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The political context of social inequalities and health

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Abstract

This analysis reflects on the importance of political parties, and the policies they implement when in government, in determining the level of equalities/inequalities in a society, the extent of the welfare state (including the level of health care coverage by the state), the employment/unemployment rate, and the level of population health. The study looks at the impact of the major political traditions in the advanced OECD countries during the golden years of capitalism (1945–1980) — social democratic, Christian democratic, liberal, and ex-fascist — in four areas: (1) the main determinants of income inequalities, such as the overall distribution of income derived from capital versus labor, wage dispersion in the labor force, the redistributive effect of the welfare state, and the levels and types of employment/unemployment; (2) levels of public expenditures and health care benefits coverage; (3) public support of services to families, such as child care and domiciliary care; and (4) the level of population health as measured by infant mortality rates. The results indicate that political traditions more committed to redistributive policies (both economic and social) and full-employment policies, such as the social democratic parties, were generally more successful in improving the health of populations, such as reducing infant mortality. The erroneous assumption of a conflict between social equity and economic efficiency, as in the liberal tradition, is also discussed. The study aims at filling a void in the growing health and social inequalities literature, which rarely touches on the importance of political forces in influencing inequalities. The data used in the study are largely from OECD health data for 1997 and 1998; the OECD statistical services; the comparative welfare state data set assembled by Huber, Ragin and Stephens; and the US Bureau of Labor Statistics.

Keywords: Social inequalities; Health; Welfare state

Introduction: the importance of politics

A very important development in the social science and health literature over the last ten years has been a focus on how social inequalities are affecting the health of populations (for an extensive review of the literature in this area, see Kawachi, Wilkinson and Kennedy (1999); for a description of how these types of studies have not always been so "popular," see Navarro (1998a)). In this growing area of research, however, a subject rarely studied is the impact on social inequalities and health of political forces (such as political movements and parties) and the public policies they follow when in government. Indeed, a review of the latest literature on the relationship between social inequalities and health shows the dearth of references that either include or focus on political variables and their impact on health (Kawachi et al., 1999). This lack of attention to the importance of political variables also appears in the growing field of research on comparative international studies of health status. The state of Kerala in India, for example, has been widely studied, showing the relationship between its impressive reduction of inequalities in the last forty years and improvements in the health status of its population. With very few exceptions (Navarro, 1993; Cereseto & Waitzkin, 1986; see below), however, these reductions in social inequalities and

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improvements in health have rarely been traced to the public policies carried out by the state's governing party, the Indian Communist Party, which has governed in Kerala for the longest period during those forty years.

Similarly, we have seen several studies that refer admiringly to the developments occurring in the north-eastern regions of Italy in the last forty years, with active popular participation in the governance of these regions paralleling active policies of reducing social inequalities and discouraging hierarchical relations. These studies are silent, however, on a critical element: all those regions were governed by the Italian Communist Party, which was to a large degree responsible for such policies. (An example here is the otherwise excellent book by Wilkinson (1996).)

Some studies have included political variables to explain variations in health status, tracing the variations to different political configurations. Cereseto and Waitzkin (1986) have analyzed the health status and quality of life in capitalist countries and in countries they defined as socialist. And Navarro (1993) has analyzed changes in the health status of populations during the 20th century, comparing the performance of comparable countries under different political regimes. But these are exceptions. For the most part, the abundant literature on health status and health inequalities does not include many studies on the importance of political variants in shaping social inequalities and population health.

Our article aims at correcting this deficit. Its objective is to show the importance of political parties, and the policies they implement when in government, in determining the level of equalities or inequalities in a society and in explaining the level of health of its population. The article also analyzes the mechanisms by which these political influences take place and their social and health consequences in advanced countries of the OECD. Data for this study are largely from the OECD Health Data 98, an interactive database comprising systematically collated data on key aspects of the health care systems of the 29 OECD member countries within their general demographic, economic, and social contexts. Also used are data on political, economic, and social variables derived from the Comparative Welfare State Data Set assembled by Huber, Ragin and Stephens (1998); data on household income and wage differentials are extracted from the OECD Data Set (1997) and the US Bureau of Labor Statistics.

