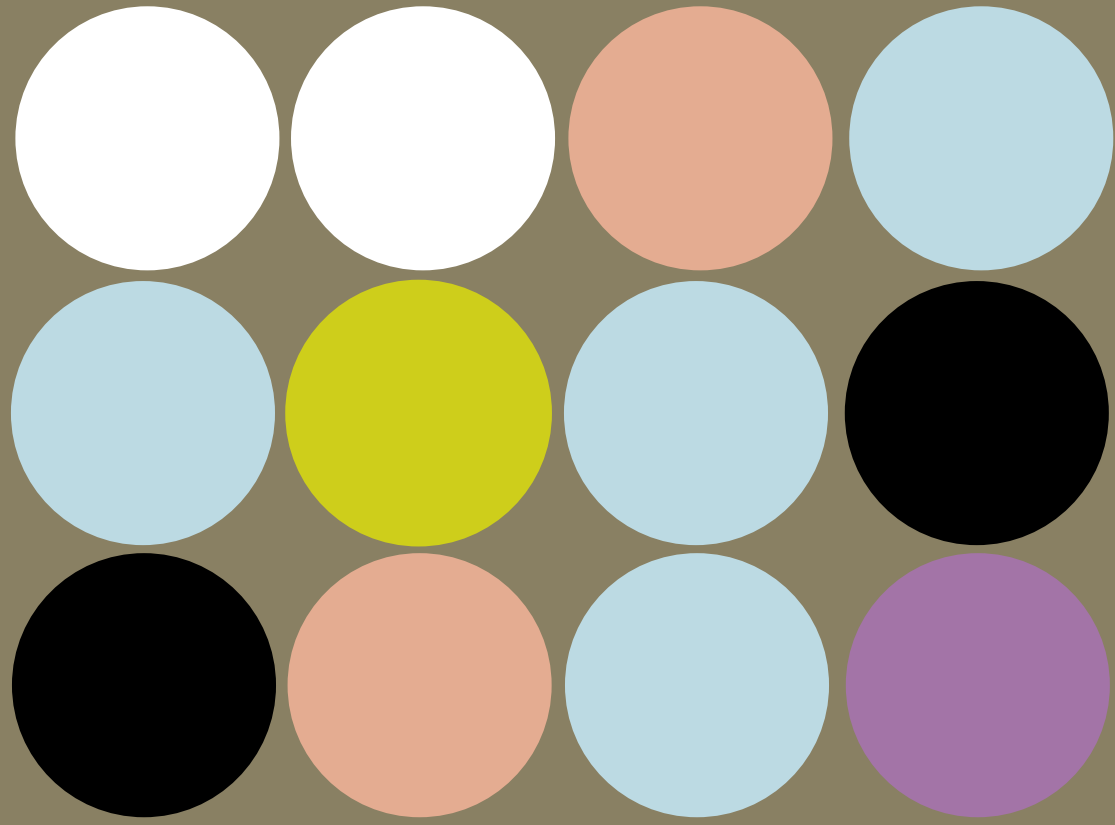


All well in the welfare state?

Welfare, well-being and the politics of happiness

EDITED BY CARL MARKLUND



NordWel Studies in
Historical Welfare State Research 5

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Preface

BENT GREVE

I went to a happiness conference, researchers looked very unhappy.¹

The search for happiness has been there for very many years. In the old times Greek philosophers discussed, for example, what constituted the good life and how it could be achieved. The American Declaration of Independence from 1776 saw happiness as important for society and individuals, and the same can also be seen in the French constitution from 1793.² Societies have thus historically, as well as today, shown an interest in how to ensure a good, prosperous and happy life.

Recent years have further seen a dramatic increased interest in the search for an understanding of what happiness is as well as what might promote both individual and societal happiness. A whole new brand of research across traditional disciplines within social science has tried to cast light over what happiness is, whether we can measure happiness, and if we can compare happiness across societies.

The search for and use of indicators related to happiness and well-being has also its roots in a growing awareness that economic measures, such as GDP and GDP per inhabitant, although being objective in themselves, do not properly include the impact of economic development on, for example, the environment. Robert Kennedy is quoted as having said: 'It measures everything, in short, except that which makes life worthwhile'. In the same vein it has been argued, that there is a need to 'shift emphasis from measuring

1 Taleb, Nassim Nicholas (2010) *The Tale of Procrustes*. London: Penguin, 24.

2 Greve, Bent (2012) *Happiness*. London: Routledge.

economic production to measuring people's well-being'.³ The international economic organization OECD has at the same time increased its focus on non-economic factors including publication of data related to the *How's Life?*-project. Many countries have also embarked upon how to find information to supplement the more traditional economic types of measurement. The same has been done by many and very different kind of think tanks around the world. In general the quest for happiness and ways to measure and understand conditions for the good life and good society has increased.

It is thus timely to ask, as the title of this book does, is 'all well in the welfare state'? Especially in the Nordic welfare states, often portrayed as the happiest nations around the globe, this question is an important one. How can it be, I have often been asked in Denmark, that the Danish often come out as one of the happiest people in the world when we have so many suicides, people suffering from depression, and stress-related diseases? Can we really mark ourselves as a happy nation when so many are outside the labour market or in other ways excluded from societal development?

The simple, but naturally not fully sufficient answer is, that an average of many happy people does not mean that all people are happy at all times. We know that well-being also depends on changes over life time and people losing one of their beloved (wife, husband, partner, family member, children etcetera) will, for example, have times when they are not happy. Having had a hard time looking for a job and being rejected many times is not the best starting point for being a happy person. Happiness also changes over the life-cycle – typically happy as very young and as elderly (often with different kinds of arguments), as less happy during the hard working years establishing families and with difficulties to balance work and family life. Therefore it is also obvious that not all is well for all – at least not all the time, as pointed out by Carl Marklund in the introductory chapter of this volume. Still, this also raises the question of whether it is possible to ensure that most people most of the time have conditions and options – or set of capabilities, in Amartya Sen's view – to pursue the good and happy life.

3 Stiglitz, Joseph E., Sen, Amartya & Fitoussi, Jean-Paul (2009) *Report by the Commission on the Measurement of Economic Performance and Social Progress*. Paris: Commission on the Measurement of Economic Performance and Social Progress, 12.

By looking into various issues and concerns of different groups in the welfare state, this book thus supplements existing knowledge and broadens the perspective on how and to what extent all actually is well and how the search for happiness is both an individual and societal issue. However, by raising issues related to the absence of happiness (unhappiness) in the first three chapters, health and mental illness as central aspects of modern welfare states are emphasized. This further underlines how the focus on being a 'normal' citizen might influence the well-being of others in society. The risk is that happiness will be mainly for those fulfilling the ambition of the modern welfare states and who are, in the active life years, gainfully employed on the labour market. This should remind us that modern welfare states also have tendencies of social exclusion.

The relation between health and societal development, including well-being has been known for a long time. However, recent focus on the impact on societies of inequality of health has highlighted that society might help in ensuring a better life for all citizens, and that societal focus on how to ensure better health for the individual may not only have an impact on inequality and daily living standard, but also on the general well-being and happiness in societies. This also implies a focus on not only physical diseases, but also on mental health. Likewise a focus on prevention of substance abuse, as discussed in the chapter by Pekka Sulkunen and Trygve Ugland, is an indicator of an important area for welfare states having an ambition to ensure welfare for its citizens.

It is sometimes argued that a smile can be infectious. This might also be the case for happiness, for as is shown in Olli Kangas' chapter, immigrants are happier in happy nations. Naturally, there might be differences depending on where you are moving. Southern European men seem happier in the Nordic countries, more so than Southern European women. Still, as written by Kangas: 'Happy immigrants live in happy countries'. They have also a larger degree of trust. It might be that the institutional and structural features of the Nordic welfare states imply that the citizens are having, at least for the clear majority, a good life.

Studies of happy nations often focus on adults and overlook the children and young persons. In her chapter, Margrét Einarsdóttir focuses on young persons in Iceland, many of whom want to have money of their own, as this will imply a better well-being. This again highlights that, in accordance with Richard Easterlin's position, money matters at least until a certain level, and that comparison among individuals have an impact on the degree of happiness. Even for young persons, work can be an important part of life, as this makes it possible to live life like their peers do. Furthermore, it may serve as a very early indication that work has become a still more central part of the Nordic welfare states way of life.

The balance between work and family life, between work and free time, and the balance between included or excluded in modern societies are thus an important issue for the happiness of nations. This is also the issue of the last chapter in the book, which discusses whether in principle individual issues of subjective happiness can be made part of political debate and political decision making. It thus also raises the issue whether there is an emerging global politics of happiness that attempts to combine our knowledge in very diverse areas – such as economic growth, equality, health, and environment, etcetera.

A further question concerns the criteria by which to distinguish between different policies and to choose between different projects. Even in the rich Nordic countries, there is a constant quest for economic efficiency and need to prioritize between different policy goals. The question of how to balance a perspective on happiness with a perspective of efficient use of resources is thus still open for debate. Just one example to illustrate: From an economic perspective more police in the street will be a waste of money, but for ensuring an increasing level of personal security and thereby possibly increased level of happiness this could be an important issue.

Conflicts on how to prioritize in the welfare state have thus not been solved with the increased interest in what makes us happy. Neither can we ensure that the quest for happiness will not imply a further division in society between those who are well and those who are not. However, the increased focus on happiness has made us more aware that even if money

matters, money is not the whole story of a good life. By bringing to the fore these issues the welfare state will no longer only seek to provide material goods and income security, but presumably also adopt a broader role for social inclusion with a new focus on more subjective and individual needs. At the same time, the welfare state has to respect that individual lives are lived differently and that there is an individual right to choose a lifestyle fitting the individual. The welfare state's role revolves to a large degree around setting the framework. This also implies a role for the welfare state in ensuring capabilities for individuals to make choices, and to be active in society's development.

In this way this book, by questioning whether all is well in the welfare states, contributes a new perspective while at the same time continuing in the tradition of welfare research, emphasizing the importance to also keep the focus on the vulnerable and those in need.

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- Stiglitz, Joseph E., Sen, Amartya & Fitoussi, Jean-Paul (2009) *Report by the Commission on the Measurement of Economic Performance and Social Progress*. Paris: Commission on the Measurement of Economic Performance and Social Progress.
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Introduction

CARL MARKLUND

Introduction

From having been treated with considerable scepticism by politicians and scholars alike during much of the post-war era, happiness has recently won renewed actuality in public debate, both as a target of scientific enquiry as well as an explicit concept in public policy evaluations.¹ While individual well-being has long been closely connected with prosperity, high material standards of life, and good physical health – in short, welfare – recent interest has increasingly turned towards the role of various non-economical factors in promoting healthy living, psychological well-being, quality of life, and subjective happiness on the societal level.

This renewed attention has, among other things, manifested itself in a recent surge of international rankings which aim to measure the level of quality of life, satisfaction with life, and subjective well-being (SWB) – as distinct from objective well-being (OWB) – within and across different societies.² Recently, ‘satisfaction with life’ has been added to traditional measures, such as Gross Domestic Product (GDP), according to which different societies are being compared and evaluated. Other examples include the Human Development Index (HDI), the Satisfaction with Life Index (SLI), the Gallup World Poll (GWP), the World Values Survey (WVS), the European Values Survey (EVS), and the European Social Survey (ESS).

1 This scepticism has been the norm in Western Europe and North America, while explicit notions of happiness have continued to play a decidedly political function in East Asian as well as South East Asian politics.

2 Costanza, Robert et al. (2007) ‘Quality of Life: An Approach Integrating Opportunities, Human Needs, and Subjective Well-Being’. *Ecological Economics*, Vol. 61, Issues 2–3, 267–276.

The enthusiastic media reception of these new rankings and their eager appropriation by governments as well as intergovernmental and international non-governmental organizations around the world warrants the growing interest and global importance of non-economic and immaterial factors for human well-being, in advanced welfare states as well as in developing countries.

Partly, this renewed attention follows from advances in scientific research, not only in psychology and psychiatry, where the commonsensical inverse of happiness, depression, has long been the object of concern, but also in the natural sciences and the social sciences more broadly. Partly, it has been promoted by a long-standing commercial interest in 'life coaching', 'self-help', and psychotherapy. In both these aspects, it primarily addresses the preconditions for individual happiness and well-being.

Certainly, images and notions of individual happiness have long been employed for advertising purposes, at least since the emergence of mass consumption from the late nineteenth century and onwards. The fulfilment of desires, needs, and wants through the consumption of various products and services have fused into a cultural mix of social norms, signifiers, and symbols of pleasure, satisfaction, and personal success that the individual may subscribe to or resist at different points in life.³

Recent research appears to confirm the importance of consumption and 'shopping' for satisfaction with life.⁴ Yet, this commercial appropriation of happiness has been criticized for reproducing 'false needs' by generating a kind of 'treadmill syndrome', whereby consumers are conditioned to crave for the next experience, product, or service but rarely achieving the desired satisfaction. This may generate economic growth, critics assert, but does not necessarily lead to societal progress, personal development, or, for that matter, individual happiness.⁵

3 Kellner, Douglas (1983) 'Critical Theory, Commodities, and the Consumer Society'. *Theory, Culture, and Society*, Vol. 1, No. 3, 66–84.

4 Roos, John Magnus (ed.) (2012) *Konsumtionsrapporten 2012*. Göteborg: Centrum för konsumtionsvetenskap, Handelshögskolan vid Göteborgs universitet.

5 Slater, Don (1997) 'Consumer Culture and the Politics of Need'. In Nava, Mica, Blake, Andrew, MacRury, Iain & Richards, Barry (eds) *Buy This Book: Contemporary Issues in Advertising and Consumption*. London: Routledge; Bruni, Luigino & Porta, Pier Luigi (eds) (2007) *Handbook on the Economics of Happiness* Cheltenham: Edward Elgar; Dahmén, Micael (2008) *Nextopia – Livet, lyckan och pengarna i förväntningssamhället*. Stockholm: Volante förlag.

In the early 1970s, Richard Easterlin, American economist and happiness research pioneer, pinpointed the subjective and relative character of the income–happiness nexus, claiming that:

“[i]n all societies, more money for the individual typically means more individual happiness. However, raising the incomes of all does not increase the happiness of all. [...] The resolution of this paradox lies in the relative nature of welfare judgments. Individuals assess their material well-being, not in terms of the absolute amount of goods they have, but relative to a social norm of what goods they ought to have.”⁶

The attention upon individual happiness as distinct from societal happiness has also been criticized for supporting a materialistic and market-oriented approach towards life, which may primarily serve commercial interests and hence support ‘neoliberal’ biopolitics.⁷ More recent critics have also claimed that the commercialization of the moral imperative for the individual to achieve happiness, however defined, underpins the existing socio-economic order, channelling the proverbial ‘pursuit of happiness’ into competition between atomized individuals, rather than promoting collective effort towards solving common problems and pursuing common values in society at large.⁸

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- 6 Easterlin, Richard (1973) ‘Does Money Buy Happiness?’ *The Public Interest*, Vol. 30, 4; see also Easterlin, Richard (1974) ‘Does Economic Growth Improve the Human Lot?’ In David, Paul A. & Reeder, Melvin Warren (eds) *Nations and Households in Economic Growth: Essays in Honor of Moses Abramovitz*. New York: Academic Press, 89–125.
 - 7 Lasch, Christopher (1978) *The Culture of Narcissism: American Life in an Age of Diminishing Expectations*. New York: Norton; Rimke, Heidi Marie (2000) ‘Governing Citizens Through Self-Help Literature’. *Cultural Studies*, Vol. 14, No. 1, 61–78; Moskowitz, Eva S. (2001) *In Therapy We Trust: America’s Obsessions with Self-Fulfillment*. Baltimore: John Hopkins University Press; Hazelden, Rebecca (2003) ‘Love Yourself: The Relationship of the Self with Itself in Popular Self-Help Texts’. *Journal of Sociology*, Vol. 39, No. 4, 413–428; McGee, Micki (2005) *Self-Help, Inc. Makeover Culture in American Life*. Oxford: Oxford University Press; Rose, Nikolas (1989) *Governing the Soul: The Shaping of the Private Self*. London: Routledge; Rose, Nikolas (1996) *Inventing Our Selves: Psychology, Power and Personhood*. New York: Cambridge University Press; Foucault, Michel (2004) *Security, Territory, Population. Lectures at the Collège de France, 1977–1978*. New York: Palgrave Macmillan.
 - 8 Ahmed, Sara (2010) *The Promise of Happiness*. Chapel Hill: Duke University Press; Ehrenreich, Barbara (2009) *Bright-Sided: How the Relentless Promotion of Positive Thinking Has Undermined America*. New York: Metropolitan Books/Henry Holt & Company.

According to this critique, the booming market for self-help literature, life coaching, and the subsequent commodification of psychology and psychotherapy reinforces the image of self-governing and self-regulating 'rational economic man' as the ideal human being. This personality type supposedly copes individually with adverse circumstances either through adaptation, competition, or therapy, rather than through voicing protest or political engagement. Thereby, critics assert, the ideal type of rational economic man may serve to marginalize or even replace the ideal of the socially embedded and politically active citizen. The rise of 'the happiness agenda' or 'the happiness industry' has thus been interpreted as a commercial-cultural symptom of the neoliberal economic order.⁹

But the renewed interest in happiness has also followed from a possibly more 'progressive' (as distinct from neoliberal) interest in alternative ways of assessing policy outcomes as well as providing a more fair ground for the comparison of different societies than the straitjacket of GDP and the mono-dimensional focus upon economic growth as the primary goal.¹⁰ Here, the concern with SWB is rather connected with socio-economic equality, life chances, social integration, and ecological and social sustainability.¹¹

The emerging field of happiness economics has served as a channel of communication between the distinct academic fields of social statistics and happiness research as it seeks to quantify and measure subjective well-being while analyzing its relationship to measures of competitiveness, growth, and prosperity.¹² This concern has become more acute in the wake of the recent recession, as financially strapped governments point to 'austerity policies'

9 Ahmed 2010; Burnett, Simon (2011) *The Happiness Agenda: A Modern Obsession*. Basingstoke: Palgrave Macmillan.

10 Gandelman, Néstor & Hernández-Murillo, Rubén (2009) 'The Impact of Inflation and Unemployment on Subjective Personal and Country Evaluations'. *Federal Reserve Bank of St. Louis Review*, Vol. 91, No. 3, 107–126.

11 Sen, Amartya (1993) 'Capability and Well-being'. In Nussbaum, Martha & Sen, Amartya (eds) *The Quality of Life*. Oxford: Clarendon Press, 30–53; Dahrendorf, Ralf (1979) *Life Chances: Approaches to Social and Political Theory*. London: Weidenfeld and Nicolson.

12 Ahmed 2010; Abdallah, Saamah, Thompson, Sam & Marks, Nic (2008) 'Estimating Worldwide Life Satisfaction'. *Ecological Economics*, Vol. 65, No. 1, 35–47; Oswald, Andrew (1999) 'A Non-Technical Introduction to the Economics of Happiness'. Online. Available HTTP: <<http://www2.warwick.ac.uk/fac/soc/economics/staff/academic/oswald/intro.pdf>> (accessed October 2012); Powdthavee, Nattavudh (2007) 'Economics of Happiness: A Review of Literature and Applications'. *Chulalongkorn Journal of Economics*, Vol. 19, No. 1, 51–73.

and 'sufficiency economy' as a way of coping with weaker economic growth, rather than questioning the focus upon economic growth.

As of yet, the findings of happiness economics remain inconclusive. Some studies suggest real GDP at purchase power parity (PPP) per capita affect happiness positively.¹³ Other studies show little or no correlation between absolute and relative income levels and SWB, positing the existence of a 'satiation point' in the range between USD 15 000–20 000 GDP (PPP), beyond which wealthier countries register no further increase in SWB.¹⁴ Recently, for example, Angus Deaton has used Gallup polls to show that the current financial crisis has had little verifiable impact upon the SWB of Americans, despite widespread public perceptions to the contrary.¹⁵ In a related vein, it has been suggested that SWB is rather determined by personality traits than by external circumstances. According to some observers, this would seem to indicate that there is an individual 'happiness set point' to which people tend to return to after both positive and negative experiences.¹⁶

These divergent results of happiness research render eventual policy implications of this emerging discipline difficult to assess. Some members of the research community have been reluctant to make policy recommendations before the complex links between income, wealth, leisure, freedom of choice, and welfare policies and their impact upon SWB have been more fully explored. American lawyer Derek Bok has recently questioned whether the research results could warrant a new politics of happiness, claiming

13 Discussing the link between income and well-being, Betsey Stevenson and Justin Wolfers argue that 'several interesting variants of the question could be asked—such as whether it is GDP, broader measures of economic development, or alternatively, changes in output or in productivity that drive happiness', but note that '[u]nfortunately, we lack the statistical power to resolve these questions'. Hence, they concentrate their study on the GDP–SWB relationship. See Stevenson, Betsey & Wolfers, Justin (2008) 'Economic Growth and Subjective Well-Being: Reassessing the Easterlin Paradox'. NBER Working Paper No. 14282. Online. Available HTTP: <http://www.nber.org/papers/w14282.pdf?new_window=1> (accessed October 2012)

14 For recent discussions, see Layard, Richard (2005) *Happiness: Lessons From A New Science*. London: Penguin; Layard, Richard (2012) 'Mental Health: The New Frontier for the Welfare State'. Online. Available HTTP: <http://cep.lse.ac.uk/textonly/_new/staff/layard/pdf/LAYARD6-March-lecture.pdf> (accessed October 2012); Layard, Richard, Mayraz, Guy & Nickell, Stephen John (2008) 'The Marginal Utility of Income'. *Journal of Public Economics*, Vol. 92, Issues 8–9, 1846–1857; Stevenson & Wolfers 2008.

15 Deaton, Angus (2011) 'The Financial Crisis and the Well-being of Americans'. *Oxford Economic Papers*, Vol. 64, No. 1, 1–26.

16 Bruni & Porta 2007.

that the welfare state shows a low impact upon SWB.¹⁷ Nevertheless, Bok supports an expansion of welfare state commitments in the USA with a view of improving quality of life and SWB. Other researchers have more explicitly supported the government policy of maximizing SWB with regard to specific policy areas, such as employment policies and psychological therapy, as well as public policy more generally. In a typical statement, one of the most vocal proponents for a new politics of happiness, British economist Richard Layard, has argued that a government's role should be to increase happiness and reduce misery and that 'well-being and mental health need to be the new frontier for the welfare state'.¹⁸ Given the inconclusiveness of the research, however, it remains uncertain exactly what kind of policies would constitute such a 'new frontier'.

Happiness, well-being, and the (Nordic) welfare state

So far, the Nordic countries have scored well in comparative statistics on SWB. The Danes, for example, were ranked first on happiness according to the Gallup World Poll 2005–2011, followed by the Finns, the Norwegians, and the Dutch.¹⁹ Similarly, in the OECD's Better Life Index of 2012 Norway, Sweden, and Denmark came out among the top five.²⁰

While the rankings in themselves do not explain the underlying causes, the Nordic model of welfare, with its focus upon collective and universal social security, has typically been seen as a key factor for these favourable results. This notion has a tradition, too, as the Nordic countries have for a long time been presented as utopian 'happy democracies' where freedom and welfare have been successfully combined.²¹

17 Bok, Derek (2010) *The Politics of Happiness: What Government Can Learn from the New Research on Well-Being*. Princeton: Princeton University Press.

18 Layard 2012.

19 For a discussion of earlier scores, see Greve, Bent (ed.) (2010) *Happiness and Social Policy in Europe*. Cheltenham: Edgar Elgar; Helliwell, John F., Layard, Richard & Sachs, Jeffrey D. (eds) (2012) *World Happiness Report*. New York: The Earth Institute, Columbia University.

20 Organisation for Economic Co-operation and Development (OECD) (2012) 'Better Life Index'. Online. Available HTTP: <www.oecdbetterlifeindex.org> (accessed October 2012)

21 See for example Tingsten, Herbert (1966) *Från idéer till idyll: Den lyckliga demokratien*. Stockholm: Bokförlaget PAN/Norstedts.

As the global financial crisis has forced national governments to adopt austerity policies and cut public spending, welfare state supporters across the world point to the success of Nordic countries in these rankings, underlining the role of social policies in promoting growth and stability in the midst of recession.²² Admittedly, the Nordic score in terms of SWB may simply reflect performance on a number of traditional parameters – such as GDP per capita, growth, competitiveness, market freedom, productivity, as well as social equality (Gini), healthcare, safety, and public trust – which are usually also taken into account in various rankings of SWB. Yet, it is becoming more widely acknowledged that social policy may have a direct positive influence on SWB, not only through providing for economic growth and creativity, but also through ensuring redistribution, social security, and social equality.²³ In short, the welfare state may be a decisive factor for ‘Nordic happiness’.²⁴

Yet, all is not necessarily well in the Nordic welfare states – at least not for all, and certainly not all of the time. For example, mental disorders are reportedly on the rise in all Nordic societies.²⁵ The increasing prevalence of stress symptoms and mental illness stands in a complex relation to recent shifts in the scope and means of social benefits and social security more generally, in the Nordic countries as well as elsewhere.²⁶ International studies have shown that mental distress has become a more common reason for early retirement since the early 1980s and onwards, especially among young adults.²⁷ At the same time, socio-economic gaps are also reported as widening in the Nordic welfare states.

22 Marklund, Carl (forthcoming 2013) ‘A Swedish Norden or a Nordic Sweden? Image Politics During the Cold War’. In Jonas Harvard & Peter Stadius (eds) *Communicating the North: Media Structures and Images in the Making of the Nordic Region*. Farnham: Ashgate.

23 Saari, Juho (2012) *Onnellisuuspolitiikka – Kohti sosiaalisesti kestävää Suomea*. Helsinki: Kalevi Sorsa Säätiö; Wilkinson, Richard G. & Pickett, Kate (2009) *The Spirit Level – Why More Equal Societies Almost Always Do Better*. London: Penguin.

24 Greve 2010; Saari 2012.

25 Olofsson, Jonas & Östh, John (2011) *Förtidspensionering av unga. En fråga om utsortering efter utbildningsnivå och socioekonomisk bakgrund? Underlagsrapport till den parlamentariska socialförsäkringsutredningen*. Stockholm: Parlamentariska socialförsäkringsutredningen.

26 See for example OECD (2011) *Sick on the Job? Myths and Realities about Mental Health and Work*. Paris: OECD Publishing; OECD (2013) *Mental Health and Work: Sweden*. Paris: OECD Publishing.

27 Olofsson & Östh 2011.

Traditionally, universalist welfare policies do not only provide a basic social security for all. They also seek to help people through transitory periods of difficulty in life. But what happens in the trade-off between the needs of those with transitory problems and the needs of those who risk permanent problems?

In response to this query, this book brings together social scientists and historians in a discussion of how these emerging trends interrelate with one another. The volume is based on some of the contributions presented at the conference 'All well in the welfare state? Mental well-being and the politics of happiness' at the Department of Economic and Political Studies at the University of Helsinki in the autumn of 2011, which was a part of the activities of the Nordic Centre of Excellence: The Nordic Welfare State – Historical Foundations and Future Challenges, *NordWel*. The conference was organized by one of its theme groups: 'The Normative Charges of Work: The Labour Market and the Welfare State'.

The contributions focus upon two different aspects of the relationship between SWB on the one hand and welfare on the other hand. If a given society's 'quality' can be assessed by its attitude towards and the assistance it provides its most sensitive members, it first becomes of interest to ask what the recent attention to SWB may mean for those who are the least likely to possess the economical and social means that are 'normally' expected to enhance either OWB or SWB. It is by no means self-evident who may, at times, belong to these groups. But given the demonstrably unequal access to life chances, likely groups may include the physically ill and the mentally disabled as well as substance abusers. Also children, elderly, immigrants, and the unemployed may face similar challenges. The question is whether the SWB of these groups is strengthened or obscured by the new interest in the happiness of society as a whole, with its concomitant focus upon the needs of the majority, e.g. the gainfully employed and economically more secure members of society.

Second, the contributions also address the relationship between economic and non-economic factors, between OWB and SWB, and between welfare and well-being for perceived life satisfaction. The links between income, wealth, and work on the one hand and social relations, stress, and

safety on the other hand, as well as physical health and mental health, are not only complex in their own right. Post-materialist and progressive discourses on happiness are increasingly merging with neoliberal discourses on liberty and self-actualization, posing new and complex challenges to welfare states, not only in the Nordic countries, but in other welfare states as well.

