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Title of Comment: Why we should expect Nordic countries to show large relative socioeconomic differences in mortality

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In endeavoring to explain why Nordic welfare states would show large relative inequalities in health, Wilkinson1 crucially overlooks the statistical tendency whereby the rarer an outcome, the greater the relative difference in experiencing it and the smaller the relative difference in avoiding it.2-7. Thus, a country like Sweden would be expected to have comparatively large relative socioeconomic differences in adverse health outcomes (though comparatively small relative socioeconomic differences in favorable health outcomes) simply because it is a healthy society with generally low rates of adverse health outcomes.2,7.

The study of health inequalities in Nordic welfare states presents a particular irony if one assumes Wilkinson is correct that more egalitarian societies are generally healthier. For the egalitarian nature of Nordic welfare states, by causing them to have generally lower rates of adverse health outcomes, tends to cause them also to have comparatively large relative differences in those outcomes and hence to be perceived as having comparatively large health inequalities.

Wilkinson suggests that the welfare systems of Nordic countries are benefiting those societies by eliminating many causes of death but leaving untouched the relative difference in other causes. The reality is likely a good deal more complicated. The strong welfare system of a country like Sweden may well in fact be causing the risk distributions for all causes of mortality to become more similar among the social classes than in other countries and may at the same time be reducing mortality from such causes. The greater similarity of risk distributions will tend toward reducing the relative differences in mortality rates from each cause (as well as reducing the relative difference in rates of avoiding mortality from such causes). But the tendency whereby the rarer an outcome the greater the relative difference in experiencing it is nevertheless strong enough that a country with low mortality often will show larger relative differences in adverse outcomes than countries that both are less healthy and have less similar risk distributions.

The perception problem lies in the uncritical acceptance of the size of relative differences in rates of experiencing adverse outcomes as a meaningful indicator of the severity of health inequality in different settings. That acceptance underlies the inordinate emphasis

that has been placed on the three-fold difference in death rates among British civil servants working in the same office that Wilkinson mentions in his review, as well as the view that health inequalities in the United Kingdom (and elsewhere) have been increasing. The large relative differences in mortality rates among British civil servants – considerably larger in fact than in the United Kingdom's population at large – are to be expected simply because mortality is likely to be comparatively low among civil servants.6 And one should expect relative differences in mortality rates to have increased in the United Kingdom and other developed countries in recent decades simply because mortality has been declining substantially during those decades. Until researchers realize that increasing relative differences in mortality and other adverse outcomes are near inevitable consequences of declining prevalence of those outcomes – and, for that matter, that all measures of health inequality are in some manner affected by changes in the overall prevalence of an outcome 2,6 – there will be little progress in appraising whether health inequalities are changing in any meaningful way.

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