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Populism and health inequality in high-income countries

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ABSTRACT

The rise of populist parties and movements in general and right-wing populist parties in particular has been noted also in the public health literature. While economic and other factors behind the populist surge have been systematically analyzed in the political and social science literature, the understanding of this political phenomenon seems weak in important parts of the public health literature. The lack of analysis of economic effects on health inequity of immigration of people with low levels of work skills to many high-income countries is given with the WHO Commission on Social Determinants of Health report as an example. Public health scholars should be able to fully analyze all effects on health inequity within countries. Public health scholars and professionals may lose credibility if they do not fully assess all relevant determinants, and the investigation of health inequity within countries should consider all systemic roots. Health inequity between countries is a crucial issue and should be addressed through international cooperation between countries, regions and international organizations. The approach from political science and social science should be adopted.

The populist challenge

Recent decades have witnessed the rise of political populist movements. The populist challenge seems to have emerged in many high-income countries (and some medium-income countries), irrespective of welfare and healthcare systems of particular countries. Politically, populism may be either left (e.g. Syriza in Greece or Podemos in Spain) or right (e.g. the National Rally in France), although in recent decades it has mostly been discussed in relation to right-wing populist parties which are more or less anti-immigration, culturally conservative and nationalist (Mudde, 2010). Two recent events in 2016 with profound policy consequences and implications were the success of the Brexit campaign in the UK referendum, and the election of Donald Trump as the president of the USA. A highly significant later event was also the election of Jair Bolsonaro as president of Brazil October 2018. In the UK general election in December 2019, the Labour Party experienced its lowest number of elected MEPs since 1935. The Labour Party even lost historically "safe" seats in working class dominated constituencies in e.g. the Midlands. This electoral decline for Social democratic parties has also been seen in the Netherlands, Germany, France etc. The victory of the Conservative Party under its new leadership swiftly finalized the prolonged Brexit process which seems to have been mainly caused by the apparent opinion gap between the major parties and their elected politicians in the House of Commons as opposed to their respective voters prior to the December 2019 election. Still, traditional Conservative parties have also suffered electoral decline in several countries caused by the surging trend of right-wing populist parties.

Populism is a highly contested and vague concept, but it entails a strong personal leader who exercises power with direct, unmediated, non-institutional support from a broad base of supporters who remain predominantly unorganized (Laclau, 1977, 2005bib_Laclau_1977bib_Laclau_2005; Weyland, 2001). Another characteristic is that populism sets the will of a presumably virtuous and homogeneous people against a set of elites (political and expert elites) and "dangerous others" who threaten the rights, values, prosperity and voice of the people (Albertazzi & McDonnell, 2008), and confronts the "pure" people against a corrupt elite with the claim that the populists represent the people and its interest (Mudde, 2010). Lasch (1995) named this people versus elite dimension the revolt of the elites and the betrayal of democracy by the liberal elites in the western world (Lasch, 1995), but the same arising conflict dimension has also been described in positive terms as the rise of the creative class (Florida, 2002). Populism may be seen as a counter-reaction against a growing liberalism which entails increasing individualism, internationalism, globalism, multiculturalism and liberal border policies. Inglehart and Norris (2016) concluded that there are two broad demand side explanations for the recent rise of populist political parties: 1) the growth of economic inequality presumably caused by governmental neoliberal austerity policy, technological change, decline of traditional manufacturing industry, and global labor flows, among them migrants and refugees, and 2) the cultural backlash against

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the progressive culture change since the late 1960s and 1970s which has promoted increased social tolerance and diversity of religions, cultures/subcultures and lifestyles (Inglehart & Norris, 2016; see also; Speed & Mannion, 2017). The stricter immigration policies (point 1) and more restricted development of progressive culture change (point 2) in East Asian high-income countries has probably mitigated the development of populist movements in countries such as Japan, Singapore, South Chorea and Taiwan.

