

In defence of (social) democracy: On health inequalities and the welfare state

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Article word count = 1136

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Abstract

This issue features a comparative study on oral health inequalities. They conclude that health inequalities are present in all European welfare states and that they are not smaller in the Social Democratic welfare states. This is consistent with a growing body of comparative research into the international patterning of inequalities in health whereby the Social Democratic welfare states fare best in terms of general population health outcomes but less well in terms of socio-economic inequalities in health. This mismatch has been termed a 'public health puzzle' and is seen to represent a *failure* of both public health theory and Social Democracy. In this editorial I interrogate this issue, concluding that inspiration on public health and equality can still be drawn from social democracy.

In defence of (social) democracy: On health inequalities and the welfare state

This issue features a comparative study by Guarnizo-Herreno and colleagues on oral health inequalities in European welfare states [1]. Looking at socio-economic (occupational, educational and subjective social status) inequalities in functional dentition and edentulousness amongst adults aged 45 and over, using data from the 2009 Eurobarometer, they conclude that relative and absolute health inequalities are present in all European welfare states (n=21) and that they are not smaller (and may actually be largest) in the Social Democratic welfare states of Denmark, Finland, Norway, and Sweden.

This is consistent with the findings of a growing body of comparative research into the international patterning of inequalities in health by welfare state regime whereby the Social Democratic welfare states fare best in terms of general population health outcomes (e.g. life expectancy of all social groups tends to be higher) but less well in terms of socio-economic inequalities in health [2][3]. Guarnizo-Herreno and colleagues findings are similar to those for self-reported health [4][5], oral quality of life [6], and obesity, smoking and mortality [7] for which “*no evidence for systematically smaller inequalities in health in countries in northern Europe (Scandinavia)*” were found [7]. Reviews of the political and welfare determinants of health have concluded similarly [3][8][9].

This mismatch between doing well in overall health outcomes whilst doing less well in terms of reducing health inequalities has been termed a ‘public health puzzle’ or ‘paradox’ [2][8][10][11] the nature of which is two-fold: Firstly, that there is an implicit expectation (or normative ‘belief’) within public health circles that better general health outcomes *should be* accompanied by smaller health inequalities; and secondly, that, following public health theory, the Social Democratic welfare states with their more extensive, generous and egalitarian universal welfare systems *should have* smaller health inequalities. In terms of the first issue, the naivety of this public health tenant has been exposed theoretically, by Krieger who argued that the social determinants of health are different from the determinants of health inequalities [12], and empirically, by the work of Eikemo and colleagues who found that countries with better health outcomes actually have larger relative health inequalities [10][13]. The second aspect of the puzzle offers a more fundamental challenge to existing public

health theory as, aside from some support to the artefact [13] (e.g. the 'total mortality' method of Popham et al has found less evidence that health inequalities are larger in the Social Democratic welfare states)[14] and health behaviour explanations (e.g. smoking is more socially stratified in the Social Democratic countries) [7], existing theories of health inequalities are unable to explain the relatively poor showing of the Social Democratic countries [2][15].

Beyond the dry world of public health theory though, there are important political and policy repercussions of this puzzle: how can countries reduce or eliminate health inequalities if *even* Sweden has failed? However, whether the health patterns that we see in comparative social epidemiology should be regarded as a *failure* of the Social Democratic model is contestable on empirical and political terms. Firstly, it was not always the case that the Social Democratic welfare states performed below expectations - until 1980s, the few comparative studies that had been conducted into socio-economic inequalities in health had concluded that the Social Democratic Scandinavian welfare states (particularly Norway and Sweden) had the smallest socio-economic health inequalities [16]. For example, a study by Valkonen, which examined educational inequalities in mortality in six European countries in the 1970s, found that relative inequalities were smallest in Denmark, Norway and Sweden [17]. It is only since the 1980s that studies have found the performance of the Social Democratic welfare states to be more questionable [18]. So the patterns of health inequalities that we see now in European welfare states are from a period in which social democratic ideology and policies have been in relative decline. Denmark, Finland, Norway, and Sweden have not been immune to the processes of globalisation, neo-liberalism and welfare reform resulting in rising social inequality [19]. The extent to which these welfare states still represent the Social Democratic ideal (or still differ significantly from the Bismarckian welfare states) is therefore contestable.

Secondly, whilst inequalities in health are not necessarily smaller in the Social Democratic welfare states, in absolute terms everyone does better. Taking the case of mortality amongst middle-aged men in Sweden, Lundberg and Lahelma (2001: 64) comment that: *"On the basis of relative risk it would be possible to draw the conclusion that more than half a century of egalitarian policies have failed, since inequalities in mortality among middle-aged men are as large in Sweden as elsewhere in*

Europe. This sort of simplistic conclusion would ignore the fact that Swedish working class men have extremely good survival rates compared to similar men in other European countries, which in turn may very well result the wide range of welfare state policies implemented since the 1930s” [20]. The life expectancy of all socio-economic classes is relatively higher than the equivalent groups in other developed countries, and pre-mature mortality risks are also lower (especially in Norway and Sweden) [20][21]. This is reinforced by the work of Wilkinson and Pickett which has shown that everyone does better in more equal countries [22]. Comparative studies have also shown that the most vulnerable social groups - the old [23], the sick [24], and children [25] – fair better in the Social Democratic welfare states [26] and higher social expenditure on welfare has health benefits of the least educated men and women [27]. The scale of social deprivation (and therefore who experiences the worst health) varies by country with, for example, the lowest educated in the Social Democratic countries amounting to around 15% of the population as opposed to around 40% of the population in Anglo-Saxon countries [1] – more people therefore experience the sharp end of health inequalities in England than in Sweden.

Finally, the comparison of absolute and relative health inequality also raises important normative and political issues about whether the role of the Social Democratic (and to some extent the other) welfare states is to improve the status of those at the very bottom of society or whether it is about promoting more general equality. Implicitly, cross-national research to date has tended to favour the latter view, however, it is possible to suggest that it should move beyond relative comparisons and focus instead on absolute ones [2]. This would perhaps also enhance the policy relevance of such research, after all, as Geoffrey Rose famously commented, *“relative risk is not what decision-taking requires ... relative risk is only for researchers; decisions call for absolute measures”*. [28] Future comparative research could therefore benefit from examining the absolute health of the most marginalised, poorest and vulnerable within different types of welfare state and from this find *meaningful* new ways to reduce inequalities within all advanced welfare states.

Inspiration can still be drawn from Social Democracy.

COMPETING INTERESTS

None declared

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