The major political regimes in developed capitalist countries

To show the importance of political forces in explaining social phenomena, including the level of inequalities and the health and well-being of populations, we have grouped the major developed capitalist countries according to the dominant type of political force that governed them during the time when their welfare states were established (from the end of World War II to the 1980 s): s*ocial democratic, Christian democratic* (or conservative parties within the Christian tradition), *liberal,* and *fascist* (the typology is adapted from Huber and Stephens (1998); see also Navarro (1999). The assignment of a country to a particular political tradition is based on the political orientation of parties that have governed either alone or as the major partner in a coalition for the greatest proportion of the time between 1945 and 1980. This period (1945–1980) was selected because, for most OECD countries, these were the years when welfare states were established and fully developed. It was in these expansive years, the golden years of capitalism, that the major characteristics of welfare states were shaped.

The social democratic tradition

In the first group — the social democracies — we include those countries (Sweden, Finland, Norway, Denmark, and Austria) that have been governed by social democratic parties (either alone or as the major party in a coalition) for the majority of years in the period 1945–1980 (Table 1). As the table shows, the social democratic parties governed for an average of 23.5 yr in these countries during that period.

In this group of countries, the labor movements and their socialist parties have been very strong, while the capitalist classes and the political parties they have chosen to represent their interests have been weak and usually fragmented (for an explanation of this situation, see Huber & Stephens (1998)).

Table 1 shows also how these countries have been characterized by high union density (percentage of the working population enrolled in unions), high social security expenditures (as percentage of GDP), high taxation (as percentage of GDP), and high public employment in health services, education, and welfare (as percentage of the working-age population). They have the most extensive welfare states.

Table 2 shows that (on average) the social democratic countries also had the largest public expenditures in health care during the period 1960–1990, followed by the Christian democratic countries. The liberal countries and the ex-fascist countries had, in general, the lowest public expenditures on health in that same period.

Table 3 shows that (on average) the social democratic countries covered almost the entire population with a public medical care program, while this coverage was lower, on average, in Christian democratic countries and even lower in liberal countries. The coverage in the ex-fascist countries, while low (during the fascist dictatorships, the lowest in all countries studied in this article), increased significantly during the democratic periods to

Table 1
Political characteristics, policy outcomes, and the welfare state (late 1970s)[a]

	Yrs of social democratic government, 1946–1980[b]	Yrs of Christian democratic government 1946–1980[b]	Union density[c]	Social pact[d]	Social security expenditures[e]	Total taxes[f]	Public employment in health, education, and welfare[g]	Redistributive effect of the state[h]	Women's participation[i]
Social democratic political economies									
Sweden	30	0	82	4	31	56	20	53	74
Norway	28	1	59	4	20	53	15	40	62
Denmark	25	0	70	3	26	52	18	39	71
Finland	14	0	73	3	17	36	9	35	70
Austria	20	15	66	4	21	46	4	-	49
Mean	23.5	3.2	70	3.6	23.2	48.8	13.2	41.8	65.2
Christian democratic political economies									
Belgium	14	19	72	3	21	43	7	47	47
Netherlands	8	22	38	4	27	53	4	41	35
Germany	11	16	40	3	23	45	5	38	51
France	3	4	28	1	25	45	9	35	54
Italy	3	30	51	2	20	33	5	29	39
Switzerland	9	10	35	3	13	33	7	19	54
Mean	7.8	16.7	43.9	3.0	21.6	41.8	6.2	34.8	46
Liberal Anglo-Saxon political economies									
Canada	0	0	31	1	13	36	4	25	57
Ireland	3	0	68	3	19	39	—	34	36
Great Britain	16	0	48	2	17	40	8	36	58
United States	0	0	25	1	12	31	5	26	60
Mean	4.7	0.0	43.0	1.8	15.2	36.5	5.7	30.3	52.8
Conservative or fascist dictatorships									
Spain	0	3	0	0	9	18	3	15	28
Greece	0	2	0	0	6	16	2	18	24
Portugal	2	3	0	0	8	15	3	16	26
Mean	0.7	2.6	0	0	7.7	16.3	2.6	16.3	26

[a] Source: Huber and Stephens (1998). For conservative dictatorship countries, our own elaboration. For expansion of the description of the political economy of these countries, see Navarro (1999).

[b] Years in Cabinet, scored 1 per year, less for coalition (Huber & Stephens, 1998).

[c] Union density as percentage of the labor force.

[d] Scale of 1 to 4 used to measure social pact (Huber & Stephens, 1998).

[e] Social security as percentage of GDP.

[f] Total taxes as percentage of GDP.

[g] Public employment in health, education, and welfare as percentage of working-age population.