Overview of the book

As Varda Soskolne shows in her chapter, advances in medicine and social policy have led to major improvements in health and to extended life expectancy globally, affecting SWB positively. But Soskolne asks whether this occurs in all sections of society. In Israel, health inequalities have widened since the 1990s, in parallel with an increase in income inequalities and a shift from welfare state policies to more neoliberal policies, including the privatization of the healthcare sector and the transfer of more health and welfare services to NGOs and private companies. Soskolne shows that socioeconomic status (SES) correlates with rising inequalities in health, probing the extent to which the psychosocial environment may explain these inequalities. Soskolne notes that the interventions and policies aimed at ‘closing the gap’ between different socio-economic groups is not yet fully covered in the scientific literature, confirming the notion that the relationship between happiness research and welfare state policies remains uncertain.

In her chapter, Katarina Piuva shows how ‘normality’ has become an expected precondition for health and happiness in Sweden: While the mentally ill are supposed to be integrated into society at large, they are also to be viewed as if they paradoxically did not have any specific needs. Normality, in its turn, is closely connected with performance in various social activities, including work. As ‘health’ is increasingly defined as ability to work through the concept of ‘employability’, Piuva concludes that implicit understandings of normality may serve as an obstacle to the social integration of the severely mentally ill. In other words, the principles of normality that have become the ideology of social integration may turn out to be a demand on the individual to live a life just like ‘everybody else’ – a demand which may have been the cause of the discomfort to begin with.

The dehospitalization movement exemplifies an attempt to close the gap between the well-being of the mentally ill and the majority population. In their chapter, Anna Alanko and Carl Marklund show how mental health care planning in Finland has adapted to the international trend towards dehospitalization, partly in the interest of increased cost-efficiency, but also with the SWB of the mentally ill in mind. However, as the categories of mental illness continue to expand, so does the demand for inpatient treatment rise in parallel with the demands for more outpatient treatment. Rising mental problems, especially among the young, can be interpreted as a sign of decreasing SWB and higher stress in society, running the risk of putting further strain on the already limited resources available for those in the most need of special care.

While some groups in society may thus require protection from the demands of 'normal' life in order to achieve SWB, other groups may instead increase their well-being as a result of being exposed to precisely these challenges and rewards. In her contribution, Margrét Einarsdóttir looks at the relationship between part-time work and SWB among teenagers in Iceland. In particular, she tracks the sensitive balance between the independence and autonomy that follows from being gainfully employed and the risks and demands being posed by work. Einarsdóttir notes that monetary reasons are not necessarily the determining cause for teenagers' work in Iceland, but that work ethics, independence, autonomy, socialization, and enjoyment play key roles, too. Her findings underline that teenagers, even in a welfare state under considerable economic strain, typically enter the job market primarily to enact a consumer identity, which in its turn affects teenage perceptions of the relationship between work, income, and happiness.

Einarsdóttir's study deals with part-time work, but points to the relationship between permanent (un)employment and SWB. Most studies show that involuntary unemployment is as strongly related to negative SWB as leisure is linked to positive SWB. Nordic welfare states have recently been grappling with the problem of rising unemployment in particular groups whose social inclusion and protection is sometimes seen as an onerous cost, in what amounts to a criticism of the welfare state and its

ability to provide not only jobs but also well-being for all. According to this criticism, governmental policies should singularly focus on creating jobs rather than social protection. In his chapter, Olli Kangas compares the well-being of immigrants in different European countries, noting that immigrants report the highest levels of SWB in the countries which have the most generous welfare policies, thus challenging the arguments of the welfare-state critics.

In their chapter, Pekka Sulkunen and Trygve Ugland address the relationship between substance abuse, abuse control, and SWB by comparing French and Nordic policies against the backdrop of emerging common EU policy goals. While alcohol policy aims to improve not only public health and reduce health care spending, but also to further the well-being of the population in general, there is also a tension between the duty to further the well-being of those who are the least likely to conform to societal norms about happiness without infringing upon the independence and identity of the individual person. If welfare policies then may then have direct implications for individual as well as societal well-being, it also becomes important to consider under what conditions well-being and happiness should or should not be made the target of political agency.

In the closing chapter, Carl Marklund looks at the emerging rankings of different societies with regard to SWB. Noting that the generation of scientific knowledge often constitutes the first step towards the establishment of a new policy field, the chapter discusses how these new rankings may affect welfare-state policy making. However, the inclusion of these categories into global rankings appears to play a soothing rather than spurring function, confirming that the rising interest in happiness has not, at least not just yet, been explicitly politicized.

Yet, given the way in which the discussions on happiness activate critical tensions in contemporary society, of material welfare versus subjective well-being, prosperity versus sustainability, and state responsibility versus individual responsibility, the public discourse on happiness may well develop into a critical site of political contest in the near future. Due to the inconclusive status of happiness research, however, the political consequences

of this possible ‘new frontier’ in welfare state policies can just as well serve to expand the responsibility of the welfare state as it may further limit the reach of politics, pointing to the responsibility of the individual for his/her own happiness.

Conclusions

The high score of the Nordic welfare states in the rankings of happiness could possibly indicate that the welfare state – originally concerned with the universal provision of basic social benefits while providing additional social support to those most in need – already makes a substantial contribution to SWB. Is all well in the welfare state, then?

The contributions to this book point in two possibly diverging directions when addressing this question. On the one hand, acknowledging the risks posed by mental as well as material sources of stress, a continued commitment to welfare state universalism could take on responsibility for the overall happiness and well-being of the population, representing a kind of ‘politics of happiness’ reaching beyond the concerns of material welfare. SWB could thereby become another public good, alongside the more customary objectives of welfare policy.

On the other hand, several tendencies in contemporary society point towards the greater medicalization of various social conditions, while stress and discomfort are reportedly on the rise due to the high demands of work and pressures in social life, potentially expanding the number of people who report dissatisfaction and low SWB as well as mental ill health. Here, the renewed attention to SWB could possibly signal the advent of a negative ‘politics against unhappiness’ – as distinct from a positive politics of happiness which would be more concerned with the need for individual therapy than the reduction of collective risk.

Either way, the arrival of SWB on the political agenda activates the dual duty of the welfare state to not only answer to the basic social demands of the population at large, even when these expand beyond basic provisions and social services, but to continue to extend assistance and care to those in the most need.

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Social inequalities in health and well-being – A review of research and the case of Israel

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Introduction

The issue of health inequalities has become a central topic for research, practice, and policy at regional, national and global levels. A substantial and rapidly growing literature has in recent decades provided consistent evidence that although the advances in medicine and improvements in standard of living have contributed to overall better health and extended life expectancy, significant differences in health exist between social groups. The Commission on Social Determinants of Health (CSDH) of the World Health Organization (WHO) states that inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age.¹ The most important determinants of health inequalities are those that produce stratification within society, namely the structural determinants such as the distribution of wealth and income, or gender or ethnic discrimination rooted in the context of the society.

Another issue that has attracted attention from health and social scientists in diverse fields in recent decades is the concept of well-being. The changing demography and ageing of the population in many countries has brought to the fore a focus on quality of life and subjective well-being. The WHO defines health very broadly as a multidimensional construct, ‘a state of complete physical, mental, and social well-being and not merely the absence

1 Commission on Social Determinants of Health (CSDH) (2008) *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Final report. Geneva: World Health Organization.

of disease or infirmity.² The approach to measuring health, beyond that of the traditional morbidity and mortality data, has thus been broadened, but the measurements of well-being are contested, because the concept remains ambiguous and ill-defined.³ Researchers often use a multiplicity of terms that sometimes seem to be synonymous and at other times rather different, such as positive emotions, subjective well-being, life satisfaction, happiness, and quality of life. The most commonly used conceptualization of well-being focuses only on psychological aspects and differentiates between global judgments of life satisfaction and feelings.⁴ Based on evidence of the association of well-being with health, this conceptualization elucidates the convergence of health and well-being in the scientific literature and in health policy.⁵ In addition, well-being is relevant to the health inequalities agenda, because recognition that well-being is an appropriate measure of what people value in life, makes it a popular topic for public health policies and interventions aimed at reducing health inequalities. A more detailed definition of well-being and evidence of inequalities in well-being together with a focus on health inequalities are necessary for a fuller understanding of the complex causes of inequalities at global or local levels.⁶

This chapter aims to expand this understanding by reviewing the definitions and the scope of social inequalities in physical health and well-being, and the major underlying explanatory mechanisms of these inequalities. Rooted in the social determinants of health framework, this chapter focuses mainly on socioeconomic status (SES), defined mainly by income, education or occupation, as a major social feature of health and well-being inequalities. People with a higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life

2 World Health Organization (WHO) (1946) *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946*. Online. Available HTTP: <<http://www.who.int/suggestions/faq/en>> (accessed September 2011)

3 Carlisle, Sandra & Hanlon, Phil (2008) “Well-being” as a Focus for Public Health? A Critique and Defence. *Critical Public Health*, Vol. 18, 263–270.

4 Diener, Ed (2000) ‘Subjective Well-Being: The Science of Happiness and a Proposal for a National Index’. *American Psychologist*, Vol. 55, Issue 1, 34–43.

5 Diener, Ed & Chan, Micaela Y. (2011) ‘Happy People Live Longer: Subjective Well-Being Contributions to Health and Longevity’. *Applied Psychology: Health and Well-Being*, Vol. 3, Issue 1, 1–43.

6 Carlisle & Hanlon 2008.

and have better health. Furthermore, these topics are elaborated by a review of the Israeli context in order to demonstrate how they are expressed at a specific local level, yet representing the broader issues of health inequalities and the well-being agenda and their relationship to the welfare state. In the last decades, the universal/citizenship-based policy of Israel's welfare system was trimmed, and a more explicitly neoliberal and non-universal welfare approach took effect.⁷ Although one cannot ignore the problems unique to Israel, above all the political conflict with the Arab world and the substantial national security expenditures, the retrenching welfare state is subject to many of the same pressures and discontents as are other societies in Europe and North America. The welfare policy shifts and the subsequent increase in social inequality are relevant when we seek to study the way in which SES affect health and well-being. Finally, the chapter suggests several implications of this review for further research while analysing policies that contribute to and are necessary for tackling health inequalities.

Israel: General background and social inequalities

Israel, established in 1948, has a population of 7.7 million: 76 per cent are Jews, 20 per cent Arabs (86 per cent of whom are Muslims), and the rest are Druze and other groups.⁸ The immigration of Jews is central to Israel's development, with major waves arriving in the 1950s and 1960s. A more recent large wave of close to one million immigrants arrived in the 1990s from the former Soviet Union. By now, 28 per cent of the Jewish population is foreign-born.⁹ These figures represent the multi-ethnic and multi-cultural characteristics of Israeli society and its major social divisions. The major and most salient rift is between Jews and Arabs, constantly affected by the Israeli-Palestinian conflict. The Israeli Arabs, who are native-born, became a minority in 1948 and found themselves in a subordinate posi-

7 Gamliel-Yehoshua, Haya & Vanhuysse, Pieter (2010) 'The Pro-Elderly Bias of Social Policies in Israel: A Historical-Institutional Account'. *Social Policy & Administration*, Vol. 44, No. 6, 708–726.

8 Israel Central Bureau of Statistics (2011a) *Statistical Abstract of Israel 2010*. Jerusalem: Central Bureau of Statistics. Online. Available HTTP: <<http://www1.cbs.gov.il/reader/shnatonenew.htm>> (accessed July 2012)

9 Israel Central Bureau of Statistics 2011a.

tion to the Jewish population, politically, socially and economically. They have lower education, income, occupational and standard-of-living levels than their fellow Jewish citizens. The Jewish population is also characterized by an ethnic cleavage between those of European or American (Ashkenazi) origin and those originating from North African or Middle Eastern/Asian countries (Sephardi origin). The latter group has been subordinate to the former in many socio-economic indicators – education, income and occupational status.¹⁰

Israel, as one of the Mediterranean group of welfare states, was originally influenced by the Beveridgean legacy in which social protection programmes are funded through general tax revenues, including, for example, the introduction of residual safety-net programmes for the poor in 1980.¹¹ Since the mid-1990s, however, the welfare regime characterized by universalism and comprehensive risk coverage has shifted towards a market-oriented economy.¹² Policies aimed at retrenching the welfare state became more apparent with the significant reduction of most benefits, in conjunction with cutbacks or spending freezes on many programmes, in keeping with the stated aim of reducing government expenditure. This more explicitly neoliberal and non-universal welfare approach took effect particularly after Benjamin Netanyahu first became a prime minister in 1996 and when he became finance minister in 2002, and has left an indelible mark on welfare in the country.¹³ A further non-progressive policy of reducing tax rates was introduced, the benefits of which have accrued to those in the highest income deciles.¹⁴ Thus, the direct effect of government policy on the levels of poverty and inequality through social welfare allowances and direct taxes

10 Semyonov, Moshe & Lewin-Epstein, Noah (2011) 'Wealth Inequality: Ethnic Disparities in Israeli Society'. *Social Forces*, Vol. 99, 935–959.

11 Gal, John (2010) 'Is There an Extended Family of Mediterranean Welfare States?' *Journal of European Social Policy*, Vol. 20, Issue 1, 283–300.

12 Zambon, Alessio, Boyce, Will, Cois, Ester, Currie, Candace, Lemma, Patrizia, Dalmasso, Paola, Borraccino, Alberto & Cavallo, Franco (2006) 'Do Welfare Regimes Mediate the Effect of Socio-economic Position on Health in Adolescence? A Cross-National Comparison in Europe, North America, and Israel'. *International Journal of Health Services*, Vol. 36, Issue 2, 309–329.

13 Gamliel-Yehoshua & Vanhuysse (2010).

14 Bank of Israel (2011) *Bank of Israel, Annual Report, 2011*. Chapter 8: Welfare Policy Issues. Online. Available HTTP: <http://www.boi.org.il/en/NewsAndPublications/RegularPublications/Documents/Doch2011/pe_8.pdf> (accessed July 2012)

has weakened. In the past decade, the incidence of poverty in individuals increased from 21.1 per cent in 2002 to 24.4 per cent in 2010, and the income gap (the average gap between the poverty line and the income of poor persons) increased from 29.7 per cent to 35.8 per cent during these years.¹⁵ Poverty rates parallel ethnic and social division in the population, with rates reaching close to 57 per cent among Israeli Arabs and ultra-Orthodox Jews, populations that are characterized by large families, low educational level and low employment rates.¹⁶ The above mentioned policy changes in Israel are reflected in the increase in inequality levels measured by the Gini coefficient (a standard measure of income inequality that ranges from zero to one, the higher the coefficient the greater the inequality): from 0.32 in the 1980s to 0.38 in the late 2000s, ranking third in inequality among OECD countries.¹⁷ The ratio of the average income of the richest 10 per cent of the population to that of the poorest 10 per cent is 9 to 1 in the OECD countries; it is much lower in the Nordic countries, but reaches 14 to 1 in Israel.¹⁸

One of the effects of these growing social inequalities in Israeli society is reflected in health status inequalities and in utilization of health services, despite the fact that the right to health is fundamental in Israel. The Israeli health system has traditionally offered universal health care administered by four health maintenance organizations (HMOs) that were initially set up by the country's labour unions before the establishment of the state in 1948. However, persons not in the workforce were usually uninsured. Since January 1995, under the provisions of the National Health Insurance Law, all permanent residents are insured and are entitled to health services in accordance with the principles of justice, equality, and mutual support. However, the Israeli health system is far from being able to adhere to these principles. Although a basic basket of medical services is provided under the Law, health inequalities persist between the major social divisions in Israeli

15 Bank of Israel 2011.

16 Bank of Israel 2011.

17 Organisation for Economic Co-operation and Development (OECD) (2011a) *Growing Income Inequality in OECD Countries: What Drives It and How Can Policy Tackle It?* Online. Available HTTP: <<http://www.oecd.org/dataoecd/32/20/47723414.pdf>> (accessed October 2011)

18 OECD 2011a.

society, between those with high and low SES levels, between central and peripheral areas, and between the Jewish majority and the Arab minority.¹⁹ In order to fully understand these differences in the Israeli context, the following sections review the general evidence of the definition and scope of inequalities in health and well-being globally and their explanatory variables, followed by the evidence in Israel.

Socioeconomic inequalities in health

Health inequalities refer to the difference in health status between social groups that is not only unnecessary and avoidable, but is also considered unfair and unjust.²⁰ Although the term health inequities has been used in recent years to emphasize the injustice of the difference in health status, I use the term health inequalities, which emphasizes the unequal distribution of health, and is often used interchangeably with the term health disparities in the American literature. SES inequalities are most commonly measured as differences in income, education, occupation or household assets at the individual level, and as per capita gross domestic product (GDP) at community, regional or national levels.

The importance of poverty has been recognized as a major social factor of health since the 19th century when it was recognized as a determinant of infectious disease – e.g. Rudolf Virchow's conclusion that poor sanitation, ignorance of basic hygiene, lack of education, and near starvation were the root problems of a typhus epidemic.²¹ The more recent awareness of the effects of these factors on non-communicable diseases, on general health status and on mortality, has generated compelling evidence that lower SES

19 Chernichovsky, Dov (2011) 'The Healthcare System.' In Ben-David, Dan (ed.) *State of the Nation Report – Society, Economy and Policy 2010*. Jerusalem: Taub Center for Social Policy Studies. [Hebrew]

20 Adler, Nancy E. & Stewart, Judith (2010) 'Health Disparities across the Lifespan: Meaning, Methods, and Mechanisms.' *Annals of the New York Academy of Sciences*, Vol. 1186, 5–23.

21 Reese, David M. (1998) 'Fundamentals – Rudolf Virchow and Modern Medicine.' *Western Journal of Medicine*, Vol. 169, 105–108.

is associated with higher mortality rates and poorer health.²² Typically, the age-adjusted risk of death for those at the lowest socioeconomic level is two or three times as high as that of the highest level.²³ The magnitude of the inequalities is stronger for mortality than for morbidity and varies between countries. For example, among European countries, relative inequalities in mortality between men with the lowest and the highest level of education were just under two in Sweden and in England and Wales, and were four or higher in Hungary, the Czech Republic, and Poland; on the other hand, the relative inequalities in the prevalence of poor self-assessed health were 1.2 in Germany and about 1.7 in Portugal.²⁴ It is important to note that these trends have been observed not only for the general population but also within age sub-populations. The rate of reporting their children as being in fair/poor health was almost twice as high among families in the bottom 25th income percentile compared with those in the 75th income percentile.²⁵ Similarly, health inequalities persist even among the oldest-old (85 years of age or older) but the evidence is less consistent and is confounded by significant methodological issues.²⁶

Differences are found not only between those in the extreme SES categories. Consistent evidence from various countries shows that there is a social gradient of mortality and morbidity: each step one moves up the social lad-

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- 22 Lantz, Paula M., House, James S., Mero, Richard P. & Williams, David R. (2005) 'Stress, Life Events, and Socioeconomic Disparities In Health: Results from the Americans' Changing Life Study'. *Journal of Health and Social Behavior*, Vol. 46, Issue 3, 274–288; Mackenbach, Johan P., Stirbu, Irina, Roskam, Albert-Jan R., Schaap, Maartje M., Menvielle, Gwen, Leinsalu, Mall & Kunst, Anton E. (2008) 'Socioeconomic Inequalities in Health in 22 European Countries'. *New England Journal of Medicine*, Vol. 358, Issue 23, 2468–2481; van Oort, Floor V. A., van Lenthe, Frank J. & Mackenbach, Johan P. (2005) 'Material, Psychosocial, and Behavioural Factors in the Explanation of Educational Inequalities in Mortality in the Netherlands'. *Journal of Epidemiology & Community Health*, Vol. 59, 214–220.
 - 23 Phelan, Jo C., Link, Bruce G. & Teranifer, Parisa (2010) 'Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications'. *Journal of Health and Social Behavior*, Vol. 51, Suppl., S28–S40.
 - 24 Mackenbach et al. 2008.
 - 25 Chen, Edith, Martin, Andrew D & Matthews, Karen A (2004) 'Why Socioeconomic Status Affects The Health Of Children: A Psychosocial Perspective'. *Current Directions in Psychological Science*, Vol. 13, 112–115.
 - 26 Guille, Edith, Bopp, Matthias, Faeh, David & Paccaud, Fred (2010) 'Socioeconomic Gradients in Mortality in the Oldest old: A Review'. *Archive of Gerontology and Geriatrics*, Vol. 51, Issue 3, e37–e40.

der, the better one's health.²⁷ Moreover, an important issue is the evidence that socioeconomic inequalities in health in various Western countries persist or have widened despite various programmes aimed at reducing them.²⁸ However, the mechanisms responsible for these health inequalities are still being debated.

SES inequalities in health in Israel

Significant differences in health between the major social divisions in the population have been consistently reported. For instance, differences in life expectancy at birth between Jews and Arabs persist. Among men, life expectancy was 80.4 and 76.8 years for Jews and Arabs respectively, and 83.7 and 81.0 years among women, respectively.²⁹ Infant mortality rates, which declined to 4 per 1000 live births in 2010, have declined more steeply among Arabs during the last decades, but are still double the rate among Jews.³⁰ General measures of morbidity, for example self-rated health (SRH), are poorer and the rate of disabilities higher among Arabs than among Jews.³¹ It is important to note, however, that a comparison between Arab and Jewish residents found no differences in health status between the two populations in localities with a low socio-economic standing, although they persisted in middle and higher status localities.³² Similarly, differences in mortality were found between sub-groups of the Jewish population, e.g. higher mortality rates among those of North-African origin, but the difference disappeared

27 Siegrist, Johannes & Marmot, Michael (2004) 'Health Inequalities and the Psychosocial Environment – Two Scientific Challenges'. *Social Science and Medicine*, Vol. 58, 1463–1473.

28 Davey-Smith, George, Dorling, Danny, Mitchell, Richard & Shaw, Mary (2002) 'Health Inequalities in Britain: Continuing Increases Up to the End of the 20th Century'. *Journal of Epidemiology and Community Health*, Vol. 56, Issue 6, 434–435; Mackenbach, Johan P., Bos, Vivian, Andersen, Otto, Cardano, Mario, Costa, Giuseppe, Harding, Seeromanie, Reid Alison, Hemström, Örjan, Valkonen, Tapani & Kunst, Anton E., (2003) 'Widening Socioeconomic Inequalities in Mortality in Six Western European Countries'. *International Journal of Epidemiology*, Vol. 32, Issue 5, 830–837.

29 Israel Central Bureau of Statistics 2011a.

30 Israel Central Bureau of Statistics 2011a.

31 Israel Ministry of Health (2010a) *Tackling Health Inequality*. Jerusalem: Ministry of Health. [Hebrew]

32 Shemesh, Annarosa A., Nacamulli Levi, Diana, Horowitz, Pamela & Averbuch, Emma (2011) *Health Gaps and Social Periphery*. Jerusalem: Ministry of Health. [Hebrew]

completely when SES measures were taken into account.³³ These findings suggest that health differences between Jews and Arabs or by ethnic origin within the Jewish population are confounded by SES (see details above in the introduction). In line with the focus of this chapter on SES inequalities in health, evidence is provided of the SES inequalities in health within the Arab or the Jewish population, using data from national representative samples.

Within the Jewish population, significant SES inequalities presenting a clear social gradient from those at the lowest to those at higher levels were found in adult mortality rates,³⁴ as well as in infant mortality as measured by the mother's educational level or by the socioeconomic community score of the place of residence.³⁵ Likewise, inequalities were observed in regard to morbidity, measured by SRH or limiting longstanding illness (LLI). For example, the odds for those with low vs. high education (age and gender adjusted) were more than four for fair/poor SRH, and about two for LLI in the Jewish population.³⁶ Similar findings were observed within the Arab population: the respective odds ratios were close to four for fair/poor SRH, and about 2.5 for LLI.³⁷

There is also evidence that health inequalities have widened in the past two decades. One example is a study comparing adult mortality rates in two cohorts (early 1980s and mid-1990s) within the Jewish population. Special attention was given to avoiding biases due to distributional changes across

33 Jaffe, Dena, H. Neumark, Yehuday, D. Eisenbach, Zvi & Manor, Orly (2008) 'Educational Inequalities in Mortality Among Israeli Jews: Changes over Time in a Dynamic Population'. *Health and Place*, Vol. 14, 287–298.

34 Manor, Orly, Eisenbach, Zvi, Peritz, Eric & Friedlander, Yehiel (1999) 'Mortality Differentials Among Israeli Men'. *American Journal of Public Health*, Vol. 89, 1807–1813; Manor, Orly, Eisenbach, Zvi, Israeli, Avraham & Friedlander, Yehiel (2000) 'Mortality Differentials Among Israeli Women: The Israel Longitudinal Mortality Study'. *Social Science and Medicine*, Vol. 51, 1175–1188.

35 Israel Ministry of Health 2010a.

36 Soskolne, Varda & Manor, Orly (2010) 'Health Inequalities in Israel: Explanatory Factors of Socio-economic Inequalities in Self-Rated Health and Limiting Longstanding Illness'. *Health & Place*, Vol. 16, 242–251.

37 Daoud, Nihaya, Soskolne, Varda & Manor, Orly (2009a) 'Educational Inequalities in Self-Rated Health within the Arab Minority in Israel: Explanatory Factors'. *European Journal of Public Health*, Vol. 19, Issue 5, 477–483; Daoud, Nihaya, Soskolne, Varda & Manor, Orly (2009b) 'Examining Cultural, Psychosocial, Community and Behavioral Factors in Relationship to Socioeconomic Inequalities in Limiting Longstanding Illness Among the Arab Minority in Israel'. *Journal of Epidemiology and Community Health*, Vol. 63, 351–358.

socioeconomic groupings, and transformations within social structures that occur over time (such as mass immigration from the former Soviet Union to Israel in the early 1990s). Using a composite household amenities variable as a measure of asset-based wealth to represent the social hierarchy unique to each cohort, and dividing the second cohort into stable residents and recent immigrants, widening inequalities were observed in overall mortality: odds ratios for overall mortality for those at the lower level compared with those at the highest level of wealth among stable residents grew from 1.34 to 1.44 among men and from 1.30 to 1.42 among women.³⁸ In an additional analysis, the risk of mortality from cardiovascular disease among women with low vs. high levels of education increased from two to five times over these two study periods.³⁹ Other data show that disparities in infant mortality between those born to mothers with lowest vs. highest educational level increased from a relative risk of 3.5 in 1993–1996 to 4.6 in 2000–2002.⁴⁰

Explanatory models of SES inequalities in health

Several approaches to revealing the underlying mechanisms and the explanatory factors of SES inequalities in health have been proposed over the years.⁴¹ The material factors approach suggests that individual income and material living conditions have a direct influence on health. The health behaviours approach views differences in life-style behaviours, such as in smoking, dietary habits, physical activity or alcohol consumption as major factors of differences in health. The life-course approach argues that early-life SES effects, such as poverty and limited environmental resources affect the health in childhood and are carried into adulthood along with cumulative SES inequalities in health. The psychosocial environment approach suggests that material factors or health behaviours alone are insufficient for explaining SES inequalities in health; individual psychosocial factors (for

38 Jaffe, Dena H. & Manor, Orly (2009) 'Assessing Changes in Mortality Inequalities in Israel Using a Period-Specific Measure of Socioeconomic Position, 1983–92 and 1995–2004'. *European Journal of Public Health*, Vol. 19, Issue 2, 175–177.

39 Jaffe et al. 2008.

40 Israel Ministry of Health (2005) *Health in Israel, 2005*. Jerusalem: Ministry of Health.

41 Bartley, Mel (2004) *Health Inequality. An Introduction to Theories, Concepts and Methods*. Cambridge: Polity.

example, life events, lack of social support, working conditions) or community factors such as neighbourhood characteristics, community socio-economic level, and social capital are mediating pathways that link SES to health-related behaviours and biological response.⁴² While there may be disagreement about the specific approach, there is consensus that social position is linked to health via complex multilevel (individual and macro-level) pathways of diverse factors.⁴³ The explanatory power of the factors refers to their statistical power in mediating the association between SES and health, or in other words, in reducing the SES inequalities in health.

