Brain-be 2.0
Belgian **R**esearch **A**ction through **I**nterdisciplinary **N**etworks

POLICY BRIEF

Policy Brief No. 3

Re-InVEST.be
Health policy and poverty reduction: a social investment perspective

This Policy Brief is the third in a trilogy on social investment as a strategy for poverty reduction. The theoretical framework (based on the concept of social investment and Sen and Nussbaum's capability theory) remains essentially the same, but the focus here is on (physical and mental) health. We begin with an examination of the socio-economic determinants of health inequalities, with a particular focus on the role of social protection and housing. We zoom in on mental health care because this is an underexplored theme in the literature on health and poverty. We then ask how the right to health (care) is realised in practice. A set of policy implications are then derived from the analysis.

Context and research questions

This Policy Brief summarises the main findings and recommendations of the third part of the Re-InVEST.be study. Health policy is examined here as a (potential) investment in sustainable poverty reduction. The focus is on the interplay between health, housing, financial security and social protection. In terms of the health gap between rich and poor, Belgium not only scores relatively poorly in a European context, but has also deteriorated over the past ten years (EuroHealthNet, 2025). The differences in life expectancy by socio-economic status (SES – defined multidimensionally) speak for themselves: men in the highest SES quartile live 9.3 years longer than those in the lowest SES quartile; for women, the difference is 6.3 years. The differences in “healthy life expectancy” for both sexes exceed 10 years and have increased over the past 20 years (Bourguignon et al. 2021). They are often related to differences in chronic conditions such as lung, cardiovascular and diabetes diseases, which in turn are related to differences in dietary and lifestyle habits as well as living conditions. It is noteworthy that inequalities in mental health are much greater than those in physical health (Renard et al. 2022).

We examine again three sets of research questions at the intersection of social protection, housing and health policy as investments in sustainable poverty reduction:

- What can be said about the impact of socio-economic inequality on the health gap between rich and poor? What are the mitigating effects of social protection and housing policy: to what extent do they contribute to closing that gap?
- How effectively is the right to health (care) enshrined in law? Where are the gaps and how can rights be strengthened? We focus specifically on mental health (care) because this has remained an under-researched topic in the literature to date.
- How do public and intermediary services (RIZIV, mutual health insurance funds, community health centres, etc.) function in the implementation of the right to healthcare?

Main findings

Several studies have already been conducted in Belgium on social inequalities in health and in the use of healthcare. For an overview, we refer to Demonty et al. (2023) and Coene et al. (2025). Our contribution begins with an analysis of the interrelationship between various socio-economic conditions and health. Two data sources (both limited to Belgium) were used for this purpose: the European Quality of Life Survey (EQLS) and the Survey on Income and Living Conditions (EU-SILC).

Housing and health

Using an extensive analysis of data from the 2016 EQLS survey, Heylen (2025) shows that various aspects of the housing situation, including affordability, housing quality and neighbourhood environment, are strongly correlated with both self-reported general health and mental well-being. The results are in line with previous international research on this correlation.

Using logistic regression analyses, Heylen examined, among other things, the interaction between *housing status* and affordability problems. He found that owner-occupiers are generally in better health than tenants. However, when owners are faced with payment arrears, they have a significantly higher risk of poor health than tenants with similar financial problems. This points to the particular psychological strain that mortgage arrears and the risk of losing one's home can entail.

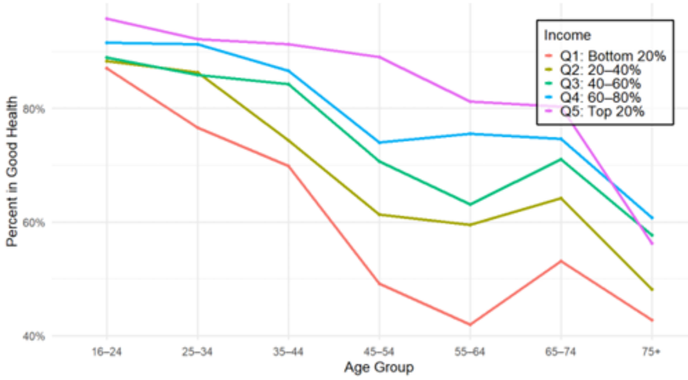
For *social* tenants, the risk of poor health does not increase when there are *payment arrears*, unlike for private tenants and owners. This result may be related to the protective role of the social rental sector, where there is greater housing security and support is more structurally organised than in the private rental market.

Furthermore, this study emphasises the importance of *housing quality* for health, and more specifically the presence of a good heating and cooling system. Neighbourhood characteristics also play a clear role. For example, people who feel unsafe in their neighbourhood in the evening are more likely to have poor health. Finally, it was shown that people who feel socially excluded have a significantly higher risk of both poor general and mental health.

