome in teenage mothers significantly [48–51]. In this case, teenage pregnancy outcome may be comparable with, or even better than, that in older mothers [4, 52]. The second goal is the efficient reduction of teenage pregnancies per se. The World Health Organization published guidelines in 2011 to prevent early pregnancies and reduce poor reproductive outcomes [1]. The six main objectives were defined as follows:

1. reducing marriage before the age of 18;
2. creating understanding and support to reduce pregnancy before the age of 20;
3. increasing the use of contraception by adolescents at the risk of unintended pregnancy;
4. reducing coerced sex among adolescents;
5. reducing unsafe abortion among adolescents.

The main purpose of this program is to avoid getting pregnant. Unfortunately, sex education is lacking in many countries and consequently young girls are not aware about physiological basis of reproduction and contraceptives. Furthermore, many girls may feel too inhibited or ashamed to seek contraception services. On the other hand, contraceptives are sometimes too expensive or not widely or legally available. Consequently, the most important strategies to avoid teenage pregnancies are improved education of girls, the introduction or improvement of sexual education, and the availability of cheap and easy to use contraceptives [1, 53].

A cornerstone in reducing adolescent sexual-risk behaviors and promoting reproductive health is sex education programs. School-based programs have the potential to reach the majority of adolescents in developed countries and large number of adolescents in countries where school enrollment rates are high [54, 55]. European countries prefer school-based sex education because schools in industrialized countries are the only institution in these societies regularly attended by nearly 95% of all youth aged between 6 and 16 years [53]. It is well documented that sex education programs may increase knowledge of human reproduction and methods of contraception [56]. Developed countries with the lowest rates of teenage motherhood are characterized by advanced school-based sex education but also broad availability of contraceptives including postcoital emergency contraception, and a liberal abortion law [57–59]. Since not all adolescents are in school especially in developing countries, sex education programs have also to be implemented in clinics, community organizations, and youth-oriented community agencies.

7. Teenage motherhood in Austria

According to the Forbes list 2012, Austria is the 12th richest country in the world and according to the gross domestic product (GDP) per capita the third richest country in the European Union. The standard of living is exceptionally high in Austria; this is especially true of the social welfare system which includes public health service for all inhabitants on nearly equal conditions and universal health insurance coverage. Furthermore, 9 years of education are mandatory in Austria. After compulsory basic school for 4 years, pupils have the option to visit higher-learning institutions that prepare one for university for 8 or 9 years, or to go on to vocational-preparatory schools for 5 years. Since 1971, sex education is mandatory in all schools and is provided at the age of 10, 14, and 16 years. Beside school-based sex education programs, special outpatient departments for adolescents such as the so-called first love outpatient department in Vienna were implemented. Adolescents have access to these institutions free of charge. They get sex education there but also access to contraceptives. Contraceptives and even emergency contraceptives are available. In 1974, the so-called mother-child passport was introduced. The mother-child passport is a highly sophisticated system of care, which includes seven checkups during pregnancy starting at the eighth week of gestation and eight postnatal checkups of the child between birth and the fourth year of life [60]. All checkups are free of charge and are performed in the gynecologist's or pediatrician's consulting rooms. Abortion has been fully legalized in 1974. Abortions can be performed on demand in hospitals, outpatient departments, and private practice for women whose pregnancies have not exceeded 12 weeks; however, abortions are not paid for by the government health system.

As pointed out above during the early 1970s marked changes in public advances to improve reproductive health took place. The mother-child passport was introduced, abortion became legal, and sex educations in public schools became obligatory. At the same time, teenage motherhood started to decrease markedly. Unfortunately, only births and not pregnancies are recorded in Austria [61]. Therefore, we have no information how many adolescent girls became pregnant because no official abortion statistics exist in Austria. Nevertheless as to be seen in **Figure 1** from 1974 to 2015 the number of girls aging between 15 and 19 years, that is, older adolescents, who gave birth dropped down from 14,387 to 1698 [61]. A marked decrease of motherhood was also observable for girls younger than 15 years (**Figure 2**). Among this early adolescent group, teenage motherhood dropped down from 66 births in 1974 to 15 births in 2015. During the same period, the mean age at first birth increased in Austria from 23.8 years in 1984 to 29.1 years in 2015 [61] (see **Figure 3**). This reduction started with 1974 when abortions became fully legal. In order to prevent teenage pregnancies, several governmental and nongovernmental programs were developed. In a first step, special help desks for young girls were introduced. Young girls can contact gynecologists in special consulting hours at private practices and hospitals free of charge to get information regarding contraception, abortion but also medical care during pregnancy. One example is the "Young Mom" outpatient department of the Hospital "Göttlicher Heiland." This hospital supports young girls during pregnancy and birth and provides advice after birth too. In general, Austrian girls older than 14 years have access to hormonal contraceptives without parental approval. In case of pregnancy girls older than 14, they may decide for abortion without approval by their parents. These private

and governmental activities helped to reduce teenage motherhood markedly. Although teenage motherhood in Austria is not among the lowest in developed countries, the positive effects of mandatory sex education and legal abortions on teenage motherhood rates can be seen. On the other hand, social programs for young mothers were introduced. Teenage mother receives medical care during pregnancy, birth, and after birth free of charge. Additionally, social and financial support improved the situation for teenage mothers markedly. In detail, young mothers are supported to finish school and professional training. Consequently, teenage motherhood is not strongly associated with poverty in Austria. Medical and social care during pregnancy improved pregnancy outcome markedly. These positive effects could be shown in the Viennese teenage pregnancy project.

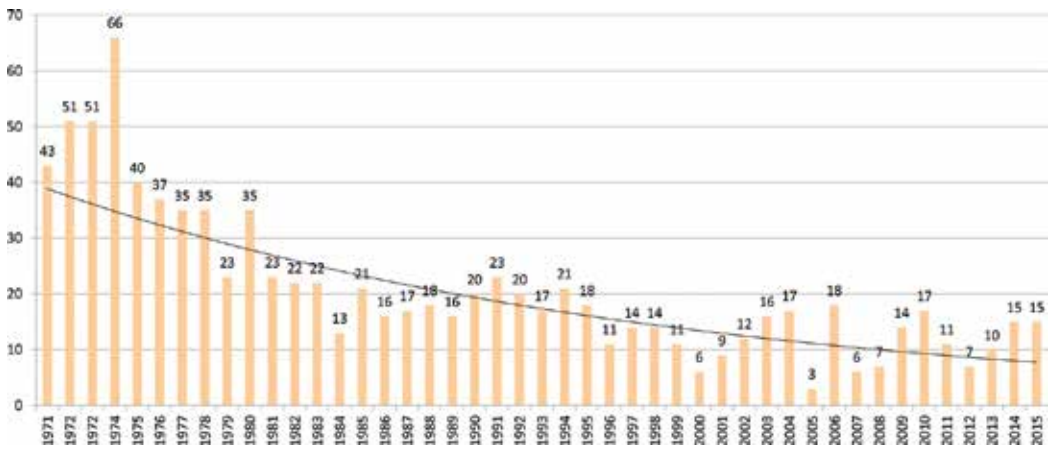


Figure 1. Absolute number of life birth among girls aging below 15 years in Austria between 1971 and 2015.

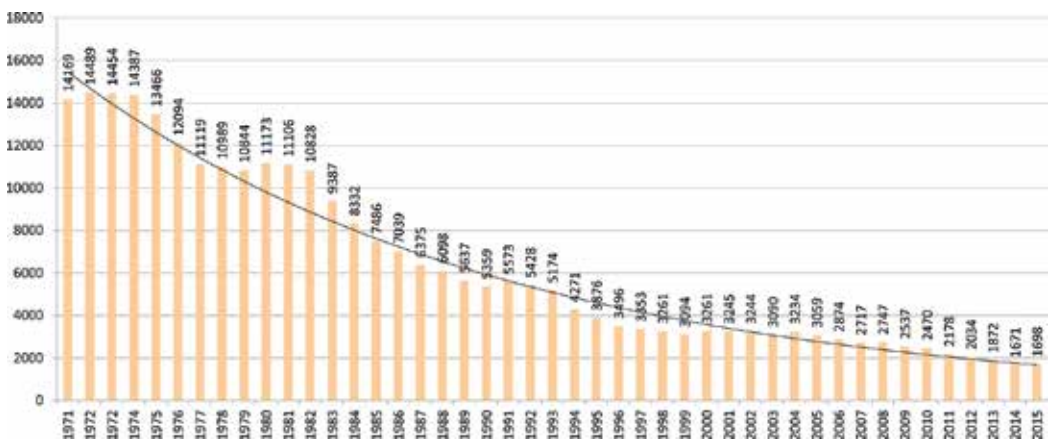


Figure 2. Absolute number of life birth among girls aging 15-19 years in Austria between 1971 and 2015.

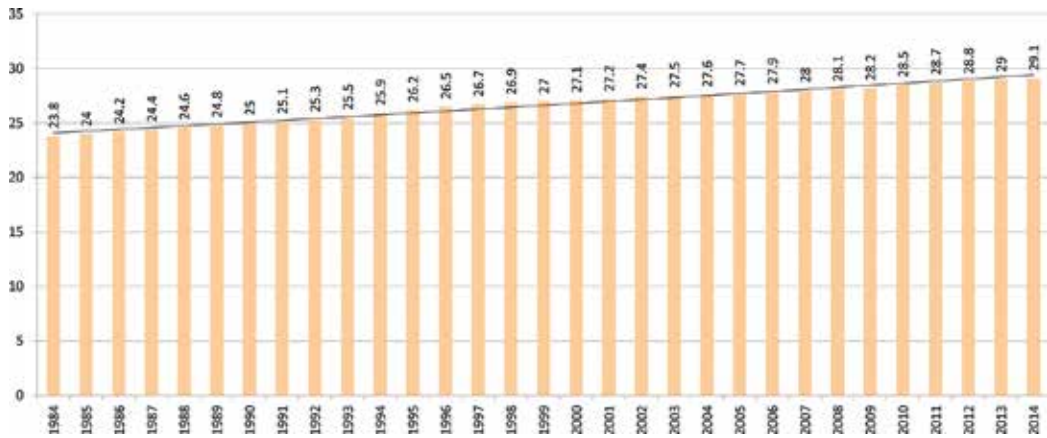


Figure 3. The mean age at first birth between 1984 and 2015.