Right-wing populist parties seem to have been able to attract voters from both left and right. However, the motivations of former Social Democratic and Conservative voters to vote for right-wing populist parties seem to partly differ. There is a social science debate regarding the degree to which economic factors explain the growth of right-wing populism even in times of economic prosperity (Mols & Jetten, 2016). Economic instability and deprivation seems to partly explain the electoral losses of Social Democratic or centre-left parties to right-wing populist parties, while the explanatory value of economic factors regarding electoral losses of traditional Conservative or non-socialist parties to right-wing populist parties seems to be considerably weaker (bib_Jylhä_et_al_2019Jylhä, Rydgren, & Strimling, 2019). Future studies may still reveal whether relative deprivation of social groups (Urbanska & Guimond, 2019) can explain mobility from traditional Conservative or non-socialist parties to right-wing populist parties. While economic factors such as income are less plausible for the electoral movement of Conservative or other center-right voters to right-wing populist parties, education seems to be of some importance. In a recent Swedish study, the group of Conservative (Moderate) voters who continued to vote for the traditional Conservative (Moderate) Party had comparatively higher level of education than the group of former Conservative (Moderate) Party voters who voted for the right-wing populist Sweden Democrats in the new election (Jylhä et al., 2019), a finding which may support the notion that higher education is negatively associated with authoritarian and political anti-immigration political orientation (Kitschelt & Rehm, 2014).

The response in the public health literature

Authors in the public health literature have responded to the populist challenge by referring to it in the academic public health literature as "post-truth populism" (Speed & Mannion, 2017), "often based on outright lies" (McKee & Stuckler, 2017), based on "fake news" (Taggart, 2018), "policies of exclusion" (Halikiopoulou, 2018), and "the ability of key protagonists in the transnational capitalist class and allied domestic elites to misdirect the identification of threats to the health and well-being of populations left behind by neoliberal economic integration" (Schrecker, 2017). When leading academic public health scholars and professionals depict a major political phenomenon in one of the major parts of the world as "post-truth", "based on outright lies" and "fake news" at least two options are possible. The first option is that just about everything in terms of causes behind the populist challenge is post-truth, outright lies and based on fake news. While this may certainly be true to some important and in no way negligible extent, the political and social science literature presented above suggests important underlying critical economic and other explanatory factors beyond the categories post-truth, outright lies and fake news. The political science literature even suggests different specific motives and explanations for voters who left Social Democratic or other center-left political parties to instead vote for right-wing populist parties as opposed to voters who left traditional Conservative or other center-right parties to instead vote for right-wing populist parties. The second option is that the academic public health literature at least to some extent entails a component of political bias. Since the political and social science literature cited above presents critical economic and other explanatory factors behind the populist challenge, some component of political bias in the academic public health literature in relation to this major political phenomenon seems plausible, for example with regard to economic explanatory factors. The rest of this short communication will suggest a specific and central example regarding economic factors, particularly effects of immigration to high-income- and some medium-income countries on health inequality and inequity in these countries, leaving cultural and other factors aside for the sake of brevity in a short communication. The specific purpose of this communication is to highlight and question the complete lack of discussion of the effects on health inequality and inequity in high-income countries of immigration from low-income countries to high-income countries in the 2008 WHO report "Closing the Gap in a Generation".

Health inequality and the WHO commission "Closing the Gap in a Generation"

In August 2008, the Commission on Social Determinants of Health, a global collaboration of policy makers, researchers and civil society led by commissioners who represented a mix of academic, political and advocacy backgrounds, published its final report commissioned by the World Health Organization (WHO) (CSDH, 2008). The main objective of the Commission's report is very ambitious, and sets out to reduce and even eliminate systemic differences in health for different groups of people that are avoidable by reasonable action, taking climate change into account in the process. Such systemic differences between population groups are rightly regarded as unfair, and have in these cases been defined as health inequity. Health inequity is thus a concept which includes an ethical dimension of fairness versus unfairness (Bell, Taylor, & Marmot, 2010; Marmot, Friel, Bell, Houweling, & Taylor, 2008). In contrast, the concept of health inequality includes no ethical dimension. Health inequalities in the form of higher age specific mortality among the very old compared to the very young is for example commonly not judged as unfair.

The Commission and the Commission report took a holistic view of social determinants of health already at the outset:

The poor health of the poor people, the social gradient in health within countries, and the substantial health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives-their access to health care and education, their conditions of work and leisure, their homes, communities, towns, or cities- and their chances of leading a flourishing life (Marmot et al., 2008).

