Letters to the Editor

The IEA Dictionary and who should be the editor

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Readers of the European Journal of Epidemiology will be aware of the debate this Journal started by inviting O. S. Miettinen to provide a review of our dictionary.1 Miettinen’s latest response in this debate is as always interesting reading, written in a hyped language that matches true novel pieces of writing in the scientific literature.2 It is partly English, partly Latin but mostly a fascinating use of familiar and unfamiliar words. Miettinen is alive and is doing fine.

Miettinen criticizes our (IEAs) choice of editors of the dictionary (John Last and now Miquel Porta) and he thinks it should be the drivers of the development of our discipline (Greenland and Robins are mentioned—Sander Greenland is actually an associate editor of the dictionary’s 5th edition), but then why not Miettinen himself? Was he too modest to suggest this although modesty is not one of his strongest personal characteristics?

We are pleased with the choices made by the IEA. The avant-garde in journalism or fiction inspires new ways of using language but they do not decide how the language is used. The users do that in an informal democratic way. Dictionaries have to reflect how language is used by listening to the users and by taking to consideration the inspirations from the front-runners. Miettinen will find plenty of Miettinen in the dictionary. We understand that he wants more, but editors of a dictionary have to balance actual use of words with new inventions. Both Last and Porta understand that they have to listen to many to reach a dictionary that is actually used. As written in the Foreword to the newest version of the dictionary (5th edition) ‘No dictionary will ever be able to satisfy all, nor should it try to’.

References


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Answer to the commentary: Politics and public health—some conceptual considerations concerning welfare state characteristics and public health outcomes

From A ESPELT,1,2 C BORRELL,1,3,4+ M RODRÍGUEZ-SANZ,1,3 C MUNTANER,5 MI PASARÍN,1,3,4 J BENACH,3,6 M SCHAAP,7 AE KUNST7 and V NAVARRO4,8

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We appreciate the detailed analysis of our paper1 by Olle Lundberg,2 including his criticisms, even though many are unfair and unwarranted. Lundberg takes us to task for emphasizing politics rather than policies in our quest to understand health outcomes. He also erroneously assumes that we ignore the context in
which politics occurs. He writes that Sweden and Austria, for example, have been governed by social democratic parties for long periods of time and yet have different welfare states, and he presents this as proof of how wrong it can be to take politics and years in government of a political party as a predictor of the type of welfare state or health outcomes. Moreover, he adds that welfare state regimes behave differently with respect to social transfers vs public services, and that this makes it difficult to determine the impact of politics on welfare states and health outcomes. Finally, Lundberg concludes that politics is of even less value when we try to understand health inequalities.

We are concerned that some of this criticism may be due to a deficient reading of our paper (for which we take some responsibility) and/or a limited acquaintance with our work. In any case, we have written extensively on the points he raises and are surprised that he seems to be unacquainted with this work. It is unfair, for example, to assume that we are making a one-to-one relationship between politics and health outcomes. A reading of some works that we cite in our article will show that we are fully aware of the context. Several of us have discussed, for example, how Austria and Sweden have different types of welfare states because social democrats governed for a long period of time with the Christian Democrats in Austria, which was not the case in Sweden. These different sets of alliances produced different welfare state policies, with larger participation of women in the labour force in Sweden than in Austria. We have also analysed how different political traditions shaped different public policies that affect health and welfare outcomes, and have quantified the statistical relationship between those policies and health outcomes. We concluded that, with some exceptions, political parties committed to redistributional policies are more successful in improving the health and welfare indicators of the majority of the population than are political traditions not sensitive to such redistributitional policies.

Also, several of us wrote recently and many years ago on how political traditions affect health and social services, not just social transfers. Here, we used as our reference the work of Walter Korpi and of Huber and Stephens, who took politics as the shaper of the welfare state. That politics does not explain everything is something we would agree on. But that politics (how power is expressed in representative institutions) is not so important, as Lundberg seems to posit, is a thesis we disagree with and have presented evidence to disprove. Not to consider politics in our analysis would be like attending to the symptoms rather than the causes of a disease. Moreover, ignoring politics is tantamount to accepting that democracy is irrelevant, and transforms democracy into technocracy. The evidence that politics matters appears constantly in our daily press. If we put politics aside, how can the dramatic changes in life expectancy in Russia be explained? Or the evolution of Cuban health indicators from the 1950s to the 1960s? Or the remarkable changes in Sweden under social democracy? Even in the United States, the significant changes in infant mortality under the Bush administration cannot be understood without considering politics (i.e. what class interests the Bush administration represents). Politics affects health outcomes through policies, of course. We do not disagree on this. But politics is the starting point. And our concern is that this dimension has been the least studied part of health policy research. A recent article described that approximately 10% of the variation of self-perceived health between European countries was associated to national welfare state characteristics.

Finally, we must express our disagreement with the conclusion that politics may be of limited interest in understanding reductions in health inequalities. In a previous study, several of us found a clear relationship between types of political tradition that govern a country (alone or in alliance with other parties), redistributive policies and health outcomes. In these studies, the dependent variable was health outcomes. More recently, we have studied the impact of political traditions on health inequalities. Espelt et al. paper is part of this study. Here the evidence is less robust, but does exist. Lundberg questions this, presenting data that compare manual with non-manual workers in various countries belonging to different political traditions. We find the data useful, and at the same time intriguing. We are not dismissive of the evidence that Lundberg presents. But we are more skeptical than he is about using differences between manual and non-manual workers as valid indicators of class differentials. Indeed, such a categorization has limited value since non-manual workers may include both highly paid administrative workers and very low paid unskilled workers. We need to improve our class categories in international comparative studies on social stratification. In our study, we used class categories that we believe are comparable. And we so for relative as well as absolute inequalities.

We do not want to leave the impression that we do not value Lundberg’s comments. We do. They will help us make sure we are clearer in future presentations of our work.

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Authors’ Response
Politics and public health—some conceptual considerations concerning welfare state characteristics and public health outcomes
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Espelt, Borell and colleagues make two substantial points in their answer to my commentary of their paper. First, they strongly argue that politics matter, second they claim that politics have to affect health through policies. On these points our views are in perfect agreement, and hence the discussion could end here. However, I would like to make a few more remarks on these issues, mainly because I believe that the research questions addressed by Espelt, Borell and their colleagues—the role of social policies in general for public health—are extremely important, not least in the light of the Commission on Social Determinants of Health (CSDH) report and its potential influence. But because of the importance of these issues, we also need to be careful when designing and interpreting our analyses.

First, our common starting point appears to be that different welfare states do operate differently, and that these differences may affect health and health inequalities. If we also agree that it is differences in welfare state institutions, policies and programmes that are the key mechanism on a societal level, then a logical consequence would be to undertake empirical analyses of these institutions and their characteristics directly. For example, analyses that we recently published suggest that the type and generosity of family support is linked to infant mortality. More precisely, greater generosity in family policies designed to support dual earner families were linked to lower infant mortality in 18 OECD countries between 1970 and 2000. This relationship is likely to be generated at least in part through variations in child poverty, but a range of mediating factors at