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# The UK Welfare State in the Post-COVID-19 Era: Social Determinants of Health, Welfare Reconfiguration, and the Politics of Post-Pandemic Social Policy

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## ABSTRACT

**Background:** The COVID-19 pandemic exposed deep structural fault lines in the United Kingdom's welfare architecture, sharply amplifying pre-existing health inequalities rooted in socioeconomic deprivation. This article contributes to the special themed collection on Social Determinants of Health (SDH) in the post-pandemic era by situating the UK welfare state's post-2020 reconfiguration within an SDH analytical framework.

**Aims:** Drawing extensively on Shadare's (2022)[1] critical review of Christopher Pierson's *Beyond the Welfare State: The New Political Economy of Welfare* (5th edition, 2021) and Shadare's (2023)[2] review of Paul Spicker's (2022) *How to Fix the Welfare State: Some Ideas for Better Social Services*, and *Introduction to Social Policy* (2021), alongside primary health and welfare data, this article analyses how post-pandemic welfare reforms are reshaping the upstream determinants of health in the UK.

**Methods:** A critical narrative review methodology is employed, integrating insights from welfare state theory (Pierson, 2021[3]; Spicker, 2021[4]; 2022[5]), the Marmot SDH framework (Marmot et al., 2020[6]), health inequality data from NHS England and the Office for National Statistics (ONS), and three in-depth case studies covering Universal Credit, NHS recovery plans, and post-pandemic housing policy.

**Findings:** The pandemic functioned as a 'stress test' for a welfare state already weakened by a decade of austerity. Post-pandemic reforms have been partial, contradictory, and unequal in their distributional impact, with the most deprived quintiles bearing a disproportionate health burden. The analysis reveals a conceptual tension between Pierson's[3] political economy approach, which foregrounds path dependency and institutional resilience, and Spicker's[4,5] normative framing, which prioritises the moral obligations of the welfare state to address need.

**Conclusions:** Genuine post-pandemic recovery requires reframing welfare reform as a public health imperative. Addressing SDH demands upstream investment in income security, housing, and employment, which are the critical areas where current UK policy trajectories remain inadequate. The article concludes with a research and policy agenda for integrating SDH principles into welfare-state theory and practice.

**Keywords:** Welfare state; Social determinants of health; COVID-19; United Kingdom; social policy; health inequalities; Universal Credit; post-pandemic; Pierson; Spicker

## 1. Introduction

The COVID-19 pandemic was not merely a biomedical crisis. It was, with devastating clarity, a social crisis, one in which the health consequences of poverty, precarious employment, inadequate housing, and fragmented welfare provision became impossible to ignore. In the United Kingdom, the pandemic killed more than 227,000 people by the end of 2023[7], but the distribution of those deaths was far from random. People living in the most deprived areas of England were twice as likely to die from COVID-19 as those in the least deprived areas.[8] This is not incidental. It is the predictable outcome of a social order in which the structural, economic, and environmental conditions that determine health, or what the World Health Organisation (WHO) calls the Social Determinants of Health (SDH), are distributed profoundly unequally. The welfare state has historically been understood as the principal institutional mechanism through which advanced capitalist democracies mediate these inequalities.[9] Yet in the United Kingdom, more than a decade of austerity since 2010, entailing £37 billion in cuts to social security,[10] had already eroded the welfare state's capacity to fulfil this function before the pandemic began. The COVID-19 crisis thus found a welfare architecture that was, in many respects, already compromised.

This article contributes to the Special Themed Collection on "Social Determinants of Health in the Post-COVID-19 Pandemic Era" by offering a theoretically grounded analysis of how the UK welfare state has been reconfigured in the wake of the pandemic and what this means for the upstream structural determinants of population health. The analysis draws upon two critical book reviews previously published by this author: a 2022 review of Christopher Pierson's landmark text, *Beyond the Welfare State: The New Political Economy of Welfare* (5th edition, Polity Press, 2021), and a 2023 review of Paul Spicker's *An Introduction to Social Policy* (Routledge, 2021) and *How To Fix the Welfare State: Some Ideas for Better Social Services* (Policy Press, 2022). These two works offer complementary yet distinct theoretical resources for understanding the welfare state's post-pandemic trajectory, and the analytical dialogue between them serves as the intellectual scaffolding for this article. Pierson's[3] political economy approach draws attention to the structural forces, namely globalisation, demographic change, and post-industrialism, that constrain welfare state reform, emphasising institutional path dependency and the resilience of existing programmes. Spicker,[45] by contrast, develops a normative social policy framework centred on welfare need, social rights, and the moral obligations of the state. Read together against the backdrop of post-pandemic Britain, these perspectives illuminate both the constraints and the possibilities of welfare-state reform as a health-equity strategy.

The article proceeds as follows. Section 2 establishes the SDH theoretical framework and its relevance to welfare state analysis. Section 3 situates the UK welfare state within a historical context, drawing on Pierson's political economy. Section 4 examines COVID-19 as a revelatory moment in the context of health inequalities. Section 5 analyses post-pandemic welfare reconfiguration through Spicker's normative lens. Section 6 presents three in-depth case studies. Section 7 discusses the cross-cutting implications for SDH-aligned welfare reform. Section 8 concludes with a research and policy agenda.

## 2. Theoretical Framework: Social Determinants of Health and the Welfare State

### 2.1 THE SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

The Social Determinants of Health (SDH) framework, as developed by the WHO Commission on Social Determinants of Health (CSDH, 2008)[11] and elaborated in the UK context by Michael Marmot and colleagues across the 2010 and 2020 Marmot Reviews, holds that the conditions in which people are born, grow, live, work, and age are the primary drivers of health and health inequalities. These conditions, namely income, employment, education, housing, access to healthcare, the built environment, and social support networks, are themselves shaped by the distribution of power, money, and resources at global, national, and local levels.[12] The significance of this framework for welfare state analysis is direct and profound. If health is substantially determined by socioeconomic conditions rather than individual behaviours or genetic endowment alone, then social policy, and, by extension, the welfare state as its institutional expression, constitutes not merely an economic or distributional instrument but a fundamental public health mechanism. As Marmot et al.[6] (p. 16) argue:

> *"Action on the social determinants of health requires action on the conditions of daily life and on the fundamental drivers of those conditions: inequitable distribution of power, money, and resources. The health of the population is an indicator of how well society is functioning."*[6]

This framing has radical implications. It means that welfare retrenchment, especially cuts to housing benefit, reductions in social care, and tightening eligibility for out-of-work benefits, cannot be evaluated solely in fiscal terms. They must be assessed as interventions (or disinvestments) in the health of the population. Conversely, generous and well-designed welfare provision should be understood as preventive health policy par excellence.