Individual-level explanatory variables

The factors and their power in explaining health inequalities may differ according to the health outcome selected. For example, material variables are the most significant explanatory variables when mortality rates are used as an outcome measure.⁴⁴ In contrast, psychosocial factors⁴⁵ or physical working conditions⁴⁶ are significant explanatory factors of SES inequalities in health when self-rated health (SRH) is used as the outcome measure. These examples should not be taken as contradictory, but rather as an indication of the complexity of the underlying mechanisms of the SES inequalities in health. This understanding as well as the persistence of SES inequalities in overall health in recent decades⁴⁷ provide evidence to the theory of fundamental causes of the SES association with health,⁴⁸ which states that a) SES is

42 Kawachi, Ichiro, Kennedy, Bruce P., Lochner, Kimberly & Protow-Stith, Deborah (1997) 'Social Capital, Income Inequality, and Mortality'. *American Journal of Public Health*, Vol. 87, 1492–1498; Marmot, Michael & Wilkinson, Richard G. (2001) 'Psychosocial and Material Pathways in the Relation Between Income and Health: A Response to Lynch et al'. *British Medical Journal*, Vol. 322, 1233–1236.

43 Singh-Manoux, A., Macleod, J. & Davey, S. (2003) 'Psychosocial Factors and Public Health'. *Journal of Epidemiology and Community Health*, Vol. 57, No. 8, 553–556.

44 van Oort et al. 2005.

45 Molarius, Anu, Berglund, Kenneth, Eriksson, Charli, Lambe, Mats, Nordström, Eva, Eriksson, Hans G. & Feldman, Inna (2007) 'Socioeconomic Conditions, Lifestyle Factors, and Self-Rated Health Among Men and Women in Sweden'. *European Journal of Public Health*, Vol. 17, Issue 2, 125–133.

46 Kaikkonen, Risto, Rahkonen, Ossi, Lallukka, Tea & Lahelma, Eero (2009) 'Physical and Psychosocial Working Conditions as Explanations for Occupational Class Inequalities in Self-Rated Health'. *European Journal of Public Health*, Vol. 19, Issue 5, 458–463.

47 Phelan, Link & Teranifer 2010.

48 Link, Bruce G. & Phelan, Jo C. (1995) 'Social Conditions as Fundamental Causes of Disease'. *Journal of Health and Social Behavior*, Special No., 80–94.

related to multiple disease outcomes via multiple psychosocial, behavioural and biological risk factors, and b) that the deployment of resources plays a critical role in the association between SES and health (thus supporting the combination of the above mentioned explanatory models). However, they also argue that c) SES maintains an association with disease over time even when intervening mechanisms change, because the risk factors are replaced by new ones. For example, behavioural risk factors such as smoking replaced old ones such as poor sanitary conditions. This argument suggests that when new knowledge is produced or new technologies developed, those at a higher SES level adopt it in ways that benefit their health, thus maintaining their health advantage over those at lower SES levels.

In Israel, two studies have shown the contribution of individual material and psychosocial variables as explanatory factors of SES inequalities in health. Adjusting for various individual and community psychosocial variables and health behaviours, the educational inequalities in SRH and in LLI were substantially reduced and became non-significant in the Arab population.⁴⁹ In the Jewish population these intervening variables fully explained the educational inequalities in LLI but only partially in SRH, suggesting that other variables mediate this association.⁵⁰

Societal-level explanatory variables

Additional approaches suggest that beyond the above mentioned individual-level characteristics, macro-level societal factors are significant explanatory variables of health inequalities. Richard G. Wilkinson claims that the more unequal a society's rate of inequality, the worse its health, and that socioeconomic inequality affects psychosocial factors such as social relations, low social status, family functioning, and stress, thereby impacting on health.⁵¹ For every 0.05 increase in the Gini coefficient, mortality increased by 7.8 per cent, with an estimated 1.5 million excess deaths each year in 30

49 Daoud, Soskolne & Manor 2009a; Daoud, Soskolne & Manor 2009b.

50 Soskolne & Manor 2010.

51 Wilkinson, Richard G. (2005) *The Impact of Inequality: How to Make Sick Societies Healthier*. New York: The New Press.

OECD countries.⁵² The evidence in Israel does not, as yet, support this association; although Israel ranks third highest in the rate of social inequality (Gini coefficient) among OECD countries, life expectancy is higher than the average for OECD countries.⁵³ This could be the result of the presence of a retrenched, yet high quality public health-care system in Israel.

Another societal measure is welfare state regime. Based on evidence that morbidity and mortality rates in Scandinavian countries (welfare state regime types that offer universalism, comparatively generous replacement rates, and extensive welfare services) were lower than in other welfare state regimes, the expectation was that health inequalities would also be the smallest; yet, the findings showed otherwise.⁵⁴ Bismarckian and Southern regimes fairly consistently exhibited smaller educational inequalities in health than Scandinavian regimes across most age groups.

In Israel, the evidence of widening gaps in health could partially reflect the changes in welfare policy in Israel since the late 1990s. Although Israel enjoys high-quality medicine, the health-care system suffers from major funding and organizational problems. While all Israelis are required to register with one of the HMOs to be entitled to a basic government-funded health-care package, the National Health Insurance Law permitted HMOs to create supplementary medical insurance that Israelis could purchase, allowing them greater access to affordable private care. Some 80 per cent of Israelis now hold supplementary medical insurance (of which only 55 per cent is via the HMOs and the rest is commercial) that covers a portion of private care. Furthermore, the government pays for 59 per cent of Israeli health-care expenditures, the lowest share among developed countries that provide universal health care, and a sharp decrease from close to 70 per cent in the mid-1990s.⁵⁵ National expenditure on health as a percentage of the

52 Pickett, Kate E. & Wilkinson, Richard G. (2009) 'Greater Equality and Better Health'. *British Medical Journal*, Vol. 339, 1154–1155.

53 OECD 2011a.

54 Bambra, Clare, Netuveli, Gopalakrishnan & Eikemo, Terje A. (2010) 'Welfare State Regime Life Courses: The Development of Western European Welfare State Regimes and Age-Related Patterns of Educational Inequalities in Self-Reported Health'. *International Journal of Health Services*, Vol. 40, Issue 3, 399–420.

55 Chernichovsky 2011.

gross national product (GDP) in 2009 was 7.6 per cent in Israel compared with 10 per cent in Sweden, 9.8 per cent in the UK, and 8.7 per cent in Australia.⁵⁶

This situation has created a shift towards private medicine, which fewer people can afford, while the public hospitals (almost all the hospitals in Israel) and community health-care services suffer from shrinking budgets. Indeed, inequality in access to health services has been increasing. People at lower income levels report greater difficulties in obtaining access to medical care than those at a higher income level.⁵⁷ These findings at the individual level were further supported by evidence at the community level. The availability of specialty care physicians is 5–10 times lower, and the hospital beds ratio per 1000 residents is about two times lower in localities of low SES status or in the periphery.⁵⁸ These conditions led to a five-month doctors' strike in Israel in 2011, the demands being not only an increase in wages and a decrease in working hours, but also a substantial shift in budget allocations in order to rescue the public medical system. During the strike, a prominent Israeli journalist described the situation:

“Suddenly, people are realising that without a strong public sector there is no strong economy. Health care is an instructive example... The Finance Ministry did not appreciate the rare Israeli achievement of the health-care system. Its officials wanted America. So they reduced expenses, lowered costs and encouraged privatization. They subjected the health system to market forces. The treasury's privatisers ignored the fact that the basic conditions that enable and justify a market economy do not exist in the health system. The result has been devastating.”⁵⁹

56 Israel Central Bureau of Statistics (2011b) *CBS Statistical Abstract of Israel 2011*. National Expenditure on Health, International Comparisons. Online. Available HTTP: <http://www.cbs.gov.il/shnaton62/st28_02.pdf> (accessed March 2012)

57 Gross, Revital, Bramli-Greenberg, Shuly & Waitzberg, Ruth (2009) *Public Opinion on the Level of Service and Performance of the Healthcare System in 2007 and in Comparison With Previous Years*. Jerusalem: Myers-JDC-Brookdale Institute.

58 Israel Ministry of Health 2010a.

59 Shavit, A. (2011) 'Health Care in the Privatized Lane', *Haaretz*, 10 March 2011. Online. Available HTTP: <<http://www.haaretz.com/print-edition/opinion/health-care-in-the-privatized-lane-1.348255>> (accessed October 2011)

The central role of the state in widening SES inequalities in health is regarded as destroying the fundamental right to health. The Association for Civil Rights in Israel (ACRI) claims that consecutive Israeli governments have shirked their social and economic responsibilities, and the deterioration in the scale and quality of services provided by the health system has actually resulted in two health systems that differ substantially in quality – one for the rich and the other for the poor.⁶⁰

Well-being and health

In the following sections a more detailed definition of well-being and evidence of SES inequalities in well-being is elaborated in order to arrive at a better informed use of well-being targets in the health inequalities agenda.

The conceptualization of well-being is broad and without a single, accepted definition. In health and epidemiological studies, well-being focuses on assets in functioning, including positive emotions and psychological resources, the absence of negative emotions, and satisfaction with life, fulfilment and positive functioning.⁶¹ However, the other common measure, that of health-related quality of life (HRQOL), includes some of these components in its definition as ‘an individual’s or group’s perceived physical and mental health over time’, yet it generally focuses on deficits in functioning, e.g. pain, negative affect.⁶²

The ambiguity of the concept is thus often based on the differences between measures that include physical health as one of the components of well-being, and those that view well-being as more a subjective psychological concept, separate from health. The Gallup Well-being Index is an average of six sub-indexes of life evaluation, physical health, emotional health, work environment, health behaviours and access to basic necessities.⁶³ In contrast,

60 ACRI (Association for Civil Rights in Israel) (2011) *The Right to Health*. Association for Civil Rights in Israel. Online. Available HTTP: <<http://www.acri.org.il/en/?p=2658>> (accessed August 2011)

61 CDC (Centers for Disease Control) (2001) *Well-being Concepts*. Online. Available HTTP: <<http://www.cdc.gov/hrqol/well-being.htm>> (accessed March 2012)

62 CDC (Centers for Disease Control) (2000) *Measuring Healthy Days: Population Assessment of Health-Related Quality of Life*. CDC Monographs. Atlanta: Centers for Disease Control and Prevention.

63 Gallup-Healthways (2011) *The Gallup – Healthways Index of Well-being*. Online. Available HTTP: <<http://www.well-beingindex.com>> (accessed August 2011)

the most commonly used conceptualization of well-being focuses only on the psychological aspects and makes the distinction of defining it as global judgments of life satisfaction and of feelings, ranging from depression to joy.⁶⁴ Subjective well-being should, therefore, differentiate between two concepts that are often confounded: emotional well-being, which refers to the emotional quality of an individual's everyday experience, the frequency and intensity of experiences of joy, stress, sadness, anger, and affection; and life evaluation, which refers to the thoughts people have about their life when they think about it.⁶⁵ Studies have confirmed the validity of this division between the affective and the cognitive dimension dimensions of subjective well-being, concluding that well-being is not an unidimensional construct.⁶⁶

Findings from prospective studies demonstrate the influence of subjective well-being, especially in the form of positive affect, on health and longevity in healthy populations, as well as in some samples of patients living with a chronic disease.⁶⁷ Cross-sectional studies show that life satisfaction and positive and negative affectivity is significantly related to perceived health.⁶⁸ However, this association may be bi-directional: health status is strongly linked to life satisfaction.⁶⁹ Less is known about the scope of SES inequalities in well-being, as well as whether well-being plays an important role as a potential explanatory variable of SES inequalities in physical health.

64 Diener 2000.

65 Kahneman, Daniel & Deaton, Angus (2010) 'High Income Improves Evaluation of Life But Not Emotional Well-Being'. *Proceedings of the National Academy of Sciences*, Vol. 107, Issue 38, 16489–16493.

66 Kahneman, Daniel & Krueger, Alan, B. (2006) 'Developments in the Measurement of Subjective Well-Being'. *Journal of Economic Perspectives*, Vol. 20, Issue 1, 3–24; Watson, Dorothy, Pichler, Florian & Wallace, Clare (2010) *Second European Quality of Life Survey: Subjective Well-Being in Europe*. Luxembourg: Office for Official Publications of the European Communities.

67 Diener & Chan 2011.

68 Cloninger, C. Robert & Zohar, Ada, D. (2011) 'Personality and the Perception of Health and Happiness'. *Journal of Affective Disorders*, Vol. 128, 24–32.

69 OECD (2011b) *How's Life? Measuring Well-being*. Chapter 12. Subjective Well-being. Online. Available HTTP: <http://www.keepeek.com/Digital-Asset-Management/oecd/economics/how-s-life/subjective-well-being_9789264121164-14-en> (accessed July 2012)

SES inequalities in well-being

Although few studies have examined SES inequalities in well-being, their findings show a similar pattern to that of SES inequalities in health. Yet, the association of SES (measure by income) with well-being was found to vary by the nature of the well-being dimension: the slope was much steeper for life evaluation than for measures of feeling (positive affect and [no] negative feelings), suggesting milder income inequalities for the emotional dimensions of well-being than for the (cognitive) life evaluation.⁷⁰ Similar, but more specific results among American respondents showed that people's life evaluations rise steadily with income, but that the emotional dimensions of well-being are fully satiated at an annual income of about \$75 000; above this level there was no improvement whatsoever in any of the three measures of emotional well-being. Moreover, the association differs within the emotional dimension: the strength of the association of income is greater with negative measures ('not blue' affect, and stress free) than for positive affect.⁷¹

Similarly, satiation points were found in educational inequalities in life satisfaction, happiness and emotional well-being in the European Quality of Life Survey. People with low levels of education had significantly lower levels of subjective well-being than those who had completed secondary-level education. There was, however, no additional benefit to subjective well-being from education beyond secondary level when income and living standard are controlled.⁷²

Data on mediating factors that may explain the SES inequalities in well-being are relatively limited. One study found different mediators of the association between income and the life evaluation and emotional dimensions of well-being. The strongest mediation between income and life evaluation was satisfaction with a material factor (standard of living), while social psychological prosperity was a more significant mediator for feelings.⁷³ A

70 Diener, Ed, Ng, Weiting, Harter, James & Arora, Raksha (2010) 'Wealth and Happiness Across the World: Material Prosperity Predicts Life Evaluation, Whereas Psychosocial Prosperity Predicts Positive Feeling.' *Journal of Personality and Social Psychology*, Vol. 99, 52–61.

71 Kahneman & Deaton 2010.

72 Watson, Pichler & Wallace 2010.

73 Diener, Ng, Harter & Arora 2010.

community-level study demonstrated that the negative association between societal income inequality and individual-level happiness was explained by perceived fairness and general trust.⁷⁴ Additionally, while the income inequalities in the positive measure of emotional well-being were fully explained by the inclusion of explanatory variables, the association of income with negative feelings remained significant.⁷⁵ Others have also demonstrated that in addition to income level, explanatory factors of positive affect differ from those of negative affect and are usually weaker or non-significant,⁷⁶ echoing Leo Tolstoy's famous quote: 'Happy families are all alike; every unhappy family is unhappy in its own way.'⁷⁷

Although this chapter adopts the convergence of health and well-being, one may still question whether subjective well-being is an explanatory factor of SES inequalities in physical health. The evidence is sparse. One direction rests on the indication that positive affect may have distinctive biological correlates that can benefit health, and that positive affect is associated with protective psychosocial factors, thus suggesting that positive affect may be part of a broader profile of psychosocial resilience that reduces the risk of adverse physical health outcomes.⁷⁸ In fact, positive and negative states produce independent effects on health when controlling for the other.⁷⁹ Other evidence from a meta-analysis showed that negative measures slightly more strongly predicted short-term health outcomes, whereas positive well-being slightly more strongly predicted long-term health outcomes.⁸⁰ These findings may indicate the potential role of well-being in explaining physical health inequalities.

74 Oishi, Shigehiro, Kesebir, Selin & Diener, Ed (2011) 'Income Inequality and Happiness'. *Psychological Science*, Vol. 22, Issue 9, 1095–1100.

75 Diener, Ng, Harter & Arora 2010.

76 Katz, Ruth (2009) 'Intergenerational Family Relations and Subjective Well-Being in Old Age: A Cross-National Study'. *European Journal of Ageing*, Vol. 6, Issue 2, 79–90.

77 Tolstoy, Leo (2000 [1873]) *Anna Karenina*. London: Allen Lane/Penguin.

78 Steptoe, Andrew, Dockray, Samantha & Wardle, Jane (2009) 'Positive Affect and Psychobiological Processes Relevant to Health'. *Journal of Personality*, Vol. 77, Issue 6, 1747–1776.

79 Steptoe, Dockray & Wardle 2009.

80 Howell, Ryan T., Kern, Margaret L. & Lyubomirsky, Sonja (2007) 'Health Benefits: Meta-Analytically Determining the Impact of Well-Being on Objective Health Outcomes'. *Health Psychology Review*, Vol. 1, Issue 1, 83–136.

SES inequalities in well-being in Israel

In the OECD survey of well-being, Israelis rate life satisfaction at 7.4 (on a scale from 0 to 10), which is higher than the OECD average of 6.7, thus ranking Israel eighth out of 36 countries.⁸¹ This result is surprising as it stood in contrast to the grading of Israel's positive affect balance which was much lower than the OECD average. While in most OECD countries, people reported experiencing more positive than negative affect, reaching an average of eighty per cent for all OECD countries but only 69 per cent in Israel.⁸² The contradiction between the levels of the two dimensions of well-being in Israel can be explained by the fact that they are influenced in different ways by social indicators. Whereas positive affect is only weakly associated with income, life satisfaction is strongly influenced by income: the bottom 20 per cent of the Israeli population has a level of 6.6 in life satisfaction, while this score reaches 8.0 for the top 20 per cent.⁸³ Additional data supports these findings showing that income is significantly associated with the cognitive dimensions of well-being (quality of life and life satisfaction), but not with the affective dimension (depression).⁸⁴

These inequalities in life satisfaction provide additional evidence for the consequences of the societal changes and the situation of the health-care system in Israel as described above. They shed additional light on the circumstances of the growing social inequalities, the increasing proportion of economically deprived people, and the feeling among many working people that their earnings do not enable them to afford basic necessities. In fact, these factors were fertile ground and a major catalyst for the outbreak of the nation-wide social protests in Israel that continued throughout the summer months of 2011. The protests were initiated by mainly middle-class people against the significant rise in the cost of living, unaffordable public housing, rising food, fuel and basic amenity prices, as well as increasing privatization of the public education system and health services. Thousands of people

81 OECD 2011b.

82 OECD 2011b.

83 OECD 2011b.

84 Amit, Karin & Litwin, Howard (2010) 'The Subjective Well-Being of Immigrants Aged 50 and Older in Israel'. *Social Indicators Research*, Vol. 98, 89–104.

camped in the country's squares, and hundreds of thousands from all social strata took to the streets clamouring 'the people demand social justice'. After weeks of demonstrations, Prime Minister Benjamin Netanyahu appointed a committee to pinpoint the grievances and propose solutions to Israel's socioeconomic problems (Trajtenberg Committee). The Committee's recommendations were submitted to the government within two months and were perceived to be beneficial for the 'hard-working middle classes', but faced strong political opposition inside the government; instead of adopting all the recommendations, an approach of gradual implementation was eventually adopted and only one recommendation has been implemented. By winter the movement seemed to be dead, but protests resumed in June 2012 because nothing happened, and prices increased.⁸⁵ Thus one may expect even lower levels of positive affect than those detailed above.

Two recent studies highlight the role of well-being as an explanatory factor of SES inequalities in health in Israel. One study demonstrated that when vigour, a dimension of emotional well-being (positive affect) was included in the final regression analysis, educational inequalities in overall mortality became non-significant.⁸⁶ Similarly, another study showed that the association between education and SRH among middle-aged people becomes non-significant when life satisfaction and negative feeling (depression) measures are included in the final step of the hierarchical regression analysis.⁸⁷ These are important contributions to advancing scientific knowledge on the role of well-being in explaining SES inequalities in health.

85 For more details see Alimi, Eitan Y. (2012) "'Occupy Israel:' A Tale of Startling Success and Hopeful Failure'. *Social Movement Studies: Journal of Social, Cultural and Political Protest*, Vol. 3–4, No. 11, 1–6.

86 Shirom, Arie, Toker, Sharon, Jacobson, Orit & Balicer, Ran D. (2010) 'Feeling Vigorous and the Risks of All-Cause Mortality, Ischemic Heart Disease, and Diabetes: A 20-year Follow-Up of Healthy Employees'. *Psychosomatic Medicine*, Vol. 72, 727–733.

87 Iecovitch, Esther & Cwikel, Julie (2010) 'The Relationship between Well-Being and Self-Rated Health among Middle-Aged and Older Women in Israel'. *Clinical Gerontologist*, Vol. 33, Issue 4, 255–269.

Conclusions and implications

The evidence of SES inequalities in physical health outcomes is highly consistent and convincing. It is generally understood that a complex, multi-level array of material, psychosocial, behavioural, societal and policy factors, as well as biological mechanisms, intervene in mediate the association between SES and health. Yet, further research is necessary to elucidate these explanatory pathways, in particular, the way biological mechanisms interact with psychosocial and behavioural factors.

This review also shows that the increasing interest in well-being has produced important information, clarifying the concept and validating its two dimensions. Furthermore, the evidence of SES inequalities in well-being, although in need of further research, has produced clear indication that SES inequalities in life evaluations differ from those in the emotional dimension of well-being. In particular, the preliminary evidence regarding SES inequalities in positive vs. negative measures of emotional well-being dimension call for further research directed at disentangling those that explain inequalities in negative as against positive measures. Such an approach may lead to understanding of mediating protective factors that contribute to positive emotions rather than mainly risk factors for negative emotions and may redirect future interventions aimed at reducing inequalities in well-being to focus on these positive factors. Additionally, regarding the role of well-being as an explanatory variable of SES inequalities in health, this review shows that the evidence is still limited. Prospective studies of life course approaches are necessary in order to assess whether well-being dimensions are determinants, and if so in what way, of the SES inequalities in physical health and mortality. Yet, the preliminary data is sufficient to show the relevance of well-being for the health inequalities agenda as it elucidates different approaches to interventions aimed at reducing SES inequalities in health.

The Israeli case study highlights not only the widening SES inequalities in health, similar to those in several other countries, but also the complexity of the multilevel explanatory factors of SES inequalities in health. Supporting the social determinants of health approach, research findings

indicate that individual-level psychosocial factors are explanatory factors of SES inequalities in health. In addition, the Israeli case demonstrates the role of societal-level factors for health inequalities. Welfare policy changes and growing social inequality in recent decades have exerted their influence on SES inequalities in health, beyond the effects of individual-level differences. At the same time, evidence on life satisfaction and emotional dimensions of well-being is sparse and somewhat contradictory, and no long-term information on changes over time or assessments of the underlying macro- and micro-level explanatory mechanisms of SES inequalities in well-being. Greater effort is required in order to better understand what well-being means for Israelis and, as in other societies, its potential role as an explanatory factor of SES inequalities in physical health. Additionally, the Israeli data showed that the explanatory power of psychosocial and behavioural factors of the SES inequalities in health within the Jewish or the Arab populations differs. No data on ethnic differences in well-being, or differences in SES inequalities in well-being and changes over time with the retrenching welfare state are available. This evidence is essential for Israel and implies that research on SES inequalities in health and well-being within different cultural, ethnic or racial sub-populations, as well as comparative studies of different welfare regimes is a priority in order to provide a basis for evidence-based interventions for many societies.

Implications for practice and policy

The complexity of the mechanisms explaining SES inequalities in health and well-being, and the evidence that the underlying explanatory factors are often replaced by new ones, may lead professionals and policy makers to abandon all hope that health inequalities can be reduced. This, of course, is not the case. Efforts can be made to address the underlying causes, the risk factors, so that the core causes of fundamental factors are tackled.⁸⁸ This requires concerted efforts at all levels: local, regional, and governmental. Data on SES inequalities in well-being as well as the potential role of well-being in

88 Phelan, Link & Teranifer 2010.

explaining health inequalities may subsequently adopt a different approach to interventions by addressing mediating protective factors, rather than only risk factors. For example, interventions aimed at enhancing life satisfaction and positive affect among socio-economically deprived sub-populations may lead to reduction of inequalities in physical health.

It should also be clear that changes are not the sole responsibility of health-care professionals and health policy makers, but rather of many sectors of society. It is evident that reducing economic, educational or occupational inequalities will ultimately affect inequalities in health. Nevertheless, several implications for practice within the health-care system arise from this review. Above all, in all settings, health-care workers should be aware of the magnitude of SES inequalities in health and the factors explaining them, so that they routinely inquire about them and make decisions about appropriate care. Health promotion programmes, whether for primary or secondary prevention, should be creative in not only tackling the underlying factors of health inequalities, but also include interventions to enhance subjective well-being.

Whatever interventions are planned, they will not be successful without political will. The reduction of these inequalities demands coherent policy responses across sectors and across countries, and a firm political commitment by all parties. This idea requires 'governance for health', namely, the pursuit of health as integral to well-being through both a 'whole of government' and a 'whole of society' approach.⁸⁹ Clearly defined goals of reducing SES inequalities in health and well-being need to be defined and routinely monitored. This means that specific measures of subjective well-being, if not already in use, should be incorporated into on-going surveys. Additionally, evaluation research of interventions and of policy changes is imperative.

The efforts aimed at reducing health inequalities are still in their infancy in Israel. Only recently, in 2010, the Ministry of Health responded to the accumulation of research findings regarding the scope of health inequalities in Israel, and to reports and recommendations issued by the Israel Medical

89 WHO (World Health Organization) (2011) *Governance for Health in the 21st Century: A Study Conducted for the WHO Regional Office for Europe*. Copenhagen: WHO Regional Office for Europe.

Association,⁹⁰ and decided to include the reduction of health inequalities as one of the Ministry's major multi-year goals.⁹¹ It was the culmination of pressures from prominent Israeli public health professionals, as well as the impact of the WHO CSDH report. Although this does reflect political will, the initial activities of a special unit in the Ministry have been limited, mainly directed at reducing co-payments by economically deprived populations.⁹² The consistent social gradient in health suggests that although it is tempting to focus limited resources on those most in need, everyone should be targeted. The social protests in Israel have highlighted the plight of the middle class in many life domains, including health. Thus, if the focus is on the worst-off, what would happen to those just above the bottom, or at the median, who have worse health than those above them?

In consequence, a far greater effort to reduce inequalities is required, not a separate health agenda, but action across the whole of society. This is likely to work only if a more integrated approach is adopted, one that links closely to wider social inequalities in the society in order to avert the continued consequences of the neoliberal policy in health care. Despite other enormous problems being faced by Israeli society, above all political and security issues, the health of the nation needs to be more equally distributed. At a national policy level, this requires recognition by the government that reducing health inequalities is a national priority, to be achieved by coordinated actions of health, education, labour, housing and welfare ministries. Better understanding of the explanatory factors of inequalities in health and in well-being is needed as a basis for designing evidence-informed programmes at national and local levels either by universalist welfare policies or by particularist ones, such as progressive payment programmes. In Israel's ethnically and culturally highly diverse society, the explanatory factors of SES inequalities in health may be different across population groups and over the lifecycle. Policies aimed at reducing the SES inequalities in health

90 Israel Medical Association (2008) *Inequality in Health in Israel*. Ramat-Gan: Israel Medical Association.

91 Israel Ministry of Health (2010b) *Health Policy Main Goals 2011–2014*. Online. Available HTTP: <<http://www.health.gov.il/PublicationsFiles/moh2011.pdf>> (accessed March 2012) [Hebrew]

92 Israel Ministry of Health 2010a.

may therefore easily be ineffective in some populations. Therefore, involvement of stakeholders and sub-populations in each locality will assure that 'bottom-up' together with 'top-down' planning of programmes may find effective ways to help distributing health more equally. This is particularly relevant now. The Israeli social protest of 2011 has not (yet?) resulted in policy changes but has propelled an important shift in public and media discourse, forcing the government to take the public voice into consideration more seriously than before.

