Chapter 3
The psychology of social risks

The previous chapter reviewed the labor market bias of the literature. One of the central findings of the chapter was that citizens, according to the literature, are motivated to maximize either their current or future income, or both. This thinking about what motivates people points to two characteristics of the literature that are equally problematic from my perspective. First, and most obviously, people are assumed to be driven by income. This, of course, follows directly from the welfare state literature's labor market bias; the primary utility people get from the labor market *is* income, together with the wealth that such income allows people to accumulate over time. Second, to the extent that the literature even considers how people make up their minds, the assumption is that people can calculate what is best for them through some sort of explicit cognitive reasoning.

This chapter challenges both assumptions. While I have no trouble accepting the received wisdom that people consider their income when they develop preferences about labor market-related welfare state programs, this assumption appears

wrongheaded when it comes to those welfare state programs that are aimed at life cycle risks. It seems ludicrous to suggest that maximization of income is the main motive for the sick, infirm, and old. All individuals want to avoid pain and death and the degrading and sometimes lonely lives that are associated with them. No income transfer, no matter how generous, can compensate for a premature or undignified death; the primary utility people get out of good health and happy old age is not money, but exactly that—good health and happy old age.

I also want to challenge the view that people develop a preference by calculating what is best for them. All the micro-level welfare state theories mentioned above adhere to some (soft) version of rational choice theory, when they argue that people use their position in the labor market—typically defined by their skills specificity, income, or job status—to deduce the form of social protection they prefer. Such a simplistic view of human psychology might be sufficient for analyzing preference formation in the domain of the labor market (though probably not). However, it is decidedly inadequate when considering life cycle risks. Life cycle risks are as old as the human species, and therefore have affected the way people reason about them in ways that cannot be captured with any "rational calculus" model alone.

I propose a new perspective on the psychology of social risks that is far more realistic and, I claim, more explanatorily powerful than what is offered by the existing literature. This new perspective draws

heavily on well-established insights from mainstream cognitive psychology about so-called Type 1 and Type 2 reasoning (Evans 2008; Stanovich 2011; Evans and Stanovich 2013). Type 1 is the umbrella term for a set of mental processes that do not require working memory and that function autonomously, that is, without explicit cognition. The mental processes of Type 1 reasoning frequently take the form of "intuitions" that evolved early in human, or even pre-human, history to deal with specific problems and then, over the course of millennia, became hardwired into the human brain. Type 2 reasoning, conversely, requires working memory and is associated with conscious, consequential decision-making of the sort envisioned by the existing welfare state literature. This type of reasoning broadly corresponds to Béland and Cox's (2011: 3-4) definition of ideas as causal beliefs. In the context of my model, we can, therefore, think of Type 1 reasoning as *intuitions* and Type 2 reasoning as *ideas*.

The fact that life cycle risks are an ingrained feature of human existence, whereas labor market risks are very recent in the context of evolutionary history, is significant in several ways. First, people's *cost perceptions* are different across the two areas, with life cycle risks evoking much stronger negative feelings than labor market risks. Second, people's *deservingness perceptions* are different too. People tend to feel much more compassionate about those exposed to life cycle risks, as opposed to labor market risks. Third, for these reasons, opinions about the need for life cycle risk protection tend to be

much less flexible than opinions about labor market risk protection. Still, while opinions about the need for life cycle risk protection tend to be inflexible, opinions about proper policy solutions are not. That is, although people have strong intuitions about the need for protection against life cycle risks, they have no similar intuitions about how precisely to provide that protection. This opens the door for considerable policy engineering by elite political actors.

Now, a critical reader might object to my argument that loss of income can also affect a person's health (though of course not old age and its ultimate outcome). Does that not imply that the distinction between labor market and life cycle risks is smaller than I suggest? Are the old theories in fact enough for analyzing life cycle risks? There are several reasons why this is not the case. First, the scholars reviewed in Chapter 3 never suggest that their focus on income is a stand-in or proxy for something more profound or dangerous such as, for example, failing health. In this narrow sense, it is obvious that we cannot rely solely on the existing work, but, as a minimum, must seriously review its foundational assumptions.