The Commission's holistic view was motivated by the fact that health inequities are often the result of a combination of poor social policies, poor social programmes, unfair economic arrangements and distributions, and politics resulting in cemented or even increased health inequity (Marmot et al., 2008).

The Commission's definition of the social determinants of health was thus more ambitious and wider than previous definitions of social and economic differences in health. This was to an important extent due to the fact that the Commission went one or several steps back ("upstream") in the chain of causality leading to health inequity compared to many previous studies. Social class was originally defined and analyzed in relation to health in terms of different skills in the labor market: professionals (e.g. lawyer, doctor, accountant), intermediate (e.g. teacher, nurse, manager), skilled non-manual (e.g. typist, shop assistant), skilled manual (e.g. miner, bus driver, cook), partly skilled manual (e.g. farm worker, bus conductor), and unskilled manual (e.g. cleaner, labourer) (Whitehead, 1988; Townsend & Davidson, 1988), but the extended concepts socioeconomic position (SEP) and socioeconomic status (SES) refer not only to occupation but also principally to education and income (Lynch & Kaplan, 2000). A common trait of these definitions of SEP or SES is that they have been utilized to characterize individuals in order to classify them into more or less economically and socially privileged groups. The rationale is then to identify SES groups with unhealthy lifestyles with regard to tobacco smoking, alcohol consumption, physical activity, diet and other behaviours and risk markers

in order to direct health promotion programmes towards these groups of individuals and for instance their health-related behaviours (Blaxter, 1990), which would seem rational in societies dominated by cardiovascular disease and cancer mortality as well as morbidity caused by other health behaviour related wholly or partly to preventable diseases. The strength, but also the potential weakness, of the Commission is that it goes to the systemic roots of health inequity within and between societies, far beyond lifestyles and the traditional proximal scope of public health.

The strength of the Commission is that it takes a holistic view on the systemic roots of health inequity, and directs attention to "upstream" factors in politics, policies, programs and economic arrangements in order to change these conditions. The potential weakness is that the holistic view implies that all roots of health inequity should be considered. No area that affects public health and health inequity should be spared or omitted. It is thus surprising that the Commission report only deals to a limited extent with the issue of migration, particularly immigration to many western high-income and some medium-income countries from low-income countries. A reading of the full report ends up with box 9.17 regarding policy options to stop the brain-drain from poorer to richer countries (CSDH, 2008, p. 106). The issue of brain-drain by external migration is also mentioned in boxes 9.16 and 15.4, while brain-drain through internal migration is mentioned in box 9.14. This somewhat superficial treatment of the topic is surprising, because migration has profound effects on the economic distribution, and consequently health inequality and health inequity, of society from the interdependent and complex perspectives of countries of immigration, migrants and countries of emigration. The WHO report rightly discussed other important issues such as different welfare and healthcare systems across different countries, but a factor with such profound demographic, economic and social importance as immigration to many high-income countries should also have been discussed seriously.

The neglected effects of immigration in relation to health inequality and inequity