7.1. The Viennese teenage pregnancy project

The Viennese teenage pregnancy project focused on the impact of maternal age on birth outcome among Viennese primiparae women between 1985 and 1995. Furthermore, the effects of social support on the outcome of a small sample of teenage pregnancies were tested. The results of this project have already been published [62–65].

7.1.1. Study: maternal age and birth outcome

The first study was based on a data set of 10,240 singleton term births (39–41st gestational weeks) which took place at the largest birth clinic in Austria, the University Clinic for Gynecology and Obstetrics in Vienna between 1985 and 1995. In this study, the data of 10,231 women aging between 12 and 49 years ($x = 25.7$; standard deviation (SD) = 5.8) at the time of giving first birth and their newborns were analyzed. Exclusively healthy women originating from Austria or Central Europe with no registered maternal diseases before and during pregnancy who gave birth to a single infant were enrolled in the study. The following maternal characteristics were documented: Chronological age, age at menarche, gynecological age (years between menarche and conception), stature, prepregnancy weight, prepregnancy body mass index (BMI) (kg/m^2), weight at the end of pregnancy, gestational weight gain, and the pelvic dimensions distantia spinarum (DSP) and distantia christarum (DCR). Immediately after birth, newborn weight, newborn length, head circumference, diameter fronto-occipitalis, and acromial circumference were taken directly from the newborn. A low birth weight was defined as <2500 g, a high birth weight (macrosomia) as >4000 g according to the recommendations of the WHO [66]. In addition to anthropometric features, the 1- and the 5-min APGAR scores [67] for the evaluation of the newborn were determined. As obstetric characteristics, the mode of delivery, spontaneous versus cesarean section, and the intrauterine position of the infant at the time of delivery (head presentation, breech presentation, and transverse presentation) were

documented. A more detailed description of data collection and statistical analyses has been published previously [62–64].

The data set of 10,240 single births was divided according to maternal age at the time of giving birth into five subgroups: Groups 1 and 2 corresponded to the definitions of teenage pregnancies. In detail, group 1 comprised 19 extremely young mothers aging between 12 and 14 years at the time of giving first birth, while group 2 comprised 1532 mothers aging between 15 and 19 years at the time of giving first birth. The majority of these teenage mothers gave birth at the ages of 18 and 19 years (see **Figure 4**). Group 3 contained 6460 mothers aged between 20 and 29 years, group 4 comprised 2090 women aging between 30 and 39 years, and group 5 comprised 130 women aging 40 years and above. Consequently, the percentage of teenage mothers was 15.2% of the whole sample; only 0.2% of the mothers were less than 15 years when giving birth. The main focus of this study laid on the 19 extremely young mothers aging between 12 and 14 years. As demonstrated in **Table 1**, youngest mothers (<15 years) exhibited the significantly lowest menarcheal age, the lowest gynecological age. Furthermore, these early adolescent girls were significantly shorter and lighter than all older age groups, even late adolescent mothers. Even the pelvic dimensions *distancia spinarum* and *distancia cristarum* of early adolescent mothers were significantly smaller than those of older mothers. Furthermore, the youngest age group experienced the lowest gestational weight gain.

Maternal age group	<15 years	15–19 years	20–29 years	30–39 years	>40 years	Significance
Variable	<i>x</i> (SD)	<i>x</i> (SD)	<i>x</i> (SD)	<i>x</i> (SD)	<i>x</i> (SD)	<i>p</i> -value
Age at menarche	11.5 (0.8) ^{b-e}	12.9 (1.4) ^{a,d,e}	13.3 (1.5) ^{a,d,e}	13.5 (1.5) ^{a,b}	13.7 (1.7) ^{a,b}	<0.001
Gynecological age	2.3 (0.9) ^{b-e}	5.1 (1.6) ^{a,c,d,e}	10.8 (3.1) ^{a,b,d,e}	19.8 (3.1) ^{a-c,e}	27.8 (1.9) ^{a-d}	<0.001
Stature height (cm)	159.1 (5.2) ^{b-e}	162.6 (6.0) ^a	163.4 (6.5) ^a	162.8 (6.9) ^a	163.5 (6.7) ^a	<0.001
Distancia spinarum (cm)	24.7 (2.5) ^{d,e}	24.5 (1.9) ^{d,e}	24.9 (2.0) ^{b,e}	25.4 (1.9) ^{b,e}	25.8 (1.9) ^{a-c}	<0.001
Distancia cristarum (cm)	26.8 (1.7) ^{b,c,d,e}	27.6 (2.1) ^{a,d,e}	28.1 (2.0) ^{a,e}	28.4 (1.9) ^{a,b,e}	29.5 (5.8) ^{a-d}	<0.001
Prepregnancy weight (kg)	52.2 (7.1) ^{b-e}	57.1 (8.6) ^{a,d,e}	59.2 (9.9) ^{a,e}	61.9 (11.5) ^{a,b,e}	66.4 (12.3) ^{a-d}	<0.001
End of pregnancy weight (kg)	67.2 (9.5) ^{c-e}	70.0 (10.7)	73.1 (12.1) ^a	74.9 (13.4) ^a	75.9 (13.1) ^a	<0.001
Pregnancy weight gain(kg)	12.8 (7.5)	13.1 (5.5)	13.1 (5.4)	12.3 (5.6)	10.8 (5.6)	n.s.
BMI (kg/m ²)	20.47 (2.12) ^{c-e}	21.59 (2.99) ^{d,e}	22.10 (3.44) ^{a,e}	23.28 (4.04) ^{a,b,e}	24.74 (4.56) ^{a-d}	<0.001

^a Significantly different from maternal age group <15 years.

^b Significantly different from maternal age group 15–19 years.

^c Significantly different from maternal age group 20–29 years.

^d Significantly different from maternal age group 30–39 years.

^e Significantly different from maternal age group >40 years.

Table 1. Maternal reproductive and somatic characteristics according to maternal age group (Duncan analyses).

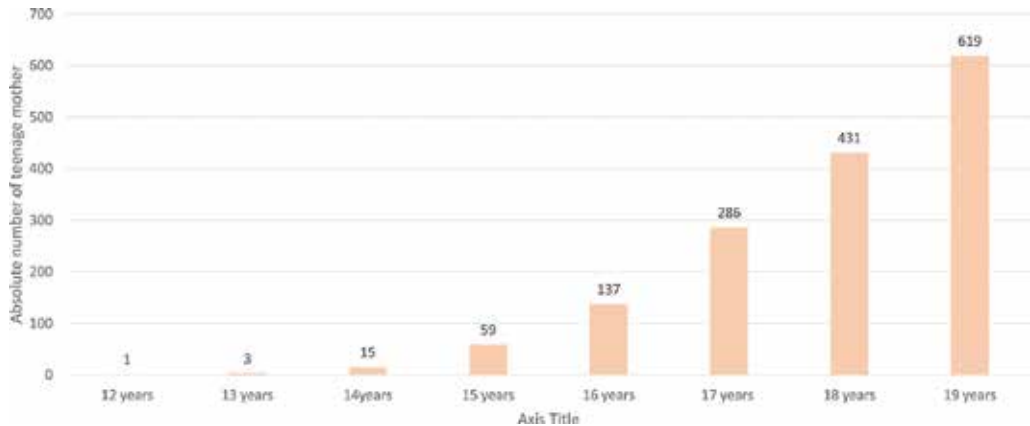


Figure 4. Absolute number of teenage mothers according to age (Kirchengast and Hartmann).

Maternal age group	<15 years	15–19 years	20–29 years	30–39 years	>40yrs	Significance
Variable	<i>x</i> (SD)	<i>x</i> (SD)	<i>x</i> (SD)	<i>x</i> (SD)	<i>x</i> (SD)	p-value
Birth weight (g)	2959.4 (362.4) ^{b-e}	3293.9 (402.8) ^a	3368.9 (425.3) ^a	3395.7 (462.6) ^a	3435.8 (406.1) ^a	<0.001
Birth length (cm)	48.5 (1.7) ^{b-e}	49.6 (1.9) ^a	49.9 (1.9) ^a	49.9 (2.1) ^a	50.2 (1.5) ^a	<0.001
HC (cm)	33.3 (1.1) ^{b-e}	34.1 (1.4) ^a	34.4 (1.4) ^a	34.5 (1.4) ^a	34.6 (1.5) ^a	<0.001
AC (cm)	35.8 (2.2) ^{c-e}	36.5 (2.2) ^{d,e}	36.8 (2.3) ^a	37.1 (2.5) ^{a,b}	37.4 (2.1) ^{a,b}	<0.001
DFO (cm)	11.0 (0.6)	11.2 (0.8)	11.3 (1.3)	11.3 (0.8)	11.2 (0.8)	n.s.
APGAR 1	8.3 (1.5)	8.6 (1.3)	8.6 (1.3)	8.6 (1.3)	8.5 (1.4)	n.s.
APGAR 5	9.7 (0.7)	9.7 (0.8)	9.8 (0.7)	9.8 (0.7)	9.8 (0.6)	n.s.

HC, head circumference; AC, acromial circumference; DFO, diameter fronto-occipital.

^a Significantly different from maternal age group <15 years.

^b Significantly different from maternal age group 15–19 years.

^c Significantly different from maternal age group 20–29 years.

^d Significantly different from maternal age group 30–39 years.

^e Significantly different from maternal age group >40 years.

Table 2. Newborn characteristics according to maternal age group (Duncan analyses).