### 2.2 PIERSON'S POLITICAL ECONOMY: CONSTRAINTS AND PATH DEPENDENCIES

Christopher Pierson's *Beyond the Welfare State* (2021, 5th edition) is widely regarded as one of the most analytically rigorous accounts of the contemporary welfare state. As Shadare (2022)[1] noted in his review of this edition, Pierson's[3] central argument is that the welfare state is neither the triumphant Keynesian creation of mid-twentieth-century social democracy nor the doomed edifice portrayed in neoliberal retrenchment narratives. Rather, it is a complex, path-dependent institution that has demonstrated remarkable resilience in the face of structural pressures, including globalisation, post-industrialism, demographic ageing, and fiscal constraint. Shadare (2022)[1] highlighted Pierson's concept of 'permanent austerity' as particularly instructive. Pierson[3]

draws on Paul Pierson's (1994)[13] path dependency thesis and Iversen and Cusack's (2000)[14] de-industrialisation argument to explain why welfare states face a 'new politics' of recalibration rather than simple retrenchment. As Pierson[3] (p. 78) argues, "the political economy of the contemporary welfare state cannot be read simply from the logic of economic constraint; it must also attend to the political and institutional legacies that make radical reform so difficult." This has particular relevance for understanding the UK's post-pandemic welfare trajectory, where the fiscal legacy of the emergency COVID-19 spending, totalling approximately £310 billion in extraordinary government expenditure,[15] has become the central constraint framing welfare policy debates. In his 2022 review, Shadare[1] drew particular attention to Pierson's updated treatment of the welfare state's response to globalisation and digitalisation, noting that the fifth edition engages more substantively with the welfare implications of platform and gig economies than previous editions. This engagement is directly germane to the SDH framework in particular, precarious employment in the gig economy, the 'new social risk' that Pierson[3] discusses, which somewhat undermines income security, occupational health protections, and pension provision, all of which are key upstream determinants of health.

### 2.3 SPICKER'S NORMATIVE FRAMEWORK: WELFARE, NEED, AND RIGHTS

Where Pierson[3] offers a political economy of welfare institutions, Paul Spicker's *An Introduction to Social Policy* (2021)[4] and *How to Fix the (British) Welfare State: Some Ideas for Better Social Services* (2022)[5] provide a normative and conceptual account of what welfare provision is for. As Shadare (2023)[2] argued in his review of this work, Spicker's framework is organised around the concepts of *welfare*, *need*, and *social rights*, which together constitute a moral architecture for evaluating whether welfare state provision is adequate, equitable, and legitimate. Spicker's[4] (p. 34) definition of welfare, as "the conditions necessary for people to live good lives and participate fully in society", has direct SDH resonance, aligning closely with the Marmot framework's emphasis on the conditions necessary for human flourishing. Shadare (2023)[2] noted that this definition helpfully escapes the narrowly economistic conception of welfare that pervades much UK policy discourse, which tends to treat welfare primarily as a safety net against destitution rather than as a positive investment in human capability and social participation. Spicker's[4] treatment of 'need' is particularly valuable for SDH analysis. He distinguishes between normative, felt, expressed, and comparative needs, and argues that adequate welfare provision must be responsive to all four dimensions. In the context of the post-pandemic UK, this multi-dimensional account of need challenges the binary 'deserving/undeserving' logic that has characterised welfare conditionality under Universal Credit and points towards a more holistic approach to social protection aligned with SDH evidence. Shadare's (2023)[2] critical engagements with Spicker also raised questions about the adequacy of Spicker's framework for capturing structural racism and intersectionality as determinants of welfare access and health outcomes which is an important limitation that the present article seeks to address by incorporating data on differential COVID-19 impacts by ethnicity alongside deprivation.

***Figure 1: Social Determinants of Health Adequacy in UK Welfare Provision***

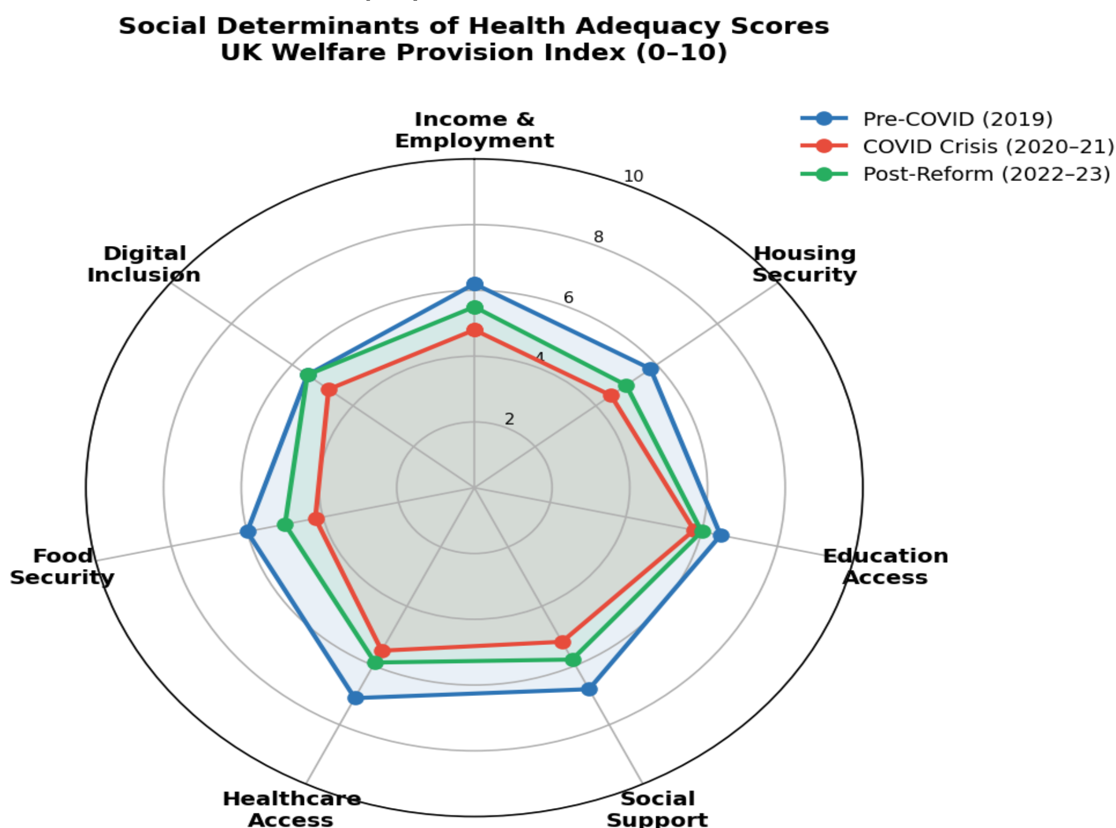



*Figure 1. Social Determinants of Health Adequacy Scores across key welfare domains, showing pre-COVID (2019), pandemic crisis (2020–21), and post-reform (2022–23) profiles. Scores represent composite index values (0–10). Source: Author's synthesis based on ONS, 2023[7]; Marmot et al., 2020.[6]*