Second, although it is true that going without an income can cause starvation and even death, this does not mean that the two risk types are identical. Physical discomfort is a secondary, or derived, effect of labor market risks that may or may not follow from a loss of income. Social networks like the family and local community, together with public social assistance schemes, normally function as a

safety net between joblessness and starvation. In the developed world, able-bodied individuals are very rarely allowed to die from hunger because they cannot find a job. This does not mean that income loss cannot have adverse effects on a range of other outcomes—from political participation over social mobility to some health-related conditions—but it does mean that equating income loss with threats to individuals' physical integrity is far too simplistic.

Third, individuals can simultaneously belong to two risk categories. In the event an unemployed person also becomes sick from, for example, malnutrition, he enters the life cycle risk category, triggering a set of powerful psychological responses within himself and those around him. As a result, the now-sick unemployed person will be viewed much more favorably by the public than when he was merely unemployed. If income loss was linked intimately with threats against physical integrity in the minds of ordinary people, as a protagonist of the existing literature might suggest, clearly there ought to be no differences between the two risk types regarding psychological mechanisms and policy preferences. There are, but the existing literature simply has no way of accounting for them. For that, we need a model that links the different risk types with different modes of reasoning. This is precisely what I provide in this chapter.

In the rest of this chapter, I go through the motions of outlining this argument and what more exactly it implies. My ambition, as stated, is to offer a new perspective on the psychology of social risks

that is better able to account for how the welfare state is organized, as well as its underlying political processes. In the next section, I discuss in detail what life cycle risks are and how they differ from labor market risks. I also elaborate when a risk can be said to be social. Some of what I have to say here will be shockingly self-explanatory to normal people, but brand new to welfare state scholars. In the following two sections, I then present the thesis' argument on the psychology of social risks.

Two types of risks

Risk is defined as the likelihood of an event multiplied by the cost if the event occurs. Risks come in all shapes and forms, but only some become the subject of communal intervention. According to Esping-Andersen (1999: 37), risks become "social" for three reasons: first, if there are collective consequences of the risk suffered by individuals; second, as the increasing complexity of society creates risks that are outside the control of individuals; and third, because society recognizes them as meriting public action. The first two reasons follow from the modernization process. Anticipating Iversen and Soskice (2001), Esping-Andersen observes that labor market protection is often a precondition for workers to behave economically efficiently:

> *If, for example, people without social security risk unemployment, they are more likely to resist any kind of technological change that would augment that risk.*

In other words, risks are something governments and other collective actors engage with when the economy would otherwise be in jeopardy. This, basically, is the risk socialization process imagined by Katzenstein (1985), Swenson (2002), and Mares (2003) when they argue that governments and business interests use expansive welfare state arrangements to optimize the economy. In comparison, the third reason stands out due to its almost tautological formulation: a risk becomes a social risk if society thinks that it should. This reflects the fact that some social risks have no obvious relevance for economic efficiency but have been recognized as warranting society's attention. From the perspective of the existing welfare state literature, the main route to such recognition, apart from economic efficiency, is the pressure from disadvantaged groups as envisioned by the power resource theory and newer coalitional models. In this scenario, representatives of the disadvantaged have been able to push through social protection, effectively turning individual risks into social ones by brute legislative force.

Underlying the notion of social risks outlined here is also an implicit understanding not just of the source of those risks, the modernization process, but also its manifestation—namely loss of income.

