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Health, Wealth, and the Nordic Model Revisited

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The stubborn persistence of health inequalities in the otherwise egalitarian Nordic countries is a continual source of political and scholarly befuddlement. Both when it comes to morbidity and mortality outcomes, socially patterned health gaps keep gaping wide (Balaj et al., 2017; Eikemo, Bambra et al., 2008; Eikemo, Huisman et al., 2008; Institute of Health Equity, 2023; Mackenbach et al., 1997, 2008, 2018). Why have institutional constellations globally renowned for equalising life chances failed to address and redress unequal burdens of disease and death? Therborn (2013, pp. 132–137) goes as far as to rank this phenomenon among the top three 'inequality puzzles' of the twenty-first century. How can it be explained? And what does it tell us about the Nordic welfare model?

Existing Accounts

Several theoretical frameworks have been proposed and reviewed to account for this distinctive brand of egalitarian inequality (see Bambra (2011) and Mackenbach (2012, 2017, 2019) for detailed references). Some portray the seeming paradox as a mathematical or statistical artefact: the lowered background disease and mortality risk, it is said, that goes with secular improvements in population health inevitably produces relative inequalities. Others draw on fundamental cause theory (Link & Phelan, 1995) by emphasising opportunity hoarding at the top of the social order, whereby inequalities persist and increase over time. Related approaches highlight differential psychosocial stress and intergenerationally transmitted biological burdens. Others yet emphasise new social mobility dynamics that induce

selection on health and associated characteristics, such as cognitive ability and personality traits, yielding a social structure jointly stratified by social and biological properties. Some scholars have drawn attention to the socially differentiated adoption of health innovations whereby health-related technology and behavioural templates go to the top of the social order before gradually 'trickling down', yielding a long-run medical Kuznets curve. A final group of scholars has spotlighted 'cultural capital' and other non-material mechanisms of consumption and social distinction as being of growing importance for the shaping of unequal health behaviours.

Against this backdrop, Bambra (2011) suggests (*a*) that existing theories fall short of offering complete and cogent explanatory accounts, (*b*) that we may need to look beyond reified welfare state typologies to understand both differences and commonalities within and between entrenched analytical categories (see also Barnes et al. (2023)), and (*c*) that more emphasis on relative rather than absolute inequalities may shroud the big picture – which may simply be that Scandinavian welfare states are the victims of their success. The latter point further suggests that 'paradox' might be a misnomer because the Nordics perform well on health depending on the chosen inequality metric (Popham et al., 2013).

Dahl et al. (2014) and Dahl and van der Wel (2015) further dismiss the language of 'puzzle' or 'paradox' – but for the opposite reason. Insofar as social inequality is far from eradicated in the Nordics and may even have been amplified in recent years, they argue, there is no reason to believe that the social determinants of health have lost their causal efficacy. They point to stable patterns in the joint distribution of social resources and health outcomes over time, suggesting that levelling efforts have been less successful in Nordic countries than commonly believed. In this view, persistent health inequalities have a simple explanation: if the social determinants of health have not been levelled, why should health outcomes?

Recent calls have been made to move beyond the description of correlational relationships and use novel tools to shed fresh light on the matter. Friedman et al. (2021) argue that major societal disruptions like COVID-19 offer unique means by which we can assess how different social welfare systems are equipped to protect their populations from harm. This urgent task warrants additional research endeavours mobilising high-quality data and cutting-edge causal inference methods to offer rigorous and solution-oriented empirical insights. We draw on the extant literature to complement this view with five challenges that can guide future work.