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Happy without reason? Mental illness and the 'right' to happiness in Sweden

KATARINA PIUVA

Introduction

The question 'All well in the welfare state?' points at the emerging trends about happiness in Western societies. In the field of social research about mental illness and mental disability, happiness – or rather the absence of happiness – is a well-known theme. In view of this fact, it may appear surprising that mental health issues have until recently only rarely been seen on the international political agenda. In 2007, a document published by the World Health Organization (WHO) stated that:

Mental health may be the most neglected public health issue. In much of Europe it remains a taboo to discuss the challenges that mental health raises for governments, societies, and particularly for people with mental health problems themselves.¹

Mental health is seldom in the focus of political discourses on health. Yet, happiness cannot be measured without an idea about unhappiness at the other end of the scale, as its hidden opposite. Knowledge about happiness and health is always a concern for the political administration. Health and happiness is a tempting goal that concerns both the individual and the whole of society; a goal which can be traced through modern public health history. The recently formulated concept of happiness is in some respects

1 Klein, Judith (2007) 'Foreword'. In Knapp, Martin, Mc Daid, David, Mossialos, Elias & Thornicroft, Graham (eds) *Mental Health Policy and Practice across Europe: The Future Direction of Mental Health Care*. Maidenhead: Open University Press, xxii.

very similar to earlier articulations of positive mental health.² It is the same mix of psychology, politics and social science, characteristic for the welfare society guided by the ideals of reason. In the post-war period from 1945 until the early 1970s, the Human Relations School and the concept of 'mental hygiene' carried the message of happiness, relying on 'mental health' and especially 'positive mental health' as the main concepts.³

Public health policies regarding mental health can be split into two aspects: first, to prevent mental illness in the population; and second, to manage the care of the severely mentally ill. The concept that combines those two aspects is 'normality'. Prevention is about keeping the population in good health in order to promote 'normal' mental health. The care of the mentally ill is about taking care of people who are considered as deviant in that respect.

Normality, however, is a difficult concept to grasp; it is seldom explicitly described, yet it is often implicitly assumed as the opposite to deviant behaviour.⁴ Furthermore, it is almost impossible to distinguish definitions of mental health from definitions of normality. When normality is defined, the three following meanings are expressed: the statistical meaning, e.g. the most common, 'like everybody else', the ideal meaning or moral notions about how it should be, and the medical meaning, which implies no health problems, e.g. no deviations from an expected state of health.⁵

The general understanding of normality usually consists of a mix of the three aspects. Of course, the common understanding of normality trans-

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- 2 For a recent conceptualization of happiness, see Pacek, Alexander & Radcliff, Benjamin (2008) 'Assessing the Welfare State: The Politics of Happiness'. *Perspectives on Politics*, Vol. 6, Issue 2, 267–277; for positive mental health, see Jahoda, Marie (1958) *Current Concepts of Mental Health*. New York: Basic Books.
 - 3 Mayo, Elton (1943) *The Social Problems of an Industrial Civilization*. Boston: Harvard Business School; Mindus, Erland (1969) *Arbete och mental hälsa*. Stockholm: Folksam/Tiden; Thomson, Mathew (1995) 'Mental Hygiene as an International Movement'. In Weindling, Peter (ed.) *International Health Organizations and Movements*. Cambridge: Cambridge University Press.
 - 4 Hacking, Ian (1991) *The Taming of Chance*. Cambridge: Cambridge University Press; Tengland, Per-Anders (2001) *Mental Health. A Philosophical Analysis*. Dordrecht: Kluwer Academic Publishers; Piuva, Katarina (2005) *Normalitetens gränser. En studie av den mentallhygieniska rörelsen under 1900-talet*. Stockholm: Stockholm University.
 - 5 Jahoda's division of the normality concept is twofold as she distinguishes between the statistical and the normative ideal. Tideman, Magnus (2000) *Normalisering och kategorisering: Om handikappideologi och välfärdspolitik i teori och praktik för personer med utvecklingsstörning*. Lund: Studentlitteratur; Piuva 2005, 56–60; Jahoda 1958, 18–21.

forms over time, as demands of health and quality of life expectations change. What is considered normal is the result of cultural and political negotiations. Over time, various values, such as autonomy and integrity, have been added to the understanding of normality. These values are also connected to the ethics of welfare. Furthermore, these values work in two directions; as a top-down demand on self-reliant citizens, citizens' and as bottom-up expectations of individual freedom and a minimum of governance by state authorities. The mentally ill, especially those with severe mental illness, often end up with long-term inability to work and to maintain economical self-support. This also entails a lifelong dependency on medical and social services, thereby jeopardizing the contract of autonomy between the welfare state and the individual.

The aim of this chapter is to discuss the problems surrounding the concept of happiness in relation to mental illness. It explores how different understandings of normality affect expectations of happiness. First, the chapter turns to the two main official investigations about mental health care in Sweden during the second half of the twentieth century. The exploration is undertaken with a focus on how mental illness is connected to the health and happiness of the whole population. Second, mental health policy is discussed in terms of practical social work. How are happiness and normal life conditions rendered by the social service administration and how do social interventions affect the autonomy and integrity of the severely mentally ill and their families? Finally, the chapter reflects on the social integration of the severely mentally ill.

The politics of mental illness, normality and happiness

Institutionalization and deinstitutionalization of the mentally ill

Mental care as we understand it in the history of welfare in Western Europe can be briefly summarized as consisting of two periods. The first period of institutionalization refers to the expansion of in-hospital care from the early nineteenth century to the mid-twentieth. The second period covers the closing of the mental hospitals starting from the end of the Second World War

and the policy of integrating people with severe mental illness. The period of institutionalization resulted in a professionalization of care in more organized settings.⁶ The former care of the mentally ill undertaken by the local communities was often inferior to the standards of health care, a condition that repeatedly caused severe criticism from official inspections and investigations.⁷ Historical sources describe the community-based care that the mentally ill had to endure in Scandinavia during the nineteenth and early twentieth century as being terrible.⁸ Patients were described as work house or poor house inmates.⁹ The period of deinstitutionalization after the Second World War is closely connected to the development of the welfare states in Europe. The development of medical care and the political concerns about public health contributed to the integration of the severely mentally ill in national social security plans. However, this was merely an organizational and administrative integration, despite the 1950s and 1960s being an era of institutional growth. Most European countries, with the notable exception of the UK and Ireland, increased the number of hospital beds in mental care during these two decades.

During the 1970s, the deinstitutionalization process aimed for the social integration of the mentally ill. This period of on-going integration is characterized by the expansion of community-care systems. State mental hospitals were replaced by smaller nursing homes and housing facilities in community settings. Official statistics reflect a decline of beds in state psychiatric hospitals from the end of the 1970s. In Sweden, for example, the number of state hospital beds in psychiatric care declined from 75 per cent of all psy-

6 Qvarsell, Roger (1982) *Ordning och behandling. Psykiatri och sinnessjukvård i Sverige under 1800-talets första hälft*. Umeå: University of Umeå.

7 Piuva, Katarina (2010) 'The Meaning of Normality. The Controversy About the Mental Health Campaign in Sweden 1969'. *Scandinavian Journal of History*, Vol. 35, Issue 2, 198–216.

8 Community-based services concerning the severely mentally ill in the cities meant poor houses and mad houses. In rural areas the poor, including the handicapped and severely mentally ill without economical resources, were adapted to the system of *rotehjon*, a kind of ambulating care between estates and farms. According to official investigations, the mentally ill considered as being dangerous or otherwise unruly were locked up in wooden cages or chained in stalls.

9 Berge, Anders (2007) *Sjukvårdens underklass: Sjukvården i den kommunala fattigvården 1910–1950*. Umeå: Borea; Shorter, Edward (2007) 'The Historical Development of Mental Health Services in Europe'. In Knapp, Martin, McDaid, David, Mossialos, Elias & Thornicroft, Graham (eds) *Mental Health Services and Practices Across Europe. Future Directions of Mental Health Care*. Maidenhead: Open University Press.

chiatric beds to 0 per cent between the years 1972 and 2001.¹⁰

However, statistics of this kind do not present an entirely clear picture of the actual development of mental health care during this time. Taking Sweden as an example, the decline in the number of hospital beds represents the closing down of old-fashioned state hospitals. In-hospital care was still conducted by municipalities, community-based nursing homes and by an increasing number of private entrepreneurs to this day. Therefore, it is worth noting that the widespread periodization of mental health care as two 'eras', as presented above, is rather rough and simplified. In addition, research about the social integration of the mentally ill shows a recent trend of 'reinstitutionalization'.¹¹ Nevertheless, institutionalization and deinstitutionalization were the two common public policies in the West European countries, even if the reality always turned out to be more complex. Despite the general tendency of successive political decisions, confinement, community-oriented care and family-oriented care have always co-existed as parallel systems.

The official investigations on the development of the mental-health policy in Sweden reveal the same patterns of deinstitutionalization, followed by a policy of integration, as in all the European welfare states, although the expansion of state managed in-hospital care in Sweden was late in comparison to Europe. This period of expansion during the first decades of the twentieth century was rapid, just as the deinstitutionalization during the last 20 years of the same century has been swift.¹²

10 Shorter 2007, 24–25.

11 Priebe, Stefan, Badesconyi, Alli, Fioritti, Angelo, Hansson, Lars, Kilian, Reinhold, Torres-Gonzales, Francisco, Turner, Trevor & Wiersma, Durk (2005) 'Reinstitutionalization in Mental Health Care: Comparison of Data on Service Provision from Six European Countries'. *British Medical Journal*, Vol. 330, 123–126.

12 Piuva 2010, 200.

In between two regimes of mental health care: The 'caring state' versus the 'autonomous citizen'

The two most important official investigations about mental health care in Sweden were written in 1958 and in 1992, respectively.¹³ As historical documents, they are of great interest as time-bound indicators of how mental illness, mental health and normality have been related to the happiness of the population during the two periods of welfare state policies. The titles of the investigations display two different purposes, adjusted to the welfare agendas of the time. Irrespective of the time they were written, however, both these official texts about mental care and social services struggle to integrate the target group into the welfare society.

When reading SOU 1958:38, it becomes clear that the intentions with regard to mental health care were to expand, modernize, and reorganize the treatment of the mentally ill in an 'up-to-date fashion'. The concept of mental hygiene, representing the latest trends of preventive care and the development of out-hospital care in Western Europe and the US, was adjusted to in-hospital care in the Swedish context. The investigation made a considerable effort in describing how the physical surroundings should be shaped in order to look as normal as possible. According to the plans for the new mental hospitals, there would be libraries, hair-dressers, and shops in addition to the traditional wards. Attention was also paid to the out-door surroundings. The plans also outlined large recreation grounds as well as areas for sport and other activities. As the severely mentally ill were excluded from normal social conditions during the period of welfare reforms that characterized Swedish social policy during the post-war period until the middle of the 1970s, the ambition was to 'normalize' the inner milieu at the institutions. It might be said that patients were included into the welfare program by this modernization of care but still physically excluded from the 'normal' society.

This rapid expansion of in-hospital care, which continued until the early 1960s, belonged to the welfare reform programme of Sweden. The di-

13 SOU 1958:38. *Mentalsjukvården – Planering och organisation*. Stockholm: Fritzes; SOU 1992:73. *Välfärd och valfrihet*. Stockholm: Fritzes.

mension of inclusion in the excluded sphere implied that the mentally ill also had their share of material welfare. Although the expansion of mental health care during the 1950s and 1960s belonged to the Swedish welfare programme, little is known about whether the expansion improved the life conditions for the mentally ill. It is certain, however, that the expansion led to a large increase in the number of psy-professionals being trained, who later became involved in the modernization of mental health care.

The political decisions in the Western societies about deinstitutionalization have been made for a range of reasons, mostly related to the well-being of service recipients and concerns about the quality of care. A number of factors coincided and became an advantage for the shift:

1. The use of new drugs which enabled independent living for a large number of the mentally ill.
2. A transformation of costs from the governmental state level to the local political level.
3. Claims from user organizations together with an increasing public criticism about the quality of care at the large mental hospitals.

Economic and humanitarian motives coincided in the claims for a deinstitutionalization of mental health care. This political consensus on both the left and the right facilitated the process of deinstitutionalization.¹⁴ After the deinstitutionalization at the close of the twentieth century, a new situation emerged. In the 1990s, the welfare politics in Sweden began to waver between two welfare regimes. The state's responsibility for the welfare of the population as a collective was reduced in favour of a more liberal agenda founded on the individual's position in society. The titling of SOU 1992:73 – Valfärd och valfrihet [Welfare and Freedom of Choice] – signals the committee's attempt to mediate between the ethos of the traditional welfare state and the ethos of freedom of choice, as two key concepts of modern welfare policy. The psychiatric care and the social services to the severely mentally ill became, through the Psychiatric Health Care Reform in 1995, integrated

14 Krieg, Randall (2001) 'An Interdisciplinary Look at the Deinstitutionalization of the Mentally Ill'. *The Social Science Journal*, Vol. 38, Issue 3, 367–380.

within the concept of a new public health policy, individual freedom of choice and risk minimization.¹⁵ The ambition was to increase the patients' influence and to promote out-hospital care. The coordination of care and service became the responsibility of the social service administration as a step in the direction of realizing these ambitions. The Psychiatric Health Care Reform sought to enrol the mentally ill into the new regime of the organization of the welfare state: the regime of the 'autonomous citizen'.

The normalization of living conditions and the goal of a 'better life' were formulated in similar ways both in 1958 and in 1992. A difference, however, can be found in how normality was interpreted in the texts. Normal living conditions for the severely mentally ill in the 1950s implied an institutionalized high standard of mental care at the same level as somatic care. In 1992, normal living conditions for the severely mentally ill instead implied personal autonomy and integrity, in short, in a normal life outside the walls of the institutions. In the former investigation, happiness was connected to normal conditions for any patient in medical care. The latter investigation emphasized happiness in terms of equal living conditions to any person in society at large. A normal life is equal to have the same life conditions as everybody else.¹⁶ This shift of meaning is essential, as it marks the political ambition to include the mentally ill in the disability discourse, a policy that is emphasizing the individual rights to be included into the society.

In between normality and deviance

Who is normal, then, and who is not? The following part of this chapter is an effort to describe how the investigations handled definitions of mental illness, mental health and normality. These definitions were central for the implementations of the reforms and for the living conditions and hence the happiness and the well-being of the severely mentally ill. Estimating the

15 The proposals of SOU 1992:73 were transformed to a suggestion of implementation in the Governmental Proposition 1993/94:128. *Psykiskt stördas villkor*; see also Petersen, Alan & Lupton, Deborah (1996) *The New Public Health. Self and Health in the Age of Risk*. London: Sage; Rose, Nicholas (1999) *Powers of Freedom: Reframing Political Thought*. Cambridge: Cambridge University Press.

16 Brusén, Peter & Hydén, Lars-Christer (2000) *Ett liv som andra: Livsvillkor för personer med funktionshinder*. Lund: Studentlitteratur.

number of severely mentally ill people in the population has been a governmental activity in Sweden since 1901.¹⁷ In the early years, an investigation came to the result that there were 17 300 individuals needing in-hospital mental care, i.e. 0.34 per cent of the Swedish population. The calculations continued during the twentieth century, chiefly with the aim of calculating the need of beds, doctors and staff in the mental hospitals.

The investigation of 1958 calculated the need of hospital beds to 0.05 per cent of the population.¹⁸ In only a few years, the number of patients had risen to 0.45 per cent of the population.¹⁹ In fact, the official investigation in the 1950s had proposed deinstitutionalization as a solution. Yet, this proposal to minimize the in-hospital care was not realized; instead Sweden held the top-position in Europe, regarding the number of patients in mental care, for at least ten years. The number of beds within mental hospitals peaked in 1962 when Sweden had the highest number of patients in mental hospitals in Europe.²⁰

Both the investigation of 1958 and the investigation of 1992 struggled to define the target group in a way that would make mental illness and normality concordant with the suggested changes. Both investigations presented calculations about the prevalence of mental illness in the whole population. In addition, the investigation of 1958 made estimations of hospital beds, while the investigation of 1992 calculated how many of the mentally ill persons suffered from long-term illness equal to a disability (handicap). In 1958 the calculations were made in order to motivate the expansion of preventive mental health and the education of staff in out-hospital care, while the calculations in 1992 aimed to estimate how many individuals that would have legal rights to special social services. In both cases, severe mental illness (schizophrenia) is presented in relation to milder ill-health. Due to the lack of exact data, the calculations were based on earlier investigations, research articles, and statistics compiled from case records and the use of hospital beds.

17 Medicinalstyrelsen [Swedish Royal Medical Board] (1903) *Medicinalstyrelsens underdåniga berättelse angående sinnessjukvården i riket för år 1901*. Stockholm: P.A. Norstedt & Söner.

18 SOU 1958:38.

19 Sjöström, Bengt (1992) *Kliniken tar över dårskapen*. Göteborg: Daidalos.

20 33 752 patients in hospital care, e.g. 487,3 per 100 000 inhabitants. Sjöström 1992, 14.

The calculations of the prevalence of schizophrenia are quite similar at the different points in time. In the calculation of hospital beds, the investigation from 1958 did not propose an increase; on the contrary, only 0.05 per cent of the population was expected to need in-hospital care. The proposal concerning in-hospital care in 1958 was about replacing the old mental hospitals with more modern clinical care in close connection to somatic health care, a proposal that contributed to a normalization of mental health care. In reality, however, the old mental hospital remained for a rather long time alongside the new clinics and the newly-built psychiatric hospitals.

The most striking difference between the calculations in 1958 and 1992 is the assumption about the prevalence of milder forms of mental ill-health. The investigation from 1958 came to the conclusion that as much as 40 per cent of the total population suffered from milder psychiatric illness. The corresponding estimation of milder mental ill-health went down to 13 per cent in 1992. The reason behind this is probably that the aspect of prevention was no longer an issue of high priority in 1992. In 1958 though, the mental hygiene doctrine permeated the scientific field of psychiatry. The official investigation of 1958 argued that milder mental ill-health was very common and an expansion of out-door psychiatric care would decrease the need of in-hospital care. This argument is also the reason for the proposal of the investigation to increase the education of psychiatrists, psychologists, mental hospital nurses and psychiatric social workers. The task of the investigation in 1992 was more limited; to define and describe the needs of the severely mentally ill entitled to special services from the community.

The investigation of 1958 presented the spectrum of mental illness as a continuum with milder ill-health at one end and severe mental illness (schizophrenia) at the other. In 1958 the concept of mental hygiene included the whole population and, as such, the resources of mental health care expanded with the aim of preventing an increase of severe mental illness. With reference to the WHO, the argument was that preventive mental health will 'take the health of all citizens to the highest possible level'.²¹ In the conclud-

21 WHO (World Health Organization) (1951) *Mental Health: Report on the Second Session of the Expert Committee*. Geneva: World Health Organization.

Table 1. Calculations of prevalence and need of care within the adult population in Sweden (in per cent)

	<i>Calculations 1958</i>	<i>Calculations 1992</i>
<i>Milder ill-health</i>	30–40	13.0
<i>Schizophrenia</i>	0.72	0.5
<i>In need of in-hospital care 1958</i>	0.05	--
<i>Long-term illness/Handicap 1992</i>	--	0.6

Source: SOU 1958:38; SOU 1992:73.

ing chapter of the investigation – programmatically entitled *The View of Mental Hygiene Must Permeate the Whole Society* – a declaration is made:

“...so must Mental Hygiene clean up the mental environment, e.g. reveal and revise prejudices and delusions that enable generation after generation to continue to create unhappy and inhibited individuals, which generates social disorder.”²²

This statement is directed to the health of the whole population. As such, it is far from the principles about normality and autonomy of the investigation of 1992. It also represents the ethics of the former ‘caring state’, a welfare policy against unhappiness in society at large distinct from the present politics of happiness where the right to autonomy and self-management is emphasized.

Between illness and disability

The issue in 1992 was, by contrast, to add severe mental illness to the disability concept, which meant that people with disabilities should have the right to normal living conditions concerning accommodation, economy and access to social activities. This would require special care and individual solu-

²² SOU 1958:38.

tions according to different needs. Therefore the investigation had to distinguish between individuals in need of special care and individuals without the need of special care. It was not about the health of the whole population, but about finding a definition for the group within the group of severe mental illness who were entitled to special support from social services, a social status that can serve as a ticket to autonomy and integrity. Medical reasons are still present in the categorization, but the group-specific problems of social autonomy are underlined. The following excerpts are examples from the investigation that illustrate how the authors struggled with the definitions of the new social status of the ex-patient:

1. Long-term illness that has caused impairment.
2. Residual symptoms from psychosis or schizophrenia.
3. Brain injury caused by psychosis.
4. Problems of daily life equal to a handicap.

The idea of normalization in the 1990s was a two-step operation; first, through identity within the disability concept, and second, through entitlement to the legislative right to normal living conditions. In conclusion, the policy of the Psychiatric Health Care Reform in 1995 which followed upon the investigation of 1992 was to match the living conditions of those with a severe mental illness with the living conditions of people with learning disabilities, in order to include the target group into the disability discourse.

The idea of severe mental illness as a handicap or a disability can be considered either as a language modernization, as an attempt to come around the rhetoric of 'chronic illnesses' or – at its best – as a change of citizenship status, from being a long-term patient, lacking any possibilities of social inclusion, to a position of autonomy. In the investigation of 1992, the situation of the former patient status is painted in dark colours, as well as the life at institutions which is singularly described in negative terms. Underlining this critical impression, the report reprinted a picture of how a building that belonged to Säter Hospital was torn down with dynamite. The message is clear; away from institutions and forward to social inclusion.

As the policy turned away from concerns surrounding the mental health

of the whole population, severe mental illness no longer remained the worst scenario on a continuum, but something quite distinct from 'normality'. However, the problems of applying the generalized definitions of disability to individual people remained for practitioners to solve. Where should the line be drawn; who suffers from severe mental illness, and who fits into the definition that includes impairment? What happens if a person recovers from mental illness? Does that person still have the special social rights that a disabled person is entitled to? What about conditions that are fluctuating over time? According to the evaluations of the Psychiatric Health Care reform of 1995 it seems difficult to grasp the meaning of psychiatric impairment and thus the meaning of disability. According to the evaluations of the reform, only 10 per cent of the estimated number of people (2600 out of estimated 20 000–40 000 individuals) have been assessed as being disabled in accordance with the intentions of the reform.²³ The debate about the reform as a failure has continued over the years, although there is no consensus about the causes behind the problems.²⁴ In conclusion, the benevolent aim of the investigation in 1992 has turned into an obstacle for the implementation of the reform as the social services to the severely mentally ill have become stuck between the concepts of illness and disability.

A normal and happy life?

Assessing the needs, happiness and well-being of the mentally ill

For the severely mentally ill, happiness has become a question about needs and how those needs are met by social services and medical care. The political goal of a normalization of living conditions has called for some kind of agreement upon the understanding of the requirements for a normal life.

23 Socialstyrelsen [National Board of Health and Welfare] (1998) *Reformens första tusen dagar. Årsrapport för psykiatrireformen*. Rapp.1998:4; Socialstyrelsen [National Board of Health and Welfare] (1999) *Välfärd och valfrihet? Slutrapport från utvärderingen av 1995 års psykiatrireform*. Socialstyrelsen följer upp och utvärderar 1999:1; Socialstyrelsen [National Board of Health and Welfare] & Länsstyrelserna [County Administrative Boards of Sweden] (2005) *Kommunernas insatser för personer med psykiska funktionshinder. Slutrapport från en nationell tillsyn 2002–2004*. Vällingby: Elanders Gotab.

24 Dencker, Jonas & Wählinder, Jan (2004) 'Psykiatrireformen ett misslyckande för en stor grupp vårdsökande'. *Läkartidningen*, Vol. 101, Issue 5, 398.

In order to determining who has the right to special care and special social interventions, experts and scientists have developed an array of instruments to assess the needs of the severely mentally ill.²⁵ These tools for assessment emanate from standards of care (what the social services and psychiatric care is supposed to deliver) and from standards of needs (what the target group is supposed to need). International research and follow-ups of the deinstitutionalization of psychiatric care show that the social inclusion of the severely mentally ill is problematic and there are also variations among countries concerning care standards and how needs are met with social services.²⁶ Naturally, a wide variety of results are obtained depending on the research questions, on the diverse issues of the different fields of research and on which persons are included in the study. Also, the increasing development of assessment tools belongs to the evidence-based practice (EBP). It offers an opportunity to measure happiness as a kind of objective well-being, grounded on the presumption that met needs of social services and medical care are required to gain happiness. Considering the mentally ill, the needs being measured are connected to what a disabled person is supposed to need in order to live a normal life.

On the basis of the problems discussed above, a survey was carried out in a region near Stockholm between the years 2008 to 2010.²⁷ The aim was to investigate the extent that the needs of the mentally ill were met by medical and social services in the region. The construction of the survey, a tool for needs assessment, was based on the expectations of the quality of care and social support that was formulated in the Psychiatric Health Care reform of 1995 with respect to the aim of the normalization of living conditions of

25 Including for example the Camberwell Assessment of Needs (CAN), Need of Social Service Questionnaire (NSSQ), Bangor Assessment of Need Profile (BANP). Recently, a number of assessment tools in the Swedish language, concordant to the Swedish Social Law legislation, have also been launched.

26 Kovess-Masféty, Vivianne, Wiersma, Durk, Xavier, Miguel, de Almeida, José Mel Caldas, Carta, Mauro G., Dubuis, Jacques, Lacalmontie, Elisabeth, Pellet, Jacques, Roelandt, Jean Luc, Torres-Gonzalez, Francisco, Kustner, Berta Moreno & Walsh, Dermont (2006) 'Needs for Care Among Patients with Schizophrenia in Six European Countries'. *Clinical Practice and Epidemiology in Mental Health*, Vol. 2, Issue 22. Online. Available HTTP: <<http://www.cpementalhealth.com/content/2/1/22>> (accessed July 2012)

27 Åberg, Martin & Piuva, Katarina (2010) *Kartläggning av behov och insatser för personer med psykiska funktionsnedsättningar inom Nordvästkommunerna*. Sollentuna: FoU – Nordväst.

people with severe mental illness, e.g. needs met concerning housing, opportunities to work and study, economical resources and access to medical care and social services. The survey was distributed to social service staff and user organizations. Unsurprisingly, the results showed major gaps between needs and needs met. Briefly, the younger group in the survey (18–29 years) was underrepresented in the investigation. In addition, very few within the younger population received disability pension or other benefits from the social insurance system. Instead, social allowance, the minimum standard of economic support distributed by the social services, was a common source of income among the youngest. For some reason, the middle-aged persons (40–65 years) were overrepresented in the material. Furthermore, social interventions were not directed to people with drug- and alcohol dependency. Irrespective of age, severe mental illness meant exclusion from the labour market. Lastly, the needs of elderly people with mental disabilities were not well-known by the social services.

What information about the fulfilment of the political goal of the Psychiatric Health Care Reform do we get from this information? How does it conform to the political ambition of a 'life like everybody else'? This goal of normalization was to be implemented by the tools of the disability politics, i.e. to give compensation for the impairment and the social services administration was given the responsibility to define the target group, to explore their needs and thereafter decide on the interventions that would lead to the political goal of normalization (a life like everybody else). Concerning the youngest, the results indicated major problems to even identify the entitled individuals. Consequently, there are major problems concerning the task to decide on which social services that would increase the possibilities to live a normal life. Besides young age, persons with drug- and alcohol problems were at high risk of not having access to services that supports normal living conditions. The oldest group could not be identified at all by the social services, which meant that the knowledge about their disabilities and needs of medical care and social services was highly limited. However, the persons between 40 and 65 years seemed to have received adequate services in relation to the politics of normalization. The results were discussed in several

settings with professionals from the social services and members from user organizations, as the researchers wanted well-informed reflections on the outcome.

When the reform was implemented in 1995, all identified patients in psychiatric care were transferred from psychiatric care to the social services, where they still remain. This can explain the overrepresentation of people aged 40–65 years. Day centres for the long-term mentally ill were also transferred directly to the municipalities. Over the years, with a few exceptions, little has changed within those day centres. Younger people, regardless of illness or disability, have different demands for activities. Their claims are about the possibilities to study and possibilities to find job placements. Additionally, the dismantling of preventive activities, both regarding psychiatric care and social services, leads to a situation in which younger people do not receive adequate and timely help. Both professionals and members of the user organizations agreed on the lack of coordination between psychiatric care, drug- and alcohol treatment and the social services. Improvements have been made as a result of the engagement of case managers, but there are still claims for an expansion of case managers. Almost all cases of the elderly with severe mental illness were reported from the psychiatric care. The lack of knowledge about elderly people with mental illness within the social services was explained by the internal organization of the community care. Usually, the sections of elderly care in the municipalities did not cooperate with the sections responsible for social psychiatry.