[h] Percentage reduction of income inequality affected by direct taxes and transfer payments.

[i] Percentage of working-age women in the labor force.

Table 2
Public expenditures on health, percent of GDP, 1960–1990[a]

	1960	1970	1980	1990
Social democratic				
Austria	3.0	3.4	5.3	5.3
Sweden	3.2	6.1	8.7	7.9
Denmark	3.2	5.2	7.7	7.1
Norway	2.3	4.1	5.9	6.5
Finland	2.1	4.2	5.1	6.5
Mean	2.8	4.6	6.5	6.7
Christian democratic				
Belgium	2.3	5.0	5.5	6.9
Germany	3.2	4.6	7.0	6.7
Netherlands	1.3	5.0	5.9	6.1
France	2.4	4.3	6.0	6.6
Italy	3.0	4.5	5.6	6.3
Switzerland	1.9	3.1	4.6	5.7
Mean	2.4	4.4	5.8	6.4
Liberal				
United Kingdom	3.3	3.9	5.0	5.1
Ireland	2.9	4.3	7.1	4.9
United States	1.3	2.7	3.9	5.1
Canada	2.3	5.0	5.5	6.9
Mean	2.4	3.9	5.3	5.5
Ex-fascist				
Spain	—	2.4	4.4	5.7
Portugal	—	—	—	—
Greece	—	—	3.1	3.5
Mean	—	2.4	3.8	4.6

[a] Source: OECD Health Policy Unit (1998).

Table 3
Coverage: total public medical care, percentage of population, 1960–1996[a]

	1960	1970	1980	1990	1996
Social democratic					
Austria	78.0	91.0	99.0	99.0	99.0
Sweden	100.0	100.0	100.0	100.0	100.0
Denmark	95.0	100.0	100.0	100.0	100.0
Norway	100.0	100.0	100.0	100.0	100.0
Finland	55.0	100.0	100.0	100.0	100.0
Mean	85.6	98.2	99.8	99.8	99.8
Christian democratic					
Belgium	58.0	97.8	99.0	97.3	99.0
Germany	85.0	88.0	91.0	92.2	92.2
Netherlands	71.0	86.0	74.6	70.7	72.0
France	76.3	95.7	99.3	99.5	99.5
Italy	87.0	93.0	100.0	100.0	100.0
Switzerland	74.0	89.0	96.5	99.5	100.0
Mean	75.0	91.6	93.4	93.2	93.8
Liberal					
United Kingdom	100.0	100.0	100.0	100.0	100.0
Ireland	85.0	85.0	100.0	100.0	100.0
United States	20.0	40.0	42.0	44.0	45.0
Canada	71.0	100.0	100.0	100.0	100.0
Mean	69.0	81.3	85.5	86.0	86.3
Ex-fascist					
Spain	54	61	99	99.8	99.8
Portugal	18	40	100	100	100
Greece	30	55	100	100	100
Mean	34	52	99.7	99.9	99.9

[a] Source: OECD Health Policy Unit (1998).

a high level, primarily because of the social democratic governance during these periods.

The social democratic parties governing these countries were also characterized by their implementation of (1) *full-employment policies*, which explains their low unemployment (the lowest in these OECD countries during the period 1945–1980) (Table 4), and (2) *universalistic social policies*, aimed at covering the whole population. Table 3 shows, for example, how health care benefits coverage includes the entire population.

Such policies have used the social services of the welfare state (health, education, and family supportive services such as child care and domiciliary services) as a means of creating employment and facilitating the integration of women into the labor force — which explains the high rate of female employment (Table 1) in these countries. The social democratic countries have had a very large percentage of the adult population working in the labor market, a consequence of the high rate of women's participation in the labor force, in particular in the social services of the welfare state. The exception here is Austria, where a Catholic tradition emphasizing the family (rather than the state) as the primary provider of services to children and the elderly has kept women out of the labor force. This also explains the very low percentage — 4 percent — of the working-age population in Austria employed in the social services of the welfare state, compared with 20 percent in Sweden, 18 percent in Denmark, and 15 percent in Norway. There is a clear relationship between the size of these sectors and the percentage of women in the labor force. This explains why the percentage of the working-age population employed in the social services of the welfare state and the percentage of women who are working are lower in Christian democratic countries (6.2 percent and 46 percent, respectively), and much lower in ex-fascist countries (2.6 percent and 26 percent, respectively), than in social democratic countries (13.2 percent and 65.2 percent, respectively).