A Fivefold Petition for Future Research

We argue that to revamp the scientific understanding of the relationship between the Nordic model and health – and thus to breathe fresh understanding into attendant 'puzzles' or 'paradoxes' – scholars should centre their research efforts on addressing five principal challenges – the first three of which are centred on empirics, the last two on concepts. Firstly, previous work has shown that education gaps correlate strongly with health gaps (Eikemo, Huisman et al., 2008). Moreover, qualification thresholds to enter the labour market have steadily risen, making it harder for those with low levels of formal education to access gainful employment (NOU, 2019:7). As labour markets have become more segmented, socially marginalised groups – when they do gain employment – find themselves mired in precarious, low-paid sectors bereft of serious prospects of upward mobility and outside the reach of collective bargaining agreements. This has led to a growing social underbelly – characterised by self-reinforcing precarity at the labour market periphery – to the 'standard' Nordic model, which is typically characterised by secure employment, coordinated collective

bargaining, high productivity, high wage floors, and positive wage growth (Alsos, Nergaard & Trygstad, 2019 Dølvik, 2013; Dølvik et al., 2015; Fløtten et al., 2014). In a society where education and work are the two major interlocking vectors of social mobility, life chances are seriously retrenched for the small minority effectively barred from long-run and upwardly mobile labour market access. Especially for disadvantaged youth with low levels of formal education and work experience who, for lack of competitive credentials, undergo prolonged spells of involuntary joblessness and benefit receipt, the distance to the rest of society becomes disproportionately large. It becomes a conduit for the layered accumulation of social disadvantage and accompanying health problems. Future research should, therefore, probe the mechanisms of such exclusionary closure and identify policy levers that can be targeted for undoing this growing dualisation.

Secondly, we encourage scholars to revisit material inequalities in the Nordic context and especially to take wealth inequality seriously. Although the Nordic income distribution remains relatively compressed by the distinctive wage formation model, wealth gaps are large and persistent – on par with other European countries – and constitute major fault lines in the Scandinavian context (Hansen & Toft, 2021). Future research should harness individual-level and cross-national wealth data to examine the pathways by which such wealth gaps may or may not map onto inequalities in health.

Thirdly, health inequalities are typically geographically patterned. In Norway's capital, Oslo, mortality gaps are firmly fastened onto administrative neighbourhoods dividing the city's east and west sides – and have been so for decades, with little change over time (Elstad, 2017; Nosrati, 2023). Taking this geographical anchoring into consideration emerges as an essential task for future research. The correspondence between social and physical space merits further investigation, and the mutual imbrication between multilevel – including place-based – causal forces is a source of continued social epidemiological interest.

Fourthly, we call special attention to the operationalisation of the very concept of 'inequality'. Balaj and Eikemo (2022) argue that for the Nordic health paradox to be rendered scientifically intelligible, constellations of social health determinants must be understood relationally and not in isolation from one another. In this view, a renewed analytic approach is required to grasp the complex interplay between (among other things) occupational factors, living conditions and lifestyle, and social ties and networks. In an extension of this line of argument, we propose, more generally, that a serious engagement with inequality – both as a theoretical concept and as empirical reality – is predicated on a substantively informed choice of 'focal variables' in relation to which both interpersonal and group-level comparisons can be meaningfully articulated. In other words, we invite scholars to render explicit the 'space' of relations within which persons and groups are to be compared (cf. Sen, 1992). Confining such a space to that of income or education is common, but analytically restrictive. Given the high-quality administrative data available in the Nordic countries, future research should seek to develop a more complete mapping of the space of social relations in which inequalities unfold and thereby empirically substantiate the complex configuration of causal forces at work in their making.

Finally, in the spirit of this special issue, we call for renewed attention to the institutional dynamics of Nordic capitalism. If institutional arrangements are important for the study of 'the causes of the causes', then we must study concrete institutions and the mechanisms by which they are meant to impact health and inequality (see Beckfield et al., 2015). There is a clear paucity of work that directly tackles such institutional mechanisms and how they might differ within and between welfare state categories. Despite a revived focus on the health consequences of modern capitalism (e.g., Case & Deaton, 2020), few scholars take

capitalism and its institutional infrastructure as a serious object of investigation. When they do, emphasis is invariably placed on the 'varieties' rather than on the 'capitalism' (Hall & Soskice, 2001). We hope that future work on the Nordic health paradox will examine the distinctive institutions of the social democratic project, their evolution over time, and the interplay between commodification and decommodification in the making, unmaking, and remaking of inequalities in health.

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