To conclude, the assessment of needs and decisions on social rights made by the social administration are so complex and the requirement of ‘proving’ one’s disability are so high, that the important ten years after entry into adult life passes by before the person eventually qualifies for the special interventions directed to persons with disabilities. A possible consequence of this could be that the number of adult people with severe social problems and disabilities caused by mental illness may expand in the future.

A normal and happy family

The second study, on which this discussion about the implementation of mental health policies and its relation to the happiness and well-being of the mentally ill is based, focuses on a pilot study comprizing 16 interviews with mothers to adult children with severe mental illness.²⁸ The interviewees were accessed through the user organizations, Riksförbundet för Social och Mental Hälsa [The National Association for Social and Mental Health, RSMH] and Schizofreniförbundet [The Schizophrenia Association]. These interviews present perspectives on happiness and normality as narrated by individuals with close experience of mental illness and mental health care. Including these perspectives in research is novel as the lifelong responsibility and caring experiences of the family members have generally been neglected in Swedish welfare policy and research.²⁹ Traditionally, research on mental illness and its consequences for family members has tended to focus on the increasing care burden. As a consequence, mental illness has been studied as a phenomenon causing major stress in the family, finally resulting in dysfunctional family relations. Moreover, previous research has commonly regarded the cause of mental illness as likely to be found in family life in general and in the relationship between the mother and the child in particular.³⁰ This pathological understanding of families and mothers of children suffering from mental illnesses has come under critical assessment in more recent studies. Most families endure whatever stress that might follow with a child suffering from mental illness. Also, most families adapt successfully to the situation and become important actors in processes of recovery.³¹

28 Piuva, Katarina & Brodin, Helene (forthcoming) 'En familj som alla andra? Mödrar till vuxna barn med psykiska funktionsnedsättningar berättar om sina erfarenheter'. In Karlsson, Lis-Bodil, Rantakeisu, Ulla & Kuusela, Kirsti (eds) *Marginalisering i socialt arbete*. Lund: Studentlitteratur.

29 Jeppsson Grassman, Eva, Whitaker, Anna & Taghizadeh Larsson, Annika (2009) 'Family as Failure. The Role of Informal Help Givers to Disabled People in Sweden'. *Scandinavian Journal of Disability Research*, Vol. 11, Issue 1, 35–49.

30 Syrén, Susanne (2010) *Det utsagda och ohörsammade lidandet. Tillvaron för personer med långvarig psykssjukdom och deras närstående*. Växjö: Växjö University.

31 Schön, Ulla-Karin, Denhov, Anne & Topor, Alain (2009) 'Social Relationship as a Decisive Factor in Recovering From Severe Mental Illness'. *International Journal of Social Psychiatry*, Vol. 55, Issue 4, 336–347.

The method of research was adapted to the life-story perspective, as we wanted to encourage personal narratives. The main findings from the interviews were the overall theme of resistance to social exclusion in the life stories. The oldest mothers, through lifelong relations to professional caregivers, had experiences from both regimes of welfare politics in Sweden, e.g. the period of in-hospital mental care that was practised until the late 1970s, as well as the process of deinstitutionalization during the end of the century. In many respects, the narratives illustrated the problems connected to the politics of happiness and normalization, not the least with regard to the organization of everyday life and economy, both being important for how you experience personal autonomy and integrity.

The normal everyday life

Regarding the quality of care and social service, all of the interviewees agreed that much has improved since the 1960s and 1970s, when the experiences of families and relatives were systematically rejected. The present community-based services, including housing, contact persons and case managers were seen as positive resources. However, the experiences of the policies of normalization also contained some lessons. Having access to an apartment connected to social services might also include a set of principles of normal life, such as standards of 'normal furnishing', expectations of normal hobbies and normal destinations for one's travels. Normalization was also about social rules, for instance that adult persons normally visit their parents on Sundays, not anytime they like. This 'regime of reason' made the parents feel incapacitated and their adult children feel underage. The principle of normality that guides the social services implies that people with functional disabilities due to severe mental illness should have the opportunity to live as other citizens, but this positive aim is sometimes applied as a template according to which disabled people should live their lives. Thus, in reality, the 'principle of normalcy' might come out as forced moral values based on what the social services and the social workers think constitutes a good life.

Autonomy and economy

Although reports repeatedly point to the fact that mental illness and functional disabilities due to severe mental illness generate poverty and economic marginalization,³² the financial situation for adults with mental issues seems to be a non-issue, judging from the interviews. Mental illness is one of the most common reasons for a disability pension in Sweden and many of the recipients, as most have not been gainfully employed, are only entitled to the lowest levels of benefits from the Swedish social insurance. The mothers being interviewed confirmed this situation. The families and the mothers had often had to help their adult children with money. In addition, the mothers have assisted by sorting out the jungle of bureaucratic rules, certificates and paperwork that are needed in order for their children to receive the benefits they are entitled to. The mothers also described how their children had been living for years on end at the lowest levels of social allowance as they have been unable to approach the psychiatrists and clinics they needed to visit in order to receive benefits from the National Insurance System.

The overall conclusion of this pilot study was that – contrary to the norms of able-bodiedness, which frames mental illness as “abnormal” and as a reason for lifelong unhappiness – the mothers described how they and their adult children had managed to integrate mental illness in their ordinary life. The neglected economy of the severely mentally ill was rather surprising. Help from the social services meant that the mentally ill children were entitled to resources *in natura* so to speak. Their incomes, either as social allowances or benefits from the Social Insurance System were so low that they never had enough money to make plans for the nearest future or to pay for something ‘extra’ beyond covering the most minimal expenditure. In the long run, insolvency also had consequences for the family financial situation. That long term mental illness causes economic concerns or even pov-

32 Bülow, Per (2004) *After the Mental Hospital – A Study in the Wake of the Deinstitutionalization of Psychiatric Care*. Linköping University; Riksförsäkringsverket [Swedish National Social Insurance Board] (2004) *Sjukdomar som orsakat pensionering*. Rapport 2004:3; Statistiska centralbyån [Statistics Sweden] (2003) *Levnadsförhållanden för personer med funktionshinder 1988–1999*. Stockholm: Statistiska centralbyån; SOU 2006:100. *Ambition och ansvar*. Stockholm: Fritzes.

erty is a well-known fact.³³ The narratives of the mothers added the experiences of the consequences of poverty in a lifelong perspective, pinpointing also how poverty may influence family relations and, hence, the well-being and happiness of the mentally ill.

Happy without reason?

The issue of this chapter was to discuss the problems surrounding the concept of happiness in relation to mental illness, a discussion that necessarily has to relate to the concept of normality and its time bound and vacillating meaning. The two most important official investigations about mental health care in the after war period in Sweden were initially the focus of this investigation. The first official investigation mirrored the policies of the 'caring state' as the welfare policies concerning mental health in the 1950s and 1960s, was to reduce the genesis of the illness and mental hygiene was the route. At the end of the twentieth century, when the second investigation was undertaken, normal living conditions were presented as the solution that would increase the quality of life for the severely mentally ill. The latter investigation struggled to integrate the severe mentally ill into an ethos of welfare which emphasized individual autonomy. To be normal, e.g. to have the "right to 'normal' living conditions" include individual autonomy, integrity and opportunities to make one's own choices in life. In a broad meaning, these are the same values that are connected to the concept of happiness, which are highly ranked values in our age of reason. The same values turn out to be almost everything that is regarded as the opposite to mental illness.

Despite the broad consensus about the problems of the concepts of normality, mental health and positive mental health, they are often implicitly rendered as simply the absence of mental ill-health, thus indicating a state of normality. In 1958, Marie Jahoda, for example devised a list of characteristics which were present in the majority of people who were regarded as mentally healthy, though she notes that is an inherent problem that the ideal norm of normality is similar to positive mental health. These characteristics

33 SOU 2006:100.

include high self-esteem, personal growth, the ability to cope with stress, autonomy in the sense of self-regulation, a sense of reality orientation, the ability of empathy and the ability to environmental mastery.³⁴ After 1958, critical investigations about the concept of 'mental illness' have been in focus within the social sciences. Per-Anders Tengland's reflections on the concept of 'mental health' in 2001 represents a return to a discussion that have been absent for quite a long time.

The problems that we have to deal with when discussing happiness and mental illness are strongly connected to the three-dimensional meaning of normality: the statistical, the ideal and the medical meaning. 'Positive mental health' and thus the ideal meaning of normality is very close to the values of happiness, but not close to the concept of normality that permeates the Swedish Psychiatric Health Care Reform, which relies on the statistical meaning of normality as being the most typical life circumstances.³⁵ To follow this line of argument would lead to the conclusion that the mentally ill have the right to expect the same amount of happiness as the average citizen (but not more?). In addition, the moral dimension of this kind of normality can cause frustration. Family members, in this case the mothers, tells us that the ideals of 'a normal life' can be converted into demands. If following the medical dimension of the normality concept, mental illness (deviant from mental health) means among other things, loss of self-control, loss of ability to master the environment and loss of reality orientation, just the opposite qualities to mental health and normality presented by Jahoda in 1958. Paradoxically, the social practice of normality, concerning the mentally ill, has turned out to be a requirement that the presumptive patient has lost control, otherwise the individual is not entitled to the social rights that come with the definitions of disability.

Irrespective of time and rhetoric, a borderline between expectations of happiness for normal citizens as distinct from people suffering from long-term mental illness, is being drawn. Implementing this practice of separation

34 Jahoda 1958, 22–64; Tengland 2001, 35–49; Nordenfeldt, Lennart (1997) 'The Stoic Conception of Mental Disorder: The Case of Cicero'. *Philosophy, Psychiatry & Psychology*, Vol. 4, Issue 4, 285–291.

35 Tideman 2000; Piuva 2005, 56–58.

when it comes down to administration, more precisely the administration of social rights, is problematic. Again, the crucial concepts of normality, illness and disability are dependent on cultural values and hence difficult to measure. This may be one reason why the concept of 'needs' has returned together with the evidence-based practice (EBP) within social work. This is 'safe territory' as we can rely on knowledge about social problems and on the traditional goals of welfare policies, assuming that the increase of welfare is of crucial importance for subjective well-being, e.g. that happiness is a function of welfare.³⁶

From the survey about needs and unmet needs and the interviews discussed earlier in this chapter, we can conclude that the severe mentally ill are unfavoured concerning economy, access to medical care and social services. This is merely the same conclusion as evaluations of the Psychiatric Health Care Reform have told us before. The present discussion adds the conceptual dimension. Several inherent paradoxes are active and generate sometimes unintended and frequently counter-productive consequences. There are considerable problems connected to the administration of welfare (needs met) when the categorization of the individuals is ambiguous. In addition, the practice of categorization is also connected to ethical problems. For example, if a person is unemployed as many of the mentally ill are, the contract between the autonomous individual and the state is severed. Autonomy is strongly connected to access to work and money of one's own – something which the severely mentally ill rarely have. It is the work (the employment) that generates the possibilities to normality and happiness.

In the recent *World Happiness Report* mental health is identified as 'the biggest single factor affecting happiness in any country'.³⁷ At the same time, however, the report tells us that the opportunities for treatment are limited in the advanced societies and even more limited in poorer countries. This 'happiness paradox' is also true regarding social policy of mental health. The

36 For this discussion, see Sumner, Leonard Wayne (1996) *Welfare, Happiness, and Ethics*. Oxford: Clarendon Press; Frey, Bruno & Stutzer, Alois (2002) 'Happiness, Economy and Institutions'. *Economic Journal*, Vol. 110, Issue 466, 918–938.

37 Helliwell, John, Layard, Richard & Sachs, Jeffrey (2012) *World Happiness Report*. New York: Earth Institute, Columbia University. Online. Available HTTP: <<http://issuu.com/earthinstitute/docs/world-happiness-report>> (accessed July 2012)

universal state did not solve the problem of mental illness by addressing the whole population. In all probability, it is not likely that the neoliberal welfare state will solve it either. The idea of solving problems belongs to the utopian dimension. The more pragmatic questions deal with what kind of problems follows from different policies of mental health. The problems that emerged from the universal welfare policy – the caring state – can roughly be summarized as an 'isolation-trap'. The intentions to include the mentally ill into the social community by strengthening their position as patients with access to high quality mental care, turned out to exclude them from 'normal' society. The neoliberal ethos of the responsible citizen – the autonomous individual – will cause another kind of problems concerning mental health care. The question: who has the right to treatment (in order to be normal and thus happy?) will of course generate new problems. Where is the line to be drawn between the mentally ill that are entitled to get help and those that are not?

Several contributions to this volume describe happiness as a returning phenomenon in the social sciences and social policy. The 'return' can also be applied to the field of mental health. Today when the care of the severely mentally ill is a task for social science and social work, there is reason to believe that the question of happiness and mental health will be expressed more explicitly. Happiness with the meaning of 'positive mental health' has so far dwelled within the fields of social psychology and social medicine during the post-war period. Instead, mental illness and abnormal social behavior, with the qualities of being social problems, have been issues of social research for quite a long time.

The top-down scientific interpretations of happy citizens is becoming increasingly challenged by a bottom-up interpretation of subjective well-being. In the field of mental health, this concerns taking into account the mental health service users' own perceptions of the services provided and their effects upon their well-being. Happiness, as it is used in the social sciences today,³⁸ is often understood as a kind of evaluation of welfare policies, a measure of how content the citizens are concerning the state's ability to pro-

38 See for example Rothstein, Bo (2010) 'Happiness and the Welfare State'. *Social Research*, Vol. 77, Issue 2, 1–28.

vide safety, freedom, democracy and possibilities of pleasure. Is this bottom-up perspective true for the severely mentally ill? Do we expect happiness and well-being on the same conditions as other citizens when it concerns people with severe mental illness? Do we ask people with severe mental illness (schizophrenia, bipolar illness, personality disorders and other severe conditions of ill-health) if they are healthy and happy? When the doctor or the social worker asks 'Is everything all right, do you feel well?' the implicit meaning is often 'Are you free from symptoms, do the voices disturb you? Are you satisfied with your medicine dose?' It is more unlikely (though possible) that professional agents ask if the person is satisfied with his or her life circumstances, if he or she is able to cope with illness/disability, or perhaps does not mind the illness at all.

Certainly, this chapter provides no solution to this landscape of paradoxical questions. But it is hoped that it can contribute to problematize the underlying cultural assumptions about citizenship, happiness and social conditions for individuals with severe mental illness. The discourses of health and happiness can be considered as aspects of 'the broken dialogue' with mental illness, or the broken dialogue with deviance from what we consider as normal.³⁹ When we talk about 'populations' and 'expectations', the severely mentally ill are often being disregarded – owing to their status of being abnormal, unusual and therefore not representative. The challenging questions for the future are about the ability to foresee obstacles and to present the uncomfortable questions. Are all individual choices the same as good choices? Will it be possible to ask for help without proving a personal incapability to understand that help is needed? In conclusion, the discussion presented here has sought to show that the singular focus upon individual freedom may, in the context of well-being of the mentally ill, run the risk of turning into new forms of social exclusion, instead of the social inclusion all contemporary mental health policy strives for.

39 Foucault, Michael (2006 [1964]) *Madness and Civilization. A History of Insanity in the Age of Reason*. London: Routledge.

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Who needs mental health services? Mental health care planning and the image of the service user in Finland

ANNA ALANKO & CARL MARKLUND

Introduction

Internationally, mental health policy has undergone important changes in the last decades, just as welfare policies in general.¹ A central element in mental health care planning has been the ambition to reduce or to avoid psychiatric hospital care through so-called psychiatric dehospitalization.² The criticism of the potentially negative effects of psychiatric hospital treatment – not only with regard to patients' recovery, but also for patients' individual well-being and sense of self-determination while in treatment – dates back to the late nineteenth century. As a broader international movement towards policy change, however, dehospitalization only became influential after the Second World War.³

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- 1 By 'mental health policy' we refer to both the society's efforts in mental health promotion and in the prevention and treatment of mental health problems. In addition, we distinguish between 'mental health care', which encompasses all activities in the field and 'mental health services', which we use to refer to service provision. Cf. Pilgrim, David (2009) *Key Concepts in Mental Health*. London: Sage.
 - 2 The term 'deinstitutionalization' can also be used in the same meaning, even though it may be criticized for neglecting the institutions that remain in mental health care. See for example Helén, Ilpo, Hämäläinen, Pertti & Metteri, Anna (2011) 'Komplekseja ja katkoksia – psykiatrian hajaantuminen suomalaisen sosiaalivointivaltioon'. In Helén, Ilpo (ed) (2011) *Reformin pirstaleet. Mielenterveyspolitiikka hyvinvointivaltion jälkeen*. Tampere: Vastapaino.
 - 3 Castel, Robert, Castel, Françoise & Lovell, Anne (eds) (1982) *The Psychiatric Society*. New York: Columbia University Press; Barham, Peter (1997) *Closing the Asylum: The Mental Patient in Modern Society*. London: Penguin; Grob, Gerald (1991) *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press; Scull, Andrew (1984) *Decarceration. Community Treatment and the Deviant – A Radical View*. Cambridge: Polity Press.

Dehospitalization has been seen as a result of several different phenomena.⁴ Some scholars have stressed the effect of the advances in psychiatry, especially in pharmacological treatment and the development of antipsychotic chlorpromazine in the early 1950s.⁵ Others have argued that the harmful effects of psychiatric hospital treatment as presented by proponents of critical psychiatry and social psychiatry have played a decisive role.⁶ It has also been suggested that economic factors may have worked in favour of dehospitalization in different ways.⁷ Lastly, it has been observed that 'psychiatrization' – the spreading of psychiatry beyond the confines of the hospital and into everyday life – has contributed to dehospitalization by making mental health matters a normal aspect of life for many people.⁸

As in most industrialized countries, dehospitalization has influenced Finnish mental health policy. However, Finland was a latecomer: While dehospitalization had elsewhere already started after the Second World War, in Finland the psychiatric hospital capacity was still perceived as insufficient during the 1950s and 1960s. Opposition against institutional treatment and related civil rights violations was voiced in Finland from the 1960s and onwards.⁹ Yet, the number of psychiatric hospital beds continued to grow until the late 1970s, when dehospitalization took off.¹⁰ Finnish dehospitalization

- 4 The classification of different histories presented here is influenced by the work of Enric Novella, but his classification is not followed as such. Novella, Enric J. (2008) 'Theoretical Accounts on Deinstitutionalization and the Reform of Mental Health Services: A Critical Review'. *Medicine, Healthcare and Philosophy*, Vol. 11, Issue 3, 303–314.
- 5 Shorter, Edward (1997) *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley; Grob 1991.
- 6 Salo, Markku (1996) *Sietämisestä solidaarisuuteen. Mielisairaalaareformit Suomessa ja Italiassa*. Tampere: Vastapaino.
- 7 Scull 1984; Novella 2008.
- 8 Rose, Nikolas (2006) 'Disorders Without Borders? The Expanding Scope of Psychiatric Practice'. *BioSocieties*, Vol. 1, Issue 4, 465–484; Hautamäki, Lotta, Helén, Ilpo & Kanula, Saara (2011) 'Mielenterveyden hoidon lääkkeellistyminen Suomessa'. In Helén, Ilpo (ed.) (2011) *Reforminirstaleet. Mielenterveyspolitiikka hyvinvointivaltion jälkeen*. Tampere: Vastapaino; Castel, Castel & Lovell 1982; Helén, Hämäläinen & Metteri 2011.
- 9 The so-called 'November movement' was founded in 1967, partly inspired by the works of sociologist Erving Goffman and his analysis of the negative effects of hospital treatment. Niemelä, Anna (2003) *Laitoksista hallittuun vapauteen: Marraskuun liikkeen poikkeava, sosiaalinen kansalaisuus ja hallintaratonaalisuus*. Unpublished master's thesis. Helsinki: University of Helsinki; Honkala, Kaisa (2011) *'YK:n ihmisoikeudet vankiloihin!': Marraskuun liikkeen suomalaisen kontrollipolitiikan kritiikki 1967–1972*. Unpublished master's thesis. Helsinki: University of Helsinki; Salo 1996.
- 10 Hyvönen, Juha (2008) *Suomen psykiatrinen hoitojärjestelmä 1990-luvulla historian jatkumon näkökulmasta*. Kuopio: Kuopio University Publications; Eskola, Jarkko (2007) 'Mielenterveystyö ja yhteiskunnan muutos'. In Eskola, Jarkko & Karila, Antti (eds) *Mielekäs Suomi. Näkökulmia mielenterveystyöhön*. Helsinki: Edita, 14–44; Tiitta, Allan (2009) *Collegium Medicum. Lääkintöhallitus 1878–1991*. Helsinki: National Institute for Welfare and Health.

policy primarily emerged from within the health administration rather than from advocacy groups and ‘radicals’ as in for example Italy.¹¹ Dehospitalization in Finland was also rapid and dramatic. During the period discussed in this chapter, from the late 1970s until the late 2000s, the number of psychiatric hospital beds in relation to the population can be estimated to have fallen by approximately four fifths.¹²

This shift has generated considerable criticism over the years, and it has often been argued that the reduction of the psychiatric hospital beds has not been compensated with a sufficient amount of outpatient care.¹³ Most of the criticism has emphasized the difficulties of implementing the dehospitalization reform under the economic and social crisis in the 1990s.¹⁴ The Finnish welfare system has changed remarkably during the period and the shift has been conceptualized as a move from an expansive to post-expansive welfare state.¹⁵ Previous studies on diverse social and health care fields have pointed out that the emphasis and demand for the citizen’s autonomy have increased along with these changes.¹⁶

11 Salo 1996.

12 The highest number recorded in Finnish official statistics is 19 866 beds in 1976. While the exact number of annual hospital beds has not been recorded since 1995, the official statistics are using an estimate based on the number of annual treatment days in psychiatric hospitals divided by the amount of days in a certain year. This figure was 4272 in 2009. Koskinen, Riitta (1994) *Terveystienhuolto: katsaus väestön terveyteen, terveyspalvelujen käyttöön ja resursseihin*. Helsinki: Stakes; Forsström, Jari & Pelanteri, Simo (2011) *Psykiatrian erikoisalan laitoshoido*. Helsinki: National Institute for Welfare and Health.

13 Helén, Hämäläinen & Metteri 2011; Karlsson, Nina & Wahlbeck, Kristian (2011) ‘Finland. Från reformintention till praxis. Mentalvårdens utveckling i Finland efter år 1990’. In Lindqvist, Rafael, Bengtsson, Steen, Fredén, Lars, Larsen, Frode, Rosenberg, David, Ruud, Torleif & Wahlbeck, Kristian (2011) *Från reformintention till praxis. Hur reformer inom psykiatri och socialtjänst översatts till konkret stöd i Norden*. Gothenburg: The Nordic School of Public Health, 65–100.

14 Öhman, Kaisa (2003) *Mielenterveystyön reformi ja mielenterveyspolitiikan sosiaalinen kansalaisuus*. Unpublished master’s thesis. Helsinki: University of Helsinki; Eskola 2007; Hyvönen 2008; Helén, Hämäläinen & Metteri 2011.

15 Julkunen, Raija (2001) *Suunnanmuutos. 1990-luvun sosiaalipoliittinen reformi Suomessa*. Tampere: Vastapaino.

16 Helén, Ilpo (2011) ‘Äsiasakslähtöisyys: eli miten mielenterveystyön ajatus epäpolitisoitui’. In Helén, Ilpo (ed.) (2011) *Reformin pirstaleet. Mielenterveyspolitiikka hyvinvointivaltion jälkeä*. Tampere: Vastapaino, 153–181; Helén, Ilpo & Jauho, Mikko (2003) ‘Terveyskansalaisuus ja elämän politiikka’. In Helén, Ilpo & Jauho, Mikko (eds) *Kansalaisuus ja kansanterveys*. Helsinki: Gaudeamus, 13–32; Leppo, Anna & Perälä, Riikka (2009) ‘User Involvement in Finland: The Hybrid of Control and Emancipation’. *Journal of Health Organization and Management*, Vol. 23, Issue 3, 359–371; Kananen, Johannes (2013) ‘The Procedural Openness of Nordic Welfare State Restructuring’. In Götz, Norbert & Marklund, Carl (eds) *The Promise of Openness*. Leiden: Brill; Outinen, Sami (2012) ‘Labour Market Activation in Finland in the 1990s: Workfare Reforms and Labour Market Flexibilisation’. *Local Economy*, Vol. 27, Issue 5–6, 629–636; Ollila, Eeva & Koivusalo, Meri (2009) ‘Hyvinvointipalvelusta liiketoiminnaksi – terveydenhuollon parantamisen tärkeät valinnat’. In Koivusalo, Meri, Alanko, Anna & Ollila, Eeva (eds) *Kansalaisesta kuluttajaksi. Markkinat ja muutos terveydenhuollossa*. Helsinki: Gaudeamus, 21–47.

While it has been shown that the shortcomings of the Finnish mental health care cannot be explained with the cost cuts during the economic crisis of the 1990s, a puzzle has only partly been solved. Simultaneously with the dehospitalization, the supply of outpatient mental health care has multiplied, but Finnish mental health care is still often considered inadequate.¹⁷ Why does it seem that the overall demand for mental health services has expanded – rather than been satisfied – with the increasing supply of outpatient mental health services?

This chapter aims to find out to what degree Finnish mental health care planning has contributed to this ambiguity. The research questions are two-fold: First, what have been the key aims and proposals of Finnish mental health care planning between 1977 and 2009? Second, what is the image of the service user and which abilities and responsibilities have been assigned to the service users in the plans?

The chapter focusses on the planning of mental health policy during the period of the policy of dehospitalization starting from the late 1970s and continuing until 2009. The chapter analyses the most important planning documents published between 1977 and 2009 that discuss Finnish mental health care on a general level, without focusing on a specific problem, diagnosis, or patient group. While the plans also relate to the mental health care of children and elderly people, the present analysis concentrates upon the discussions about the mental health care of those in working age. The analysed plans are altogether seven. They have been produced by four different projects that have been working under the auspices of the Finnish Ministry of Social Affairs and Health (hereafter, MSAH).

While the earlier studies have emphasized a break between the planning of the dehospitalization during the 1970s and the 1980s, and the implementation of dehospitalization from the 1990s onwards, this chapter identifies a continuum. The analysis shows that during the whole period starting from the 1970s the plans contain what may be called revolving aims, i.e. objectives that were repeated in all the plans. The expression of the revolving

17 Helén, Hämäläinen & Metteri 2011.

aim is inspired by the notion of the ‘revolving door patient’ to denote a person who is repeatedly admitted to psychiatric hospital care.¹⁸ The revolving aims identified in the analysis range from reducing supposedly excessive psychiatric hospital or ‘inpatient’ treatment, to increasing the availability of outpatient treatment; from enhancing the possibilities of the afflicted in taking part in working life to ensuring mental health care service users an equal position with other citizens in need of care; and from following the example of other countries that have been considered forerunners with regard to mental care to even surpassing international pioneers. In addition, all the plans discuss the need to define the target groups of mental health care and mental health policy.

However, also a break within the planning is identified: the target group first expands in each of the plans. Second, the image of the ideal service user transforms in the documents, little by little, from a mentally ill or afflicted person in need of care to an autonomous individual with the ability to identify his or her own needs and to take care of him- or herself, and ensure his or her own well-being. The shifting target groups and changing images of the ideal service user as identified in this study are both likely to affect the scope of mental health care in various ways, even if the overall aims remain largely the same. The transition from ‘need’ of care to ‘autonomy’ does not only have an impact on the quantity and quality of services provided. It may also affect who is entitled to care and who is not.

The National Board of Health working group

In 1977, a working group set up by the Finnish National Board of Health (hereafter, NBOH) published a planning document in which Finnish mental health care planning was connected with the dehospitalization trend underway internationally.¹⁹ The NBOH working group was chaired by Medical

18 Shaw, Ian (2004) ‘Doctors, “Dirty Work” Patients, and “Revolving Doors”’. *Qualitative Health Research*, Vol. 14, Issue 8, 1032–1045.