The findings of this study emphasise the need for a multidimensional policy approach in the area of housing and well-being that goes beyond physical housing quality alone. Initiatives in the areas of affordability, neighbourhood safety and social inclusion are also important in reducing health inequalities and improving quality of life in Belgium.

Material and human capital, social protection and health

Mergoni & Nicaise (2025) used EU-SILC data to investigate the influence of socio-economic resources in the broad sense (income, debt and savings, education, housing comfort and social protection) on individuals' subjective perception of health. As a dependent variable for the multivariate logistic regressions, they used the dichotomised answers to the question of how well respondents rate their own health (1 = good or very good; rest = 0). Naturally, (subjective) health declines with age. Regardless of which socio-economic determinant is used as a criterion, the gap between the 'advantaged' and 'disadvantaged' appears to widen throughout the life cycle, reaching its maximum depth around retirement age. In order of impact on the cumulative gap, the determinants are: (log) equivalent income, level of education, age, gender, volume of savings buffer, home ownership, dwelling comfort (presence or absence of certain defects), ability to save or not versus debts, family composition, labour market status (employed/unemployed, etc.), level of social benefits, and arrears in utility payments. From this analysis, we can conclude that not only income, but also other financial and



material buffers such as home ownership determine people's (physical and/or mental) health. The same applies to education, which influences health in various ways (health skills, cautious behaviour, the ability to understand complex relationships, safer workplaces, earning capacity = capacity to spend on health, etc.). All of this has important implications for health policy.

The role of social protection in this context is difficult to test empirically because there is a two-way causality: the poorer the health, the greater the need for social protection; and the stronger the protection, the better the health. An alternative estimate of the impact of social protection can be made by simulating the effect of an income supplement: e.g. by raising the income of the lowest income decile to the level of the highest income decile. The simulation points to a substantial potential increase in the proportion of respondents in good health (by 13% in the youngest group, up to 30% in the oldest group).

Mental health and poverty

The Interfederal Service for the Fight against Poverty organised the 'merging of knowledge' between the academic research and the experiential knowledge of anti-poverty associations (Demonty et al. 2023 and 2025c) with a particular focus on mental health. Reference is often made to the importance of stability and balance. Among people living in poverty and associations, there is a strong fear of the psychiatrisation of the social; this makes the debate about the relationship between poverty and mental health very sensitive.

The vicious circle in which poverty causes (mental) illness and (mental) illness causes poverty is recognised by the participants in the interviews, although they mainly refer to poverty as the root cause of a lack of mental well-being and an increased risk of developing psychiatric disorders. People in poverty often experience an accumulation of difficulties (difficulties making ends meet, debts, the risk of children being taken into care, etc.) that put their mental well-being under severe strain. In addition, the long-term – and sometimes intergenerational – nature of poverty is emphasised, as is the persistent nature of the stress that comes with living with financial problems.

A crucial mitigating factor is autonomy and the ability to make one's own choices and pursue one's own goals. Another key finding is the important role played by associations where people experiencing poverty have a voice, as well as similar low-threshold grassroots initiatives, in promoting the mental well-being of the people who attend them.

The right to mental health

De Munck & Pardoen (2024) and De Munck et al. (2025) analyse the meaning of the right to mental health on the basis of in-depth interviews with a diverse set of service providers. They teach us to distinguish between three areas of meaning. The right to *cure* refers to the treatment of an acute illness by professionals in appropriate healthcare facilities, with a view to providing relief as quickly as possible. The right to *care* refers to curative or preventive care provided by professionals and non-professionals with a view to building a life with - or despite the symptoms. Finally, the right to *mental health* becomes a right to personal development when the psychological consequences of experiences in the various domains of social life are taken into account: family, school, work, neighbourhood, etc. Non-discrimination, destigmatisation, poor housing or difficult working conditions then become part of this right, which is understood in a comprehensive manner.

The development of a right to mental health as described above was accompanied by significant legal changes. Until the 1990s, the *public system* regarded health as a commodity that was managed, sometimes coercively, by the government on the advice of medical scientists. The human rights movement has radically changed this situation.

On the one hand, the *formalistic regime* has limited the role of the public government in the administration of justice by establishing a human rights framework that protects against abuse of power by psychiatrists. However, this barrier is fragile and the coordination between the two regimes remains difficult. On the other hand, legal regulation in this area is increasingly emphasising the role of mediation.

This is evidenced by important reforms, such as the evolution of the protection of adults of full age or the introduction of mediation in psychiatric institutions. In the procedures of the sheltered housing initiatives (IHP), which emerged at the end of the 1980s, we also see a new relationship between administration and respect for the individual.

