Welfare for all—or only for the needy?

> "Die Medicin ist eine sociale Wissenschaft und die Politik ist weiter nichts als Medicin im Grossen (Medicine is a social science and politics is nothing but medicine at a larger scale)"
>
> *Rudolf Virchow 1821–1902*

Over a decade ago, an editorial in *The Lancet* voiced serious concern over the degree to which epidemiology had abandoned its traditional emphasis on issues of obvious importance to public health.[1] Journal papers were increasingly occupied with refining statistical methods to address individual risk factors on a biological and molecular level. Appealing as the potential of molecular epidemiology might be, the editorial argued, "the benefits have not been, and are unlikely to be, at the population level". The editorial called for a conscious effort to restore public health to epidemiology—by, for example, "reorienting its focus to global issues such as war, poverty, and environmental warming and to the social aspects of health and disease". Multidisciplinary cooperation and between-population studies were among a range of suggestions.

If this concern was a call for research with a broader scope and greater public-health relevance, the paper by Olle Lundberg and colleagues from the NEWS Nordic Expert Group in today's *Lancet* could be a long-awaited answer, although it comes not from epidemiologists but from social scientists.[2] Nonetheless, their extensive report[3] to WHO's Commission on Social Determinants of Health[4,5] borders on social epidemiology[6] and undoubtedly addresses a major public-health issue: is there any evidence to show that measures of health are related to welfare-state policies that are based on universal coverage, as in the Nordic countries? This question is not minor, because the alternative, targeted welfare for the needy, has been in vogue for some time, even on the Nordic scene. Lundberg analysed selected cross-national data from 18 countries of the Organisation for Economic Co-operation and Development (OECD) for infant and old-age mortality on an aggregate level to test the hypothesis that the design of welfare-state programmes and their level of generosity might affect these indices of population health.

The original NEWS report (The Nordic Experience: Welfare States and public health) is long, technically complicated, and might not attract a wide readership.[3] In the short version presented today, the authors have selected a few core questions, described their methods so that critical readers can challenge the results, and provided an interpretation which is bound to raise further debate: they show that universal coverage and increased generosity in family policies are associated with lower rates of infant mortality, and generosity in basic universal pensions is associated with lower excess mortality in old age when both are compared with targeted welfare for needy people.

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Readers may find it difficult to examine all the authors' decisions about sampling, comparisons, and adjustments for confounders. Furthermore, the differences in mortality rates among most OECD countries are no longer striking. Those in southern Europe with higher mortality rates during the post-war years have largely caught up with northern European countries, and Spanish and Italian women now top the world league of lifetime expectancy. Welfare-state regimes are obviously only one of many conditions affecting public health and longevity. But, in Lundberg and colleagues' paper, there was an association in favour of universal coverage, beyond the assumption that low levels of welfare generosity do affect mortality in outlier countries, such as New Zealand and the USA.

Lundberg and colleagues' paper does not explicitly address social inequalities in health and mortality within countries. The original report does, and shows that absolute levels of mortality in manual workers in Norway and Sweden are lower than in most other countries.[3] However, a much debated issue is that there

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Resident of Rost Island, Norway

is no consistent evidence for smaller relative inequalities in health between social groups within countries in northern Europe, despite their long history of egalitarian policies.[7] It has been suggested that a reasonable level of social security and income redistribution are necessary conditions to reduce inequalities in health, but not sufficient.[8] Lifestyle factors, such as strong social gradients in smoking, could contribute substantially to relative inequalities in mortality in the northern region.[7,9]

Universal welfare programmes and redistributive policies have traditionally been promoted by the labour movement and the political left, and for reasons that reach beyond health. At least in the Nordic countries, such policies have been as much about dignity and solidarity. Targeting of "the truly needy" may seem economically attractive, but implies stigmatisation and "more tests of the poor". Furthermore, economic research shows that universal welfare programmes might be more effective in achieving sustained alleviation of poverty because such programmes are more likely to retain political support among voters.[10] Several surveys show that the Nordic countries score high on indicators of social capital, especially generalised trust.[9] Economists seem puzzled by the fact that economies with high levels of taxation and a strong public sector do work quite dynamically: "the bumble bee can fly". There is already renewed interest within several disciplines in aspects of Nordic welfare models and Lundberg and colleagues' paper will probably encourage this approach.

Steinar Westin
Department of Public Health and General Practice,
Norwegian University of Science and Technology,
Medical Technical Research Centre, N-7489 Trondheim, Norway
steinar.westin@ntnu.no

I chair a National expert group on social inequalities in health appointed by the Norwegian Directorate for Health, and Olle Lundberg is one of its ten members.

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Sure Start Local Programmes in England

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A cornerstone of the UK Government's drive to tackle child poverty and social exclusion of children in deprived areas, Sure Start Local Programmes (SSLPs), has been in operation for almost a decade.[1] SSLPs are area-based interventions to improve services for young people and their families in deprived communities with the aim of promoting health and development and reducing inequalities. Services are provided by a partnership of health, education, social services, and voluntary sectors.

Edward Melhuish and colleagues, in today's *Lancet*, present their findings from a second-phase evaluation of SSLPs.[2] These researchers used a quasi-experimental observation study to compare over 5800 children aged 3 years and their families from 93 disadvantaged SSLP areas and over 1800 children of the same age and their families from 72 similarly deprived areas in England. Although the first-phase evaluation[3] had indicated small positive and negative effects, the authors now report several beneficial, and almost no negative, effects of the programme in children and families in SSLP areas. Families in those areas used more services for supporting child and family development than did non-SSLP families, showed less negative parenting, and provided a better home-learning environment. Children in SSLP areas showed better social development, more positive social behaviour, and greater independence than did those in non-SSLP areas. The new findings suggest that these initiatives are now, as the authors argue, moving in the right direction.