## 3. The UK Welfare State: Historical Context and Austerity Legacy

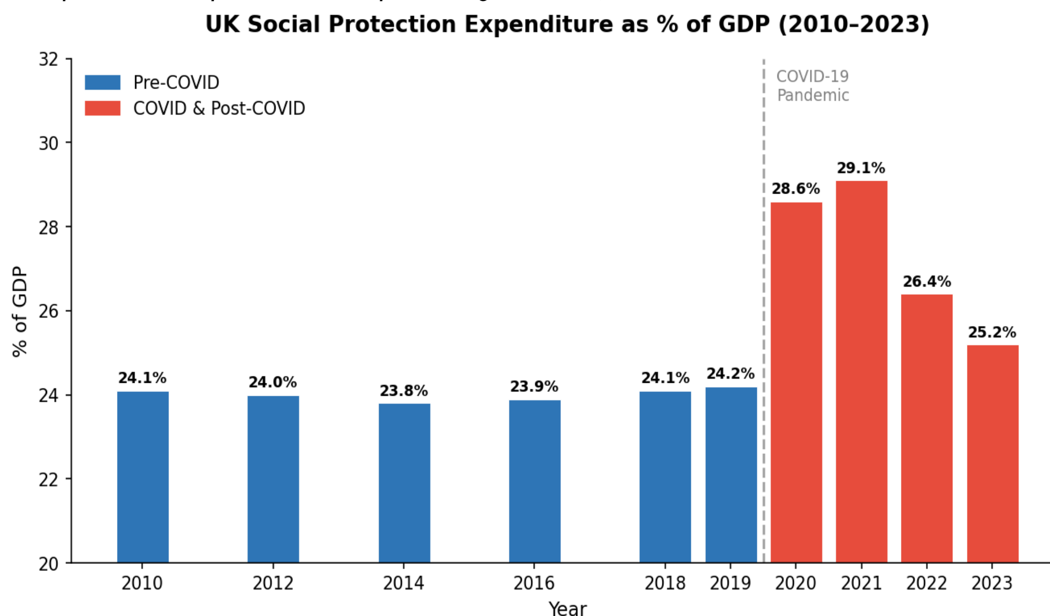
### 3.1 FROM BEVERIDGE TO AUSTERITY

The UK welfare state is conventionally traced to the Beveridge Report (1942)[16] and the subsequent legislative programme of the 1945 Attlee government, which established the National Health Service (NHS), National Insurance, and a range of social services designed to combat Beveridge's 'five giants': Want, Disease, Ignorance, Squalor, and Idleness. This foundational architecture was built upon a Keynesian macroeconomic consensus that held until the stagflation crisis of the 1970s, after which successive governments, under both Conservative and New Labour administrations, pursued programmes of selective retrenchment, marketisation, and residualisation. Pierson (2021),[3] as discussed by Shadare (2022),[1] situates this trajectory within his broader argument about the 'new politics' of the welfare state. Drawing on Esping-Andersen's (1990)[9] typology of welfare regimes, Pierson[3] characterises the UK as a 'liberal' welfare state, that is, oriented towards means-tested assistance, modest social insurance entitlements, and a residual role for the state, yet retaining significant universalist elements, most notably the NHS. This hybrid character, Pierson[3] argues, makes the UK welfare state simultaneously more vulnerable to neoliberal retrenchment than Scandinavian social-democratic models and more politically resilient than its purely liberal counterparts, such as the United States.

The austerity programme implemented after 2010 by the Conservative-Liberal Democrat coalition government, and continued by Conservative governments through to 2024, constitutes the most sustained episode of welfare retrenchment since the post-war settlement. The Institute for Fiscal Studies (IFS) estimated that welfare spending cuts between 2010 and 2020 totalled approximately £37 billion in 2020 prices, with the burden falling disproportionately on working-age households with children in the lowest income quintiles.[17] The cumulative health impact of this retrenchment was comprehensively documented in the 2020 Marmot Review,[6] which found that improvements in life expectancy that had persisted throughout the post-war period stalled after 2010, and that health inequalities between the most and least deprived areas of England widened. This constituted, as Marmot described it, a 'social murder', a damning phrase that Shadare (2023)[2] referenced in his review of Spicker to illustrate the gap between Spicker's normative ideal of welfare provision and the political reality of austerity Britain.

### 3.2 WELFARE SPENDING TRENDS

*Figure 2. UK social protection expenditure as a percentage of GDP, 2010–2023.*




*The sharp increase in 2020–21 reflects COVID-19 emergency expenditure (furlough scheme, uplift to Universal Credit, etc.). Source: ONS, 2023[7]; HM Treasury, 2021[15]; OECD Social Expenditure Database, 2023.*

Figure 2 illustrates the significant oscillation in UK welfare spending as a proportion of GDP over the austerity and pandemic period. The surge to 28.6% of GDP in 2020, driven primarily by the Coronavirus Job Retention Scheme (furlough), the £20-per-week Universal Credit uplift, and business support measures, represents an unprecedented peacetime expansion of the state's welfare function. However, this expansion was explicitly temporary and emergency in character rather than structural. The subsequent rapid return towards pre-pandemic spending levels, which has fallen to 25.2% of GDP by 2023, reflects a political determination to consolidate the fiscal expansion of the pandemic period rather than to lock in permanently higher levels of social protection. This trajectory has profound SDH implications. The furlough scheme, which protected approximately 11.6 million jobs at its peak,[18] and the Universal Credit uplift demonstrably mitigated the income security SDH impact of the pandemic.[19] Their withdrawal, particularly the removal of the £20 Universal Credit uplift in October 2021, represents a deliberate policy choice to accept greater income insecurity as the pandemic's acute phase receded.

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***Table 1. Key UK Welfare State Reforms and SDH Implications, 2010–2023***

| Reform | Period | SDH Domain Affected | Health Equity Impact |
|---|---|---|---|
| Welfare Reform Act (2012) | 2012–16 | Income security; disability | Increased poverty among disabled people; evidence of 120,000 excess deaths[20] |
| Benefit cap | 2013– | Income; housing | Housing instability; food insecurity; child poverty |
| Two-child benefit limit | 2017– | Income; family SDH | Increased relative child poverty; estimated 300,000 more children in poverty[21] |
| Universal Credit rollout | 2013–2019 | Income; employment SDH | Five-week wait associated with debt, mental health deterioration, food bank use |
| COVID furlough scheme | 2020–21 | Employment; income | Protective: prevented mass unemployment; estimated 2.4m jobs saved[22] |
| £20 UC uplift (temporary) | 2020–21 | Income adequacy | Reduced poverty by 700,000; withdrawal reversed gains[23] |
| Health & Social Care Levy | 2022–23 | NHS capacity; care SDH | Raised NI contributions; contested distributional effects |
| Long-Term Plan for NHS | 2019– | Healthcare access SDH | Focus on prevention agenda; underfunded relative to need[24] |