Political economist Paul Collier reviewed the economic literature regarding the economic effects of migration from low-income to high-income countries in recent decades from three different perspectives: the economic effects on the population in the countries of immigration, the economic consequences for the migrants themselves, and the economic consequences for the countries of emigration (Collier, 2013). First, his conclusions regarding the countries of immigration are that the economic effects are directly related to socioeconomic position in ways that tend to increase social and economic differences between population groups. The big companies and the upper socioeconomic strata are the clear economic winners. An expanding population of consumers will increase the demand for daily consumer products as well as more expensive and infrequently acquired products, which will increase profits. Immigration will have no immediate negative effects on wages for important parts of the skilled working population. In contrast, some segments of indigenous unskilled workers and the poorest parts of the indigenous population will end up losing economically due to the lowering effects of increased labor market competition on wages and the increased pressure on social welfare. Poor migrants also compete with poor indigenous people for social housing, and the crowd-out effects will further increase by the specific lowering effects on the wages of some segments of unskilled workers and the increased strain on social welfare, according to Collier (Collier, 2013). Additionally, the social consequences of immigration seem to include the loss of trust, not just *between* culturally increasingly diverse groups but also *within* them (Putnam, 2007, cited by; Collier, 2013). Cultural diversity will also tend to reduce the willingness to redistribute income within a society. According to Paul Collier, these adverse economic effects which tend to increase economic inequality and inequity can be mitigated by moderate, controlled migration. The overall effects on health inequality and inequity in countries of immigration from low-income countries are to increase economic and social inequality and, as a consequence, most probably inequity. These circumstances are not stated in the Commission report. Second, the economic effects on the migrants from low-income countries are to increase their real incomes, provided they manage to get a job on the labor market, which may be hard for a proportion of migrants from low-income countries with low education and skills if the rate of immigration is high, although the likelihood of employment increases strongly with increasing level of education and skills in the knowledge-based economy in high-income countries. Even unemployment resulting in dependency on social welfare may in some instances yield a considerably higher material standard of living than in the country of emigration, according to Collier. These effects are not stated in the Commission report. Third, the economic effects on low-income countries of emigration is a combination of negative economic effects of brain-drain (correctly stated in boxes 9.17, 9.16 and 15.4 in the Commission report) and positive economic effects of sending back money to the countries of emigration (not stated in the Commission report) (Collier, 2013).

The complexity of migration as a determinant of population health and a source of health inequity is thus not reflected in the Commission report. Most aspects of the migration process are not discussed. In particular, the effects on public health and health inequity in the countries of immigration are not discussed at all. This may partly reflect the Commission's ambition to tackle health inequity both *within* and *between* countries. The Commission's agenda has been applied to different countries, regions and cities. But if the Commission report neglects some important sources of health inequity in its agenda, the question may rightfully be asked for whom it was intended if it does not correctly reflect the systemic roots of health inequity in a specific geographic area or country? How could it then be used as a tool to reduce health inequity *within* such countries, other political units or geographic areas?

The work of the Malmö commission in the city of Malmö, southern Sweden, directly inspired and to some extent copy-pasted from the report of the WHO Commission, is an example of the apparent problem when this "holistic" model is applied to a city which has experienced very high levels of immigration in recent decades. The Malmö commission claimed to assess the root causes of health inequity in Malmö by the use of the holistic perspective considering upstream determinants and systemic roots of health inequity in Malmö, but essentially omitted maybe the most prominent feature of demographic, economic and social development in Malmö during recent decades in the main report (Malmöstad (the City of Malmö), 2013). In Malmö, the effects of immigration from low-income countries on health inequity are not exactly known, simply because they were not assessed when applying the WHO Commission report framework to the analysis. In conclusion, the 2008 WHO Commission report is difficult to apply to high-income countries with substantial immigration from low-income countries in particular, because it is not holistic in this institutional, economic and social context, at least not when causes of health inequity *within* a specific country are supposed to be considered.

Keeping strictly to the economic factors presented by the political and social science literature in the beginning to explain the populist challenge, current trends regarding socioeconomic inequality and inequity could be extended to middle class segments of the population regarding more general effects of economic globalization. The Luxembourg Wealth Study found that the Gini index for wealth (instead of income) was 89 in Sweden in 2002 compared to 84 in the USA, 75 in Canada, 68 in Finland and 60 in Italy. A major reason was that 32% of all households in Sweden owned nil or negative net worth compared to 23% in the USA, 23% in Canada, 17% in Finland and 10% in Italy. The Luxembourg study's conclusion was that the Swedish middle class was too heavily taxed to accumulate any substantial net worth (Sierminska, Brandolini, & Smeeding, 2006), while taxation on larger companies and their net profits were substantially lower. Since then, several taxes on

big companies and wealth have been lowered or even abolished in Sweden.