It is also the social democratic countries that have smaller household income inequalities (Table 5), larger supportive services for families (such as child care services and domiciliary services for the elderly and disabled), and lower poverty rates for the overall population and for children (Table 5).

Why do the social democratic countries have the lowest household income inequalities? To answer this

Table 4
Economic growth and unemployment[a]

	Economic growth				Unemployment					
	1960–1973	1974–1979	1979–1989	1989–1995	1960–1973	1974–1979	1980–1988	1990	1993	1995
Social democratic political economies										
Sweden	3.4	1.5	1.8	−0.1	1.9	1.9	2.5	1.6	8.2	7.7
Norway	3.5	4.3	2.3	2.9	1.0	1.8	2.5	5.2	6.0	4.9
Denmark	3.6	1.6	1.8	1.6	1.4	6.0	8.1	8.3	10.7	7.0
Finland	4.5	1.8	3.2	−1.1	2.0	4.6	5.3	3.6	17.9	17.1
Austria	4.3	3.0	2.0	1.3	1.7	1.6	3.3	3.2	4.2	3.8
Mean	3.9	2.4	2.2	0.9	1.6	3.2	4.3	4.4	9.4	8.1
Christian democratic political economies										
Belgium	4.4	2.1	1.8	1.3	2.2	5.7	11.5	8.8	12.0	12.9
Netherlands	3.6	1.9	1.1	1.8	1.3	5.0	10.0	7.5	6.7	7.1
Germany	3.7	2.5	1.7	1.3	0.8	3.4	6.7	6.2	7.9	8.1
France	4.3	2.3	1.6	0.8	2.0	4.6	9.0	9.1	11.7	11.5
Italy	4.6	3.2	2.4	1.1	5.3	6.3	9.1	10.5	10.6	12.0
Switzerland	3.0	−0.1	1.7	−0.5	0.0	0.4	0.6	0.5	3.8	3.3
Mean	3.9	2.0	1.7	1.0	1.9	4.2	7.8	7.1	8.7	9.2
Liberal Anglo-Saxon political economies										
Canada	3.6	2.9	1.8	−1.0	5.0	7.2	9.5	8.1	11.2	9.5
Ireland	3.7	3.3	2.7	5.8	5.2	7.6	14.2	13.7	15.6	12.1
Great Britain	2.6	1.5	2.2	0.7	1.9	4.2	9.9	5.4	10.2	8.6
United States	2.6	1.4	1.5	0.9	5.0	7.0	7.8	5.6	6.8	5.5
Mean	3.1	2.3	2.1	1.6	4.3	6.5	10.3	8.2	11.0	8.9

[a] Source: Adapted from Huber and Stephens (1998, Tables 2 and 3).

question, we need to understand the primary reasons for income inequalities in a country: (1) the percentage of national income that goes to capital versus labor, (2) the wage dispersion within labor, and (3) the redistributive effect of state interventions, i.e., changes in disposable income of households and individuals as a result of adding transfers from the state and subtracting income paid in taxes and fees to the state.

The social democratic countries have (1) the lowest percentage of national income derived from capital and the highest derived from labor; profits derived from ownership of capital have historically tended to be the lowest among the countries under study (Table 6); (2) the lowest wage disparities within the labor force (Table 6); and (3) the highest redistributive effect of the state (Table 1).

It is important to note that although wage differentials in social democratic countries (2.24 in 1990) were lower than those in Christian democratic countries (2.56 in 1990), they were not much different (Table 6). The household income inequalities in social democratic countries (2.79), however, were much lower than those in Christian democratic countries (3.14) as a result of the much more favorable treatment of capital and lower redistributive effect of the state in the Christian democratic countries (Table 5).

We should also mention that while income derived from capital was lower in social democratic countries than in Christian democratic countries (Table 6), the rate of investment, measured by gross fixed capital formation as percentage of GDP (Table 6), and economic growth (Table 4), were higher than in the Christian democratic and liberal countries. Only during the years 1989–1995 was the rate of economic growth of the social democratic countries lower, on average, than that of the Christian democratic and liberal countries. These empirical data question the assumption made by the Christian democratic and liberal parties that public policies favoring income derived from capital and high-income groups are required to stimulate investment and economic growth. Tables 4 and 6 show otherwise. Rather than inequalities being a requirement for growth (as classical economics maintains), the *reduction* of such inequalities has been a precondition for economic efficiency and economic growth (for an expansion of this point, see Navarro (1998b)). *These social democratic countries have also been the countries with the lowest infant mortality rates* (Table 7) *during the period 1960–1996*.