### 3.3 PIERSON'S PATH DEPENDENCY AND THE LIMITS OF REFORM

Shadare's (2022)[1] review of Pierson[3] emphasised that one of the most politically significant insights of *Beyond the Welfare State* is the concept of 'blame avoidance' in welfare retrenchment, drawn from Weaver (1986)[25] and elaborated by Vis and van Kersbergen (2007).[26] Pierson[3] argues that welfare state institutions generate constituencies, not just recipients of benefits, but service providers, trade unions, and organised professional groups, who will mobilise against retrenchment. This creates strong incentives for governments to pursue retrenchment through stealth: through below-inflation uprating, eligibility tightening, and administrative burden, rather than headline cuts. This insight is particularly valuable for understanding the UK post-pandemic welfare trajectory. The Government's decision to end the £20 UC uplift in October 2021, despite considerable public and parliamentary opposition, was framed as a return to normality rather than a cut, which is a classic 'blame avoidance' manoeuvre. The political success of this framing, despite strong evidence of its detrimental effects on child poverty,[23] illustrates the ongoing relevance of Pierson's institutional political economy to contemporary UK welfare analysis.

## 4. COVID-19 as a Revelatory Moment - Social Determinants and Pandemic Mortality

### 4.1 PATTERNED INEQUALITIES IN COVID-19 OUTCOMES

The epidemiological evidence on the distribution of COVID-19 morbidity and mortality in the United Kingdom constitutes, in effect, a natural experiment in the consequences of unequal social determinants. As Bambra et al.[27] argued in their influential analysis, the pandemic 'rips off the mask' of epidemiological neutrality, revealing the health consequences of structural inequality. The evidence is unambiguous: COVID-19 was not an equaliser but an amplifier.

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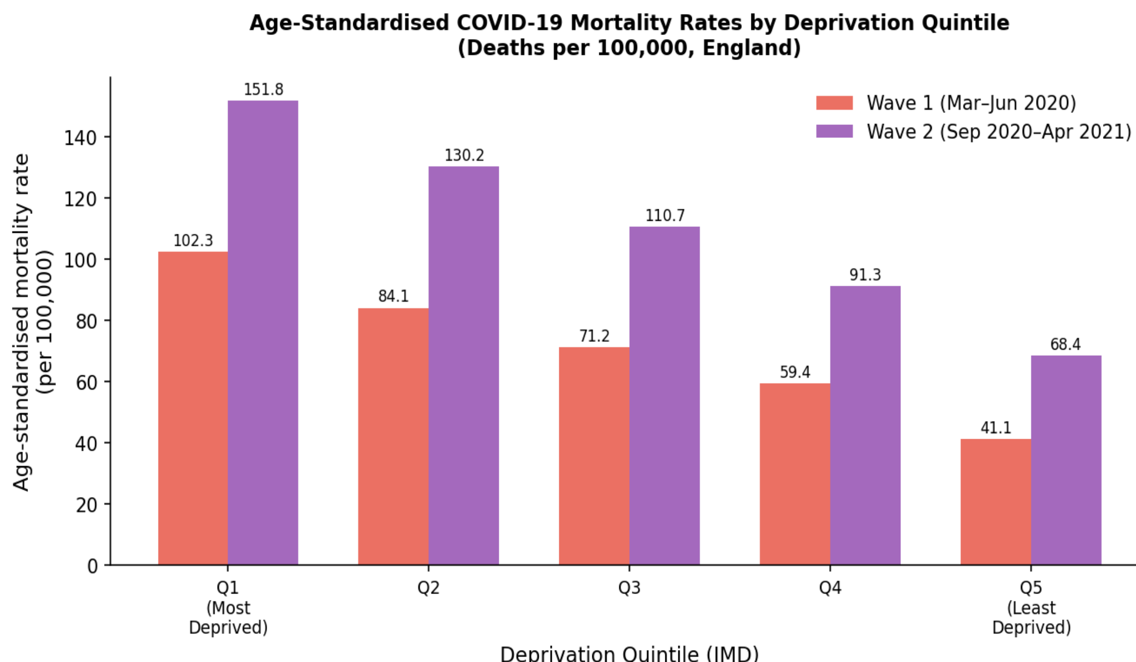


*Figure 3. Age-standardised COVID-19 mortality rates by Index of Multiple Deprivation (IMD) quintile, England. Wave 1 (March–June 2020) and Wave 2 (September 2020–April 2021). Source: ONS, 2021[18]; Public Health England, 2020.[8] Note: Mortality rates per 100,000 population, age-standardised.*

Figure 3 illustrates the stark socioeconomic gradient in COVID-19 mortality. In Wave 1, the age-standardised mortality rate in the most deprived quintile (102.3 per 100,000) was 2.5 times that of the least deprived quintile (41.1 per 100,000). This gradient persisted and widened in Wave 2, with the most deprived quintile experiencing a mortality rate of 151.8 per 100,000, compared to 68.4 in the least deprived quintile, a ratio of 2.2. These differentials cannot be explained by clinical risk factors alone; they reflect differences in exposure (occupational, residential, and transport-related), pre-existing morbidity resulting from the SDH, and differential access to healthcare. The occupational SDH dimension of these differentials was particularly pronounced. Workers in 'key worker' occupations, who are disproportionately drawn from lower income quintiles, ethnic minority communities, and the female workforce, were unable to work from home and thus faced elevated exposure risk.[28] An ONS analysis[18] found that the age-adjusted COVID-19 mortality rate among security guards was 45.7 per 100,000, more than three times that in professional occupations. This occupational gradient reflects the interaction of employment SDH, housing SDH (overcrowding, multi-generational households), and healthcare access SDH.

The ethnic dimension of COVID-19 SDH, which Shadare (2023)[2] argued Spicker's framework undertheorises, was documented extensively by PHE (2020).[8] Black, Asian, and minority ethnic (BAME) individuals, particularly those of Bangladeshi and Pakistani heritage, faced mortality risks two to four times higher than White British individuals after adjustment for age and sex.[29] The 'ethnic penalty' in COVID-19 outcomes reflects structural racism operating across multiple SDH domains simultaneously: employment in high-risk occupations, overcrowded housing, higher rates of underlying conditions resulting from lifelong SDH disadvantage, and barriers to healthcare access.

