Jean Calvin, Calvinism, and population health: impressions from Switzerland

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Is religion still important for population health? As John-Paul Vader noted in his recent editorial in this journal, which accompanied the annual European Public Health Association meeting in Montreux, this is an under-researched question. And in an increasingly secularized continent like Europe the answer is certainly far from obvious. After the Montreux meeting I therefore decided to go to Geneva, the great city of the Reformations, as well as the ‘Mur de la Réformation’ which was erected in 1909 to commemorate the 400th anniversary of Calvin, the greatest of the Geneva Reformers.

Jean Calvin (1509–1564) was a French exile and follower of Martin Luther, who developed a specific doctrine which spread to parts of Germany, the Netherlands, and Scotland, and crossed the Atlantic to North America where many early settlers were Calvinists. The central issue of Calvinist theology is its view of salvation. By nature, no man is capable of doing anything good, God alone is the initiator of every stage of salvation, and God’s grace is entirely ‘predestined’: only those are saved whom God has chosen from eternity. Although this could have been interpreted as to discourage doing good works, the reverse was actually the case. For a Calvinist, constant labour is a sign of predestination and, a belief in ‘predestination’ went hand in hand with the ‘protestant work ethic’. According to Max Weber, this Calvinist ethic of hard work and refraining from personal luxury lay at the basis of the economic success of early capitalism in the North-Western part of Europe and the United States.

One of my own first studies of population health in the Netherlands dealt with regional variations in mortality. Since the late 19th century, various reports had indicated that mortality rates were higher among Roman-Catholics than among Protestants in the Netherlands, and this was confirmed by our study of mortality during the 1950s to 1980s. We found that mortality was consistently higher in those parts of the country which had remained predominantly Roman-Catholic, due to an accidental treaty line during the Dutch war of independence against the Spanish in the early 17th century. This association could not be explained by the slightly lower average income of Roman-Catholic areas, and although it gradually diminished over the decades was still clearly present in the early 1980s. We also found survey data indicating that Protestants smoked and drank less than Roman-Catholics, and more often fastened their seat-belts while driving their cars. We did not hesitate to ascribe this to Calvinist attitudes.

Unfortunately, opportunities for investigating the effect of religious denomination on health, adjusted for obvious confounders like other social and cultural factors, are rare. There are only a few countries where Protestants and Roman-Catholics live together more or less peacefully, and under more or less similar circumstances. Scotland, for example, another country where Calvinism has left deep traces, has both Protestants and Roman-Catholics but most of the latter are Irish or of Irish descent. These migrants were, and are, poorer than the host population, and their different ethnic and religious background gave rise to prolonged discrimination. Most of the elevated mortality and morbidity rates of Roman-Catholics in Scotland cannot be explained, it seems, by higher smoking or drinking rates. Northern Ireland is an even more difficult setting to study the association between religious denomination and health. If there is any effect of religion on mortality and morbidity in this country, this is likely to be completely overwritten by a history of political oppression and deprivation.

As a matter of fact, the ideal country for investigating the association between this particular religious contrast and health is Switzerland. Protestants and Roman-Catholics have lived peacefully together for centuries, in both French- and German-speaking parts of the country, so it should be feasible to do a thorough study of mortality and morbidity differentials. Furthermore, Swiss precision guarantees good statistics. It appears, however, that the most recent study looking into this dates back to the 1940s and early 1950s—when Roman-Catholics had a distinctly higher mortality rate. In view of the on-going secularization process an update of this historical study would be most welcome.

We live in a world where religion has become more, not less important for politics. Religion has again become a major source of conflict, both within and between countries. It is likely that religion will also remain an important factor in population health, if not in the form of a divide between Protestants and Roman-Catholics then in the form of other divisions. Even if health disparities between the traditional religious denominations of Europe are something of the past rather than of the future, documenting and explaining them will help us to develop a better understanding of how religion may affect population health, and therefore remains an important topic in public health research.

References