It is not the purpose of this article to analyze the pathways by which reduction of income inequalities affects infant mortality rates. But our data show that the

Table 5
Household income and poverty

	Household income inequality relative to national median incomes, ratio 90th to 10th percentile[a]	Poverty rate (% population)[b]	
	1990–1991	Total	Children
Social democratic political economies			
Sweden	2.78	6.7	3
Denmark	2.86	7.5	5.1
Norway	2.80	6.6	4.9
Finland	2.75	6.2	2.7
Mean	2.79	6.75	3.92
Christian democratic political economies			
France	3.48	7.5	7.4
Germany	3.21	7.6	8.6
Belgium	2.79	5.5	4.4
Netherlands	3.05	6.7	8.3
Italy	3.14	6.5	10.5
Mean	3.14	6.7	7.84
Liberal Anglo-Saxon political economies			
United States	5.78	19.1	24.9
Canada	3.90	11.7	15.3
UK	4.67	14.6	18.5
Ireland	4.18	11.1	13.8
Mean	4.63	14.25	18.1
Ex-fascist			
Spain	4.4	10.4	12.8

[a] Source: Mishel, Bernstein and Schmitt (1999).
[b] Smeeding (1997).

political forces that have been more successful in reducing income inequalities, such as the social democratic parties, have also been more successful in reducing infant mortality rates. The policies in the social democratic countries resulted from the strength of the labor movements, which, in alliance with other sectors and classes (rural farmers in Northern Europe and the middle class in Austria), have been the major force behind the reduction of inequalities and, consequently, the declines in infant mortality rates. It is important to stress that even in countries, such as Italy, that have not been governed by social democratic forces, those regions of the country that have been governed by parties following social democratic policies of reducing inequalities and creating employment, such as the ex-Italian Communist Party (today the Left Democratic Party), have had lesser inequalities and better mortality indicators than other regions. The regions of northern Italy — Tuscany and Piedmont, for example — mentioned in Wilkinson's (1996) book *Unhealthy Societies* were governed by Communist parties following social democratic policies. Explaining the reduction of mortality rates in these countries (and regions) in terms of specific interventions (such as higher popular participation in civil and political societies or other types of interventions) is insufficient. Rather, it is part of a larger set of related interventions guided by a political party or parties (socialist, social democratic, communist, labor, or whatever name is used to define these labor-oriented social democratic parties) that generate and reproduce a culture of solidarity and opportunity. Attempts to disaggregate these collective responses into their different components ignore the Hegelian dictum that the totality is more than the sum of its parts. *These data seem to allow the conclusion, therefore, that to reduce income inequalities and infant mortality, it is advisable to support labor-based social democratic parties.*

The Christian democratic tradition

In this group we include countries that from 1945 to 1980 were governed for long periods by conservative parties based in the Christian tradition — parties that define themselves as Christian democratic and those that, while not defining themselves in this way, consider themselves based in the Christian tradition. These countries (Belgium, the Netherlands, Germany, France, Italy, and Switzerland) form the least homogeneous group of all the countries considered here — a consequence of Christian democratic parties having to govern in coalition with other parties, including social democrats (as in Belgium, Germany, and the Netherlands). But despite the party alliances and coalitions in these countries, the conservative parties of Christian tradition were either the dominant forces in the coalitions or were the parties governing for greater lengths of time in the 1945–1980 period (Table 1), and this is what explains their common characteristics.

First, the Christian democratic countries rely primarily on the family for the provision of social services to the elderly, the disabled, and children. Families in these societies have been burdened with caring work that in the social democracies is the responsibility of the state and in the liberal countries the responsibility of the market. This extra burden on the family in Christian democratic countries explains the very low rate of women's participation in the labor force (Table 1): only 46 percent of women participate in the labor market, compared with 65.2 percent in social democratic and 52.8 percent in liberal countries. Only the former fascist countries (Spain, Greece, and Portugal) have a lower percentage of women in the labor force (26%). In the Christian democratic countries, class inequalities have been compounded by large gender inequalities, including gender inequalities in health. Spain's government commission on inequalities in health (the Spanish equivalent of the Black Commission) found, for example, that in the 30- to 50-yr age group, women have twice as many stress-related conditions as men (Navarro & Benach, 1996). In fact, women in this group