Concerning newborn characteristics, it could be shown that mothers younger than 15 years gave birth to the significantly lightest and shortest newborns (see **Table 2**). Furthermore, these newborns exhibited the smallest head and shoulder dimensions. Concerning the Apgar scores 1 and 5 min after birth, no significant differences between the maternal age groups could be proved. Furthermore, early adolescent mothers showed the significantly highest incidence of low weight newborns (<2500 g). None of these extremely young mothers gave birth to a macrosome (>4000 g) newborn (see **Table 3**). Concerning child presentation and delivery mode, it turned out that extremely young mothers showed the significantly highest

rate of breech presentation (10.5%) but the significantly lowest rate of cesarean sections (16.7%) (see **Table 3**). In this study, it could be shown that very young mothers (<15a) were quite immature, they were significantly shorter and lighter than older mothers, even older adolescent mothers. Furthermore, they gave birth to significantly smaller and lighter newborns. On the other hand—although breech presentation was quite high—the cesarean section rate—indicating birth complications—was significantly lower than among older mothers, even lower than among late adolescent mothers. Considering in contrast to the incidence of obstetrical risks such as cesarean section or adverse child presentation, such problems are low in comparison to older gravida. Therefore, we can conclude that teenage pregnancies—even among early adolescent mothers aging below 15 years—are not associated with increased obstetrical risks.

Maternal age group		<15 years	15–19 years	20–29 years	30–39 years	>40 years	Significance
Variable							
Pregnancy weight gain	<10 kg	33.3%	24.0%	23.5%	29.3%	40.4%	$p = 0.003$
	10–15 kg	44.4%	43.8%	46.0%	45.0%	40.4%	
	>15 kg	22.2%	32.2%	30.5%	25.7%	19.2%	
Newborn weight status	Low weight <2500 g	10.5%	2.0%	1.6%	2.4%	0.8%	$p = 0.001$
	Normal weight 2500–4000 g	89.5%	93.1%	90.4%	87.8%	91.5%	
	Macrosomia >4000 g	0.0%	4.8%	8.0%	9.8%	7.7%	
Delivery mode	Spontaneous vaginal delivery	83.3%	82.9%	79.7%	72.3%	68.7%	$p = 0.001$
	Cesarean section	16.7%	17.1%	20.3%	27.7%	31.3%	
Child presentation	Breech presentation	10.5%	2.5%	3.6%	4.4%	4.6%	$p = 0.023$
	Transverse presentation	0.0%	0.3%	0.2%	0.3%	0.0%	n.s.

Table 3. Birth outcome according to maternal age group (Chi-squared).

7.1.2. Study: social support and pregnancy outcome among teenage mothers

In this study, the impact of social support on the course of pregnancy and pregnancy outcome among 51 pregnant Austrian girls aging between 13 and 18 years ($x = 16.3$ years; ± 1.3) who decided to give birth was tested [65]. All girls were interviewed based on a structured questionnaire; furthermore, data from the mother-child passport were included in the analysis.

Complications during pregnancy and birth were seldom and no adverse birth outcome was observed. The majority of participants received optimal medical treatment and sufficient social support mainly from the parents, grandparents, and to a less degree by school. Institutional support was available for the vast majority of girls. The majority of girls got information and help from the gynecologist, health centers for teenagers, such as first love outpatient department, public social institutions, private social institutions, Internet services, and public information center. More than 90% of the girls reported that they had no problems to get sufficient information and institutional support. The majority of girls was satisfied with the social support and information provided by governmental and private institutions. These results support the idea that teenage pregnancies are mainly a social and not a medical problem, because adequate social support helps to reduce medical complications

8. Conclusion

In developed countries, most teenage pregnancies, especially those during early adolescence (<15 years), are unplanned and unintended. For a long time, teenage pregnancies were interpreted as major medical problems and obstetrical risk factors. More recently, however, obstetrical risks of teenage pregnancies are predominantly interpreted as results of adverse social and economic factors rather than chronological age. This, however, is no reason to deny that teenage pregnancies are currently still an important public health problem all over the world. There is no doubt that obstetrical problems can be managed by modern medicine and so the risk of teenage pregnancies can be diminished. In Austria, an improved sexual education and the legalization of abortions since the early 1970s reduced teenage motherhood dramatically. On the other hand, special support programs—including medical care, financial, and social support—for pregnant teenage girls and teenage mothers were introduced. First of all, special consulting hours for young girls free of charge at hospitals and private practices of gynecologists improved the access to contraceptives and advanced sexual education. Governmental financial support for young mothers reduced poverty among teenage mothers dramatically. Despite these improvements of the situation of teenage mothers in Austria, we should not forget that the development of strategies to reduce teenage pregnancy rate and teenage motherhood, especially among young adolescents, effectively should be a goal of public health worldwide.

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Unemployment and Causes of Hospital Admission Considering Different Analytical Approaches

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Additional information is available at the end of the chapter

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Abstract

The association between unemployment and hospital admission is known, but the causal relationship is still under discussion. The aim of the present analysis is to compare results of a cross-sectional and a cohort approach considering overall hospital admission and hospital admission due to cancer and circulatory disease. Register-based data were analysed for the period of 2006–2009. In the cross-sectional analysis, a multiple logistic regression model was conducted based on the year 2006, and cohort information from the same year onward up to 2009 was available for a Cox regression model. Social welfare compensated unemployment and both types of disease-specific hospital admission were associated to be statistically significant in the cross-sectional analysis. With regard to circulatory disease, the cohort approach suggests that social welfare compensated unemployment might lead to hospital admission due to the disease. Given the significant results in the cross-sectional analysis for hospital admission due to cancer, the unfound cohort effect might indicate a reverse causation suggesting that the disease caused joblessness, and finally social welfare compensated unemployment and not vice versa. Comparing different study designs allows for a better causal interpretation, which should be recommended in future quantitative social welfare analysis.

Keywords: cross-sectional study, cohort study, study design result interpretation, unemployment, hospital admission

1. Introduction

When presenting quantitative social welfare studies, careful interpretation considering correct study designs in different social welfare systems is important. Therefore, the aim of this chapter

is to introduce key concepts for the most frequently used epidemiological study designs in social health inequality (cross-sectional and cohort design) and to explain and discuss different results of these study designs using the association of unemployment and hospital admissions in the Danish social welfare system. We advise the reader to carefully interpret quantitative study results in social welfare considering the relevant problems and pitfalls of the used study design. Furthermore, we suggest to the reader to be open to critical reflection and discussion in order to shed a brighter light on causality.

For causal interpretation, it is important to know the social welfare system of interest like in our case the Danish welfare system. The Danish Labor Market is based on the so-called flexicurity – model. The main focus is on security in employment and income combined with flexibility in relation to the hiring and firing of workers. The model guarantees a high level of benefit security to workers with insurance if they become unemployed. By combining flexibility and social security, both employees and workers may become more willing to take a risk on the labour market [1].

Unemployment benefits on a voluntary paid insurance are used in around 50% of Danish workers. In the case of unemployment, individuals receive up to 85% of their former salary for a period of 2 years independent from the amount of money put aside or property owned. Furthermore, individuals without such a voluntary paid insurance will instead be considered in a social benefit system to maintain a certain minimum standard of living when there is a lack of money [2–4].

The principles of universalism, participation and equity lie at the core of the Danish welfare model. Universal social rights have been one of the core principles of the welfare state in Denmark and the healthcare system is closely related to the core values and developments of the welfare state. In the Danish healthcare system, universalism means that all citizens have free and equal access to available services, for example, hospitals and general practitioners. Some characteristics of the Danish health system are funding predominantly by taxes, existence of a decentralized public governance structure and a public control of the delivery structure. Additionally, it is equity driven, with great focus on geographical and social equity and participation [5, 6].

The main financial source has been general taxation at county and national level, with redistribution mechanisms from central to more decentralized levels. Aside from the public healthcare system, a private health sector is also present. Private health insurance can be given to employees as salary benefit and is becoming more and more popular. It is estimated that nearly 30% of the Danish population has supplementary private health insurance [7].

Unemployment and health inequality have been matters of interest in many studies with different study designs and varying assessment procedures [8–12], which almost always summarize that unemployment adversely affects health. There are plausible explanations as to why unemployment causes illness and later mortality; it disrupts personal social relationships, the situation is associated with stress and it induces bereavement reactions. Each of these situations has potential to cause diseases [13]. Health risks of unemployment might also be caused by an intermittent step, such as risky behaviour. It is proven that alcohol consumption

and smoking are increased among unemployed individuals [13–15]. It is also plausible that the association might have an inverse direction. Illness, especially severe and chronic diseases, causes unemployment; cancer survivors are shown to have a small but significantly increased risk for unemployment [16]. Furthermore, bidirectional causal associations between long-term unemployment and disease were already discussed [17].

A review [18] and a Danish national study [19] showed that the specific regional situation of employment, political regulation or health service acquisition partly explains overall associations between unemployment and health outcomes. Additionally, underlying study design, used exposure assessment and considered statistical models are discussed as sources that may bias the results [10].

Therefore, the aim of the present analysis is to analyse the short-term association between unemployment and hospital admission in Esbjerg, Denmark. Therewith, the effect of different unemployment compensation, different underlying study designs (cross-sectional or cohort approach) and varying disease-specific hospital admissions (cancer and circulatory diseases) are considered.

2. Epidemiological study designs

In analytic epidemiology, the terms exposure and outcome are often used. ‘Exposure’ (or being exposed or independent variable) describes a situation of having contact with a certain factor or an element in a specific situation we want to investigate. This does not necessarily need to be a harmful factor or a situation such as smoking or exposure to loud noise; it may also be protective, such as physical activity or healthy diet. The ‘outcome’ (or dependent variable) describes the result we want to investigate. It may also be potentially harmful or positive, depending on the research question. Examples of outcomes can be the development of a disease or the improvement of health.

In a **cross-sectional study**, data are collected on a defined, fixed point in time. Figuratively speaking, the researcher takes a snapshot of the study population with all relevant information at the given point in time. Cross-sectional studies cannot be informative when considering a period of time as they only collect data from a single time point or short period of time. Therefore, they are not suitable for showing cause-effect relationships considering exposure and outcome. Let us take a look at an example: In a cross-sectional study design, is it possible to answer to the research question of whether low socio-economic situation (SES) creates paraplegia in a population? Both low SES and paraplegia are assessed at the same point in time. What happens if the study shows a relationship? Does that mean that low SES causes paraplegia or could it be the other way around where paraplegic patients have difficulties in finding a job and therefore have a potentially lower SES? **Figure 1** displays how cross-sectional studies only allow statements regarding associations. It cannot be concluded which of the factors was present before the other or which one is the exposure and which is the outcome, respectively. Cross-sectional studies are important in descriptive epidemiology as they can be used to describe the distribution of health-related factors, SES and diseases in the population.