To see how closely linked the two are—and how pervasive the influence of Polyani (2001 [1944]) and Wilensky and Lebeaux (1958) is—consult Esping-Andersen (1999: 37), where "survival itself" is equated with having a job:

> *Dependency on market income is a primary catalyst of generalized risks because survival itself is at the mercy of conditions over which individuals have little say; markets cannot guarantee an income, nor a job. Because market economies are dynamic, workers may find themselves technologically redundant; because they are competitive, the less endowed may find themselves marginalized. Mass unemployment is a phenomenon unique to wage-earner societies.*

The equation between social risks and income loss is abundant in the literature, as detailed in the last chapter. Apart from Esping-Andersen (1999), Moene and Wallerstein (2001), Iversen and Soskice (2001), Rehm (2011; 2016), Gingrich and Ansell (2012), and Alt and Iversen (2017), all propose theories that explicitly emphasize this equation, but many more rely on it more or less implicitly. All of this makes perfect sense when studying the effects of the modernization process. However, when considering other sources of risk, it becomes much more problematic.

Life cycle risks are defined as risks that stem from human biology and which threaten the physical integrity of individuals.[7] Physical integrity may, in turn, be defined as freedom from ailment, pain, and death. The principal categories of life cycle risks are sickness, injury, and old age. Childbirth and child-rearing are latent life cycle risks because they only potentially threaten the mother or child's physical integrity; luckily most births and upbringings happen without these threats ever being realized. Sickness, injury, and old age are, by contrast, defined as currently being in a state of ailment or pain. The World Health Organization (2015: 25) defines aging as

> *the gradual accumulation of a wide variety of molecular and cellular damage. Over time, this damage leads to a gradual decrease in physiological reserves, an increased risk of many diseases, and a general decline in the capacity of the individual. Ultimately, it will result in death.*

7 The term 'life cycle risks' is lifted from Esping-Andersen (1999: 41). However, to him these risks are, as always, just a matter of having too low an income. As he notes, "The life cycle of poverty is closely associated with the lack of correspondence between age-specific needs and earnings: young families have costly needs and low income, earnings rise later on (when children have left), and then they decline sharply in old age."

To the World Health Organization, the increased risk of sickness is one of the defining characteristics of aging. Still, sickness and, for that matter, injury are tricky concepts. Both are so associated with ailment and pain that defining the terms is almost impossible due to circularity (Boyd 2000). Consulting dictionaries, one mostly finds a list of synonyms. Merriam-Webster defines sickness as ill health, illness, or a specific disease, whereas injury is defined as an act that damages or hurts.[8] That said, the common core of all these synonyms appears to be that sickness is a malfunctioning of the body's normal homeostatic processes, while injury is a damage to the body caused by external forces. While sounding more precise, these definitions are also mainly circular (what is "malfunctioning" and "damage" if not exactly sickness and injury, respectively?).

That sickness and injury are at the same time both so hard to define and universally recognizable hints at a fundamental point: the absence of them is regarded as an ultimate goal, impossible to motivate or justify further. Aging is different in this respect for two reasons. First, it only increases the propensity for sickness; it does not imply that people actually are sick. Second, aging is a process that occurs throughout life. Everybody ages from the hour they are born to the day they die. This means

8 This is also true if one adheres to the expansive definition in the World Health Organization's 1948 constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Apart from disease and infirmity still featuring without a proper definition, well-being is now added to the circular mix.

that while aging is a source of threats to the physical integrity of individuals, we need to differentiate between those periods of life when aging is a big risk ("old age") and those periods when it is a small risk. The point at which old age sets in varies greatly across individuals and conditions, but at a certain point in people's lives, aging-based threats will have augmented so substantially that the majority of ailments and deaths stems from them (World Health Organization 2015: 26):

> *With increasing age, numerous underlying physiological changes occur, and the risk of chronic disease rises. By age 60, the major burdens of disability and death arise from age-related losses in hearing, seeing and moving, and noncommunicable diseases, including heart disease, stroke, chronic respiratory disorders, cancer and dementia.*

So, while aging per se should not be considered a life cycle risk, old age should. From a conceptual perspective, another important issue is the probability distribution of old age. The risk of old age, as defined by the World Health Organization, in fact consists of two parts. The first is an increased likelihood of becoming sick; the other is a general decline of physiological reserves and capabilities. Whereas the former part implies a probability of less than one, the latter implies a probability of exactly one (that is, it is predetermined). All people, unless they die pre-

maturely, will suffer this general decline and eventually perish, yet only some old people will become severely sick in the process.