19 The plan was signed by 17 members, although five additional people were listed that had also taken part in its writing. The group reported having heard 11 experts and having sent hearing requests to 70 professional or civic organizations, of which 50 responded. National Board of Health (NBOH) (1977) *Psykiatrisen terveydenhuollon kehittäminen. Psykiatrisen terveydenhuollon kehittämisohjelma 1977–1986*. Helsinki: National Board of Health.

Counsellor Raimo Miettinen, a psychiatrist by profession.²⁰ The working group noted that Finland's volume of psychiatric hospital treatment was high by international standards and that the number of psychiatric hospital beds was 'among the highest in the world'.²¹ The NBOH working group concluded that the risk of 'hospitalism', the undesirable effects of hospital care, called for the need to develop outpatient treatment as an alternative:

"The possibility to receive psychiatric hospital treatment in recent years has been safeguarded for everyone who necessitates it. Alongside the rapid development of hospital treatment, the development of outpatient treatment has been slower than hoped for. [...] Far too little attention has been paid to the many disadvantages of long-term hospital treatment. Every hospital treatment separates and alienates the afflicted person from his/her normal environment – family, friends, workplace – and gives an exceptional character to the illness. Especially long-term hospital treatment raises detrimental attitudes towards the mentally ill, increases the tendency to isolation and promotes hospitalism."²²

Outpatient care was proposed as a means of assisting the patients in getting 'back to society', thereby helping them to gain the same status as other citizens.²³ Amending the Mental Illness Act of 1952 was suggested as a way of allowing for the establishment of boarding houses and 'semi-open treatment'.²⁴ The NBOH working group also highlighted the importance of employment. While rehabilitation to wage work was discussed, sheltered work was considered the most suitable form of rehabilitation. Noting that the then current legislation allowed for the treatment of 'the mentally ill' without their consent, unlike the physically ill, the working group suggested removing this difference from the legislation as a way of giving mental

20 Miettinen was born in 1929. Huovinen, Pentti, et al. (1970) *Kuka kukin on: henkilötietoja nykypolven suomalaisista*. Helsinki: Otava.

21 In 1977, the number of hospital beds, 19 853, was close to that of the peak year 1976. NBOH 1977, 8–9.

22 NBOH 1977, 31–32.

23 NBOH 1977, 18.

24 Mielisairaslaki [Mental Illness Act] 187/1952; NBOH 1977, 18.

health patients equal status with other citizens.²⁵ The NBOH working group also justified its positions by pointing out that similar reforms had been undertaken in Sweden and the UK.

The NBOH working group also pointed out the need for mental illness prevention at large. According to the working group, 'general social mental health work' should be taken into account when planning the mental health care of the whole population.²⁶ Yet, 'psychiatric health care' was still identified as a 'specialist level psychiatric function within the public sector'.²⁷ A major problem here was that a significant group of patients which did 'not belong to psychiatric health care' remained within the psychiatric care system.²⁸ While the overall aim was to reduce psychiatric hospital care, the working group considered some of the 'ill' to be inevitably in need of hospital treatment.²⁹ In improving the field, a key measure would be to remove the patients that were considered not to 'belong' to psychiatric health care, including the elderly, the mentally disabled as well as the substance abusers, from the psychiatric hospitals.³⁰ The NBOH working group concluded that psychiatric health care would improve if the resources were focussed on those in the most need of psychiatric services, i.e. the mentally ill or afflicted.

The Committee for Mental Health Work

The NBOH working group's proposals contributed to the amendment of the Mental Illness Act in 1978. Partly as a result of legislative changes and the policy recommendations of the NBOH, the reducing of the psychiatric hospital beds continued in the early 1980s.³¹ Also the revision of Finnish mental health care continued. In 1984, the Committee for Mental Health Work

25 This has been partly responded to in the amendments of the legislation but the possibility of using involuntary treatment has not been removed. Mäkelä, Jari (2008) *Houurinhoitoasetuksesta mielenterveyslakiin. Mielisairaanhoidon ja erityisesti tahdosta riippumattoman hoidon lainsäädännön muutokset vuosina 1840–1991*. Unpublished master's thesis. Joensuu: University of Joensuu; NBOH 1977, 18.

26 NBOH 1977, 5–7.

27 NBOH 1977, 7.

28 NBOH 1977, 41.

29 NBOH 1977, 35.

30 NBOH 1977, 41.

31 At the time of publishing the report in 1984, the amount was 17 534. Koskinen 1994.

(hereafter, CMHW or the Committee) published a new plan for Finnish mental health work, as part of its report.³² Partly made up of the same individuals as the earlier NBOH working group, the CMHW was also chaired by a psychiatrist, Professor Yrjö Alanen.³³ Like its predecessor, the CMHW saw a need for counteracting excessive hospital treatment, referring among other things to the results of the Finnish national schizophrenia project of 1981–1987.³⁴

“Even if the annual accumulation of the long-term patients is slow, a small stream grows into a sea, because the exit is slow. Some of the patients have been in treatment more than half a century. [...] In a way, the hospital is ‘pregnant’ with future long-term patients.”³⁵

The CMHW argued that increasing the supply of outpatient treatment would make it possible to reduce the number of psychiatric hospital beds by half.³⁶ The Committee also argued that at least five times more opportunities for sheltered work would be needed.³⁷ At the same time, the CMHW reasoned that the resources in the mental health sector were lagging behind the rest of the economy. Given the economic growth and continuous expansion of the welfare state during the 1980s, the CMHW considered it justifiable to increase the resources directed to mental health at the same rate as the annual growth of GNP, at least if the goal of achieving parity between mental health service users and other citizens should be met.³⁸ Also this time, the need to reduce the number of psychiatric hospital beds was ratio-

32 There was some member turnover in the committee, but the document was finally signed by 24 persons. The committee heard 157 experts in the process. Committee for Mental Health Work (CMHW) (1984a, b, c) *Mielenterveystyön komitean mietintö*. Helsinki: Ministry of Social Affairs and Health.

33 A supporter of the Social Democratic Party, Alanen was born in 1927. Tarkka, Jukka (1986) *Kuka kukin on: henkilötietoja nykypolven suomalaisista*. Helsinki: Otava.

34 NBOH (1981) *Skitsofrenian tutkimus-, hoito-, ja kuntoutustyön valtakunnallinen kehittämissuunnitelma*. Helsinki: National Board of Health.

35 CMHW (1984a) *Mielenterveystyön komitean mietintö I. Mielenterveystyön kehittämisen perustelut*. Helsinki: Ministry of Social Affairs and Health, 175.

36 The suggested reduction was reached already in 1991. CMHW (1984b) *Mielenterveystyön komitean mietintö II. Mietinnön tiivistelmä ja komitean ehdotukset*. Helsinki: Ministry of Social Affairs and Health, 180; Koskinen 1994.

37 CMHW 1984a, 154.

38 CMHW 1984b, 194; cf. Julkunen 2001.

nalized with reference to international experiences. After having noted that only Ireland had more psychiatric hospital beds per capita, the Committee pointed to Sweden, Norway, Denmark, Iceland, Italy, the Soviet Union, the UK, and the US as examples of outpatient service-based systems.³⁹

Yet, not all of those countries provided good examples, the CMHW observed. In the US, resources had been diverted from institutional treatment without establishing an alternative care system. As a consequence, patients had been 'left without treatment and sometimes even abandoned'.⁴⁰ However, the Committee expected that the welfare state would prevent such adverse outcomes from dehospitalization in Finland.⁴¹

Most importantly, the CMHW suggested that a new law should be drafted using a new legislative nomenclature, pointing to 'mental health' rather than 'mental illness' as the target of policy reform. Despite some differences between the Committee's initial suggestions and the Mental Health Act adopted in 1991, the new legislation added a novel emphasis on the mental health of all citizens, and not only those suffering from or having a risk of mental health disorder.⁴²

As the CMHW sought to define the target population, it also noted that many patients in the hospitals could not be considered to be in need of psychiatric hospital treatment.⁴³ At the same time, and in contrast to the NBOH working group, the CMHW did not distinguish between psychiatric care and other mental health work and included general living circumstances in its analysis.⁴⁴

In response to this broader stance, the CMHW did not only focus on the work of psychiatrist specialists exclusively, but referred to many other health and social care professions as relevant to mental health care work, such as medical doctors, psychologists, nurses and social workers. Perhaps

39 CMHW 1984a, 9, 325–364.

40 CMHW 1984a, 361.

41 CMHW 1984a, 364.

42 It was not the first time this nomenclature was suggested, but the previous proposal of a mental health act of a committee in 1964 had failed. Mielenterveyslaki [Mental Health Act] 1116/1990; Hyvönen 2008, 211.

43 CMHW 1984b, 190–192.

44 Helén, Hämäläinen & Metteri 2011; Öhman 2003.

as a result of this wider interpretation of the scope of mental health care professions, the Committee expressed the need to outline some restrictions, stating that ‘the work of lawyers and construction engineers is no longer professional mental health work’.⁴⁵

Following this broader outlook, the CMHW considered mental health problems to be very frequent in the population at large, citing a report which stated that only ‘a third of the population were completely healthy’.⁴⁶ As a result, the Committee gave the slightly paradoxical recommendation that the number of hospital beds should be reduced, while at the same time claiming that the need for psychiatric services, including hospital services, was greater than the supply.⁴⁷

In the end, the CMHW apparently expected that its suggestions for a shift from mental illness care to mental health work and a renewal of the legislation would guarantee the economic and social prerequisites for the enhanced mental wellbeing of the population at large. The patients were thought to be in need of support in order to be able to cope with the new freedom that would result from the prescribed dehospitalization. In the words of the Committee, ‘adding freedom demands adding more personnel. The locks should be replaced with human relationships.’⁴⁸

Meaningful Life(!)

By the mid-1990s, the process of reducing the number of hospital beds had already been underway for two decades.⁴⁹ However, by the time the Mental Health Act of 1991 came into effect, Finland was facing deep recession. The subsequent administrative and budgetary restructuring of the Finnish welfare state during the early 1990s spelled trouble for mental health care, necessitating a renewed overview of policies.⁵⁰

45 CMHW 1984a, 44.

46 CMHW 1984a, 171.

47 CMHW 1984a, 199.

48 CMHW 1984a, 87.

49 In the beginning of the process leading to the establishment of the Meaningful Life!-project, the estimated number of hospital beds was 6232. Nenonen, Mikko, Pelanteri, Simo & Rasilainen, Jouni (2000) *Mielenterveyden häiriöiden hoito Suomessa 1978–1998*. Helsinki: Stakes.

50 For a discussion of broader reforms in the context of the 1990s recession in Finland, see for example Sulkunen, Pekka (2006) ‘Projektiyhteiskunta ja uusi yhteiskuntasopimus’. In Rantala, Kati & Sulkunen, Pekka (eds) *Projektiyhteiskunnan kääntöpuolia*. Helsinki: Gaudeamus, 17–32; Julkunen 2001; Eskola 2007; Hyvönen 2008; Öhman 2003.

In 1996, the task of reviewing Finnish mental health care planning was given to Vappu Taipale's one-person committee.⁵¹ Taipale's work resulted in a memorandum entitled *Meaningful Life*.⁵² Taipale concluded that by 1996, Finnish dehospitalization had shifted from 'controlled change to uncontrolled shutdown'.⁵³ The reduction of the number of hospital beds had been even faster than planned, resulting in a situation where there were more patients than adequate spaces in the hospital wards.⁵⁴

Taipale's work was later expanded into a broader project, also known as Meaningful Life, but distinguished from Taipale's memorandum by the addition of an exclamation mark to the project name. The Meaningful Life!-project delivered a number of reports which proposed further developing outpatient treatment as a way to remedy the negative effects of uncontrolled dehospitalization.⁵⁵ While these suggestions turned against excessive hospital treatment, just as the NBOH and the CMHW had done before, the Meaningful Life!-project took an even stronger interest in international comparisons than either of these projects, noting that similar problems resulting from dehospitalization could be detected abroad.⁵⁶ In her preceding memorandum, Taipale had even suggested that the challenges which confronted mental health planners internationally could provide an opportunity for Finnish mental health care to establish itself as a pioneer in the field.⁵⁷

51 Born in 1940, Vappu Taipale, MD, a supporter of the Social Democratic Party and a participant in the so-called November movement (cf. footnote 9 above) in the late 1960s and early 1970s, had been a member of the CMHW in 1981–1982 and Minister for Social Affairs and Health in 1982–1984. In 1996, she was Director General of the Finnish National Research and Development Centre for Welfare and Health (STAKES). Rantala, Risto (1998) *Kuka kukin on: henkilötietoja nykypolven suomalaisista*. Helsinki: Otava.

52 The memorandum was based on hearings of 100 mental health care experts and citizens who were not individualized in the document. Taipale, Vappu (1996) *Mielekäs elämä. Sosiaali- ja terveystieteiden tutkimuskeskuksen tutkimusraportti*. Helsinki: Ministry of Social Affairs and Health.

53 Taipale 1996, 16.

54 Taipale 1996, 17.

55 According to the final report of the project, 35 publications were published under the auspices of the project. Among them was so-called 'grey literature', polytechnic school theses, abstracts in conference proceedings, and public disseminations. In addition to Taipale's report, three publications of the Meaningful Life!-project have been selected for analysis here: MSAH (1997) *Mielekäs elämä! -ohjelman esisuunnitelma: työryhmän muistio*. Helsinki: Ministry of Social Affairs and Health; MSAH (2000) *Mielekäs elämä: mielenterveyspalvelujen kehittämissuosituks*. Helsinki: Ministry of Social Affairs and Health; Immonen, Tuula, Kiikkala, Irma & Ahonen, Juha (eds) (2003) *Mielekäs elämä! -ohjelman loppuraportti*. Helsinki: Ministry of Social Affairs and Health.

56 Taipale 1996, 13.

57 Taipale 1996, 11–12.

During the early 1990s, Finland experienced high unemployment rates due to recession, causing social exclusion and social problems as well as straining the resources of the welfare state. Paradoxically, the unemployment security policy during the crisis increasingly emphasized the individual's responsibility for making one's living from wage work.⁵⁸ In the beginning of the Meaningful Life!-project in 1996, the project still focused on developing employment for people suffering from mental health problems within sheltered work.⁵⁹ Tellingly, by time the project came to an end in 2003, the emphasis had shifted towards wage work.⁶⁰

From the very beginning, the Meaningful Life!-project openly acknowledged the adverse social position of users of mental health care services compared to other citizens, noting that the shortcomings were 'worse in mental health care than in any other sector'.⁶¹ A report published in 2000 stated that '[t]he mental health patients have not been guaranteed the same rights to good treatment according to their needs as other patient groups', despite all earlier efforts to ensure parity in this regard.⁶² The images of the service user ranged in the publications of the Meaningful Life!-project from 'mental health patients' who should be protected from being abandoned in consequence of the dehospitalization policy to 'rehabilitees' who would mainly be responsible for their own rehabilitation.⁶³ Yet, the need for support to the latter was still to be taken into account:

"In a patient-oriented operations model, the patients' own responsibility for care should be supported. This must not, however, lead to failing to treat the patients that are severely disturbed or lack initiative; the treating professional must be active both in relation to the patient and the patient's social network."⁶⁴

58 Outinen 2012; Kananen 2013.

59 Taipale 1996, 22.

60 Immonen, Ahonen & Kiikkala 2003, 93.

61 Taipale 1996, 46.

62 MSAH 2000, 7.

63 Taipale 1996; MSAH 2000, 10.

64 MSAH 2000, 12.

In line with the broadening of both the concept of mental health care as well as its intended target groups, the Meaningful Life!-project took an interest in ‘the meaningful life’ of all citizens, despite the fact that the project had originally started out from the need to focus on those suffering from severe mental disorders.⁶⁵ At the close of the project, mental ‘health care’ in terms of ‘service provision’ played a minor role, while widening ‘the understanding of the wide nature of mental health care’ was seen as a core achievement of the project.⁶⁶

Mind 2009

In spring 2004 – only a year after the Meaningful Life!-project had delivered its final report – a motion suggesting a new national mental health programme was presented in the Finnish Parliament. Initiated by Kirsi Ojansuu, an MP representing the Finnish Green League, the motion won exceptionally broad support, being signed by 106 of the 200 Members of Parliament. While the motion did not refer to the work of the Meaningful Life!-project, it revoked many of the concerns which had served as a starting point for the project in 1996, in particular by emphasizing the shortcomings of mental health care and addressing the imperfect implementation of the dehospitalization policy during the 1990s recession.⁶⁷

In response to the broad political support for policy reform, the MSAH appointed the Mind 2009 working group in 2007, chaired by MSAH Assistant Director of Department, Master of Laws (trained on the bench) Marja-Liisa Partanen. The proposals of the Mind 2009 working group were published in 2009.⁶⁸ At the time of writing, the plan is still being implemented.⁶⁹

65 Taipale 1996, 41–42.

66 Immonen, Ahonen & Kiikkala 2003, 85.

67 Kansallinen mielenterveysohjelma [National Mental Health Programme] TPA 36/2004 vp.

68 The Mind 2009 working group had 14 members and organized six hearing events. MSAH [Ministry of Social Affairs and Health] (2009) *Mielenterveys- ja päihdesuunnitelma. Mieli 2009 työryhmän ehdotuksen mielenterveys- ja päihdetyön kehittämiseksi vuoteen 2015*. Helsinki: Ministry of Social Affairs and Health.

69 For an investigation on the implementation of the plan, see Kuussaari, Kristiina & Partanen, Airi (2010) ‘Administrative Challenges in the Finnish Alcohol and Drug Treatment System’. *Nordic Studies on Alcohol and Drugs*, Vol. 27, Issue 6, 667–684; Stenius, Kerstin, Kekki, Tuula, Kuussaari, Kristiina & Partanen, Airi (2012) ‘Päihde- ja mielenterveyspalveluiden integraatio – kirjava käytäntö Suomen kunnissa’. *Yhteiskuntapolitiikka*, Vol. 77, Issue 2, 167–175.

Again, the unequal position of mental health care service users was highlighted as a fundamental problem and the Mind 2009 working group argued in favour of treating the problems of mental health care service users and substance abusers with the same diligence as the health problems of any other patient group. The lack of parity in the treatment of these groups was presented as a cause for both discrimination and stigmatization. But it was also suggested that this problem could be tackled with the education of care providers and decision-makers as well as by integrating mental health care with other forms of health and social care, in particular substance abuse care.

While the plan published by the Mind 2009 working group has mostly been discussed with regard to its proposal to co-ordinate mental health care and substance abuse care, many of its other suggestions were similar to earlier recommendations.⁷⁰ For example, even though the number of psychiatric hospital beds had been considerably reduced in the preceding decades, the working group still regarded excessive hospital treatment as a major problem:

“The development of community care has played a secondary role, and there is a disproportionate focus on institutional treatment in mental health care and substance abuse care costs.”⁷¹

In this context, the Mind 2009 working group also identified the comparatively high degree of involuntary psychiatric treatment in Finland as a specific problem. The high prevalence of involuntary treatment was seen as a specific problem by the Mind 2009 working group, which addressed those in need for mental health services in terms of ‘clients’ or ‘service users’.⁷² The Mind 2009 working group envisioned the ideal service users as active clients, in need of strengthening their status, self-determination rights

70 Kuussaari & Partanen 2010.

71 MSAH (2010) *Plan for Mental Health and Substance Abuse Work. Proposals of the Mieli 2009 Working Group to Develop Mental Health and Substance Abuse Work Until 2015*. Helsinki: Ministry of Social Affairs and Health, 9.

72 The original word in the Finnish version is *asiakas*, usually translated as ‘client’ but in the official translation this is translated as ‘service user’. MSAH 2009; MSAH 2010.

and communities as well as improving their livelihood, while putting pressure on the mental health services to become more flexible. In so doing, the working group apparently expected clients or service users to primarily rely upon their 'own resources'.⁷³ The role of 'peer support' and 'user experts' was accentuated, and the opinion of the service user was to be taken into account even in the context of coercive measures.⁷⁴ In line with this, the group also suggested a 'psychiatric advance directive' to be agreed upon when a person's health status can be considered stable enough to allow for self-determination.⁷⁵

Like the earlier plans and policy reviews, the Mind 2009 working group placed strong emphasis on working ability. The growing numbers of people who could not work due to mental health problems was seen as a main challenge.⁷⁶ In response, the working group suggested that more attention should be paid to those in danger of losing their working capacity.⁷⁷ This in turn led the working group to emphasize the need for defining and, like both the CMHW and the Meaningful Life!-project, widening, the target population. The suggestion of the Mind 2009 working group was to integrate the problems to be addressed by mental health care and those to be taken care of through substance abuse care.⁷⁸ The working group motivated this suggestion by pointing to the increase of simultaneous mental health and substance problems as well as the increased rate of alcohol-related deaths among the working-age population. Since the group with 'dual diagnosis' was growing, all the treatment in both sectors should ideally be planned and coordinated together.⁷⁹

It may seem self-evident that psychiatric care should be planned in order to ensure that those in need get the required treatment. In the parliamentary

73 MSAH 2010, 10.

74 MSAH 2010, 18.

75 MSAH 2010, 19.

76 However, at the same time, another working group focussing on inability to work was created. MSAH (2011) *MASTO-hankkeen (2008–2011) loppuraportti. Masennusperäisen työkyvyttömyyden vähentämiseen tähtäävän hankkeen toiminta ja ehdotukset*. Helsinki: Ministry of Social Affairs and Health.

77 MSAH 2010, 41–42.

78 For discussion on the implementation of this aim, see Partanen & Kuussaari 2010; Stenius, Kekki, Kuussaari & Partanen 2012.

79 MSAH 2010.

motion of 2004, the central problem had been the lack of mental health services for those in need. Yet, as the Mind 2009 working group worked away on this problem, the working group finally settled on the need to reduce psychiatric hospital care and to support the target group's autonomy as the central problem. By the end of the early 2000s, then, the notion of a need of mental health services, especially psychiatric hospital services, had largely withered away from the discussions.

Conclusion: Who needs mental health services?

Six distinct aspirations or aims tend to reverberate in the planning of the Finnish mental health care throughout the period between 1977 and 2009. All the plans have called for the need to limit excessive hospital treatment; to increase outpatient care in different forms; to promote mental health service users' participation in working life; to ensure equality between mental health service users and other citizens; to provide mental health services in line with, or even surpassing, international standards; and to delineate the target group of the services. The recurrence of these aspirations has been so regular that they could well be considered revolving aims.

If the other aims have then been remarkably stable over time, there was a more visible shift regarding the groups of persons that are to be included under the purview of mental health services. These vacillations expanded the scope of individuals and issues discussed within the planning of mental health discourse. The need to provide services for the 'right' target group has also activated conflicting aims in mental health planning. As the selection of target groups vary somewhat from plan to plan, the proposals may have had a certain impact upon the practice of mental health policy while the stated aims have remained largely the same over time. As the target group expanded, the plans may well have further fuelled the demand for more mental health services.⁸⁰

The question of the target group also activated the issue of how the abilities, needs, and responsibilities of the service users were to be understood

80 Helén, Hämäläinen & Metteri 2011; Vilhelmsson, Andreas, Svensson, Tommy & Meeuwisse, Anna (2011) 'Mental Ill Health, Public Health and Medicalization'. *Public Health Ethics*, Vol. 4, Issue 3, 207–217.

and cared for. A gradual change took place from ensuring the care of those most in need in the late 1970s, via support to rehabilitation and the mental health of the broader population as a whole in the 1980s and the 1990s, to reinforcing the mental health of the autonomous citizen in the early 2000s.

Even though the widening of relevant target groups means that more and more citizens can be discussed within the sphere of mental health, the changing image from the 'mentally ill' person in need of mental care to the autonomous citizen requesting mental health services may add a new tangent to the context of planning mental health services as well as social services more generally; a decreasing emphasis on the need for services in favour of individual demands may also reflect a decrease in the public responsibility in providing for services.

This emphasis on autonomy may be connected with Pekka Sulkunen's conceptualization of the conflict between autonomy and intimacy, asking whether this emphasis on autonomy is wholly beneficial if it leads to avoiding interventions and, in this case, the reduction of service provision. Sulkunen has argued that the emphasis on autonomy may lead to the possible loss of dignity and marginalization of those unable to practise their sovereignty in the expected ways.⁸¹ There may also be certain risks and counterproductive effects from expecting – or even demanding – 'normal' behaviour from those suffering from mental health problems, as noted by Katarina Piuva.⁸² In a similar vein, Ilpo Helén has identified the risk that the attention to autonomy may lose track of that which was bothering the patient to begin with: An individual's mental health problems may exactly relate to the person's difficulties in taking responsibility for his or her own well-being.⁸³

To conclude, the results presented in this chapter may help to explain why Finnish mental health care has constantly been perceived as inadequate

81 Sulkunen, Pekka (2009) *The Saturated Society: Governing Risk and Lifestyles in Consumer Culture*. London: Sage; Sulkunen, Pekka (2011) 'Autonomy Against Intimacy: On the Problem of Governing Lifestyle-related Risks'. *Telos*, Vol. 156, 99–112.

82 Piuva, Katarina (2005) *Normalitetens gränser. En studie av 1900-talets mentalhygieniska diskurser*. Stockholm: Institute for Social Work.

83 Helén 2011.

in recent decades. The reason is not only that the welfare state has changed, but also that the planning of mental health care has changed. Two new phenomena emerged in the state-level mental health plans: psychiatrization, understood as the problematization of the mental health of a widening population, and an increased emphasis on autonomy. The concurrence of these two developments helps to explain why the demand for mental health services has grown simultaneously, but faster, than the supply of services. In other words, the state-level planning of mental health care seems to have contributed to the impossibility of fulfilling the demand for mental health services in today's Finland.

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Happy without money of their own? On the reasons for teenagers' participation in paid work – The case of Iceland

MARGRÉT EINARSDÓTTIR

Introduction

In Western societies, children and teenagers are placed outside the economy and the sphere of production, but within the sphere of reproduction, i.e. the home and the school. This situation means that the age-group is supposed to passively receive economic resources from their adult guardians, and, hence, depend on them economically.¹ Jens Qvortrup has argued that this arrangement is ahistorical and that in pre-industrial times children were placed within the economy and expected to do their part of the work from an early age.² In the wake of industrialization, new ideas about the nature of children changed this expectation. Childhood was increasingly romanticized and seen as a state of some kind of heavenly innocence, where work had no place. A proper and happy childhood came to be conceived of as almost the opposite of adulthood: 'If adults were burdened with responsibilities, children should be carefree. If adults worked, children should not work.'³ Emphasis was placed on all children being entitled to experience this

1 James, Allison, Jenks, Chris & Prout, Alan (1998) *Theorizing Childhood*. Cambridge: Polity Press; Qvortrup, Jens (1995) 'From Useful to Useful: The Historical Continuity of Children's Constructive Participation'. *Sociological Studies of Children*, Vol. 7, 49–79; Qvortrup, Jens (2001) 'School-work, Paid Work and the Changing Obligations of Childhood'. In Mizen, Phillip, Pole, Christopher & Bolton, Angela (eds) *Hidden Hands: International Perspectives on Children's Work and Labour*. London: RoutledgeFalmer, 91–107.

2 Qvortrup 1995.

3 Cunningham, Hugh (1995) *Children & Childhood in Western Society Since 1500*. London and New York: Longman, 160.

kind of childhood, it was feared that if they had to work and toil, their childhood would be an unhappy one, and it was even argued that by working, children simply lost their childhood.⁴

It is in accordance with this romantic construction of childhood to argue that, instead of undertaking work, children should spend their time playing and galloping around in nature. Nevertheless, the upsurge of bourgeois thinking and its domestic ideal during industrialization, as well as the demand from the new industry for an educated labour force, soon associated children with the home and the school, where they should spend their time in education and be protected and provided for by adults.⁵

To begin with, these new ideas of how children should spend their time were not uncontroversial and elicited strong debate. In the long run, however, advocates of children spending their time at school instead of work gained the upper hand, and the placement of children within the sphere of reproduction was sanctified by legislation on child labour and compulsory education.⁶ Needless to say, child labour laws and laws on compulsory education were passed all around the industrialized world, and are still in existence. Moreover, the placement of children within the sphere of reproduction has been further sanctified, and universalized, by the United Nations Convention on the Rights of the Child (UNCRC) recognizing children's special rights to education, protection and provision. Taken further, these special rights of children include the right *not to work*.⁷

4 Cunningham 1995; Hendrick, Harry (1997) 'Constructions and Reconstructions of British Childhood: An Interpretative Survey, 1800 to the Present'. In James, Allison & Prout, Alan (eds) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. London, Philadelphia: RoutledgeFalmer, 34–62.