The results of cross-sectional studies can be used to describe situations or to answer questions related to health service research. Furthermore, they are used to generate hypotheses as a simple basis to analyse cause-effect relationships. They can be conducted at relatively low costs and are quite robust against deliberate or unintended false information (**Figure 1**) [20].

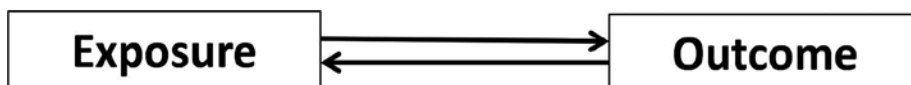


Figure 1. Problem in cross-sectional studies: The direction of the association between exposure and outcome cannot be assigned.

Cohort studies—or longitudinal studies—deal with data that are collected over a certain period of time. Figuratively speaking, the research starts with a snapshot but it goes forward like a film, collecting information in a time-dependent manner. The exposure in a previous time period can be compared to the probability of disease in a later period and cause-effect relationships can be investigated. With this study type, the shortcomings of cross-sectional studies can be eliminated. Cohort studies begin with a group of people who do not present the health situation or disease that we want to study as the outcome after the follow-up. At the onset, the exposure needs to be estimated and grouping into exposed and non-exposed is required. There is also a possibility that the participant may have a different extent of exposure. Over a fixed or variable period of time, health effects that occur in the participants are assessed. The latency period is particularly important as it considers the time from the exposure to the development of disease. During the latency period, the outcome is not defined as the relevant outcome, since the time from exposure to disease is too short to assess its development. Over the entire study period, one can observe which of the participants develops what kind of disease(s) and when. Usually, it takes quite a long time for an event to occur and thus to have the data available for analysis. Therefore, young people are mostly excluded from cohort studies because the researchers would have to wait too long for the outcome to occur. Nevertheless, it should be mentioned that the age range of choice for a cohort study can vary substantially, depending on the aim and the latency of the disease or pathological condition to be studied. However, if rare diseases such as the development of brain tumours are investigated, a cohort study is not the best design, since it would be very difficult and expensive. Too many individuals would have to be observed until a relevant event (e.g. brain tumour) occurs. To analyse such rare diseases, case-control studies are optimally suited, but are rarely done in social welfare research and therefore not presented here (**Figure 2**) [20, 21].

The biggest **challenge for social epidemiology** is that more attention for causality is required [22]. Sometimes, causalities are discussed even though reverse associations might be present [23]. In an initiated commentary, Oakes [24] defined differences between the roles of the social epidemiologist researcher and scientist. He defined researchers as those who seek the evidence to confirm what they believe is true, and by contrast scientists seek to discover the truth regardless of their hypotheses. These different views may create different opinions, discussions and debates. Therefore, it is important to clarify the research question and scientific aim. But be aware that seeking the truth in terms of science does not necessarily mean finding the truth.

Let us use a well-known example to discover causes of drunkenness. A young man drank whisky and soda on Friday, gin and soda on Saturday, vodka and soda on Sunday and did not consume alcohol on the other days of the week. When looking at common patterns, the conclusion might easily be drawn that soda was the reason for drunkenness [25]. However, considering complex associations with even more complex situations on causality might increase the potential of misinterpretations. Certainly, it is well known that smoking causes lung cancer. However, when considering smoking, what can be said of causality with regard to one's social network, advertising, social norms and taxation rates [22]?

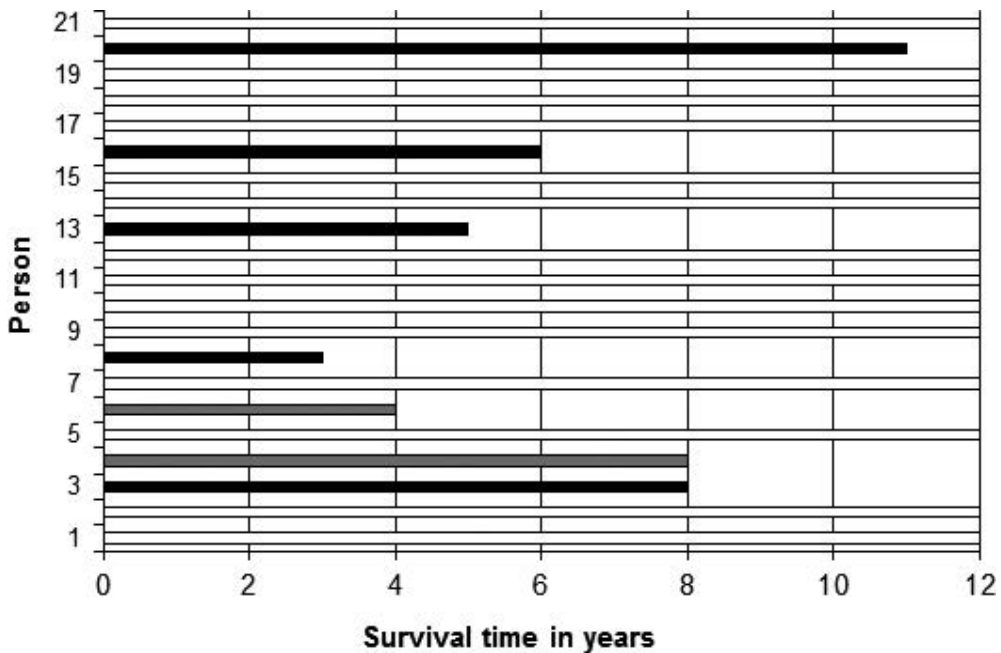


Figure 2. Example of a cohort study with 21 participants, who were observed over a period of 12 years. In this example, only exposed participants are displayed. Black bars: deceased persons; white bars: person survived the whole study period; grey bars: 'censored' data (persons that do not have any observation during the observation time).

Discussion about potential causality is based on in-depth knowledge of scientists and it is necessary to link social conditions and the results in the embodiments of health. For correct interpretation of quantitative studies, it is additionally necessary to identify potential problems and pitfalls in the study design [22]. Causality cannot be developed by quantitative research alone. The collaboration of various disciplines, such as sociology, psychology, medicine and biology, is essential. Furthermore, a combination of different methods and more complex models including life-course epidemiology, mixed methods, diverse study designs, social network analysis, multilevel analysis as well as consideration of directed acyclic graphs or effect modifications allow for a better picture of the overall causal relationship in the social environment [26].

3. Methodology

The present analysis is based on register data covering all inhabitants of the Esbjerg municipality. The data are derived from Statistics Denmark (Danmarks Statistik) and the Danish National Patients Registry (Landspatientregisteret). The Esbjerg municipality consists of three cities: Esbjerg, Ribe and Bramming and their surrounding areas. In total, data on the regional population with individual information from the years 2006–2009 were available. The analysis considered a cross-sectional and a cohort approach and hospital admission was defined as an outcome in both study designs. Of particular interest were the overall hospital admissions, hospital admissions due to cancer (ICD10 code C00-D49) and diseases in the circulatory system (ICD10 code I00-I99). The data were derived from the Danish National Patients Registry (Landspatientregisteret). In the cross-sectional analysis, hospital admission was assessed via the overall first individual inpatient hospital admission or due to the disease group in 2006. In the cohort analysis, the first relevant hospital admission was coded time-dependently for the period of 2008–2009.

The exposure of interest was the occupational situation of the citizens in the year 2006, which was drawn from Statistics Denmark. The following categories of employment status were considered:

3.1. Workers

- (1) Working population (self-employed and working population, employees including pensioners who were still self-employed).
- (2) Working citizens with prolonged sick certificates in 2006 (only considered in the cross-sectional approach).

3.2. Unemployed

- (3) Voluntary-insured unemployment benefit: Individuals who were voluntarily insured in unemployment insurance and received an enhanced unemployment benefit for up to 2 years. It also includes those who worked but additionally obtained benefits.
- (4) Social welfare benefit: Individuals who receive a minimum unemployment benefit due to the social benefit system. It ensures that the population studied can maintain a certain minimal standard of living.

3.3. Not working

- (5) Pensioners without working and invalidity pensioner.
- (6) Others (non-working population, e.g. students, parents on maternity leave).

As confounders, the following variables were considered: age, gender, number of individuals in the family, school education, municipality and nationality. Confounder information was drawn from the year 2006 (**Figure 3**).

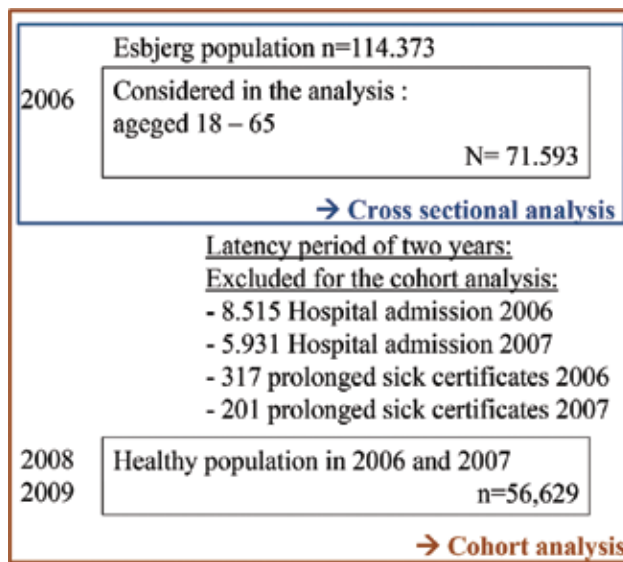


Figure 3. Study population for the cross-sectional and cohort analysis.