In contrast to the housing policy area, *negotiations between the social partners* are very active in health and disability insurance (RIZIV). They contribute significantly to the development of meso and macro structures for outpatient care, which support the continuity of care and enable the mutualisation of health costs. However, there are major inequalities between regions: mental health care is better equipped in urban areas than in rural areas, which poses a problem for equal access to care. The introduction of the new mental health care domain entails three issues: the tyranny of urgency, which reflects the failure of prevention; leaving patients to their families or to isolation; and the underfunding and lack of support for care networks. The government must recognise these issues as risks that exacerbate social inequality and the suffering of vulnerable population groups.

The figure of the legal person emerging from these changes has not yet been clearly defined. This is not an 'autonomous and responsible' subject, nor a passive object in need of specialised care, nor a member of an interest group that can organise itself as a trade union. S/he is a subject determined by and dependent on relationships with others. This decentralised subjectivity is inherent in the concept of 'care' that defines the field of mental health care. We assume this as soon as we talk about the relationship between the caregiver and the care recipient: the status of the care recipient depends on the status of the caregiver. We find this reflected in mediation processes, where the role of the ‘care giver’ is ultimately just as important as that of the 'care recipient'. The construction of this new, 'relational' subject of law is the ultimate goal of mental health care policy in the contemporary context.

Conclusion and recommendations

Based on input from various stakeholders, Demonty et al. (2023) derive several basic principles for effective social health policy: 1) it is integrated into all policy areas (‘health-in-all-policies’, including housing and social protection); 2) it is emancipatory and not coercive or patronising; 3) it covers the entire life course; 4) it follows a logic of proportional universalism; and 5) it is participatory.

1. Both our statistical analyses and our dialogue sessions with stakeholders in the field reveal a clear structural *link between the socio-economic living conditions of families and their health*. This influence is cumulative throughout the life cycle and the link becomes increasingly clear with age. This implies the following:
    a. Poverty (and social inequality in general) undeniably involves a high public health cost, which can be avoided by investing preventively in adequate social protection, education, sustainable employment and affordable quality housing.
    b. The cumulative impact of deprivation on health throughout the life cycle is an argument for adequate minimum levels of social protection. Currently, social protection is too exclusively based on a “moral hazard” logic: tightly degressive benefits and duration limits aim to incentivise the return to work. However, without adequate minimum protection, people end up in a negative spiral of disinvestment, which further undermines their health and increases costs for the individuals concerned and for the community. It is not without reason that anti-poverty associations are calling for all minimum benefits to be raised to the poverty risk threshold (AROP).
2. A set of findings concern the *link between housing policy and health*:
    a. Our research suggests that housing security and affordability are more important than ownership status per se. Indeed, payment problems weigh more heavily on the mental health of owners than on that of tenants, presumably because the latter can more easily escape them by moving house. This may (in addition to the Matthew effect) be an argument for governments to prioritise housing security over home ownership in their subsidy policy.

   b. The importance of housing security for mental health is an argument for measures to protect tenants, e.g. against eviction during the winter months, but also to be cautious about pressuring social tenants to move to the regular rental market.
   c. Equally important for health is quality of housing. This is not only about physical characteristics of housing such as insulation and hygiene, but also about neighbourhood characteristics such as pollution and safety. Governments must take into account the social benefits of investing in the upgrading of housing and neighbourhoods.
3. Specifically with regard to *mental health (care),* the following recommendations emerged from the dialogue sessions with stakeholders and associations (Demonty et al. 2025c):
   a. People (living in poverty) must be empowered to gain a sense of control over their lives, in health as well as in other areas, and in exercising their rights in relation to public services. This requires time, trust and transparency, and a framework that gives the care recipient an active role in their pathway.
   b. In addition, investment should also be made in associations where people living in poverty feel recognised, as these organisations are essential for promoting their well-being and preventing mental health problems.
4. De Munck et al. (2025c) propose four ways to improve *access to mental health rights*:
   a. They call for a shift from an emergency-based approach to more prevention and support outside of critical situations. This is not to minimise the importance of urgent psychiatric care, but to bear in mind that crisis situations are often the result of a lack of available support capacity in earlier stages.
   b. In the same vein, it is recommended that care networks be strengthened, in particular by reinforcing mobile teams and considering the status of informal carers. Both their funding and legal statutes must be geared towards sustainability so that social investment can bear fruit. The experience with sheltered housing initiatives offers advantages that can inspire policies to strengthen networks: cooperation between public administration and local associations, flexible management, and solving the housing problem.
   c. Thirdly, mediation services must be strengthened in order to offer alternative – including non-judicial – ways of resolving conflicts and facilitating access to rights.
   d. Finally, the authors emphasise the need to thoroughly reconsider the concept of 'legal person' in order to better take into account the vulnerability of those concerned. In the field of mental health, the legal person is not an autonomous and responsible being who engages into voluntary and explicit agreements. S/he is a relational being, who is dependent but nevertheless a dialogue partner who deserves respect. In addition, caregivers must also be taken into account, as their rights are just as important as those of the care recipients.

Read more

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