The OECD report "Under Pressure: The Squeezed Middle Class" recently reported that the top 10% in the income distribution holds almost half of the total wealth (OECD, 2019), but already in 2002 the top 10% held 58% of all wealth in Sweden (Sierminska et al., 2006). The middle class has also decreased rapidly in proportion of the population in most OECD countries and even more rapidly in Sweden, while the upper strata as well as the poor have increased their proportions of the population. This is a serious problem, because a strong and prosperous middle class is crucial for any cohesive society and successful economy, according to the report. The middle class sustains consumption, stimulates investment in education, health and housing, and supports social protection systems by paying taxes (OECD, 2019). It might be added that the inclusion of the entire population in the middle class in its best sense would mean equal rights to high quality education, healthcare, sickness insurance and unemployment insurance. While the decline of the middle class may be less associated with immigration than the economic effects on unskilled workers and the unemployed, other aspects of globalization such as job loss due to the transnational movements of industrial plants and companies as well as tax policy, may explain connections between the populist challenge and the middle class. In the beginning of 2017, less than four years after the publication of the Malmö commission report, the Social Democratic-led government granted an energy tax exemption for the internationally largest global social media companies who were planning to build large server halls in Sweden to serve major parts of northern Europe, a very energy consuming activity which will probably increase energy prices by creating electricity shortage without adding more than a handful of jobs. This reverse consumer tax gradient of more than 80 times lower energy tax in favor of the richest in the world seems to suggest an ongoing competition between major parties regarding who can increase socioeconomic and health inequity the most.

Discussion

Despite the claim of the WHO Commission to be "holistic", including important aspects of the systemic roots of health inequity, main parts of the migration process and their plausible effects on health inequity were omitted from the Commission report, probably due to their complex nature as well as political difficulty to deal with them, including the fact that the UN is in essence a political organization. Some issues regarding the opposition between health inequity *within* a country as opposed to *between* countries seem simply not to have been resolved. The effects on health inequity of immigration on the working class and less privileged strata *within* countries as opposed to *between* populations in different countries may go in opposite directions. If important aspects of societal development in countries of immigration are omitted in the assessment of the systemic roots of health inequity, the question should be asked: "Health equity for whom?" If the aim is health equity *between* different countries and parts of the world, which is a highly legitimate aim, then this should be stated clearly, and pros and cons should be evaluated thoroughly, taking different countries, migratory processes and other aspects of communication such as trade and exchange of other resources, services and knowledge between these countries into account. In contrast, if the aim is health equity *within* a particular country, part of a country or a city within a country, then all systemic roots and effects on health inequity *within* that country should be assessed.

The current approach within the mainstream public health literature to the populist challenge is problematic for several reasons. First, public health scholars and professionals should remember that national politics in many high- and some middle-income countries, the countries with populist parties with growing support, is still the main arena for politics and public policy with relevance for public health and the health care system. The issue of the development of health inequality and inequity *within* a country which constitutes a well-defined policy is thus crucial in politics, and should be addressed accordingly. Second, the claim to assess the roots of health inequity from a holistic perspective *within* a particular country or city should be based on the assessment of all important determinant factors. By neglecting some of the roots of economic, social and health inequity *within* countries in their assessments, public health scholars and professionals run the risk of misinterpretation of the observed economic, social and public health patterns, as well as the risk of wholly or partly erroneous conclusions. As a consequence, they also run the risk of becoming part of the "expert" elite distrusted in the eyes of increasing segments of the population who support (right or left) populist parties in several high- and middle-income countries. Third, the issue of how to reduce health inequity *between* countries and larger regions of the world is absolutely crucial in public health, and globally it is at least just as important as the issue concerning the reduction of health inequity *within* countries. More international collaboration *between* countries, larger regions and international organizations is thus needed in healthcare and public health, not less, and this is a strong argument against protectionism in public health. However, assessments of health inequity *between* countries should be addressed in ways which clearly state this specific aim.

Public health scholars should adopt a more constructive, analytical and systematic approach to the populist challenge in order to avoid political bias. This approach should be inspired by political science and social science. Public health scholars should be able to fully analyze effects on health inequity within countries taking all systemic roots into consideration. Public health scholars and professionals may lose credibility if they do not fully assess all relevant social determinants. Health inequity between countries is a crucial issue and should be addressed through international cooperation between countries, regions and international organizations. Political opinions are inevitable and may be expressly stated, but important health determinants should not be omitted from international (such as the WHO report from 2008), national and regional (such as the Malmö commission) reports, action plans and policies. This argument is not about endorsing populism, but trying to understand its relations to important health determinants.

Ethical statement

This short communication does not contain any empirical data or any participants. No inappropriate language is used.

Declaration of competing interest

None.

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