4. Results and discussion

Overall, 71,593 adults were available for the cross-sectional analysis in the year 2006. Of those individuals, 11.9% had at least 1 day of hospital admission in 2006. Of hospital admissions, 0.8% was seen due to cancer disease and 1.0% due to circulatory disease. Of adults, 74.3% was working and only 5.7% of the adult population was unemployed. With regard to completed school education, 30.9% had a basic school education and 22.4% had an advanced school education. Small differences in gender distribution can be seen. In total, there are overall more female hospital admissions in 2006. With regard to the considered diseases, there are more female cancer hospital admissions and more male hospital admissions specific to circulatory diseases. Females had more frequent sick certificates (68.8%) and received social welfare benefits (59.4%) more frequently than men (**Table 1**).

Table 2 presents the results of the multiple logistic regression models for employment status and hospital admissions. In total, less patients than expected were admitted to the hospital having voluntary-insured unemployment benefits in 2006, if no association was given. Due to the very small numbers, no odds ratios (ORs) were shown and they were omitted in order to interpret the results. Adults with social welfare benefits had a more pronounced overall hospital admission rate in 2006 compared to the working population (OR = 2.86; 95% confidence interval (CI): 2.61–3.14). Considering social welfare benefits and specific diseases, the significant association was most pronounced with cancer (OR: 2.13; 95% CI: 1.37–3.30), followed by circulatory diseases (OR = 1.76; 95% CI: 1.17–2.64).

	N	%	Female part (N (%))
Total:	71,593	100.0	35,050 (49.0)
Hospital admission			
Yes, overall	8515	11.9	4951 (58.1)
Yes, due to cancer	545	0.8	316 (58.0)
Yes, due to circulatory disease	708	1.0	253 (35.7)
Employment			
Workers	53,193	74.3	24,540 (46.1)
Sick certificate	953	1.3	656 (68.8)
Unemployment compensation			
Voluntary-insured benefit	1016	1.4	531 (52.3)
Social welfare benefit	3068	4.3	1823 (59.4)
Not working population:			
Pensioners	9155	12.8	5136(56.1)
Others	4208	5.9	2364 (56.2)
Education			
1–10 years	22,094	30.9	11,234 (50.9)
11–12 years	31,779	44.4	14,467 (45.5)
>12 years	16,042	22.4	8642 (53.9)
Not finished	1678	2.3	707 (42.1)
Age			
18–25 years	10,537	14.7	5126 (48.7)
26–35 years	14,287	20.0	6985 (48.9)
36–45 years	16,943	23.7	8284 (48.9)
46–55 years	16,174	22.6	7939 (49.1)
56–65 years	13,652	19.1	6716 (49.2)
Nationality			
Danish	66,350	92.7	33,527 (49.0)
Not Danish	5243	7.2	2523 (48.1)
Family			
1 person/family	21,133	29.5	8194 (38.8)
2 person/family	26,174	36.6	14,167 (54.1)
>2 person/family	49,232	68.8	12,689 (54.5)

Table 1. Description of the cross-sectional study population.

The results of the Cox regression with the selected healthy study population are presented in **Table 3**. The case numbers of hospital admission are higher in the cohort analysis and therefore the voluntary-insured unemployment benefit can be interpreted. Overall, there is no association between voluntary-insured unemployment benefits and any considered hospital admission. With regard to those receiving social welfare benefits, a positive association to overall hospital admission compared to the working population was seen. Related to the disease, specific results from the cross-sectional analysis were confirmed for social welfare benefits on hospital admission due to circulatory disease (hazard ratio (HR) = 1.66; 95% CI: 1.08–2.54). However, social welfare benefits were not associated with hospital admission due to cancer (HR = 0.80; 95% CI: 0.44–1.48).

	<i>n</i>	Overall hospital admission		Cancer (C00-D49)		Circulatory disease (I00-I99)	
		Cases	OR# (95% CI)	Cases	OR# (95% CI)	Cases	OR# (95% CI)
Overall population	71,593	8515		545		708	
<i>Working population:</i>							
Workers	53,193	4970	Ref.	309	Ref.	362	Ref.
Sick certificate	953	351	4.94 (4.31–5.67)***	19	4.46 (2.76–7.15)***	20	4.28 (2.69–6.80)***
<i>Unemployment</i>							
Voluntary insured benefit	1016	98	1.01 (0.82–1.26)	3		3	–
Social welfare benefit	3068	757	2.86 (2.61–3.14)***	24	2.13 (1.37–3.30)**	27	1.76 (1.17–2.64)*
<i>Not working population:</i>							
Pensioners	9155	443	2.67 (2.48–2.87)***	177	1.87 (1.50–2.33)***	273	2.38 (1.97–2.87)***
Others	4208	448	1.08 (0.96–1.21)	13	0.84 (0.48–1.50)	23	1.26(0.81–1.95)

#Adjusted for education, age, gender, nationality and number of persons living in the family. Significant results with * p < 0.05; ** p < 0.001; *** p < 0.0001.

Table 2. Multiple logistic regression model of employment and education on overall and specific diseases hospital admission (cross-sectional analyses).

In the present cross-sectional and short follow-up cohort approaches, persons with social welfare benefits had more overall hospital admissions and more hospital admissions due to circulatory diseases compared to the working population. The short-term effect in the cohort as well as in the cross-sectional analysis enables one to argue that social welfare benefits in universalistic welfare states are associated with and cause hospital admission due to circulatory disease even in this short-term follow-up of 4 years. This result is confirmed in a German study of statutory health [27], although unemployment was considered as one category and not separated in different benefit strategies. A Swedish cohort study with ca, 40,000 military conscripts also found a clear causal effect of unemployment on coronary heart disease. In contrast to our results, another cohort study analysing health effects of involuntary job loss in

a meat-processing company using public hospital admission data found no increased risk of circulatory diseases [28].

	<i>n</i>	Overall hospital admission		Cancer (C00-D49)		Circulatory disease (I00-I99)	
		Cases	OR# (95% CI)	Case	OR# (95% CI)	Case	OR# (95% CI)
Overall population	56,629	8145		695		730	
<i>Working population:</i>							
Workers Sick certificate	44,224	5915	Ref.	456	Ref.	459	Ref.
<i>Unemployment</i>							
Voluntary insured benefit	801	120	1.11 (0.93–1.33)	13	1.21 (0.70–2.12)	11	1.01 (0.56–1.85)
Social welfare benefit	1932	375	1.45(1.30–1.61)***	11	0.80(0.44–1.48)	24	1.66 (1.08–2.54)*
<i>Not working population:</i>							
Pensioners	6196	1357	1.44 (1.34–1.55)***	187	1.44 (1.18–1.76)**	211	1.63 (1.34–1.97)***
Others	3476	378	0.94 (0.84–1.05)	28	1.36 (0.92–2.01)	25	1.34 (0.88–2.02)

#Adjusted for education age, gender, nationality, number of persons living in the family, and commune. Significant results with * $p < 0.05$; ** $p < 0.001$; *** $p < 0.0001$.

Table 3. Cox regression model of employment on time period for up to the first overall and specific diseases hospital admission (cohort analysis).

The separation between the two study designs reveals controversial results with regard to the association of social welfare benefits and hospital admission due to cancer (see **Table 4**). Different results can only be interpreted when carefully considering aims, considered latency periods and purposes of the study designs (see Chapter 3). The results from a cross-sectional study can only be interpreted as an association between unemployment and hospital admission without knowing the direction of such an association considering that exposure and outcome are collected at the same time without any latency period. With regard to the presented cohort results, the causal relationship given the 2-year latency period cannot affirm that social welfare benefits and hospital admission affect cancer. Similarly, cohort results were seen in the above-mentioned German study [27]. The significant positive association in the cross-sectional analysis and the no effect of social welfare benefits on the cancer hospital admission in the cohort analysis, allow one to logically deduce a reverse causation: disease causes joblessness and ultimately social welfare compensated unemployment (see **Table 4**). This result is confirmed in a cohort study on cancer survivors, which additionally showed an increased unemployment rate [16]. Furthermore, it is well evidenced that return to work is an important health outcome for cancer patients [29, 30] and specific interventions are designed to increase one's return to work after cancer hospitalization [31]. The Danish 'flexicurity' model

explains the inverse association between hospital admission due to cancer and unemployment, as the barrier to fire individuals in the work environment is low in Denmark. On the other hand, a high level of benefit security is guaranteed if one is unemployed [1]. In future research, longer follow-up periods need to be considered in order to exclude a long-term effect of unemployment on cancer.

Disease:		Circulatory disease		
Design		Cohort		Cohort
Aim	E↔O	E → O	E↔O	E → O
	1.76*	1.66*	2.13**	0.80
Interpretation	Association in cross-sectional design, and directed (E → O) effect in cohort design leads to conclude:		Association in cross-sectional design, and no directed (E → O) effect in cohort design indicate reverse causation	
Conclusion		E → O		E ← O

Significant result with * p < 0.05; ** p < 0.001; *** p < 0.0001.

Table 4. Summarized result from the different analysis with regard to the short-term association of social welfare and hospital admission due to cardiovascular, cancer and musculoskeletal disorders.

The results suggest that voluntary insured unemployment benefit is not associated with any hospital admission. One potential explanation could be that particular workers with higher income and therefore more financial power to pay for such voluntary insurance can more easily compensate the unemployed situation compared to low income workers. Furthermore, it might be explained by the specific Danish ‘flexicurity’ model because short-term unemployment is well accepted [1]. This might only be true if the unemployment rate is rather low and therefore the trust in finding a new job is better secured.