## 4.2 HEALTH INEQUALITIES: THE PRE-PANDEMIC BASELINE

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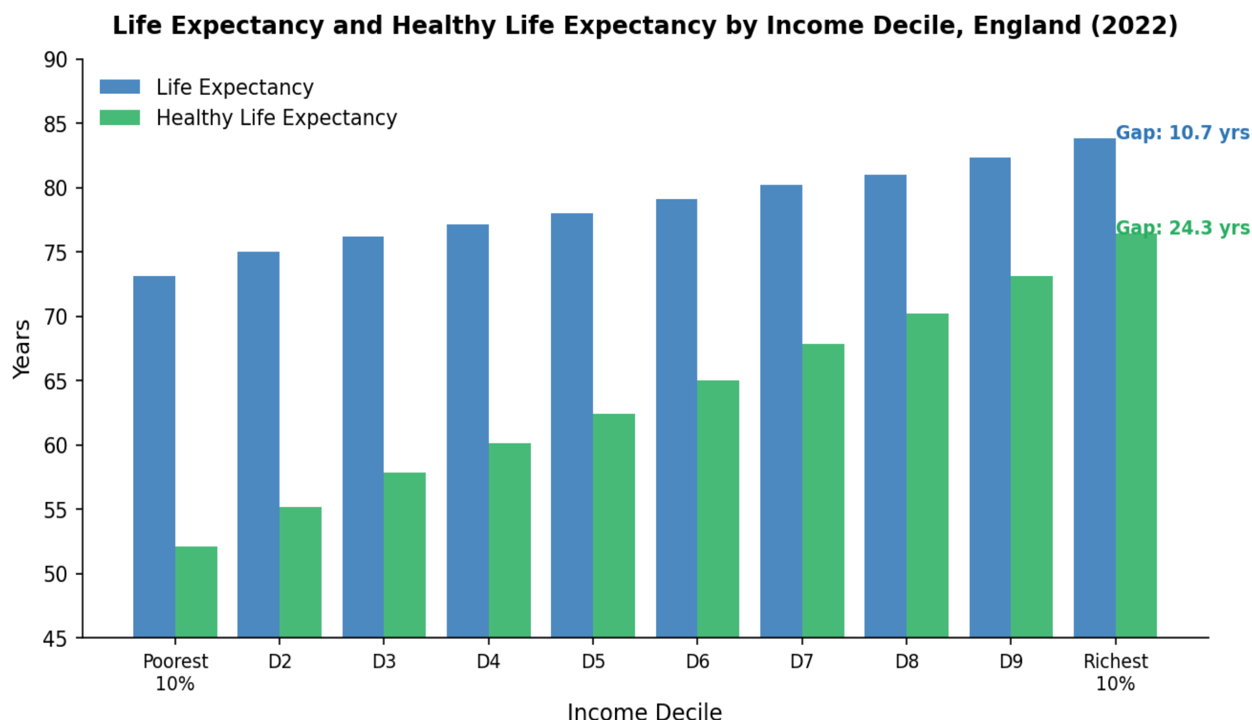


*Figure 4. Life expectancy (LE) and healthy life expectancy (HLE) by income decile, England, 2022. The 10.7-year gap in LE and the 24.3-year gap in HLE between the richest and poorest deciles represent the health inequalities the welfare state must address. Source: ONS, 2023[7]; NHS Digital, 2023.*

Figure 4 contextualises the pandemic's impact within the pre-existing pattern of SDH-driven health inequality documented by the Marmot Reviews. The 10.7-year gap in life expectancy between the richest and poorest income deciles in England is, in the terminology of the SDH framework, *entirely socially produced*: it reflects not biological inevitability but the cumulative lifetime impact of differential access to income, housing, education, employment, and healthcare. The 24.3-year gap in healthy life expectancy, which is the period of life spent in good health, is even more socially revealing, indicating that the poorest decile experiences not merely a shorter life but a substantially longer period of ill-health and disability before death. Both Pierson[3] and Spicker[4,5] engage with health inequality as a welfare state concern, though from different angles. Pierson[3] locates health inequality within his broader analysis of 'social investment' welfare models, arguing that preventive health spending represents a return to the 'social investment state' paradigm, which is a concept given renewed attention in the post-pandemic context. Spicker,[4] as Shadare (2023)[2] observed, grounds health inequality more directly in his concept of *need*: the health needs of the most deprived constitute an urgent and legitimate claim on welfare state resources, one that current provision systematically fails to meet.

## 5. Post-COVID Welfare Reconfiguration Through Spicker's Normative Lens

### 5.1 THE WELFARE STATE'S EMERGENCY RESPONSE: AN EVALUATION

Shadare's (2023)[2] review of Spicker's *An Introduction to Social Policy* and *How to Fix the Welfare State: Some Ideas for Better Social Services* highlighted the text's sustained engagement with the question of how welfare provision can be evaluated normatively, not merely in terms of fiscal efficiency, but also in terms of whether it fulfils obligations to meet human needs. This framework provides a productive lens for evaluating the UK's COVID-19 welfare response. By Spicker's[5] own criteria, the emergency welfare response of 2020 was, in important respects, a significant normative success. The Coronavirus Job Retention Scheme (CJRS), which paid 80% of the wages of furloughed employees up to a cap of £2,500 per month, represented the most direct intervention in labour market income security in post-war UK history. The £20-per-week increase to Universal Credit, representing a 25% increase in the standard allowance, was the single largest since the benefit was introduced and briefly elevated UC above the 2012 Child Poverty Action Group poverty threshold for single adults without children.[30] These interventions constituted, at least temporarily, a welfare state closer to Spicker's normative ideal, one that is responsive to felt and expressed needs, universal in its application to the labour market, and sufficient to prevent catastrophic income collapse. The Resolution Foundation estimated that without these interventions, the poverty rate would have risen by approximately 3.4 percentage points during 2020.[19] That this increase was largely prevented is a testament to the possibility of welfare-state adequacy when political will is present.

### 5.2 THE POLITICS OF WITHDRAWAL: PERMANENT AUSTERITY REVISITED

The withdrawal of emergency welfare measures from 2021 onwards, however, represents what Shadare (2023),[2] drawing on Spicker's normative framework, characterised as a profound policy failure by the standards of social rights and welfare need. The termination of the CJRS in September 2021 and the removal of the £20 UC uplift in October 2021 were followed by a period of sustained real-terms benefit

erosion as inflation, reaching 11.1% at its peak in October 2022,[31] significantly outpaced benefit uprating. The *Resolution Foundation* estimated that the real value of UC's standard allowance fell by approximately 8% in real terms between October 2021 and April 2023.[32] This trajectory is explicable, in Pierson's terms,[3] through the framework of 'permanent austerity' or the structural fiscal pressures generated by post-pandemic debt, ageing demographics, and the demands of the NHS recovery all conspire to maintain pressure for welfare retrenchment even as the acute crisis recedes. Yet Spicker's normative challenge to this fiscal determinism remains potent: the question is not only whether the UK can afford more generous welfare provision but whether, given the SDH evidence on the health consequences of inadequacy, it can afford not to.