5 Cunningham 1995.

6 Cunningham 1995; de Coninck-Smith, Ning (1997) 'The Struggle for the Child's Time – At All Times: School and Children's Work in Town and Country in Denmark from 1900 to the 1960s'. In de Coninck-Smith, Ning, Sandin, Bengt & Schrumpf, Ellen (eds) *Industrious Children: Work and Childhood in the Nordic Countries 1850–1990*. Odense: Odense University Press, 129–159; Sandin, Bengt (1997) "'In the Large Factory Towns': Child Labour Legislation, Child Labour and School Compulsion'. In de Coninck-Smith, Ning, Sandin, Bengt & Schrumpf, Ellen (eds) *Industrious Children: Work and Childhood in the Nordic Countries 1850–1990*. Odense: Odense University Press, 17–46.

7 Weston, Burns H. & Teerink, Mark B. (2005) *Rethinking Child Labor: A Multidimensional Human Rights Problem*. In Weston, Burns H. (ed.) *Child Labor and Human Rights: Making Children Matter*. Boulder, CO: Lynne Rienner Publishers, xv–xxv.

Indeed, it has been a general belief that the Western World – the Nordic welfare states included – has succeeded in its effort of securing children the right not to work, and, hence, nowadays child work is usually associated with ‘old days and distant skies’, as the Norwegian sociologist Anne Solberg puts it.⁸ Also, their happiness and well-being is believed to be secured through *the absence* of work, and, hence, that their subjective well-being can be harmed by them undertaking any paid work.⁹ Employment of children and teenagers of any kind has, therefore, been problematized whereas various kinds of unpaid activities of the age-group – such as play, education and organized leisure activities – are believed to enhance their subjective well-being.¹⁰

Recently, the construction of a work-free childhood, and its vision of children as passive receivers, whether in the social, political or economic sense, has been challenged, however. Partly, this challenge comes from international law, as the UNCRC not only recognizes children’s special rights to education, protection and provision, but also their right to participation in society. It has been argued that children’s right of participation includes their right *to* work.¹¹ Partly, this challenge is, however, academic. Within the disciplinary field of childhood studies it is, therefore, recognized that children are active social agents in the present, and the recognition reaches all spheres of society, including the political and the economic.¹² The recognition of children being economic agents in the present has not only yielded

8 Solberg, Anne (1994) *Negotiating Childhood: Empirical Investigations and Textual Representations of Children’s Work and Everyday Life*. Stockholm: Nordic Institute for Studies in Urban and Regional Planning, 19; see also McKechnie, Jim & Hobbs, Sandy (1999) ‘Child Labour: The View from the North.’ *Childhood*, Vol. 6, No. 1, 89–100.

9 Mortimer, Jeylan T. (2003) *Working and Growing Up in America*. Cambridge, Massachusetts: Harvard University Press.

10 James, Jenks & Prout 1998.

11 Karl Hanson and Arne Vandaele point out that the right to work is twofold, as it includes both the right to employment and rights in work. The argument that the participation articles of the UNCRC involve the right to work has also been raised by Madeleine Leonard. See Hanson, Karl & Vandaele, Arne (2003) ‘Working Children and International Labour Law: A Critical Analysis.’ *The International Journal of Children’s Rights*, Vol. 11, 73–146; Leonard, Madeleine (2004) ‘Children’s Views on Children’s Right to Work.’ *Childhood*, Vol. 11, No. 1, 45–61.

12 James, Allison & Prout, Alan (eds) (1990) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. London: The Falmer Press; Qvortrup, Jens, Corsaro, William A. & Honing, Michael-Sebastian (eds) (2009) *The Palgrave Handbook of Childhood Studies*. Basingstoke and New York: Palgrave Macmillan.

the argument that most children's daily activities – including their education – have some economic value, despite society usually not recognizing that value (at least not in the present),¹³ but also reveals that children under the age of 18 commonly undertake various kind of paid and unpaid work.¹⁴ For example, findings from the UK,¹⁵ the US,¹⁶ as well as from the Nordic countries,¹⁷ all show that it is not uncommon for the young generation in these countries to undertake paid work. As the vast majority of the age group goes to school, and are indeed obliged to do so until they reach 16, it should not come as a surprise, however, that the work is usually flexible part-time work and often informal.¹⁸

The recognition of children's and young people's participation within the sphere of production sheds a light on the tension that can exist in their life between the (material) well-being the participation provides and the (subjective) well-being that the absence for work might provide. A step toward understanding the tension is to explore why the young generation undertakes paid work. The aim of this chapter is to seek some answers to that question from the perspective of childhood studies which argues both for children being social agents and worthy of study in their own right.¹⁹ Childhood studies have many Nordic advocates,²⁰ but the question on the reasons behind child and teenage work is, nevertheless, under-researched in the Nordic contexts. In this chapter the question will be put in a Nordic context, however, by presenting findings of a doctoral research on paid work of 13–17-year-old Icelanders. Both qualitative and quantitative methods were

13 Qvortrup 1995.

14 See for example Liebel, Manfred (2004) *A Will of Their Own: Cross-Cultural Perspectives on Working Children*. London & New York: Zed Books; Mizen, Phillip, Pole, Christopher & Bolton, Angela (eds) (2001b) *Hidden Hands: International Perspectives on Children's Work and Labour*. London: RoutledgeFalmer; Mortimer 2003.

15 McKechnie & Hobbs 1999, 92.

16 Mortimer 2003.

17 Rafnsdóttir, Guðbjörg Linda (1999) *Barn- och ungdomsarbete i Norden*. Copenhagen: Nordic Council of Ministers.

18 Einarisdóttir, Margrét (forthcoming) *Paid Work of Icelandic Children and Teenagers: Emphasis on Protection from Work or Rights In Work?* Unpublished doctoral thesis. Reykjavík: University of Iceland.

19 James & Prout 1990; Qvortrup, Corsaro & Honing 2009.

20 See for example the Norwegian and Finnish sociologists Anne Solberg and Leena Alanen cited elsewhere in this chapter. An example of Nordic childhood studies can also be found in Brembeck, Helene, Johansson, Barbro & Kampmann, Jan (eds) (2004) *Beyond the Competent Child: Exploring Contemporary Childhoods in the Nordic Welfare Societies*. Roskilde: Roskilde University Press.

applied in the research and the teenagers were asked why they undertake paid work, how they spend their income, as well as how they evaluate that spending. In addition to the findings on those child-centred questions, findings on the association between paid work of young Icelanders and economic status of parents will be illustrated.

Child and teenage work and economic deprivation of parents

If viewed from the perspective of the construction of a work-free childhood, a reasonable answer to the question why children and teenagers in affluent societies undertake paid work could be that they only do so out of economic hardship, and hence, that the work is associated with economic deprivation of parents. This possibility has been addressed in some British and American research.²¹ Findings from those British and American studies indicate that participation in paid work is not restricted to children from poor families.²² Thus, the research of Sue Middleton and Julia Loumidis has shown that British children in single parent families were less likely to hold a paid job than their counterparts living with two parents.²³ Jeylan T. Mortimer draws the conclusion from findings of American studies that most teenage workers in America are not poor.²⁴ In fact, employed youth come disproportionately from middle class families.²⁵ Nevertheless, there are indicators of children from economically disadvantaged families working longer hours than children from affluent families, and of the importance of the child's in-

21 However, as far as I know, it has not yet been researched in the Nordic context.

22 Hobbs, Sandy & McKechnie, Jim (1997) *Child Employment in Britain*. Edinburgh: The Stationery Office; Middleton, Sue & Loumidis, Julia (2001) 'Young People, Poverty and Part time Work'. In Mizen, Phillip, Pole, Christopher & Bolton, Angela (eds) *Hidden Hands: International Perspectives on Children's Work and Labour*. London: Routledge Falmer Press, 24–36; Morrow, Virginia (1994) 'Responsible Children? Aspects of Children's Work and Employment Outside School in Contemporary UK'. In Mayall, Berry (ed.) *Children's Childhoods Observed and Experienced*. London & Washington, D.C.: Falmer Press, 128–143; Mortimer 2003; Schoenhals, Mark, Tienda, Marta & Schneider, Barbara (1998) 'The Educational and Personal Consequences of Adolescent Employment'. *Social Forces*, Vol. 77, No. 2, 723–762.

23 Middleton & Loumidis 2001.

24 Mortimer 2003.

25 Mortimer 2003, 115.

come for poorer households.²⁶ Thus, the research findings of Middleton and Loumidis revealed that the average earnings of children from disadvantage families were three times greater as a share of family income (6 per cent) than those of young people from better off families (2 per cent). The authors point out that '[t]hese differences are small in percentage terms but could be of great importance to the living standards of poorer families.'²⁷

Commodified childhood and the social meaning of consumption

The empirical fact of child and teenage work not being restricted to children from poor families suggests that the work might be connected to increasing materialism in Western societies and an upturn of the consumer society. Research that has looked into what child and teenage workers spend their income on corroborates the answer, at least at first sight. Thus, research findings reveal that only a small minority of Western child and teenage workers spend their money on things can be classified as absolute necessities, or contribute directly to their household.²⁸ However, those findings also shed a light on how debatable the question of the boundaries between necessities and luxuries is. Thus, are fashion clothes – items young workers sometimes spend their earnings on – necessities because they are clothes, or luxuries because they are fashion? What about toiletries and savings for the future as well as another items young workers in some instances spend their income on?

26 Marsh, Herbert W. & Kleitman, Sabina (2005) 'Consequences of Employment During High School: Character Building, Subversion of Academic Goals, or a Threshold?' *American Educational Research Journal*, Vol. 42, No. 2, 331–369; Middleton & Loumidis 2001; Schoenhals, Tienda & Schneider 1998.

27 Middleton & Loumidis 2001, 31.

28 Einarisdóttir, Margrét (2004) *Bara eitthvað sem krakkar gera til þess að vinna sér inn pening: Sjónarhorn blaðburðarbarna á vinnu sína sett í stærra sögulegt og félagslegt samhengi*. Unpublished master's thesis. Reykjavík: University of Iceland; Howieson, Cathy, McKechnie, Jim & Semple, Sheila (2006) *The Nature and Implications of the Part-time Employment of Secondary Schools Pupils*. Edinburgh: Scottish Executive Social Research, The Department of Enterprise, Transport and Lifelong Learning; Inghorst, Heinz (2001) 'Child Labour in the Federal Republic of Germany'. In Mizen, Phillip, Pole, Christopher & Bolton, Angela (eds) *Hidden Hands: International Perspectives on Children's Work and Labour*. London: RoutledgeFalmer, 139–148; Mizen, Phillip, Pole, Christopher & Bolton, Angela (2001a) 'Why Be a School Age Worker?' In Mizen, Phillip, Pole, Christopher & Bolton, Angela (eds) *Hidden Hands: International Perspectives on Children's Work and Labour*. London: RoutledgeFalmer, 37–54; Mortimer 2003.

An attempt is often made in political and academic discussion to define the line between necessities and luxuries in either relative or absolute terms, but '[a]ll in all, a standard of living, whether an absolute or a relative one, is always based on a subjective evaluation.'²⁹ Such subjective evaluation of what is a necessity and what is not has been salient in academic discussion on the spending patterns of child and teenage workers. In their writing on part-time work of American high school students in the 1980s, Ellen Greenberger and Laurence D. Steinberg, for example, set their own absolute criteria for necessities when they argue that the work of students, whose work is not motivated by their parents' economic hardship, is a 'luxury youth employment' as well as when they argue that the young workers' spending on things like clothing, stereo equipment, music, movies, recreation, hobbies, and car expenses is 'discretionary spending.'³⁰ Phillip Mizen, Christopher Pole, and Angela Bolton, on the other hand, view similar spending of British school-age workers as necessities in the consumer society they live in:³¹

[T]he decision to work cannot be viewed as the simple choice to consume but rather represents a necessary act on the part of many children if they are to merely participate in many of the 'normal' routines of childhood. It is no longer the case that children's and teenagers' leisure activities are mostly free. On the contrary, their leisure has been reconstituted into new and increasingly commodified forms dictated by the market, whose only entry requirement is the possession of money. For those children for whom money is something difficult to come by, the search for some sort of wage is one of the few viable alternatives.³²

29 Sturluson, Jón Þór, Eydal, Guðný, & Ólafsson, Andrés Júlíus (2011) *Íslensk neysluviðmið*. Reykjavík: Velferðarráðuneyti, 5.

30 Greenberger, Ellen & Steinberg, Laurence D. (1986) *When Teenagers Work: The Psychological and Social Costs of Adolescent Employment*. New York: Basic Books, 74, 75.

31 Mizen, Phillip, Pole, Christopher & Bolton, Angela (1999) 'School Age Workers: The Paid Employment of Children in Britain'. *Work, Employment and Society*, Vol. 13, No. 3, 423–438; Mizen, Pole & Bolton 2001a.

32 Mizen, Pole & Bolton 1999, 433.

The argument of 'commodified childhood' brings up the theory of the social meaning of consumption; not only has it been theorized that consumption of activities and goods is embedded in the social in general, but also that the consumption may be especially important in the social life of teenagers.³³ Research that has looked into the social and symbolic meaning of teenagers' consumption of goods like brand clothes and makeup confirm the theory.³⁴ Moreover, Elin Olsson's study shows that among Swedish teenagers (aged 10–18) economic resources, both in terms of the resources of the household and the teen's own resources, are positively associated with social relations of peers.³⁵ Nevertheless, in the research, the young people own economic resources were not directly linked to an income of their own, but simply defined as accessibility to cash.

The standpoint of children

The importance that consumption can have in the life of the young generation suggests the possibility of evaluating the spending from the viewpoint of child and teenage workers themselves, as does the child-centred argument of childhood studies.³⁶ Jeylan T. Mortimer heads in that direction when she points out that teenagers' definitions of 'discretionary spending' may vary considerably from adults' definitions of the concept. She puts her argument forward in the context of the question of car ownership and argues that: 'whereas car ownership on the part of an adolescent may be considered, from an adult standpoint, as a discretionary item, the situation may be perceived quite differently by a teenager who needs the car to go to school, to attend various social activities, and to get to work.'³⁷ In her writing

33 Piacentini, Maria & Mailer, Greig (2004) 'Symbolic Consumption in Teenagers' Clothing Choices', *Journal of Consumer Behaviour*, Vol. 3, No. 3, 251–262; Olsson, Elin (2007) 'The Economic Side of Social Relations: Household Poverty, Adolescents' Own Resources and Peer Relations', *European Sociological Review*, Vol. 23, No. 4, 471–485.

34 Piacentini & Mailer 2004; Gentina, Elodie, Palan, Kay M. & Fosse-Gomez, Marie-Hélène (2012) 'The Practice of Using Makeup: A Consumption Ritual of Adolescent Girls', *Journal of Consumer Behaviour*, Vol. 11, No. 2, 115–123.

35 Olsson 2007.

36 Alanen, Leena (1994) 'Gender and Generation: Feminism and the "Child Question"'. In Qvortrup, Jens, Bardy, Marjatta, Sgritta, Giovanni & Wittersberger, Helmut (eds), *Childhood Matters: Social Theory, Practice and Politics*. Aldershot: Avebury, 27–42; James & Prout 1990.

37 Mortimer 2003, 118.

on part-time work of American high school students, however, Mortimer does not present any findings on how the young workers themselves evaluate their spending, and it remains difficult to assess how Western child and teenage workers evaluate their spending.

Western child and teenage workers have, however, been questioned on why they undertake paid work (though, once again, the subject is under-researched in the Nordic context, to my best knowledge). The findings indicate that the money the young workers earn is the main reason for the work.³⁸ These findings corroborate that there is some connection between child and teenage work and a 'commodified childhood', but, notably, these findings also reveal that the monetary reasons are not the only reasons children and teenagers give to explain why they participate in paid work.³⁹ Thus, employment and career opportunities (including gaining work experience),⁴⁰ socializing and having fun,⁴¹ as well as independence,⁴² have been recognized as motivating children and teenagers to undertake paid work. It is worth noticing that research findings indicate interplay between the monetary reasons and the independence reasons; it being the independent income of paid work that enables the young workers to take a step towards their autonomy.⁴³ Thus, Mizen, Pole, and Bolton draw the conclusion from their research among British school-age workers that earning money increased the young workers 'spending power' as the money enabled them to buy things their parents disapproved of, such as cigarettes, alcohol, and makeup, and that the power 'brought with it a discernible shift in relations with parents and family'.⁴⁴

38 Einarsdóttir 2004; Howieson, McKechnie & Semple 2006; Ingenhorst 2001; Mizen, Pole & Bolton 2001a; Mortimer 2003.

39 Besen, Yasemin (2006) 'Exploitation or Fun? The Lived Experience of Teenage Employment in Suburban America'. *Journal of Contemporary Ethnography*, Vol. 35, No. 3, 319–340; Einarsdóttir 2004; Howieson, McKechnie & Semple 2006; Hungerland, Beatrice, Liebel, Manfred, Liesecke, Anja & Wihstutz, Anna (2007) 'Paths To Participatory Autonomy: The Meanings of Work for Children in Germany'. *Childhood*, Vol. 14, No. 2, 257–277; Mizen, Pole & Bolton 2001a.

40 Howieson, McKechnie & Semple 2006; Hungerland, Liebel, Liesecke & Wihstutz 2007; Mortimer 2003.

41 Besen 2006; Hungerland, Liebel, Liesecke & Wihstutz 2007; Mizen, Pole & Bolton 2001a.

42 Einarsdóttir 2004; Howieson, McKechnie & Semple 2006; Hungerland, Liebel, Liesecke & Wihstutz 2007; Mizen, Pole & Bolton 2001a.

43 Hungerland, Liebel, Liesecke & Wihstutz 2007; Mizen, Pole & Bolton 2001a.

44 Mizen, Pole & Bolton 2001a, 44–45.

Methods

The aim of the research presented here is to analyze why children and teenagers undertake paid work despite their acknowledged right not to work in a Nordic context by exploring the reasons behind paid work of Icelandic children and teenagers. Despite Iceland being one of the Nordic countries, the country deviates from the other Nordic countries in some aspects. The country had no compulsory school system until the beginning of the twentieth century and school summer holidays were relatively long.⁴⁵ Ólöf Garðarsdóttir puts the long summer holidays in context with an annual need of the country's main industry in the twentieth century, i.e. the fish industry, of a reserve army, and argues that this need fuelled a positive attitude towards child and teenage work in the country.⁴⁶ Indeed, participation in summer work is exceptionally common in Iceland; the research of Guðbjörg Linda Rafnsdóttir's research from the late 1990s has shown that 92 per cent of 13–17-year-old Icelanders undertook paid summer work compared to 70 per cent of their Danish, 42 per cent of their Norwegian and Finnish, and 35 per cent of their Swedish counterparts.⁴⁷ On the other hand, the research also revealed that the prevalence of term-time work was not exceptional in Iceland, and indeed much lower than in Denmark (but on a par with Norway and Finland). Also, term-time work of Icelandic students is commonly problematized.⁴⁸ Therefore, I infer that child and teenage work in Iceland does not differ in essence to child and teenage work in the other Nordic countries.

The data presented in this chapter originates in my doctoral research on paid work of young Icelanders, aged 13–17. The research design and the conduct of the research were based on two methodological approaches,

45 More than three months, but shortened to circa nine weeks in elementary school at the beginning of this century.

46 Garðarsdóttir, Ólöf (1997) 'Working Children in Urban Iceland 1930–1990'. In de Coninck-Smith, Ning, Sandin, Bengt & Schrumpf, Ellen (eds) *Industrious Children: Work and Childhood in the Nordic Countries 1850–1990*. Odense: Odense University Press, 160–185.

47 Rafnsdóttir 1999.

48 Ólafsson, Hannes Í., Þorgeirsdóttir, Björk & Gíslason, Garðar (2006) *Vinna framhaldsskólanema með námi: Könnun gerð í þremur framhaldsskólum á höfðuðborgarsvæðinu vorið 2005*. Online. Available HTTP: <<http://www.ismennt.is/not/gardarg/Vinna.doc>> (accessed August 2012); Sigurðardóttir, Guðriður & Karlsson, Þorlákur (1991) *Göfgar vinna með námi? Niðurstöður rannsóknar á þáttum tengdum vetturvinnu framhaldsskólanema*. Reykjavík: Rannsóknarstofnun uppeldis- og menntamála.

firstly, the approach of research *with* children, and secondly, the approach of mixed methods research. The approach of research with children is the methodological counterpart of childhood studies, and in addition to the premises of children and young people holding social agency, its frames of reference include the involvement (participation) of young people in the research; the suitability of the research methods; as well as an awareness of ethical issues within child research.⁴⁹ The approach of mixed methods research is, on the other hand, based on the pragmatic stance of the research questions determining the methods, not vice versa.⁵⁰ As the questions of the doctoral research that is presented here called upon both qualitative and quantitative methods both types of data was collected.

The quantitative part of the research constituted of a comprehensive survey on child and youth work. Together the sample constituted of 2000 Icelanders aged 13–17, randomly selected from the Icelandic Register of Persons. Totally, 952 young people responded, thus, the response rate was 48.8 per cent. The qualitative part of the research constitute on the other hand, of group interviews with around forty 13–18 years old Icelandic teenagers, of both sexes, and with various social and economic background, who all had at least some experience of paid work. The group of the interviews were relatively small, between two and five young people participated in each, and the participants in each group knew each other beforehand, in some instances they were close friends, in other instances class or school mates. The research was conducted during the peak of the 2000s economic boom in Iceland, and enquired, on the one hand, on paid work during the summer of 2007, and, on the other hand, on term–time work during the school year of 2007–2008.

49 See for example Alderson, Perscilla & Morrow, Virginia (2004) *Ethics, Social Research and Consulting with Children and Young People*. Barking: Barnardo's; Christensen, Pia & James, Allison (2008) *Research with Children: Perspectives and Practices*. New York and London: Routledge.

50 See for example Johnson, R. Burke & Onwuegbuzie, Anthony J. (2004) 'Mixed Methods Research: A Research Paradigm Whose Time Has Come'. *Educational Researcher*, Vol. 33, No. 7, 14–26; Tashakkori, Abbas & Teddlie, Charles (eds) (2003) *Handbook of Mixed Methods In Social & Behavioral Research*. Thousand Oaks, CA: Sage Publication.

Advocators of the mixed methods research disagree on whether the mixing should occur at all stages of the research process, only at the last stage of interpretation of the data and the writing of the result, or somewhere between.⁵¹ In this research the argument of Janice M. Morse ‘that each method must be complete in itself; that is, all methods used must meet appropriate criteria for rigor’, and that the mixing should therefore only be conducted at the last stage of the research was taken into account.⁵² Hence, the quantitative and the qualitative data were analysed separately, and the findings only mixed during the stage of writing.

Because of the commonality of summer work in Iceland the main focus of the results presented below is on why some Icelandic children and teenagers undertake term-time work, and what they spend their term-time earning on. Findings from both the qualitative and the quantitative part of the research are discussed.

Results

In total, 49 per cent of the respondents of the survey reported participating in paid term-time work during the school year 2007–2008; thereof 29 per cent reported being in regular employment and 20 per cent working irregularly. More than half of the term-time workers reported holding a term-time job in the retail sector. In total, 84 per cent of the respondents reported working during the summer of 2007, most commonly in the work-schools run by most municipalities in Iceland. The respondents who reported participating in term-time work were asked why they worked during term-time. The participants of the group interviews were also asked why they participate in paid work. The findings of these quantitative and qualitative enquires are presented below.

51 Johnson, R. Burke, Onwuegbuzie, Anthony J. & Turner, Lisa A. (2007) ‘Toward a Definition of Mixed Methods Research’. *Journal of Mixed Methods Research*, Vol. 1, No. 2, 112–133.

52 Morse, Janice M. (1991) ‘Approaches to Quantitative-Qualitative Methodological Triangulation’. *Nursing Research*, Vol. 40, No. 2, 120–123.

The reasons behind term-time work of Icelandic teenagers

The results on the question regarding why respondents of the quantitative research participate in term-time work are presented in Table 1. The question was asked in a multiple choice format; i.e. each respondent could mark more than one option. The results head in the same direction as other research findings on the issue, and reveal the importance of monetary reasons for child and teenage work. Therefore, the vast majority, or 86 per cent, reported that they had a term-time job because they wanted to earn some money.

The results illustrated in Table 1 are also in accordance with other research results regarding that, whereas monetary reasons are the key reasons behind child and teenage work, they are nevertheless not the only reasons. Therefore, a third of the respondents mark the option 'to gain work experience for the future', one out of three reported working to be able to get things their parents were not willing, or not able, to provide, and a quarter reported having term-time work because they wanted to have enough to do. Gender difference is only prominent in the option of 'saving for expensive things'. Thus, while half of the boys work to be able to save for expensive things, this is the case for only one out of four girls. The difference is statistically significant.⁵³

'Just the money'

Findings from the group interviews concur with the results of the quantitative part of the research regarding the fact that monetary reasons are the main reason for working. Thus, the vast majority of the participants of the group interviews answered the question regarding why they work during the school year, with remarks like 'it's the money', 'just the money', and 'just because I needed the money'. These answers are reminiscent of the answers I received in some former research on the subject, both in relation to the money being the most common answer, as well as in relation to the adverb 'just' frequently being added in the answer.⁵⁴

⁵³ $\chi^2(1)=4.28, p<.05$

⁵⁴ 'Just' is a translation of the Icelandic word 'bara'. I got answers like 'bara peningurinn', 'út af því, bara, mig vantaði pening', and 'bara aukapeningurinn'. Einarsdóttir 2004.

Table 1. Reasons for term-time work of Icelandic teenagers
(in per cent).

<i>Reason</i>	<i>Percentage</i>
<i>To earn some money</i>	86
<i>To save for something expensive (i.e. computer, travel abroad)</i>	43
<i>To gain some work experience for the future</i>	33
<i>To get or do things my parents are not willing, or not able, to provide for</i>	30
<i>To have enough to do</i>	25
<i>My parents think I should work</i>	16
<i>To have as much spending money as my peers</i>	15
<i>Wanted to try how it is to work during term-time</i>	10
<i>Because everyone else works during term-time</i>	2
<i>Other reasons</i>	11
<i>Total</i>	271

N: 411

‘To have something to do’

Also, the findings of the group interviews head in the same direction as the results of the survey regarding the possibility of other reasons than the monetary one motivating term-time work of Icelandic teenagers. Thus, both work ethics and independence emerged as important themes in the analysis of the interview, although, notably, a concern about future work experience did not. These reasons were, nevertheless, seldom the first reasons brought up by the participants when asked why they participated in term-time work, but rather a further explanation of the financial reason. This becomes clear in the answer of Valdemar. He gave his answer after my reaffirmation of the monetary reasons being the only reason for working, and, emphasized the requisite for being industrious:

...I would just find it rather awkward not to be working anywhere, to be doing nothing. Just, when you come home from school, just go home and do nothing.

Emphasis on being industrious appears in the account of some other participants of the group interviews and one girl even argued that she first and foremost works during term-time because she ‘doesn’t have anything better to do’.

‘It’s terribly boring asking your mum for money’

The group interviews reveal that some of the participants, especially the younger ones, are more or less dependent on their family financially, and may, therefore, be perceived as being economic recipients, rather than economic providers. Thus, the accounts of some of the participants who were still in compulsory education reveal that not only were they dependent on their parents and/or other family members in relation to food and shelter, but also more or less in relation to savings and money for spending. None reported receiving ‘pocket money’ from their parents, but quite a few recounted that they ‘just own money’. My enquiry into the origin of that money revealed that a part of it might be income from odd jobs, like occasional babysitting, but it could also be a birthday gift and/or savings from an amount of money a parent has given the child with the purpose of spending it on food in school, on school journeys, etcetera.