The presented analysis includes some limitations worth mentioning. First of all, even though data from about 100,000 individuals were used and followed up with for 4 years, the number of yearly disease-specific hospitalizations was still small. Therefore, only summarized groups were considered such as cancer (ICD10: C00-D49) and circulatory disease (ICD10: I00-I99). Although results show that the differentiation between these disease groups allows for gaining a better understanding of them, these groups are still heterogeneous. In cancer disease, the effect of unemployment might differ between cancer sites, between malignant or benign tumours, or between primary and recurrent tumours or metastases. As mentioned in the ‘Methods’ section, the National Patients Registry contains information on private clinics since 2008. Our cross-sectional analysis is based on data from 2006 which might lead to a selection bias as richer workers are generally using such private clinics. Therefore, the results should be discussed with caution. However, this selections bias in the cross-sectional analysis might not explain the full association considering that in the city of Esbjerg only a few private clinics are

available. Loss to follow-up bias is also possible in the cohort approach although no information on the potential loss of follow-up was available. Individuals who were not registered in the municipality within 1 year were excluded from the follow-up from that particular year onwards. It might be possible that the healthy unemployed population would be particularly more likely to leave the region due to job opportunities elsewhere. Thus, the selection of a specifically unhealthy study population, especially in the context of unemployed persons, would be warranted. In the present analysis, the loss to follow-up bias might not distort the results, as we did not find a systematically increased health risk for the unemployed.

5. Conclusion

The results derived from different study designs can add an important contribution to interpreting the results. Multidisciplinary methods criticism, results presentation and discussion help to clarify underlying causal mechanisms. There is an association between social welfare benefits and hospital admission in Denmark, but the direction of such an association is still not well established. For causality discussion in social welfare, it is important to be an open-minded scientist and regardless of your hypotheses, critically analyse relationships and reverse causation. As seen in short-term observation periods, hospital admissions due to circulatory diseases show a direction of relationship from social welfare benefits to the disease whereas hospital admission due to cancer or musculoskeletal disorders might cause joblessness and finally social welfare benefit enrolment. These results are particularly important for policy implications in connection with social inequality. For cardiovascular diseases, activities to prevent cardiovascular diseases such as the promotion of physical activity or healthy nutrition are important to implement, particularly for unemployed people. With regard to cancer, more efforts should be exercised in order to prevent job loss as a result of the disease.

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An Approach to Social Service Systems in Europe: The Spanish Case

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Additional information is available at the end of the chapter

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Abstract

This chapter endeavors to develop an attempt at characterizing the social service system in Europe, serving three areas that we understand to be present in different system models but with different logics. The first has to do with the different denominations and ways of defining social services in each country. The second refers to the logic that legitimizes it, referring to its objects and purposes, as well as the type of needs and population groups that are targeted. The third area addresses issues of governance, the way it structures its devices and the relationships it establishes between the different levels of government and the main actors (the third sector, families, and the market). Having established this characterization (following this logic), we arrive at the Spanish case, trying to analyze its current model from legislative transformations that it has developed as well as trends and processes that the system has been generating as a result of the socioeconomic crisis, which have led to the modification of its profiles and demands. Finally, we take a rudimentary approach to the different challenges that we claim the Spanish Public System of Social Services must cope with in the current context.

Keywords: social services, crisis, Welfare State, social intervention

1. Introduction

Talking about social services as an object of social policy from a European perspective presents us with a striking frame of mind. Using a *wide-angle* approach, it is evident that in virtually all countries we can identify public policies on the subject; but when approaching each country in *zoom* mode, we observe a great diversity with regard to the conceptions about the areas of their

actions, their aims and objectives, and the type of social goods that protect or promote the needs of people. Perhaps this is one of the great challenges in building a common social space in Europe, the formation of an *approved language* on social services that allow for a possible, solid analysis of comparative politics, an issue that seems to be outshone in other areas of public policy such as health and education, to name a few.

As the previous paragraph mentions, it would be inadvisable to make any attempt to narrow in on a description of social services. We understand in this paper that the ideal is more than a definition, but an identification of areas of visibility to describe its common and different factors. In this sense, we will try to establish a systematization of different fields that, according to our opinion, are present on all conceptions of social policies, even if each of them is settled on a different way depending on the social, political, and legal situation of each country. In this way, we could analyze a conceptual dimension (What the social services are, how they are defined), a dimension related to the sense (the why's of social services), and finally a dimension related to the organization and actors (how they are organized and who will be the one in charge of developing them).

After this section, we will delve deep into the Social Services System of Spain, analyzing the development of the Spanish model in detail, focusing on legislative changes in the evolution of social spending and changes in the profiles and demands of beneficiaries. We conclude by establishing, as our way of understanding, future challenges that this protectionist system must face in the coming years.

2. An attempt at characterizing social services in Europe

To carry out the attempt of characterizing social services in Europe, we understand that there are three areas that must be addressed: the first has to do with the different denominations and ways of defining social services in each country. The second refers to the sense that legitimizes them, we refer to its objectives and purposes, as well as the type of needs and population groups that it is directed at. The third area addresses issues of governance, the way they structure their devices and the relationships established among the different levels of government and between the main actors (the third sector, families, and the market). Below, we will go into each of these issues in detail.

2.1. Designations and definitions around social services: elements confluency

The existence of different denominations and treatments of these services in Europe allows us to identify a variety of approaches according to their role in the political-institutional framework. An approach to the literature on the subject allows us, however, to note that these differences converge around three key elements that permit the building of a dialogic between them. These are discussed in the following three sections:

2.1.1. Attention to the personal and/or family dimension

The designation *Personal Care Services*, deeply rooted in the Anglo-Saxon realm [1], spread to other countries throughout the nineties. It is understood here that social services are mandated to have committed individual care to social needs through an institutional response aimed at situations where citizens lack the autonomy to carry this out on their own. Today, orientation and Personal Care Services are the most common in Europe. Where targeting the personal/family intervention has never been absent, it is true that demographic and social changes are gradually being given more importance to family approaches [2], so that these services today are actually personal-family care.

2.1.2. Proximity criterion

A second aspect characteristic of Europe is the importance given to proximity. Already in 2007 the European Union stressed the need for such services to be accessible to citizens in their immediate environment: the local [3]. The demand for proximity, as discussed below, has generated the provision of social services as an almost exclusively municipalized competition in some countries. The proximity criterion operates on two lines. Sometimes it appears under the name of *Primary Care Services*. This treatment gives preference to access to social policies, especially through its position as an institution. *Primary Care Services* exercise the function of the gateway, serving the public's basic social demands, although it is true that there are different levels of development and resources to care for them, according to each country. When demands are more complex or specific, these services refer people to other systems (health, employment, etc.). Sometimes these primary care social services do not have their own space and are incorporated as a close resource within other systems of public policy; most often in these cases, their location is within the health network, part of an area of health and social care. A second denomination of these close devices are *Community Social Services*, although the contents are essentially the same, these services are intended to go beyond individual attention to needs, including outreach work with the fabric of local actors. Therefore, they require the complement of individual intervention methodologies with other group and community intervention [4] aimed at social capitalization and empowerment of the local community.

2.1.3. The transition from social care services to welfare services

In general, the consolidation of modern welfare policies in Europe have been shaping different *welfare regime*, influenced by different historical and political contexts and traditions, as suggested by Esping Andersen [5]. The purpose of these *regimes* has provided social services with a different role as a piece in the puzzle of the social policies of each country. Their evolution over time until today has also influenced, as cannot be otherwise, every society adapting to a globalized economic context. However, a trend is observed, where the role assigned to these services has evolved from being almost exclusively institutions focusing on attention to people in poverty to the provision of broader logic, where the objective of social inclusion of disadvantaged social groups coexist, with more universalistic objectives aimed at the needs of the whole population [6]. Yet it is true that this trend prods two questions: firstly, this definition of universal social services is still incomplete in some countries, as discussed below, largely

because they are incorporated late into the logics of the Welfare State. On the other hand, the current crisis is producing a significant general decline of universalist approaches, the result of cuts to social policies and the sharp increase in social risks, Rodríguez Cabrero and Marbán describe this process as *quasi-universalism* [7].

2.2. The meaning and legitimacy: objects, objectives, and content

What justifies the existence of social services in Europe? We speak of the agenda of objectives and content that have to address the role of satisfying social needs of which we have already spoken. The trend of social policies in the organizational aspect has seen their management in specialized systems in different areas of social goods. Khan and Kamerman [8] identify Personal Social Services as one of these specific systems, together with the educational, employment, income security, health, and housing systems. While not all European countries have ordained their offering as a system in the strict sense; on the other hand, those countries that have done so, contemplate them within the same areas and groups of different care [9].

The European Commission has made a tentative proposal found in a 2006 report [3] where they annotate five fields [9]:

- Care and dependent care.
- Children's and minor's care of a nonscholastic character.
- Integration and reintegration services for people in difficult social situations and/or exclusion.
- Employment services for people with disadvantages.
- Social housing.

While it is true that, as suggested by the work of Manuel Aguilar [9], in many European countries, fields such as housing or employment are placed in other, different systems. The first three areas, however, appear as highly generalizable contained throughout Europe. This allows us to infer three large common areas around which programs and intervention processes are grouped giving content to social services:

- Exclusion – social inclusion. Which would cover all actions aimed at fighting poverty and supporting population groups with social difficulties, contemplating those seeking to promote social integration in the broadest sense.
- Dependence – autonomy. Those programs created for the care of people with personal autonomy deficits. In some countries these services focus on groups of elderly or the disabled, other countries also provide for child care.
- Conflict – protection. Within this space, we find programs of intervention in families in conflict, especially highlighting the areas of child protection and the intervention in situations of gender violence.

2.3. Governance issues

The main aspect of confluence around governance is the consideration within the different states of what Demetrio Casado called a *branch of social service activities* [10]. While the structure of such an industry obeys very different forms, we will focus on this matter in greater detail below for the case of Southern countries and, especially, the Spanish case. For this reason, we limit ourselves in this section only to identifying conceptual areas of differentiation.

A first differentiating factor is the regulatory recognition of social services itself. Starting with the idea that there is a recognition of the existence of an industry in each country, we find states that have produced laws intended to govern it as an integrated system to ensure its cohesion, coordination, funding, and institutional leadership. The different positions on the consolidation of the industry as a system are situated between two ends of a continuum: on one side, those States which have a system of social services defined by a unifying legislation, characteristic of countries of the so-called *continental regime* [11]; on the other, countries that failed to address the construction of such a system and consider social services as a *variable geometry* resource network, Portugal is a paradigmatic case of this model. Governance strategies are positioned among social service systems or networks.

