The main theme, ‘public health and welfare’, was well chosen for the European Public Health Conference in Copenhagen 2012. Not only because the conference was held in a country with a strong tradition in welfare policies, but also because we live in a time of economic crisis, and support in the form of ‘cash and care’ for those who lose their jobs and incomes may be crucial for their health. The conference addressed major questions such as: ‘Which kinds of welfare models are operating in Europe? Are there differences between European countries? Do these differences have an impact on population well-being and health?’

In an introductory keynote lecture, Gosta Esping Andersen, expanded on his classical model of welfare provision in three ‘regimes’: The social-democratic or Nordic regime, the conservative or continental regime, and the liberal or Anglo-Saxon regime. Esping Andersen showed that these regimes differ substantially in their primary outcomes, i.e. in what they are primarily designed to do. For example, the Nordic welfare regime is much more effective than the other regimes in reducing poverty, particularly among children.

That is an important finding, but it is less clear whether these three regimes also differ in health outcomes. First of all, Esping Andersen showed that his typology of welfare regimes is not suitable at all for distinguishing countries with different types of health care provision. Generousness or universalism in other parts of the welfare state, e.g. for income support, does not appear to predict generousness or universalism of health care provision. The clearest example of this discrepancy is the UK, which has a liberal regime of welfare provision, but also has a National Health Service that provides universal access. This actually suggests that if we want to study the health impacts of welfare arrangements we might better not take Esping Andersen’s classification as starting point.

Esping Andersen also cited work by Olle Lundberg and others, who have shown that countries with a Nordic welfare regime also have lower infant mortality. This health effect of welfare provision is more or less accepted, although infant mortality was already lower in the Nordic countries before they started to build up their welfare states. But there is no evidence that health inequalities between socioeconomic groups are also smaller in countries with a Nordic welfare regime. There is a large literature on this, which shows that the relationship between welfare regime and magnitude of health inequalities is inconsistent at best. Contrary to expectations, health inequalities are not systematically smaller in the Nordic countries, perhaps because the relationship is confounded by large inequalities in these countries in smoking, excessive alcohol consumption and other behavioural risk factors.

These paradoxical findings are difficult to digest.

Sir Michael Marmot showed in his keynote lecture, based on the WHO Commission on Social Determinants of Health (CSDH) some of the entry-points for policies to reduce health inequalities, such as early life conditions, income inequality and the power structure of society. Many of these recommendations will have to be implemented through welfare arrangements. But has most of what the CSDH recommended not already been done in the Nordic countries? Still they have large inequalities in health, which leaves us with a big question mark.

Martin McKee’s keynote lecture gave further evidence helping to understand the health effects of economic crises. The data he showed, for example on the lack of a rise of suicides in Sweden during the economic crisis of the 1990s, suggest that welfare provision can buffer the health impacts of economic crises. His preliminary data on the effects of the current economic crisis in Greece suggest that we should urgently look at what we can do as a public health community to help the Greeks, and perhaps later the Italians, the French or even the Germans, to cope with this crisis.

But what are the main ingredients of an effective welfare state, when it comes to promoting health and preventing ill-health? I am afraid that we left the conference with more questions than answers, and that a lot of further research will be necessary to unravel these relationships. Clearly, for making progress it is necessary to move beyond the general welfare regime typology, and to start studying the specific characteristics of welfare provision and their effects on those who are directly affected. For example, if we hypothesize that income support during spells of unemployment buffers the health effects of unemployment, we should look at each country’s unemployment benefit system, and determine whether this modifies the effect of unemployment on specific health outcomes like suicide.

This is all, of course, very obvious, but has not been done yet on the scale that is needed to answer these important questions. The Nordic countries, with their extensive registers, provide excellent opportunities to contribute to these analyses, and we all look forward eagerly to hearing and reading much more about the health impacts of their unique welfare arrangements.

References