5.3 UNIVERSAL CREDIT AND THE SDH

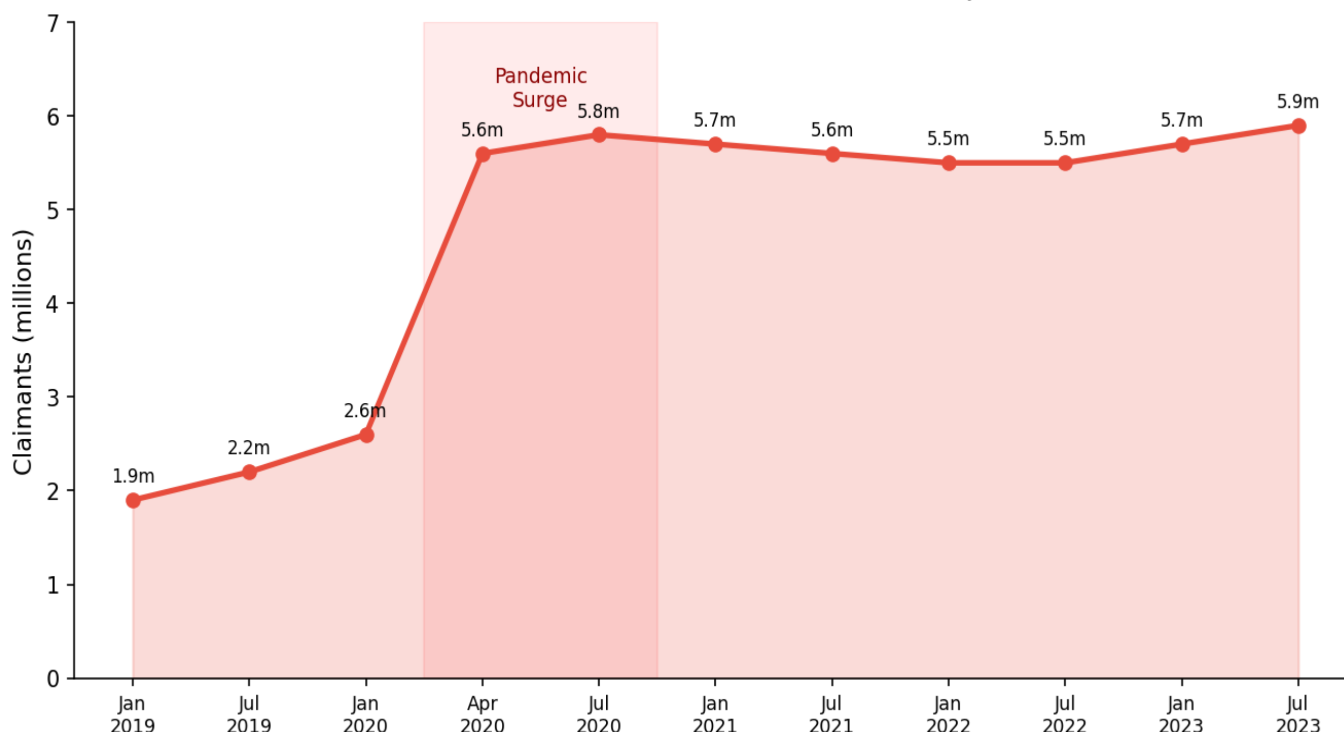


*Figure 5. Universal Credit claimants in the UK (millions), January 2019 – July 2023. The pandemic-era surge from 2.6m to 5.8m reflects both job losses and the temporary removal of the minimum income floor for self-employed workers. The subsequent plateau indicates structural embedding. Source: DWP, 2023.*[33]

Figure 5 illustrates one of the most significant structural welfare changes of the post-pandemic era: the mass migration of the UK working-age population onto Universal Credit. The pre-pandemic UC caseload of approximately 2.6 million doubled to nearly 5.8 million within weeks of the pandemic's onset, as the suspension of the minimum income floor, the removal of the seven-day wait, and the dramatic increase in unemployment and underemployment brought millions of previously self-sufficient households into contact with the benefit system. The SDH implications of this UC expansion are complex and multidimensional. On the positive side, the pandemic demonstrated that the UC system could, when politically facilitated, serve as a more effective income-protection mechanism than the fragmented legacy benefits it replaced. On the negative side, the structural features of UC, such as the five-week wait for first payment, the benefit cap, the conditionality regime, and the two-child limit, continued to generate SDH harms even during the pandemic. Research by the Child Poverty Action Group[30] documented that the five-week wait remained associated with debt, food bank use, and mental health deterioration even during the supposedly 'liberalised' pandemic regime.

## 6. Case Studies: Post-Pandemic Welfare Reconfiguration and the SDH

6.1 CASE STUDY ONE: UNIVERSAL CREDIT REFORM AND INCOME SECURITY

**Case Study 1: Universal Credit and Income Security as a Social Determinant of Health**

Universal Credit (UC) was introduced by the Welfare Reform Act 2012 as a consolidation of six legacy working-age benefits (Income Support, income-based JSA, income-related ESA, Housing Benefit, Child Tax Credit, and Working Tax Credit). By the time of the pandemic, approximately 40% of the planned caseload had been migrated to UC; by 2023, rollout was substantially complete, with 5.9 million households claiming UC.[33] From a Spickerian normative perspective, UC represents a significant regression in the adequacy of income provision as an SDH. The standard allowance for a single adult over 25 in 2023/24 (£368.74 per month) equates to approximately 15% of median earnings, which is well below the Joseph Rowntree Foundation's (JRF) Minimum Income Standard and insufficient to meet basic needs without other income. The JRF[34] estimated that 3.8 million people claiming UC were living in deep poverty (more than 50% below the poverty line), a figure that reflects the structural inadequacy of UC as an income

floor. As Spicker[4] (p. 89) argues, "a welfare system that fails to meet basic needs is not merely inadequate; it is a form of structural harm."

From Pierson's political economy perspective,[3] UC's trajectory illustrates his argument about the path dependency of institutional design. The 'digital by default' management culture, the online journal requirement, the automated payment system, and the conditionality sanctions regime were all baked into the system's original architecture and have proven extraordinarily resistant to reform despite extensive parliamentary scrutiny, NAO reports (2018[35]; 2020[36]), and a sustained civil society campaign. As Shadare (2022)[1] noted in discussing Pierson's account of welfare state governance, institutional 'lock-in' can operate just as powerfully to entrench *inadequate* provision as to protect generous provision from retrenchment. The SDH evidence on UC is unequivocal. A systematic review by Wickham et al.[37] found that UC was associated with increased odds of mental health deterioration, food insecurity, housing instability, and debt among recipients. The five-week wait for the first payment, which the Joseph Rowntree Foundation estimated affected approximately 800,000 new claimants annually, was specifically identified as a 'gateway harm' that undermined the income SDH from the moment of contact with the system. Post-pandemic calls for UC reform, including permanently restoring the £20 per week uplift, reducing the benefit cap, and abolishing the two-child limit, represent direct SDH-aligned welfare demands, yet all have been resisted by successive UK governments since 2021.