A second element is related to levels of governance, which is inevitably conditioned by the diversity of each State's institutional organization modes, although it is true that in most States, the coexistence of three institutional levels takes place: state, regional, and local. On this, governance in social services pivots between positions in which the different levels of governance are involved in the guaranteeing and management of social services for states where there is strictly municipal competition, with little or no competition role at the state and regional levels.

The third differentiating factor is in the public sector leadership regarding services and the role of other actors in this framework. This issue has been widely discussed in different works, especially in recent times in the interest of elements such as the effect of the crisis or the intensification of new social risks such as dependence [3, 11]. The trend, with very different intensities, is in systems regulated by the government (either at the state, regional, or municipal level), where the assurance of benefits is shared between public services and the third sector of social action and services provided by multinational companies. Therefore, a *mixed welfare* model of different intensity is imposed depending on the country.

The last factor of interest lies in funding. Essentially, there are four sources of funding schemes or social service networks. The common way is through taxation, which is channeled directly to public social services, or deferred through grants or concerted in third sector organizations and companies that provide services. A second way of funding is through business or workers' contributions, this occurs in states that provide these services, in whole or in part, within their national social security systems. The third source is through copay, increasingly present in areas such as care for dependents. Finally, a fourth way, not always analyzed, is the contribution in the form of kind (volunteer collaboration, provision of infrastructure, etc.) and cofinancing with own resources from third sector entities of social action [12]. These organizations have emerged as an entryway for private resources to social service systems in Europe. In this sense,

consistent with the logic of mixed governance, financing strategies have gradually been becoming more diversified.

3. The public social services system in Spain: current state and challenges

Next, we try to delve into and describe the model of social services that have been developed in Spain in response to those factors that have been discussed in the previous section of a conceptual characterization, taking into account the effects that this model has incurred over the last few years from the socioeconomic crisis.

3.1. Legislative changes

The implementation of the regulatory and legislative system referred to as social services in Spain has its starting point following the adoption of the Constitution of 1978 [13], resulting in a broad and deliberate action of reforming social services public management. Due to the changes envisaged in this transitional stage, it was thought that the Constitution would give rise to a System of Social Services at the beginning. However, after its publication surprisingly, in its content, the obligation or indication of creating social services never appears. Although they do not explicitly speak of a Public Social Services System, it appears between the lines and implicitly obliges the administration to create this system (Art. 1, 9.2, 50, 148.1, etc.).

The constitutional gaps in this matter could have been resolved with the approval of a General Law of Social Services throughout the state, as was done with other protection systems (Health and Education). Yet since this was never carried out, between 1982 and 1993 all regional governments developed (through legislation) their respective social service systems. From our point of view this is the main weakness is the Public Social Services System in Spain since although on paper there are many similarities between them, the practices are very different, which results in the current Social Services System being composed of 17 subsystems based on political will, funding opportunities, and the responsibilities of the regional administration. Thus, “depending on where you live, different types of service or equipment will be available [14]”. We believe that the lack of a common legislative framework for the entire national territory is the main cause of weakness, fragility, and lack of consolidation of this pillar of Welfare, which is very distant from the consolidation of the other pillars of the aforementioned Welfare (Education and Health). It was only with the approval of Law 39/2006 of 14 December on the Promotion of Personal Autonomy and Care for dependent people [15] that an important step in this line was taken, but with the arrival of the socioeconomic crisis, the implementation of this law was greatly reduced and in many cases completely paralyzed. Focusing on regional policy development, [14] mentions, firstly, four phases:

- The first phase spanning from 1982 to 1985, when the laws of the Basque Country, Navarra, Madrid, Catalonia, and Murcia are approved. They are, therefore, five regulations that lay the foundation and serve as an example for the rest of the regions.

- The second phase between 1986 and 1992, in which the laws of other Autonomous Communities are approved. These laws are very similar in both the substantive and operational dimension to those already approved in the first phase.
- The third phase between 1993 and 1997 where it carries out a reform of its laws in Galicia, Catalonia, the Basque Country, and Valencia. They constitute examples again for further reforms of other Autonomous Communities.
- The fourth phase that includes reforms of laws between 2002 and 2003 of La Rioja, Asturias, Madrid, and Murcia. It involves more extensive laws that incorporate elements such as the rights and obligations of users or quality control criteria as well as the inclusion of new situations that respond, for example to dependency. However, this fourth phase also includes reforms to the Law of Navarra and Aragon and the beginnings of the second reform to the laws of Catalonia and the Basque Country, which gives rise to the laws of social services for the third generation. In these recent reforms, a major change occurs which is specified in the subjectivity of rights, the explicitness of economic participation of the beneficiaries and the inclusion of a portfolio of services and equipment that make up the system.

Apart from these four phases, a fifth phase could be incorporated [16] which would remain until present, in which the law of Castile and Leon and Castilian-Manchega, or Andalusia (still under approval) would be incorporated, imbibing directly from the latest developments in the laws of the third generation.

It can be said that the set of regional legislation on social services until now, largely promotes, the principle of subsidiarity, placing the management of social services at the local level, given their greater ability to adjust the response of public powers to the social needs of the population. Nevertheless, this principle that inspired all this regional legislation is now in question and weak due to the adoption of the Law 27/2013, of 27 December, for the Rationalization and Sustainability of the Local Administration [17]. According to some authors [18] it profoundly modifies the social services system that had been developed over the last thirty years in Spain. The system had managed to consolidate itself after thirty years of slow development, where its fundamental value is its proximity to citizens, guaranteed by the management and delivery of the councils of the General Social Services. But this new legislation, specifically Article 7, amending Article 26 of Law 7/1985 of 2 April, regulating the bases of local government on powers of municipalities and specifically social services, generates uncertainty and concern when it says that the only proper authority of the municipalities will be “the assessment and reporting of situations of need and immediate care for people at risk or risk of social exclusion.”

Currently, this law has been appealed to the Constitutional Court, which failed in March 2016. In said judgment, precisely those items that most affect social services were declared unconstitutional. In this sense, we are currently faced with a number of uncertainties and questions about the future consequences of the application of this law as it has been drafted and especially many doubts about what role municipal social services will develop, as up until now, they were the guarantors of that valuable proximity to the Public Social Services System in Spain.

Although there has been a limitation in this judicial review, the trend is to disempower and take away the relevance at the local level in the implementation of the system.

3.2. Trends in a context of crisis

The long period of crisis in which Europe currently lives has had an intense impact on peripheral countries, including Spain among others. The future of social services is found here, as it cannot be otherwise, a direct parallel with the political and social evolution of the country. Spanish society has experienced a long period of growth since the beginning of the democratic era in 1978 until the crisis of 2007 as shown in the previous section referring to the legislative changes; the developmental trend hardly incurred a slowdown during the 1993–1994 period [19], to later recover its expansionist force until the beginning of the great crisis.

Social services will relatively benefit from this expansion, although as suggested by Ayala [20], the promotion of social policies in the democratic period in Spain is still evident, it is also true that their improvement has not been proportional when compared with the economic development of the country. The previous scenario to the *great crisis*, shows a country with rising macroeconomic variables (in 2007 Spain was the country with the fourth highest GDP in the EU); nevertheless with a precarious social cohesion model. It is influenced by factors such as the fragility of its labor market, its dynamics of social cohesion, and underdeveloped social policies in comparison with the rest of Europe. Referencing 2007, according to Eurostat, social spending in our country amounted to 21% of GDP, while the average in the EU 15 was 26.9%. This social expenditure, compared according to *purchasing power units* is the lowest in the EU 15, after Portugal and takes the 14th position with reference to all 27 EU countries [21]. This circumstance led to a paradoxical effect, despite the strong economic growth seen in Spain until the arrival of the great crisis, the Poverty Risk Rate hardly reduced during this period of expansion [22], reaching 19.7% in 2007 according to data from the Survey of Living Conditions.

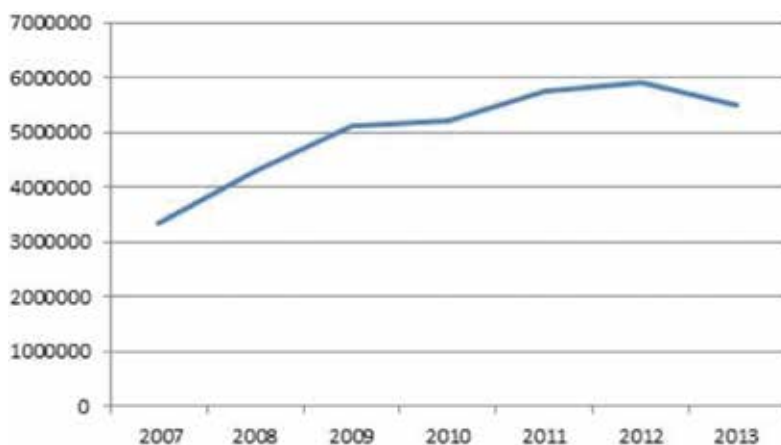


Figure 1. beneficiaries of Social Services System.
Source: Calculations based on data from the concerted plan.

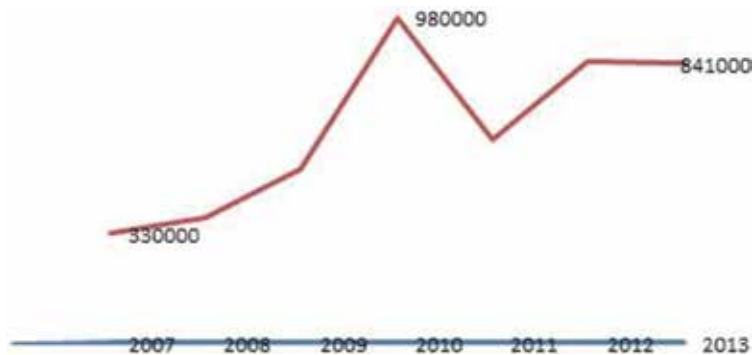


Figure 2. Evolution of beneficiaries of social emergency aid.
Source: Calculations based on data from the concerted plan.