Table 6
Total profits and gross fixed capital formation, 1960–1989[a]

	Operative surplus (corporate profits, including state enterprises) and profits from unincorporated business (including earnings of self-employed persons), % of national income			Wage inequality[b]		Gross fixed capital formation, % of GDP		
	1960–1973	1974–1979	1980–1989	1980	1990	1960–1973	1974–1979	1980–1989
Social democratic political economies								
Sweden	21	15	17	2.04	2.21	23	21	19
Norway	27	20	27	2.06	—	28	33	25
Denmark	30	24	24	2.14	2.18	24	22	17
Finland	32	24	22	2.46	2.34	25	27	24
Austria	30	23	24			27	26	24
Mean	28.1	21.4	22.8	2.17	2.24	25.6	25.9	21.8
Christian democratic political economies								
Belgium	34	25	29	—	2.07	22	22	18
Netherlands	32	25	29	—	2.59	24	21	20
Germany	30	23	23	2.69	2.32	25	21	21
France	32	25	24	3.24	3.06	24	24	20
Italy	41	28	40	2.94	2.80	25	24	21
Switzerland	31	38	23			28	23	25
Mean	33.3	27	28	2.95	2.56	24.4	22.4	20.8
Liberal Anglo-Saxon political economies								
Canada	26	25	26	4.01	4.20	22	24	21
Ireland	31	30	33	—	—	20	26	20
Great Britain	21	24	20	2.79	3.37	18	19	17
United States	25	32	21	3.65	4.43	18	19	17
Mean	25.7	27.8	25	3.48	4.00	19.4	21.9	18.8

[a] Source: Adapted from Huber and Stephens (1998, Table 4).
[b] The ratio of the earnings of the 90th percentile of workers to those of the 10th percentile of workers.

Table 7
Infant mortality (death/1000 live births), 1960–1996[a]

	1960	1970	1980	1990	1996
Social democratic					
Austria	37.5	25.9	14.3	7.8	5.1
Sweden	16.6	11.0	6.9	6.0	4.0
Denmark	21.5	14.2	8.4	7.5	5.2
Norway	18.9	12.7	8.1	7.0	4.0
Finland	21.0	13.2	7.6	5.6	4.0
Mean	23.1	15.4	9.1	6.8	4.5
Christian democratic					
Belgium	31.2	21.1	12.1	8.0	6.0
Germany	33.8	23.6	12.6	7.0	5.0
Netherlands	17.9	12.7	8.6	7.1	5.2
France	27.4	18.2	10.0	7.3	4.9
Italy	43.9	29.6	14.6	8.2	5.8
Switzerland	21.1	15.1	9.1	6.8	4.7
Mean	29.2	20.1	11.2	7.4	5.3
Liberal					
United Kingdom	22.5	18.5	12.1	7.9	6.1
Ireland	29.3	19.5	11.1	8.2	5.5
United States	26.0	20.0	12.6	9.2	7.8
Canada	27.3	18.8	10.4	6.8	6.0
Mean	26.3	19.2	11.6	8.0	6.4
Ex-fascist					
Spain	43.7	26.3	12.3	7.6	5.0
Portugal	77.5	55.1	24.3	11.0	6.9
Greece	40.1	29.6	17.9	9.7	7.3
Mean	53.8	37.0	18.2	9.4	6.4

[a] Source: OECD Health Policy Unit (1998).

Table 8
The overburdening of families (especially of women)[a]

	Percent of elders living with children	Percent of adolescents living with parents	Weekly hrs. of household work (by women)
Northern European countries			
Denmark	4	8	24.6
Norway	11	—	31.6
Sweden	5	—	34.2
Southern European countries			
Italy	39	81	45.4
Spain	37	63	45.8
Other countries			
United States	15	28	31.9
Great Britain	16	35	30
Japan	65	—	33

[a] Source: Adapted from Esping-Andersen (1999, Table 4.3, p. 63).

suffer more stress-related conditions than any other group in Spain. Table 8 shows, for example, the number of hours that women work at home in Spain and Italy, versus those in Denmark, Sweden, and the US. Women in southern European countries work much longer hours than those in northern Europe.