## 6.2 CASE STUDY TWO: NHS RECOVERY AND HEALTHCARE AS AN SDH

**Case Study 2: NHS Elective Recovery and the Healthcare SDH**

Healthcare access is itself a significant SDH domain, and the pandemic's impact on NHS capacity constitutes a post-pandemic welfare challenge with direct population health consequences. By September 2023, the NHS elective waiting list in England had reached 7.77 million pathways,[38] constituting the largest waiting list since comparable records began, with approximately 363,000 patients waiting over 65 weeks for treatment. This 'treatment SDH' deficit is not distributed evenly: analysis by the Nuffield Trust[24] found that patients in the most deprived decile were 1.6 times more likely to be on a waiting list for over 12 months than those in the least deprived decile.

The NHS Long Term Plan (2019), which forms the policy framework for NHS recovery, commits the NHS to 'strengthening its contribution to prevention and health inequalities'. However, as the Health Foundation[39] has argued, the plan's prevention agenda has been consistently underfunded, with the 'NHS prevention premium', representing the additional spending needed to shift the system towards upstream SDH intervention, estimated at approximately £4.5 billion per year, against actual investment of less than £1 billion annually. The tension between NHS recovery as an institutional priority and SDH investment as a health equity priority maps directly onto the Pierson–Spicker analytical dialogue. Pierson's political economy framework[3] draws attention to the institutional capture of health policy by 'acute care' interests, including hospitals, tertiary specialists, and emergency services, that consistently crowd out prevention and primary care investment. Spicker's normative framework,[45] by contrast, demands that health policy be oriented towards need, which the SDH evidence suggests is concentrated upstream in social conditions rather than downstream in clinical interventions. As Geoffrey Rose's[40] (p. 66) foundational insight in preventive medicine argues, "a large number of people at a small risk may give rise to more cases of disease than the small number who are at high risk", a population-level SDH logic that the current NHS recovery framework does not adequately operationalise.

## 6.3 CASE STUDY THREE: HOUSING POLICY AND THE HOUSING SDH

**Case Study 3: Post-Pandemic Housing Policy and the Housing SDH**

Housing is among the most consistently documented social determinants of health.[12,41] Cold, damp, overcrowded, or unstable housing is independently associated with respiratory disease, cardiovascular disease, mental health disorders, and childhood developmental delay. The 'housing SDH' operates at multiple scales: at the level of individual dwelling conditions; at the level of neighbourhood environment (including air quality, green space, and crime); and at the structural level of housing affordability, security of tenure, and homelessness. The pandemic exposed and exacerbated all three dimensions of the housing SDH. Overcrowded housing in deprived urban areas, identified by the ONS[18] as a significant predictor of COVID-19 transmission, reflects both the inadequacy of the social housing stock (approximately 1.2 million households on social housing waiting lists in 2023[42]) and the failure of housing benefit to match private rental market inflation. The Local Housing Allowance (LHA) freeze, maintained at 2020 levels through 2024 despite rental inflation of over 15% in many areas, has resulted in a systematic and widening gap between benefit entitlement and actual rental costs, leading to rent arrears, homelessness risk, and associated SDH harms.

The post-pandemic period has seen incremental rather than transformative housing policy. The government's Levelling Up agenda, announced in 2022, committed to increasing social housing supply and regenerating deprived communities, but spending commitments have been widely regarded as inadequate to the scale of the housing SDH deficit. Shelter[43] estimated that England needs 3.1 million new social homes over the next 20 years to meet need, against a current delivery rate of approximately 7,500 per year. Pierson's[3] analytical framework predicts that the housing SDH will continue to be under-addressed, given the powerful interests, namely, private landlords, mortgage holders, and house-builders, who benefit from the status quo.

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*Table 2. Case Study Summary: Post-Pandemic Welfare Reforms and SDH Alignment*

| Domain | Case Study | SDH Mechanism | Current Policy Gap | Recommended SDH Alignment |
|---|---|---|---|---|
| Income Security | Universal Credit | Income adequacy as upstream health determinant | UC below Minimum Income Standard; two-child limit; benefit cap | Restore £20 uplift; abolish two-child limit; increase standard allowance to MIS level |
| Healthcare Access | NHS Elective Recovery | Healthcare access as SDH; preventive investment | 7.77m waiting list; prevention underfunded by ~£3.5bn/year | Fund prevention premium; address elective inequality by deprivation; expand community health workers |
| Housing | Post-Pandemic Housing Policy | Dwelling conditions, tenure security, homelessness | 1.2m on waiting lists; LHA freeze; 3.1m social housing deficit | Unfreeze LHA; increase social housing build to 90,000/year; landlord regulation reform |

## 7. Discussion: Integrating SDH into Post-Pandemic Welfare State Theory

### 7.1 THE PIERSON–SPICKER DIALOGUE AND SDH

One of the central contributions of this article is to use the Pierson–Spicker theoretical dialogue, as illuminated by Shadare's (2022[1]; 2023[2]) review articles, to enrich SDH analysis of the UK welfare state. The two frameworks are not simply alternative accounts of the same empirical reality; they are, in a sense, addressing different *kinds* of questions. Pierson[3] asks: What structural and political forces shape the trajectory of welfare states? Spicker[45] asks: What should welfare states do, and by what normative standards should they be evaluated? The SDH framework provides a third register, namely: what are the health consequences of the choices welfare states make? Read together, these three frameworks generate a more complete analytical architecture than any one of them could provide alone. Pierson's political economy helps to explain *why* post-pandemic welfare reforms have been partial and insufficient, suggesting path dependency, fiscal constraint, blame avoidance, and institutional inertia. Spicker's normative framework helps to establish *why this matters* from a social rights and human welfare perspective. And the SDH framework helps to demonstrate *what the health consequences are*, providing an empirical basis for normative claims that go beyond welfare ideology to public health evidence.

This triangulation has particular political significance in the UK context. Arguments for more generous welfare provision that are framed primarily in terms of social rights or redistribution are easily dismissed in a political culture deeply marked by what Pierson[3] calls the 'neoliberal ideational revolution' of the Thatcher period. But arguments grounded in SDH evidence, demonstrating that current welfare inadequacy generates measurable health costs that fall on the NHS, the social care system, and the public finances, have a different political valence. They translate welfare needs into fiscal externalities in a language accessible to economists, health service managers, public finance administrators, and social justice advocates.

### 7.2 STRUCTURAL RACISM AS AN SDH GAP IN BOTH FRAMEWORKS

As Shadare (2023)[2] noted in his critical review of Spicker, *An Introduction to Social Policy*'s framework of welfare, need, and social rights does not adequately theorise structural racism and ethno-racial inequality as phenomena of the welfare state. This limitation is shared, though to a lesser degree, by Pierson's political economy framework.[3] Neither text provides a robust account of how the welfare state's design, administration, and cultural assumptions systematically disadvantage ethnic minority communities across multiple SDH domains. The pandemic SDH data, showing two-to-four-fold excess COVID mortality among Black and South Asian communities after age and sex adjustment, makes the urgency of this theoretical gap vivid. The SDH deficit faced by ethnic minority communities in the UK is not simply reducible to class disadvantage: it reflects a distinct set of mechanisms, including occupational segregation, discrimination in the private rental market, differential police contact, and cultural and linguistic barriers to healthcare access that require specific policy responses. Post-pandemic welfare state reform that fails to address structural racism as a health equity mechanism will leave a significant and well-evidenced SDH gradient unaddressed.

