THE NORDIC EXPERIENCE
WELFARE STATES AND PUBLIC HEALTH
Overview

- CSDH will need evidence on policies that work.
- Both macro- and micro-level policies should be considered when looking for such evidence.
- Our aim is to describe and analyse the Nordic experiences of welfare policies and public health.
- Research project commissioned by CSDH, financed by the Swedish Ministry for Health and Social Affairs and CHESS.
The Nordic countries
Why look at the Nordic countries?

The Nordic countries (Denmark, Finland, Iceland, Norway, Sweden) have common features in terms of policies and social organisation (welfare state regime).
Why look at the Nordic countries?

These countries have also been doing well in terms of social and material circumstances and public health.
Under five mortality per 1000 live births, 2003. Source: WHO
Why look at the Nordic countries?

Although many opinions on the pros and cons of the Nordic welfare state model in terms of economic performance or individual outcomes...

...only few attempts have been made to link systematically features of welfare policies with public health outcomes
To get forward we must combine different research traditions:

- Research on individual welfare, social policies and welfare state development
- Research on public health, social determinants of health and health inequalities
The links have been observed

"The clearest achievement of the Scandinavian welfare state has been poverty reduction and a high level of participation in society” O. Kangas & J. Palme

"Autonomy – how much control you have over your life – and the opportunities you have for full social engagement and participation are crucial for health, well-being and longevity” M. Marmot

which suggest that...
Social Determinants = Welfare Resources

Social determinants basically deals with different aspects of welfare.

Welfare is best defined as “the command over resources in terms of money, possessions, knowledge, psychological and physical energy, social relations, security and so on by means of which the individual can control and consciously direct her conditions of life.” (S. Johansson 1971)
Welfare state institutions

Determinants

- Health, mortality, LE
- Health inequalities
Three general questions:

- The issue of “Nordic uniqueness”:
  - What are the Nordic characteristics in terms of welfare policies and public health?

- The issue of causality:
  - Is there a connection between specific features of Nordic welfare state institutions and public health, and if so, what are the mechanisms?

- The issue of applicability:
  - To what extent can the Nordic experiences be applied to other countries in different stages of economic development throughout the world today?
Organisational structure

- CHESS Group
- Nordic Expert Group
- International collaborators and reference persons
Project group at CHESS

- Olle Lundberg, PhD, professor
- Johan Fritzell, PhD, professor
- Maria Kölegård Stjärne, MPH, PhD
- Monica Åberg Yngwe, MPH, PhD
- Lisa Björk, MSc
Nordic expert group

- **Denmark**
  - Finn Diderichsen, PhD, Professor, *Social medicine, University of Copenhagen*
  - Olli Kangas, PhD, Professor, *Institute for Social Research, Copenhagen*

- **Finland**
  - Mikko Kautto, PhD, Division Director, *STAKES, Helsinki*
  - Eero Lahelma, PhD, Professor, *Dept of Public Health, University of Helsinki*

- **Island**
  - Holmfridur Gunnarsdóttir, PhD, Researcher, *Research Center for Occupational Health & Working Life, Reykjavik*

- **Norge**
  - Espen Dahl, PhD, Professor, *Oslo University College*
  - Jon Ivar Elstad, PhD, Professor, *NOVA, Oslo*

- **Sverige**
  - Joakim Palme, PhD, Professor, Director, *Institute for Futures Studies, Stockholm*
Collaborations

- Leading Nordic researchers in public health and welfare state research
- CSDH networks and groups: Gender (Sen+Östlin), Asian team

amongst others
Working method

- Identify central issues to be covered
- Commissioned reports (external + internal)
- Seminar discussions to ensure scientific quality
- A final report based on commissioned reports, published literature and available statistics
Comparisons both between countries and over time

- Analysing country clusters / regimes
- Analysing certain policy traits as variables
Some preliminary results

- Early foundations
- Public health trends 1900-
- General importance of welfare policies
- Specific policies
  - Sanitation
  - Alcohol
Early foundations for welfare and public health policies

- High degrees of literacy (Sweden 85% 1800)
- Monitoring – vital statistics collected by parishes first half 18th century
- Preventive measures – midwives 18th century, vaccination early 19th
Public health trends

- Early advantage for most Nordic countries in life expectancy…
- …but Finland a latecomer and Denmark stagnates recently
- Other countries tend to catch up – Japan overtakes
- Infant mortality still among the lowest and LE among the longest
Life expectancy in Nordic countries
1900-2003
# Development of Life expectancy

<table>
<thead>
<tr>
<th>Country</th>
<th>1960-64</th>
<th>Average</th>
<th>2000-2003/04</th>
<th>Average</th>
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</tr>
<tr>
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<tr>
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<td>78.1</td>
<td></td>
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<td>73.6</td>
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<tr>
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<td></td>
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<td>78.7</td>
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<td>France</td>
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<td></td>
<td>79.4</td>
<td></td>
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<td>79.8</td>
<td>79.7</td>
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<td>Spain</td>
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<td></td>
<td>79.6</td>
<td></td>
</tr>
<tr>
<td>England/Wales</td>
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<td>78.6</td>
<td>77.9</td>
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<tr>
<td>USA</td>
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<tr>
<td>Japan</td>
<td>69.0</td>
<td>69.0</td>
<td>81.7</td>
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</tbody>
</table>
## Variability in age of deaths >10 (S10)