The second characteristic shared by the Christian democratic countries is the heavy reliance of families' standard of living on the salary and pension of the male breadwinner, considered the head of the family. This explains the enormous importance given by the labor movements of these countries to both maintaining and expanding wages and expanding social transfers (in particular, pensions) as a way of assuring families' standard of living. Thus these countries have large social transfers and underdeveloped social services. As Table 1 shows, the average level of social expenditures in the Christian democratic countries (21.6 percent of GDP) is lower than that in the social democratic countries (23.2 percent of GDP), although much higher than that in the liberal countries (15.2 percent of GDP). The same table also shows that only 6.2 percent of the working-age population was employed in services in the Christian democratic countries, compared with 13.2 percent in the social democracies. And the Christian democratic countries have lower public expenditures on health (Table 2) and a lower degree of health benefits coverage than the social democratic countries, although higher than in the liberal countries.

The relatively large social expenditures in the Christian democratic countries required relatively large fiscal revenues (41.8 percent of GDP), lower than in the social democratic countries (48.8 percent of GDP) but much higher than in the liberal countries (36.5 percent of GDP).

The labor movement in the Christian democratic countries has been weaker than that in the social democratic countries, which explains the following situations: (1) *Income derived from capital represented a much larger percentage of the national accounts than in the social democratic countries* (Table 6). (2) *Unemployment was higher than in the social democratic countries for most of the years 1945–1980* (Table 4). (3) *Wage disparities were larger than in the social democratic countries* (Table 6). (4) *The redistributive effect of the state was lower than in the social democratic countries* (Table 1). *Poverty in general and among children was also greater in Christian democratic than in social democratic countries. These are the causes of the greater household inequalities* (Table 5) *and worse infant mortality* (Table 7) *in the Christian democratic countries.*

Former fascist dictatorships in southern European countries (1945–1975)

In these countries (Spain, Greece, and Portugal) fascist regimes governed for the entire 1945–1980 period or for most of that time. These were class dictatorships

against the working and popular classes. There has been interest recently in defining such regimes as *caudillistas*, regimes based on the personal power of a *caudillo* or clan, rejecting their class character (for a good critique of this position, see Pearson (1998)). However, an analysis of the nature of the state in these three countries during that period, of its repressive nature and its social and fiscal policies, reveals its class character. Fascism was a class response by the land-based oligarchies and other sectors of capital, including financial capital, to the threat of the growing power of the working class, expressed through democratic institutions — which those dictatorships disrupted. The class character of the fascist regimes was clearly evident in (1) the highly repressive nature of the states, a repression directed primarily at the working class; (2) the most regressive fiscal policies in existence in Europe at that time; and (3) the underdeveloped welfare states. In Spain in 1960, for example, public expenditures on health and education amounted to only 60 percent of the spending on the armed police forces (UNDP, 1992). And in 1980, social expenditures in Spain (9 percent of GDP) were much lower than in the Christian democratic countries (21.6 percent of GDP). During the fascist periods, the public medical care expenditures and the level of public medical care coverage were the lowest among the countries under study. And the percentage of the working population employed in services (2.6 percent) was much lower than in the Christian democratic (6.2 percent) and social democratic (13.2 percent) countries.

It was in the former fascist countries that labor was weakest. While much has been done since the democracies have been established (primarily by social democratic parties) to correct the underdevelopment of the welfare states and to reduce the large income inequalities, these countries still have the greatest income inequalities in the EU. This results from the very large percentage represented by capital in the national accounts, the very large wage disparities, and the small redistributive effect of the state. These countries were heavily influenced by Catholic teachings that relied on women for the care of family members. They did not have supportive services for families, and poverty among children was very high. These countries also had high infant mortality rates during the 1945–1980 period, when they were governed by fascist regimes for the longest times. In all these countries, income inequalities were reduced, the welfare state expanded, women's participation in the labor force expanded, and infant mortality reduced during the democratic periods.

The liberal countries

This group (the US, Canada, Ireland, and Great Britain) consists of the Anglo-Saxon countries where labor has been particularly weak and the capitalist class particularly strong. With the partial exception of Great Britain, social democratic parties have never governed at the national level (the US and Canada) or, if they have, have done so for only short periods; they have been governed for the most part by parties clearly committed to a full expression of market forces, with as little interference from the state as possible. Some readers may be surprised that we have included Great Britain in this group, since the Labour Party governed for as long as 14 yr in the period 1960–1980. We have done so — following Huber and Stephen's typology — because Great Britain has more similarity with this group of countries than with the Christian democratic or social democratic countries. The British welfare state, for example, is not fully universal or comprehensive — with the exception of the National Health Service (defined by Churchill as the jewel in the British crown) — and has a relatively low level of social expenditures. Canada also has a universal national health program. Both countries, however, share with the other liberal countries the residual and assistential nature of the welfare state. *Benefits are provided based on proven financial need (means-tested programs) rather than on citizenship alone (as in social democracies) or on workers' rights (as in the Christian democracies)*. As Table 2 shows, the liberal countries also have, after the ex-fascist countries, the lowest public expenditures on health care, and the lowest coverage by public medical care (with the exception of Britain and Canada).