### 7.3 THE SOCIAL INVESTMENT STATE AND SDH: A POST-PANDEMIC OPPORTUNITY

One of the most significant policy paradigm debates in contemporary welfare state theory concerns the 'social investment' model of welfare provision, associated with Hemerijck (2017)[44] and discussed extensively by Pierson[3] in the section reviewed by Shadare (2022).[1] The social investment state thesis holds that welfare spending should be evaluated not primarily as consumption or a transfer from taxpayers to recipients, but as *investment in human capital and social capability* that yields economic returns through higher productivity, greater labour market participation, and reduced downstream spending on healthcare and criminal justice. The SDH framework provides a powerful empirical underpinning for the social investment thesis. If current welfare inadequacy generates measurable health costs, especially in terms of preventable morbidity, premature mortality, mental illness, and NHS utilisation, then investment in upstream SDH represents a demonstrably cost-effective use of public resources. The Health Foundation[45] estimated that every £1 invested in early years SDH interventions generates £7–12 in lifetime economic returns, a return-on-investment calculation that makes a compelling fiscal case for SDH-aligned welfare expansion that does not rely solely on normative or rights-based arguments. The post-pandemic period represents, potentially, a political

opportunity for the social investment paradigm. The extraordinary welfare expansion of 2020, and the evidence of its protective health and economic effects, demonstrated that alternative welfare configurations are politically possible. The challenge for SDH-aligned welfare reform is to build on this demonstration effect to argue for a permanent reconfiguration of the UK welfare state around social investment principles, rather than a return to pre-pandemic austerity trajectories.

### 7.4 METHODOLOGICAL REFLECTIONS AND LIMITATIONS

This article employs a critical narrative review methodology, which carries inherent limitations that should be acknowledged. First, the SDH data utilised, drawn from ONS, NHS Digital, PHE, and the Marmot Reviews, are predominantly cross-sectional and ecological in character, limiting causal inference. Second, the article's focus on England means that important intra-UK variations in welfare state provision, such as Scotland's mitigation of the two-child limit and Wales's extension of free school meals, are not fully explored. Third, the theoretical dialogue between Pierson and Spicker, while analytically productive, does not exhaust the theoretical resources available for welfare state analysis: perspectives from feminist political economy (Orloff, 1993[46]), postcolonial welfare studies (Williams, 2021[47]), and disability studies (Oliver, 1990[48]) are not fully incorporated. Future research should develop these theoretical lacunae, in particular through primary qualitative research with welfare state recipients from multiply disadvantaged groups, and through comparative analysis of post-pandemic welfare trajectories in similar welfare regimes, particularly Ireland, Australia, and Canada, to assess the generalisability of the UK findings.

## 8. CONCLUSIONS - TOWARDS AN SDH-ALIGNED WELFARE STATE

The COVID-19 pandemic did not create the United Kingdom's health inequalities, but it illuminated them with devastating clarity and urgency. The patterned inequalities in pandemic mortality, following socioeconomic, occupational, housing, and ethno-racial fault lines, constitute epidemiological evidence of SDH causation that welfare state theory must take seriously. The welfare state's post-pandemic trajectory, largely characterised by temporary emergency generosity followed by a rapid reversion to austerity, represents, in Spicker's normative terms, a failure of social rights and, in public health terms, a failure of preventive policy that will generate downstream health costs for decades. Drawing on the complementary theoretical frameworks of Pierson's political economy[3] and Spicker's normative social policy,[45] as developed and critically assessed in Shadare's (2022[1]; 2023[2]) review articles, this article has argued for an integrated analytical approach that situates welfare state reform within the SDH framework. This integration yields both analytical and political benefits. Analytically, it generates a more complete account of *why* welfare states matter for health (the SDH evidence), *what* they should do (Spicker's normative framework), and *what constrains their ability to do so* (Pierson's political economy). Politically, it provides the basis for coalitions between social policy advocates, public health researchers, and NHS system leaders around a shared agenda of upstream social investment.

The research and policy agenda implied by this analysis has several concrete dimensions. First, the welfare benefit system must be reformed to ensure that income protection operates as an effective SDH intervention: this requires, at a minimum, the abolition of the two-child limit, the restoration of the £20 UC uplift, the unfreezing of LHA, and a comprehensive review of benefit adequacy against the Minimum Income Standard. Second, housing policy must be reframed as a health equity intervention, with a substantial increase in investment in social housing and stronger protections for private renters. Third, the NHS's prevention agenda must be funded to scale, with ring-fenced investment in community-based health inequalities programmes. Fourth, structural racism must be explicitly named and addressed as a welfare state and SDH mechanism, through disaggregated data collection, anti-discrimination enforcement, and culturally competent service design. Ultimately, this article argues, the post-pandemic moment demands not merely incremental welfare reform but a *reconceptualisation* of the welfare state as a health equity institution, one whose primary purpose is to provide the social conditions necessary for all people to live healthy, flourishing lives. This reconceptualisation, grounded in the SDH evidence base and informed by both Pierson's analytical rigour and Spicker's normative clarity, represents the most important intellectual task for social policy and public health scholarship in the post-COVID-19 era.

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## Declarations

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***Table 3. Research and Policy Agenda: SDH-Aligned Welfare Reform in Post-COVID UK***

| Priority Area | Research Gaps | Policy Recommendations | Lead Actors |
|---|---|---|---|
| Income Security | Longitudinal studies on UC withdrawal and health outcomes; natural experiments using UC rollout variation | Abolish two-child limit; restore £20 uplift; set UC at MIS level | DWP; HM Treasury; JRF; CPAG |
| Housing SDH | Comparative health outcomes by tenure type post-pandemic; impact of LHA freeze on health | Unfreeze LHA; deliver 90,000 social homes/year; expand renters' rights | DLUHC; Housing Associations; Local Authorities |
| Healthcare Equity | SDH-stratified analysis of NHS waiting lists; cost-effectiveness of prevention premium | Fund £4.5bn prevention premium; mandatory SDH reporting for ICBs | NHS England; NHSE ICSs; NICE; Health Foundation |
| Structural Racism | Ethnicity-disaggregated welfare data; mechanisms of racial welfare gap | Mandatory race equality impact assessments for welfare policy; culturally competent services | Equalities and Human Rights Commission; DHSC; DWP |
| Comparative Welfare | Post-pandemic welfare trajectory comparisons (Ireland, Australia, Canada) | Share lessons from jurisdictions with stronger SDH-welfare integration | OECD; academic networks; WHO |

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