<table>
<thead>
<tr>
<th>Country</th>
<th>1960-69</th>
<th>Average</th>
<th>2000-03/04</th>
<th>Average</th>
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<tbody>
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<td>Denmark</td>
<td>13.65</td>
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<td>13.73</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>14.25</td>
<td></td>
<td>14.12</td>
<td></td>
</tr>
<tr>
<td>Iceland</td>
<td>14.76</td>
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<td>13.44</td>
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</tr>
<tr>
<td>Belgium</td>
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<td></td>
<td>14.10</td>
<td></td>
</tr>
<tr>
<td>West Germany</td>
<td>14.10</td>
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<td>13.75</td>
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</tr>
<tr>
<td>France</td>
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<td>14.79</td>
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</tr>
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<td>Spain</td>
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<tr>
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<tr>
<td>USA</td>
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<td></td>
</tr>
<tr>
<td>Japan</td>
<td>14.41</td>
<td>14.41</td>
<td>13.80</td>
<td>13.80</td>
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</table>
“Generally speaking, for the life expectancy of a population to improve, it is better to have wider coverage or universal access to care, than to have more generous benefits, which are channelled to a limited circle of citizens. The very same story is told by pension take-up rates: it is better to give decently to all than lavishly to few.”

Specific policies I – Sanitation reforms in Stockholm 1878-1925

- Combination of structural changes (water pipes, sewers) and life-style changes
- Combination of education and rather repressive policies (hygienistic propaganda and hygiene control by "health police")
- Policies often initiated by NGO:s, later incorporated into state or municipal policies
- Most improvements and interventions were implemented universally and not in a targeted way – lower social classes benefited to a greater extent in the long run
Figure 5. Diarrhoea mortality rates among children <2 years by social class, Stockholm 1878-1925
Figure 6. Overall child mortality rates among children <2 years by social class, Stockholm 1878-1925
Specific policies II – alcohol control policies with popular support

- Drinking a social problem, not least for women and children of drinking men
- Temperence movements with strong support, intermeshed with other movements
- Control measures: minimize private interests, high prices, low physical availability – combined with personal sales control and alcohol-specific social controls (1930s-50s)
- Recent liberalisations has brought increased consumption
Preliminary conclusions

- The importance of data availability for monitoring and policymaking
- The importance of an interplay between central state and local actors/authorities
- The importance of policies directed towards infants, children and youth
- The importance of combined approaches; structural change and control
- The importance of universalism
Final remarks

- The Nordic model; Welfare state institutions aim at breaking dependencies, improving opportunities for freedom.
- It should be possible to learn from Nordic examples even if historical circumstances are different.
- The Nordic way is not the only way to good public health, but may provide an alternative.
- Together with other types of experiences it may at least help to avoid poor policy options.
THE NORDIC EXPERIENCE
WELFARE STATES AND PUBLIC HEALTH
I. Nordic welfare states and public health

- The Nordic Model
  - The historical formation of a Nordic social policy model
  - Contemporary Nordic welfare states

- Public Health
  - The development of public health
  - The present state

- Health inequalities
  - Size, shape and development in Nordic countries and elsewhere
II. Specific policy areas and public health, examples

- Family policy and child mortality
- Poverty reduction, income transfers and health
- Pension system and the health of elderly people
- Alcohol policies
- Reproductive health
- Working life and labour market regulation
- Health care and dental care systems
III. Overarching themes and general issues

Introductory:
- A general model of welfare state institutions and their public health impact
- Methodological issues - what counts as evidence?

Thematic:
- Gender, the welfare state and health
- Income redistribution and health - income inequality or conditions among the poorer?
- Lessons to be learned from transitional countries – the Nordic experience applied

Concluding:
- How can the Nordic experience be applied to other countries?
## Ranking of countries by degree of inequality

**Men, 45-65 år**

<table>
<thead>
<tr>
<th>Relative differences</th>
<th>Absolute differences</th>
<th>Absolute level, workers</th>
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<tbody>
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<td><strong>Country</strong></td>
<td><strong>RR</strong></td>
<td><strong>Country</strong></td>
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<td>1,33</td>
<td>Norway</td>
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<td>Spain</td>
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<td>Irland</td>
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<td>Denmark</td>
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<tr>
<td>Sweden</td>
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<td>England &amp; Wales</td>
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<tr>
<td>England &amp; Wales</td>
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<td>Irland</td>
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<td>Finland</td>
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<td>Finland</td>
</tr>
<tr>
<td>France</td>
<td>1,70</td>
<td>France</td>
</tr>
</tbody>
</table>

Source: Kunst et al SS&M 1998;46:1459
**HDI, income inequality and life expectancy**

<table>
<thead>
<tr>
<th>Country</th>
<th>HDI rank</th>
<th>Gini index</th>
<th>Life exp</th>
</tr>
</thead>
<tbody>
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<td>77,1</td>
</tr>
<tr>
<td>Finland</td>
<td>13</td>
<td>26,9</td>
<td>78,4</td>
</tr>
<tr>
<td>Iceland</td>
<td>2</td>
<td>--</td>
<td>80,6</td>
</tr>
<tr>
<td>Norway</td>
<td>1</td>
<td>25,8</td>
<td>79,3</td>
</tr>
<tr>
<td>Sweden</td>
<td>6</td>
<td>25,0</td>
<td>80,1</td>
</tr>
<tr>
<td>UK</td>
<td>15</td>
<td>36,0</td>
<td>78,3</td>
</tr>
<tr>
<td>USA</td>
<td>10</td>
<td>40,8</td>
<td>77,3</td>
</tr>
<tr>
<td>Brazil</td>
<td>63</td>
<td>59,3</td>
<td>70,3</td>
</tr>
</tbody>
</table>
Infant mortality in EU countries, 2003

Source: Eurostat
Remaining LE at age 30 by education, women

Källa: SCB
Remaining LE at age 30 by education, men

[Graph showing trends in remaining life expectancy (LE) for men by education level from 1986 to 2002. The graph includes lines for Compulsory, Upper secondary, and Post-secondary education.]

Källa: SCB