These facts allow us to appreciate the fragility with which the social service system is constructed and understand the precariousness of it in the current context. We have addressed this issue in recent research [23] in which we pointed out three major processes that reconfigure the current situation:

- Process 1. Social services as a refuge for new social vulnerabilities.

The unemployment rate grows from 8.1 points in 2007 to 26.94 in 2012, when it reaches its highest level. Then it starts a slow descent to find itself at 22.3 points by the end of 2015. This vertiginous rising of unemployment has a direct proportional effect on the demand for social services, as shown in the following chart, they go from having to attend to just over 3.4 million users to more than 5.5 million users according to data from the Ministry of Health, Social Services and Equality (the latest data available) (**Figure 1**).

- Process 2. Intensification of welfare functions and emergency care.

The increased demand has forced a radical change in the character of the response. At the end of 2006, social services in Spain were leading the momentum of the most important legal right that would be assigned, developing a strategy of universal dependency care. The Law on Promotion of Personal Autonomy and Care for Dependent Persons was approved in the Spanish Parliament at the end of 2006, which granted social services a leading role in the development of a new individual right. However, the increased demand noted above forced a delay in expansion plans coverage for dependents and redirected much of the resources to mere attention to economic emergencies of individuals and families, as we see in the chart below, it managed to triple in the period from 2007 to 2010 (**Figure 2**).

- Process 3. Cuts and concentration of local government efforts.

The third process that has influenced the decline of the dynamic expansion of social services after the crisis has to do with the governance of the various administrations, which is especially relevant with regard to the financing of the whole system (**Figure 3**).

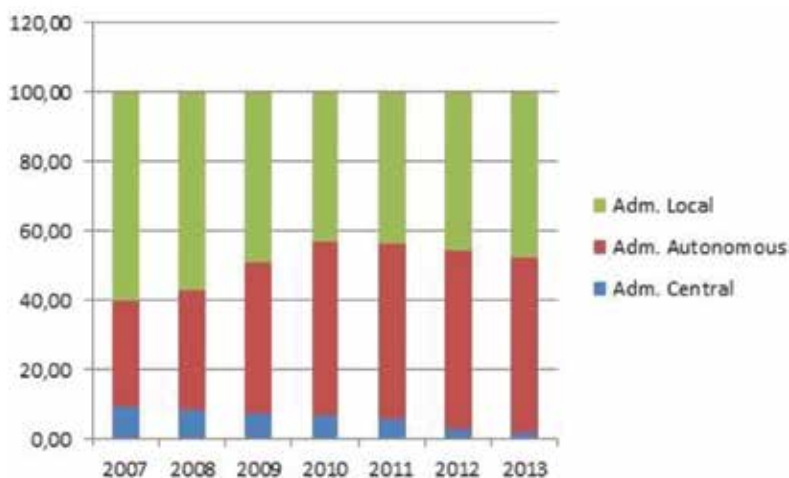


Figure 3. Percentage of funding according to each administrative level.

As shown in the chart above, we can see that movements following the crisis have concentrated the majority of the energy on municipal administrations, which have generally had to take on most of the efforts of sustaining personal social services. The Autonomous Communities have also increased their efforts, although they have especially focused on the development of specialized social services and specific attention to the field of dependency. The most pronounced effect on the strategy of financial governance of social services has been, without a doubt, the withdrawal from the State's central administration. If the regional and local administrations have intensified their support for a system of basic protection, the central one has been gradually eliminating its funding for the system to make it irrelevant.

All the three processes result in transformations in logic and demand for social services in Spain and also in the profiles of people who are now approaching the social service system for help.

3.3. Evolution of profiles and demands

Although the reason for which social services were created in Spain was universalist, practice has shown that in its further development, the Public Social Services System has been designed for people in situations of vulnerability and social exclusion, thus creating a certain "stigma" on users using it and therefore some resistance and prejudice.

These profiles traditionally linked to vulnerability and exclusion brought with them some types of demands closely linked to basic assistance needs, related to payments for supplies, financial emergency aid, etc. and the origin of these situations can be ascribed to three types of causes [16]: structural (linked to the disadvantages created by the discriminatory system itself in which we live), cultural (related to a model of life that is inherited from generation to generation), and finally linked to the same Social Services System (the lack of action and social intervention that have made the system itself contribute to the upholding of these situations).

Yet these profiles (and therefore demands that follow them) have been substantially modified in recent times mainly for two reasons:

- The adoption of the Law 39/2006 of 14 December for the Promotion of Personal Autonomy and Care for Dependent People, where, starting from its date of publication, many citizens (due to its universal vocation) took to the Public System of Social Services because they inescapably had to go through the Information, Assessment and Orientation System of the Community Social Services to begin the procedure. And, although in theory it is only an administrative procedure to start the application, the relationship endures throughout the system through the Individualized Care Program.
- The socioeconomic crisis of recent years, which still retains its consequences. There are numerous reports and studies from different sources [24, 25] and research [16, 26], which demonstrate significant increases in applicants who resort to social services (and the change in profiles) as well as the increased demands that arise (as well as the change in the type of demand).

Andalusia	76.6
Aragon	74.3
Balearics	100.0
Cantabria	67.8
Castilla – La Mancha	59.3
Castile and Leon	76.0
Catalonia	75.8
Navarra	94.1
Valencian Community	74.1
Extremadura	73.7
Galicia	74.2
Canary Islands	86.7
The Rioja	62.5
Madrid	80.9
Murcia	62.8
The Basque Country	70.2
Asturias	76.9

Source: OTSLP and ISSE (2013).

Table 1. Increased demand for social services by Autonomous Communities (%).

With regard to demands, the Social Services Report 2014 [25] shows an increase of 75.6% on average in the demands applied to social services, with this increase reaching 100% in some Autonomous Communities such as the case of the Balearic Islands (**Table 1**).

Normally they turn to social services to apply for basic aids such as supplies or loss of housing to nonpayment of mortgages. But the situation of these new groups does not stop here, and although these were initial claims, this material loss has greatly affected family relations. Therefore, there are quite a few families who also end up requesting aid from the Family Guidance Service.

With regard to the change in profiles, this report notes that in recent times, the main users of social services are people who were from the middle class before, people without any form of income, and young people.

The profile of the user “type” is as follows: female, 36–50 years, primary education, married, lives with a partner and children, unemployed with unemployed or pensioner’s subsidy.

4. Challenges of the Spanish Public Social Services System

Throughout this chapter we have tried to a picture of the situation of social services. In the first section, from a wide-angle approach, we tried to different times and ways are applied at the European level. Later, we have used the zoom mode to analyze the Spanish Social Services System, developing a much more detailed study.

But far from understanding that social policies must be static, we are in favor of continuously checking policies, in such a way that they can give a real answer to the changeable social reality. In fact, as we have studied in previous sections, the socioeconomic crisis brings forth the need to readapt the Public Social Services System in Spain, a need whose root cause is not alone in the crisis (since many of the issues that needed to be dealt with existed before the crisis) but perhaps during these times, have become much more evident.

Some of the challenges we recognize to be addressed are:

- Consolidation of the Social Services System as the Fourth Pillar of Social Welfare, together with Education, Health, and Social Security. We understand that this consolidation necessarily involves the recognition of access to the system as an individual right (which does not appear as such in all regional legislation), followed by the support and funding which the other pillars of Social Welfare (Education, Health, and Social Security) account for. The Law 39/2006 of 14 December on the Promotion of Personal Autonomy and Care for Dependent People was a breakthrough in this strategy, it being a law that recognized dependent care as an individual right. Yet in this regard, there are two weaknesses, first that despite the progress it embodied, it has had a different pace of implementation, at first, as it depends on the objectives of the Autonomous Communities (those who were competing for their implementation) and secondly, when the crisis and budget cuts in social policies completely blocked this law before it could become fully implemented. On the other hand, from our point of view, we could run the risk of social services becoming seized by this protection system intended for dependents (and in fact spoke about it as the Fourth Pillar of Welfare), but argue that the Social Services System must be a system of protection that must go beyond attention to dependent persons.

- Recovering of intervention programs above management ones. It is necessary for System professionals to be freed from the bureaucratic burden and management, which in recent times have occupied all of their professional responsibilities and carry with it a greater action related to intervention in their various lines (individual, group, and community), as well as the development of preventive actions. This occurs in order to advance and overcome the binomial: need-resources that has so influenced the development of the Social Services System and reclaimed other logics and ways of understanding social intervention beyond performance closely linked to material (monetary aid mainly).
- Advancing social innovation. The rapid pace at which society advances will continually bring about new social situations that require new responses that will not fit the traditional strategies and logic that we discussed in the previous section. We need to rethink the social intervention of Social Services System and for that, the transition through social innovation is seen as mandatory. Progress in this innovation necessarily involves a greater impact on evaluation, information management, and research. It is therefore essential that social innovation remains incorporated and recognized as an element in policy, however not only there, but also be recognized within the framework of institutional organization so that it will be equipped with a space, a time, and real actors.
- Advancing a logic for the common good in the management of social services. While certainly the System must be public, we cannot expect it to be solely and exclusively of the Public Administration. There are different trends related to this issue and is therefore a topic of great controversy. From our perspective, expecting the state to be the only actor in the development of social services is illusory. We argue that it is necessary for all stakeholders (the State, the Third Sector, and the Market) to organize the development of the System's management, guaranteeing its public coverage and access to it as a fundamental right.

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This book offers a sharp critique and a detailed analysis of some pernicious social welfare problems and the wide-ranging causes and consequences of those complex social issues on individuals, families, and communities. Unemployment, health-care disparities, teenage pregnancy, and intimate partner violence constitute the focus of this work. Based on empirical and historical analyses of primary and secondary data, the book provides a conceptual framework that facilitates the reader's understanding of how those social issues are interrelated. Each chapter offers some clear policy recommendations directed to address those social problems. Written by well-published scholars, this work will be of great interest not only to students majoring in the social and political sciences but also to academics and practitioners active in the field of social welfare, social policy, and social work.

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