In all these liberal countries, social transfers by the welfare state are supplemented by benefits acquired through the labor market through collective bargaining, with public social expenditures concentrated on the needy (need being defined by political-administrative criteria). Welfare functions are assigned to the private sector, with the state covering only the minimum. Wages tend to be low, requiring involvement of all family members in the labor force; this explains the large percentage of employed women in the liberal countries (with the exception of Ireland, whose Catholic tradition emphasizes a reliance on the family, and which thus has a lower percentage of women in the labor force). The integration of women into the labor force in the liberal countries is facilitated by an extensive, privatized personal and social services sector, the size of which is made possible by very low wages and low social protection — characteristics responsible for the marked social polarization in these societies.

In the liberal countries, the market reigns supreme. Capital has the strongest influence, labor the weakest. Inequalities are largest in these countries. Income derived from capital is the largest, wage disparities the most accentuated, and the state the least redistributive (only the fascist states were less redistributive). Tables 5 and 7 show how the liberal countries have the largest income differentials and the lowest rates of improvement

in infant mortality rates. This group includes the country with the highest infant mortality — the US (Table 7).

Conclusions

The empirical information provided in this study allows several conclusions. First, political variables such as the political party in government (either alone or as a majority partner in a coalition) for longer periods of time are important in influencing a country's level of income and social inequalities and its health indicators such as infant mortality. Second, these political forces represent the interests of classes and other social forces with different interests in redistributive policies. Third, the labor movements and the social democratic parties that have governed as a majority for long periods since World War II have generally been the most committed to redistributive policies, contributing to better health indicators such as lower infant mortality rates. Fourth, and conversely, countries with weaker labor movements and social democratic parties and stronger capitalist classes, such as the liberal Anglo-Saxon countries, have had a weaker commitment to redistributive policies and worse health indicators. Finally, the Christian democratic parties (or conservative parties rooted in the Christian tradition) have made a compromise, with redistributive policies that are weaker than in the social democracies but stronger than in the liberal countries. The Christian democratic parties have emphasized the key role of the family rather than the state (as in the social democratic tradition) or the market (as in the liberal tradition) in the care of children and the elderly, overburdening families (especially women) with these tasks.

Our conclusions need to be qualified of course. This is an introductory study. We hope it will stimulate much needed research on the relationship between political forces and health. For instance, it would be interesting to use the typology presented in this paper to analyze countries that, for specific periods, do not seem to fit the type; such atypicality calls for an expansion of the study to better explore its causes. Also, further study is required on the possible impact of a "dose-response" effect of the length of time a particular party was in power — that is, possibly a more direct causal relationship between time in government, either alone or in coalition, and reduction of inequalities and improvements in health. Also requiring further study are "mixed cases" in which the balance of forces within government may have had different effects on redistributive policies. Belgium and the Netherlands, for example, with conservative governments of the Christian tradition during most of the period 1945–1980, still have large social democratic parties. This explains, in part, their different redistributive intensity within the conservative and Christian democratic tradition compared with other countries in the same group. Comparative policy studies, such as this one, also need to be complemented by more traditional and equally informative case studies analyzing experiences and making evaluations country by country. These further areas of investigation could overcome some of the limitations of the present study, which cannot be resolved at this aggregate multi-country level.

We believe, however, that the study offers more than just pointers on the road to understanding the complex and highly sensitive (and extremely relevant) work on the relationship between politics, policy, and health. None other than Virchow, one of the founders of public health, wrote that politics is "public health in the most profound sense" (cited in Taylor & Rieger, 1985). The empirical information provided here already suggests to us to conclude that, for those wishing to optimize the health of populations by reducing social and income inequalities, it seems advisable to support political forces such as the labor movement and social democratic parties, which have traditionally supported larger, more successful redistributive policies than have the Christian democratic or liberal parties.

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