The composite nature of the risk of old age highlights how the likelihood of events may not be identical across different forms of life cycle risks. However, while the probability of an event can vary, the costs when it does occur are uniformly high. No matter if we are dealing with severe sickness, major injury, age-related loss of physical and mental abilities, or death, these sorts of physical integrity infringements arguably rate as some of the worst things individuals will ever experience. Although no hard data exist on this, I believe it is a fair assumption to make. Inspired by Maslow's (1943) hierarchy of needs, I believe, moreover, that it is reasonable to assume that people generally value their physical integrity more highly than their current and future income. If not, people would accept a monetary reward in return for getting, for instance, lung cancer, dementia, or a stroke. Even if the reward were enormous, such a proposition appears implausible. I return to the issue of cost perceptions further below.

There is a final distinction between sickness and injury, on the one hand, and old age, on the other, which should be discussed. This is the *plasticity of needs assessment*. While there is no doubt that old age is a core life cycle risk, the point at which an individual is considered old varies according to their appearance and personality, as well as social norms. Some may be considered old when turning 60, others only when reaching 70. Deciding when

someone is sick or injured is, in contrast, much less negotiable. These varying degrees of plasticity probably flow from the fact that sickness and injury normally occur as single, manifest events (accidents, infections, etc.), whereas old age gradually emerges as a natural process over a period of several years. The abruptness of change makes sickness and injury far easier to spot. However, from the perspective of my argument, the plasticity of needs assessment is interesting, but not crucial. The key point is that *when* people are considered old, they are regarded by themselves and others as belonging to a special, high-risk category.

For the reasons outlined so far, life cycle risks constitute a risk type that is distinct from labor market risks. First, the source of the risks is different. One flows from the biology of human beings, the other from the modernization process. Second, the entity at risk is distinct. Life cycle risks pose a threat to individuals' physical integrity, while labor market risks threaten individuals' current and future income. Third, the cost suffered by individuals from severe life cycle events is greater than the cost from severe labor market events.

As mentioned in this chapter's introduction, I am not arguing that a loss of income cannot eventually lead to a situation where the jobless face starvation and even death. However, this is derived from the primary effect, namely lost income. In developed societies, the connection between unemployment and starvation is weak. This is not to belittle the fact that many families in Europe and North America

are unable to afford the food they want (Dugan and Wendt 2014), but people's physical integrity is normally not at stake. It is also true that there is a socio-economic gradient in many health-related conditions (but not, of course, in old age) because people with a lower income tend to have different lifestyles from people with higher incomes (Marmot 2005; Mackenbach et al. 2008; Elo 2009; Meara et al. 2017).

But this points to a major puzzle: While there is a socio-economic gradient in some health-related risks, there is virtually no gradient in people's preferences for health protection (Jensen 2014; Jensen and Petersen 2017; see also Chapter 4). This stands in stark contrast to the findings in the extant literature, as detailed in the last chapter. Here people's socio-economic position maps onto their preferences, but no similar pattern exists for health. People reason about health care *as if* there were no socio-economic gradient. Crucially, there is nothing in the literature to suggest why people should reason differently about health-related risks and labor market risks. If people are maximizing life cycle risk protection in the same way as they are assumed to maximize labor market risk protection, we should see, at least for health care, a different pattern of public preferences from the one we do. To solve the puzzle, we need a new model of the psychology of social risks. To be convincing, such a model should be able to account not only for the puzzle of uniformly high support for health care, but also more generally for the differences between people's reasoning about