The accounts of other participants of the group interviews, especially the older ones, reveal, on the other hand, that at some point the economic equilibrium between the generations is disturbed. The young individuals begin taking on the role of an economic provider, and their journey into economic independence begins. It is worth noting that, not only did this independence surface in some of the participants emphasizing that they wanted to decide by themselves what to do and what to buy, but also, and more commonly, in the participants emphasizing that they did not want to be a burden on their parents.

The perception, that at some stage in the life course it is not proper for an individual to ask the parents for money for spending anymore, and, consequently, that the individual needs some income of his/her own appeared as an important theme in the group interviews. The perception is apparent in this discussion between two 17-year-old girls:

Erla: But, you know, I think that just no one wants to ask her mum for money, it is just...

Bára:...yes...

Erla: ... it is just wrong, or, you know.

Bára: Just hopeless.

Erla: Not when you have become old enough to be able to work.

Bára: You know, you could get away with it when you were younger because it is so 'smallish', but now, when you are older and you are asking about 3000 krona to go to a disco, no, you don't do that.

Erla: Yea, exactly.

The group interviews reveal more instances of participants describing their unease, or unwillingness, to ask their parents for money. They appear in comments like 'I don't want to ask my mum for some money' and 'I think it's terribly boring asking your mum for some money'. Some participants used stronger words than 'ask for', and, instead, talked about 'begging for money' or 'mooching money' from their parents.⁵⁵ One participant even likened teenagers that do not take up a term-time job to parasites. The other participants of that particular group interview did not oppose his words.

'Fun kids'

Socializing and fun did not appear as an important motivation of the participants to take up a job. Nevertheless, the analysis of the group interviews reveals that the young Icelanders do not consider socializing and fun as unimportant. Indeed, the findings of the group interviews reveal that it is important for many of them not to be bored, and that socializing with friends, or other people they find amusing, and having fun are strongly connected. The connection between having fun and socializing with friends has been identified in other research.⁵⁶ When I asked Sigrún, who works in a supermarket, whether she considers it important that the supermarket is mostly occupied with teenagers, she replied: 'it is more fun', and her friend Ugla continues:

55 The Icelandic words used here were 'biðja', 'belta', and 'sníkja'.

56 Besen 2006; Hungerland, Liebel, Liesecke & Wihstutz 2007.

Ugla: Of course, if you are just working alone with old ladies, or grown up women, it would just be like oh no!

Margrét: Boring?

Ugla: Yea.

The group interviews provide examples of the importance of socializing and fun affecting both the decision to carry on in a job they have started, and the decision where to apply for a job at a time of a great supply of part-time jobs. Þórður, for example, found his supermarket job boring to begin with, and states that he only stayed in the job because his friend worked there too. When the friend quit, a girl from school started working in the supermarket and gave Þórður some company. That and the fact that he had also got used to the job reduced the boredom. Similarly, Embla got a summer job in a supermarket and could have stayed there after the school started but decided not to:

It was just that I didn't find it that much fun working in the supermarket, because there were so many old people working there. There was no one of my age that I could talk to (laughter).

She decided to apply for a term-time job in a kiosk where most of the staff was her age, and got that job.

The spending patterns of Icelandic term-time workers

The research results presented in Table 2 reveal that it is most common for 13–17-year-old Icelandic term-time workers to use their term-time income as 'pocket money'. More than two thirds of the term-time workers marked that option. Also, slightly less than half of the term-time workers use their income to 'save for certain expensive things, i.e. a computer, bicycle or to travel abroad'. Both options could be classified as 'discretionary spending', e.g. if one accepts the definition of Greenberger and Steinberg that spending that can be classified as part of a commodified childhood is 'discretionary'.⁵⁷

⁵⁷ Greenberger & Steinberg 1986.

Table 2. How Icelandic teenagers spend their term-time income (in per cent).

<i>Spending</i>	<i>Percentage</i>
<i>Pocket money (i.e. to pay for sweets, pizza, movies)</i>	68
<i>Buy clothes for myself</i>	63
<i>Save for the future</i>	54
<i>Save for a certain expensive thing (i.e. a computer, travel)</i>	45
<i>Pay for schoolbooks</i>	19
<i>Pay for organized leisure activities</i>	10
<i>Buy food for the home</i>	9
<i>Pay school fees</i>	7
<i>Pay an allowance to my parent(s)</i>	2
<i>Other</i>	8
<i>Total</i>	285

N: 389

However, the results do not indicate that the young workers only spend their income on certain trivial things. Slightly less than three quarters spend their money on clothes for themselves, more than half saves for the future, and a fifth uses their income to buy schoolbooks. A tenth of the term-time workers reported paying for expenses related to organized leisure activities, slightly less than a tenth reported buying food for the household, and 7 per cent reported paying their school fees. A small fraction of the term-time workers, or 1.5 per cent, reported using their income to pay an allowance to their parents.

Gender difference is notable in relation to both saving for expensive things and purchasing clothes. The difference is statistically significant in both instances.⁵⁸ The gender difference in terms of purchasing clothes is particularly salient. Whilst 73 per cent of the girls reported using their term-time income to buy clothes for themselves, only 43 per cent of the boys

58 Purchasing clothes: $\chi^2(1)=32.62$, $p<.01$. Saving for an expensive thing: $\chi^2(1)=4.60$, $p<.05$.

did so. The boys are, on the other hand, more likely to use their term-time income to save for expensive things than the girls. The difference is, though, not as salient as before, or 52 per cent compared to 41 per cent.

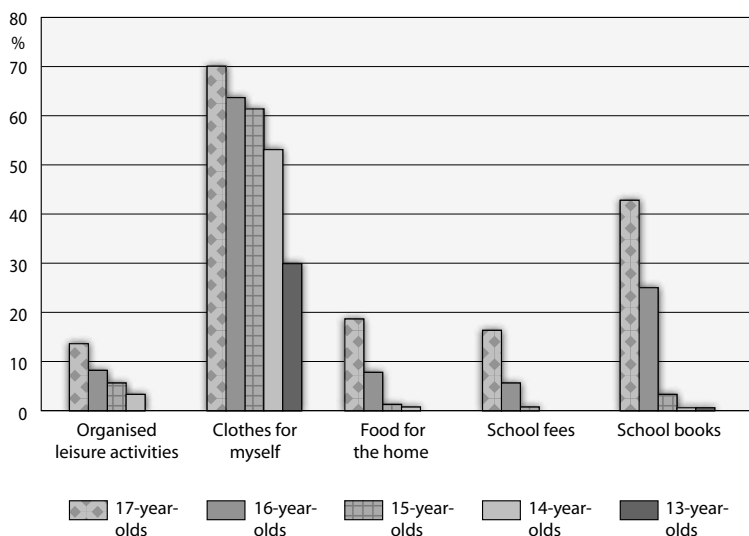
The age difference in relation to the expenses as illustrated in Figure 1, of which all can be classified as necessities, is worth further attention. The figure shows that it is exceptional for the 13-year-olds to use their income to pay for leisure activities, schoolbooks, school fees, and/or to buy food for the home, but that the commonality of paying for those expenses grows with age, although the steepness of the growth varies. Thus, 45 per cent of the 17-year-olds use their term-time work to pay for school books, 21 per cent to buy food for the home, 19 per cent to pay for school fees, and 16 per cent to pay for organized leisure activities. The age difference in relation to school books and school fees can, at least partly, be explained by the fact that, in Iceland, upper-secondary students have to buy their textbooks and pay a small fee to their school, whereas compulsory students have not. For the youngest term-time workers to use their income to buy clothes for themselves is not as uncommon as for them to use it on other necessities; 32 per cent report doing so, but the frequency of the expense rises rapidly with age and has reached 72 per cent in the oldest year. In all instances, the age difference is statistically significant.

These findings on the growing participation of young workers in purchasing necessities as their age rises are compatible with the findings of the group interview, presented above, on the interplay between young people undertaking paid work on the one hand and gaining independence on the other.

'Just something'

Group interviews are not a very suitable for collecting information on individual spending as they do not allow for a detailed mapping of every participant's behaviour. In the case of the present study, the mapping became even more difficult as the participants' incomes varied considerably; some had only earned relatively low amounts during the summer (less than 50 000 ISK), while others ranged from having no or an irregular income during the

Figure 1. Percentage of Icelandic term-time workers spending their income on certain necessities, in relation to age.



school year to having a relatively high and regular income all year around (more than 50 000 ISK per month during term-time added to the summer income). Nevertheless, the analysis of the group interviews of the present research provides some relevant results on the issue.

The group interviews do not provide detailed answers on how the participants spend the part of their income that turned into ‘pocket money’. Thus, in many instances a direct enquiry of mine on the subject provoked unclear answers like ‘just something’ and ‘just to have some money during the winter’. Nevertheless, the inference can be made from the interviews that young Icelanders use at least part of their income on things like lunch at school, eating out, going to the cinema, the mall, and/or a disco.

The car

The data provides more detailed information on other spending patterns than the data dealing with ephemeral recreational activities. Thus, the findings from the qualitative research head in the same direction as the result of the survey and reveal that it is common for Icelandic teenagers to save for certain expensive things. The group interviews gave, therefore, examples of young workers saving for both a computer and to travel abroad. Surprisingly, however, by far the most common purpose of these savings was for a car. Moreover, the 17-year-old age limit for a driving licence meant that among the oldest participants, this car-saving had turned into a spending, as some of them had already bought a car. Interestingly, the group interviews gave more than one example of young Icelanders that had bought a car several months before they turned 17. The findings reveal that driving and car-ownership entail more expenses than just the purchasing of the car itself. Therefore, a few of the participants mentioned that they needed money to pay for driving lessons and a driving licence, and 'of course that costs a lot', others said that they needed money to pay for the petrol, and a few had bought a more expensive car than their savings allowed for, and were at the time of the interview, therefore, paying off a loan. Interestingly, none mentioned paying for the insurance of the car and the annual car tax in Iceland. Possibly, it is a common habit of Icelandic parents to pay the insurance of their child's car.

The commonality of car ownership and car expenses among the participants of the group interviews elicit the question as to whether this spending is a discretionary luxury or not. The majority of the participants of the group interviews would not have given a positive answer to the question. Therefore, many of the participants, especially the ones living either in the suburbs of Reykjavík or outside the capital area, argued that it was difficult to do anything without a car, and gave several examples of their daily activities being encumbered by the long distances and limited service of public transport in Iceland. These examples included both school attendance and organized sport activities. This argument concurs with Mortimer's argument regarding the fact that many American teenagers probably do not

agree that their car expenses are discretionary.⁵⁹ Long distances and a limited public transport service are also features of American society, and in that respect Icelandic and American teenagers probably have more in common than Icelandic and many European teenagers.⁶⁰

'Always buying everything myself'

The findings of the group interviews reveal, like the results of the survey, that it is not uncommon for Icelandic teenagers to use part of their income on things that are reasonable to define as necessities. Firstly, the majority of the participants reported buying clothes for themselves. Their accounts reveal, however, that it differs whether they only buy clothes they fancy or all the clothes they need. Therefore, Kristín reported mainly using her earnings on 'food and clothes', although only fast food and food in school, and all the clothes she needs unless:

Kristín: ...the money is gone. Yes, also if I need something, a coat or something, then my mum buys it.

Margrét: Yes, so your parents buy the more expensive clothes, shoes, and so on?

Kristín: Yes, and these extra things that I need but don't bother buying myself.

The friends Erla and Bára, on the other hand, bought nearly all the clothes they need themselves. They only got clothes from their parents on special occasions, i.e. as a birthday or Christmas present or if their mothers wanted to show their affection to their daughter by inviting her to go shopping.

Secondly, a minority of the participants reported paying for some other necessities than clothes. Therefore, there were instances of term-time workers paying for at least some of the expenses related to their organized leisure activities, and moreover, of term-time workers reporting 'always pay-

⁵⁹ Mortimer 2003.

⁶⁰ Moreover, Reykjavík, the capital of Iceland, is a relatively new city, mostly constructed since the Second World War, and designed for cars rather than pedestrians.

ing everything for myself'. These workers argued that in addition to 'pocket money' they paid for all their clothes, for books they needed for school, for school fees as well as for food for the household if they bought the groceries themselves: 'You know, if you go by yourself to the grocery shop then you pay for the food with your own money'. These groups of teenagers also argued that if they wanted something special for dinner then they had to pay for it themselves. Notably, though, none of the participants of the group interviews reported paying for their own housing.

To control one's spending by saving

Some of the participants of the group interviews described that they were not able to save their earnings, and that they did not really know what they spent their income on. The money they earn somehow just 'goes in one hand and out of the other'. On the other hand, other participants reported saving almost all, or at least some part, of their earnings. Saving with the purpose of purchasing a certain expensive thing has already been mentioned, but the group interviews also gave several examples of young Icelandic workers that put part of their earnings into a future fund and/or controlled their spending by saving. The examples of 14-year-old Ásbjörn and 17-year-old Theódór illustrate this. Ásbjörn has a regular term-time job and can earn a substantial amount each month. With the help of his mother, he controls how he spends his earnings through different kinds of savings opportunities:

I got maybe 45 000 [ISK] for the last month, then 10 000 goes into a bank account, and my mum puts maybe 20 000 into a future fund, and then something onto the debit card.

The 10 000-per-month-saving was earmarked for the purchase of a car and the amount which was put onto the debit card account was for daily use. Theódór has had a regular income for several years, and has controlled his spending in a similar way, though without any help from his parents. For some years he put a certain amount every month into a 'car fund' that enabled him to buy his first car at the age of 16. At the time of the interview he had exchanged that car for a more expensive one.

'Just some extra needs'?

The findings of the group interviews not only reveal variations with regard to the way the participants use their income on necessities; they also reveal the different views of the participants towards the needs of teenagers. Therefore, some of the term-time workers argued that they needed the income because 'it is not possible to do anything here unless you pay for it'. These young workers agreed with the argument of Mizen, Pole, and Bolton of a commodified childhood, albeit not being familiar with the academic discourse.⁶¹ However, the opinion was also expressed by some of the participants that most of the things the term-time workers used their earnings on were only some unnecessary 'extra needs,' as this discussion in one of the group interviews sheds light on:

Margrét: Do you want to add something to the research that I have not enquired about yet? Something you think I should have asked you about?

Ísak: No, or maybe just that you don't need to work during term-time if you don't want to.

Kristín: You need to, anyway.

Ísak: No, I mean, you buy clothes [he is addressing Kristín], and he buys a car [he is addressing the other boy participating in the interview]. I own nothing, I mean, of course I own some clothes, you see, just because I worked during the summer, something easy. But you don't need to work during term-time. Unless you intend to buy lunch in every lunch break in school and buy a car instead of taking the bus.

Findings of the quantitative part of the research on why some Icelandic teenagers choose not to undertake a term-time work, not presented in detail here, head in the same direction as these qualitative findings, and reveal that a part of Icelandic teenagers decide not to work during term-time because they do not have the time and/or rather want to concentrate on their studies.

61 Mizen, Pole & Bolton 1999.

Association with educational status of parents

In former research on the association between the extent of child and youth work and the socioeconomic status of parents, different indicators of the socioeconomic status (SES) of the parents have been applied.⁶² Here, the summation of education of both the mother and father is used as an indicator of the SES of parents. Thus, the respondents were classified into three groups: of both parents who have only finished primary education; of both parents with tertiary education; and of other combinations of parents' education (one with primary education, the other with secondary education, one with primary and the other with tertiary education, etcetera). The association of parental education with three indicators of employment status was analysed: with participation of summer work; with the level of employment in term-time work; and with the purchasing of certain necessities.

Firstly, the result shows that children of parents with tertiary education are less likely to participate in summer work than the children of parents with a lesser education, but that the association disappears amongst the young people who have finished their compulsory education after controlling for age. In other words, the results indicate that it is more common for children of parents with a tertiary education to be older when they start working during the summer than it is for children of parents with a lesser education.

Secondly, the results reveal that pupils of parents with a tertiary education are less likely to undertake term-time work than pupils of parents with a lesser education; that those children of parents with a tertiary education who undertake term-time work are less likely to be in intensive (>12 hours per week) and regular term-time work than their counterparts of parents with a lesser education, and that the association persists after controlling for age.

Thirdly, the results reveal that children of parents with a tertiary education are less likely to spend their term-time income on two or more of the following necessities: schoolbooks, school fees, food for the household; and

62 *Inter alia* family form and income support, parental education and family income, and economic level of school areas. Middleton & Loumidis 2001; Mortimer 2003; Morrow 1994.

allowances to their parents, than children of parents with a lesser education. This result must, however, be taken with the precaution that the association disappears after controlling for age. Interestingly, the results do not indicate any association of the educational status of parents with purchasing of clothing, nor with paying for organized leisure activities. A possible explanation of the research not indicating any association between purchasing of clothing and educational status of parents is that it did not discriminate between different types of clothing. It is, therefore, possible that children of worse-off parents prefer to spend their income on practical clothing than better-off children. The non-association with paying for organized leisure activities is not as easily explained.

Conclusion

In modern Western societies childhood has been seen as a period without work and responsibility, and hence a period of dependency; in other words as the opposite of adulthood. It has been feared that if children take on adult responsibilities, such as work, their childhood will be an unhappy one and their (subjective) well-being will be at risk.⁶³ This construction of a work-free childhood has been further sanctified in legislation on child labour and compulsory education. Moreover, the construction has been universalized in the UNCRC provisions on children's rights to protection, provision, and education as well as the derivative right *not to work*.⁶⁴ It has been a general belief that this arrangement and its placement of children outside the sphere of production has made child work a thing of the past and hence the well-being of children secured in developed societies.⁶⁵ However, research on the prevalence of paid work in this part of the world does not support the belief of child and teenage work being a phenomenon of the past in Western societies. It reveals the commonality of children and teenagers undertaking paid work, although the work is usually part-time, flexible, and often informal.⁶⁶

Participation of Icelandic youths in paid work is sometimes thought to

63 Cunningham 1995.

64 Weston & Teerink 2005.

65 McKechnie & Hobbs 1999.

66 Einarisdóttir forthcoming.

be exceptionally high. Research on the extent of paid work of Nordic teenagers confirms that the participation of young Icelanders is, indeed, exceptionally high regarding summer work, but also that their undertaking of work does not stand out when it comes to term-time work.⁶⁷

But why do Western children and teenagers undertake paid work, despite they supposedly having the right not to? A feasible answer from the perspective of the discourse of a work-free childhood is that the work is restricted to those with parents in economic hardship. The connection between child and teenage work and economic deprivation of parents is under-researched in the Nordic contexts, but existing American research findings indicate that young American workers disproportionately come from middle class families.⁶⁸ The association between educational status of parents and paid work of Icelandic teenagers was also examined in the research presented here. These findings do not concur with the findings of American studies, but indicate a negative association between educational status of parents and teenage work, and, hence, indicates a connection between child and teenage work and economic deprivation of parents. Nevertheless, before more finite conclusions are made, the association need further examination, not only in the Icelandic context but in the Nordic context as well.

Likewise, more examination is needed regarding the connection between child and teenage work and the upturn of consumerism in Western societies. The social meaning of consumption has been recognized, and there is empirical evidence of consumption playing a special role in the social life of teenagers.⁶⁹ Also, British researchers argue for a connection between child and teenage work and the emergence of a 'commodified childhood' in the UK, but their research reveals that school-age workers in the UK use their income to consume the products, services, or experiences that are required as part of commodified childhood.⁷⁰

However, the discussion on consumption and materialism brings forth the debate as to where the line between absolute and relative poverty, be-

67 Rafnsdóttir 1999.

68 Mortimer 2003.

69 Piacentini & Mailer 2004.

70 Mizen, Pole & Bolton 1999; Mizen, Pole & Bolton 2001a.

tween necessities and luxuries, lies. In a recent report on the Icelandic standard of living, it is pointed out that a standard of living is always based on subjective evaluation.⁷¹ One possibility of evaluating the spending patterns of young workers is therefore to view it from the standpoint of the young people themselves. This approach has guided the present research, as the young Icelanders who participated in it were asked about their evaluation of their spending as well as why they undertake paid term-time work.

The findings revealed that Icelandic teenagers do not deviate from their counterparts in other Western countries regarding the money they earn by their work as being the main reason behind the work. Importantly, the research also shows that the young workers commonly spend their income on things some would define as discretionary luxury – even on a car. Many of the participants would not use this evaluation, but considered such spending as a necessity in the life of (Icelandic) teenager. The findings also reveal that it is not uncommon for Icelandic teenagers, especially the older ones, to spend their income on things that most would classify as necessities, i.e. school-related items and food.

I conclude from my findings that having and spending money of their own is an important part of the young people's journey towards autonomy and independence from parents, including from the parents' economic status. Thus, many of the participants stated that at a certain age it is not proper to 'beg your mum for money' any longer, and some emphasized that they did not want to be a burden on their parents. However, my findings also reveal that the young generation is not a homogeneous group, but have different views on how much spending money a young person needs to have in order to be able to participate in normal teenage life. Thus, some do not regard consumption that important factor in their social life, and choose not to work during term-time but focus on their education and leisure time activities instead.

This choice brings up the question about the tension that exist in the life of children and teenagers between their (material) well-being that paid

71 Sturluson, Eydal & Ólafsson 2011.

work can provide and their (subjective) well-being gained though their absence of work. There has been a tendency within the Western construction of a work-free childhood to ignore the existence of such a tension, but to the extent that this tension has been acknowledged, a one-way solution has been suggested: Child and teenage work has been seen as problematic and, hence, it has been suggested that it would be in the best interest of the young generation not to work.

However, the empirical fact of the commonality of child and teenage work in Western societies cannot be ignored and neither can the viewpoints of young people that, for one reason or another, undertake paid work and earn their own money. Their work and their income can enrich not only their material but also their social and psychological well-being, and the question must be raised if more emphasis should be placed on the right of the young generation right *to* work – meaning not only the right to employment but also rights in work (decent work condition, decent pay, etcetera) than at present.⁷² Simultaneously, it must be considered that increasing emphasis on children and teenagers having the right to work, might involve the danger of the young generation losing their right *not to* work, and the advantages and protection that this right can (or at least should) bring to them.

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Somewhere over the high seas there is a land of my dreams – Happiness and life satisfaction among immigrants in Europe¹

OLLI KANGAS

Introduction

The history of *Homo sapiens* is a history of constant movement. If we are creationists and believe in the Bible, the first emigrants forced out of their home were Adam and Eve. Those two ancestors of ours, expelled from their garden as such, were the start of the future trajectories for humankind that – according to evolutionists – has moved from Olduvai Gorge to the highest peak of Terra del Fuego to the banks of Bering Strait. Sometimes moves have been motivated by the search for a better life or a sheer desire for adventure and excitement. Sometimes moves are forced by violent armies or extreme poverty, hunger, disease and threat of premature death. Worldwide, there are by now about 220 million people living outside their own country. Out of those movers, some 50 million reside within the boundaries of the European Union (EU), of which 30 million come from outside the EU and 20 million have their country of origin in some other EU member state.

1 The title of the paper is inspired by the most famous and melancholic Finnish tango written and composed by Unto Mononen in 1955. The lyrics of the tango tell about a desire to move overseas to a happy country of fairytales. Thus, the allusions in the title fit very well to my former position as an H. C. Andersen Professor in the happy country of Denmark. I became interested in the happiness of immigrants while working as H.C. Andersen Professor at the Centre of Welfare State Research, University of Southern Denmark. My Danish colleague Klaus Petersen once asked me whether a Finn becomes happier when moving to Denmark, the country that is often depicted to be the happiest country in the world. This study is a humble attempt to answer Klaus's inquiry. I want to thank Wim van Oorschot and other participants of the ISA RC-19 annual meeting in Oslo for their valuable comments on the first draft of the article.

A common procedure in welfare research is to trace differences between welfare states and welfare regimes. Following Gøsta Esping-Andersen's seminal work, social scientists have clustered countries according to social policy institutions. Initially, three separate models of welfare capitalism existed: the Social Democratic (Nordic/Scandinavian), the Liberal (Anglo-Saxon) and the Conservative (Continental/Central European).² Later, two other models were added to the list: the South-European and Post-Socialist.³

Welfare state models are a handy tool for social scientists to use to explain almost all social phenomena when applied to regimes in different domains: e.g. the incidence of poverty and social exclusion, employment and unemployment, gender equality and woman-friendliness, dominance and privilege, birth and death, health and sickness, opinions and attitudes etcetera.⁴ The aim of this chapter is to expand the field of application and take a look at happiness and life-satisfaction among those 50 million or so immigrants that have their new homes in Europe.

The views of happiness and its importance to social research vary.⁵ Some critical analysts argue that happiness is an individually generated state of mind, i.e. a subjective feeling and hence not a real thing. As such, it is not a proper object for scientific inquiry. However, psychologists, armed with fancy brain probing devices, have discovered that happiness is a specific kind of electric activity in the frontal part of the brain. Thus, happiness obviously is a real and scientifically measurable thing. From the social science point of view, the key question to ask pertains to the kind of phenomena that cause

2 Esping-Andersen, Gøsta (1990) *Three Worlds of Welfare Capitalism*. Cambridge: Polity Press.

3 For a more detailed discussion on welfare state models and their characteristics, see Castles, Francis, Leibfried, Stephan, Lewis, Jane, Obinger, Herbert & Pierson, Christopher (eds) (2010) *The Oxford Handbook of the Welfare State*. Oxford: Oxford University Press.

4 For overviews on the research field, see for example Leira, Arnlaug (2002) *Working Parents and the Welfare State*. Cambridge: Cambridge University Press; Ferrarini, Tommy (2006) *Families, States and Labour Markets. Institutions, Causes and Consequences of Family Policy in Post-War Welfare States*. Cheltenham: Edward Elgar; Wilkinson, Richard G. & Pickett, Kate (2008) 'Income Inequality and Socioeconomic Gradients in Mortality'. *American Journal of Public Health*, Vol. 98, No. 4, 699–704; Cooke, Lynn Prince (2011) *Gender-Class Equality in Political Economies*. New York & London: Routledge; Kvist, Jon, Fritzell, Johan, Hvinden, Björn & Kangas, Olli (eds) (2012) *Changing Social Equality: The Nordic Welfare Model in the 21st Century*. Bristol: Policy Press; Svallfors, Stefan (ed.) (2012) *Contested Welfare States. Welfare Attitudes in Europe and Beyond*. Stanford: Stanford University Press.

5 Layard, Richard (2006) *Happiness. Lessons from a New Science*. London: Penguin Books; Saari, Juho (2012) *Onnellisuuspolitiikka*. Helsinki: Kalevi Sorsa Säätiö.

those positive electric waves in the brain. As there are plenty of reasons to explain happiness and misery, it is little wonder that a growing plethora of competing explanations exist pertaining to the preconditions for a happy life.

There are also a growing number of studies on immigrants and their happiness. For example, the academic journal *Social Indicators Research* launched a special issue on the subjective well-being of immigrants in Europe.⁶ From our point of view, the intriguing question deals with the extent to which, if any, that the level of life-satisfaction and happiness of immigrants varies between the five different welfare state regimes. We ask whether there are systematic differences between the welfare states and welfare regimes and how immigrants coming from different regimes evaluate their happiness in their new surroundings. What is the role of the prosperity of the country of residence? How important are other contextual factors such as income distribution and the level of social protection? What about gender differences between regimes? Given the discussion of the woman-friendly welfare state, we could for example expect that the Nordic countries, in particular, should contribute towards life-satisfaction among female migrants. How strongly do the individual characteristics of immigrants – age, gender, health, income, employment status and social networks affect their life-satisfaction? We are also interested to know whether relationships between explanatory variables and happiness vary between different welfare state regimes.

The structure of the chapter is as follows. The next section depicts a broader theoretical frame of reference that this study is linked to. Thereafter, a section on previous studies in the field is presented, which also specifies more detailed research tasks. This is then followed by a section dealing with the data and methods used. The section entitled *Happy immigrants live in happy countries* presents the main analyses and empirical findings, and the final section discusses the results obtained.

6 Clark, Andrew, Sauger, Nicholas & Senik, Claudia (2009) 'Welfare, Well-Being and Immigration in Europe: Evidence from the European Social Survey'. *Social Indicators Research*, Vol. 91, No. 3, 299–426; see also Eurostat (2011) *Migrants in Europe: A Statistical Portrait of the First and Second Generation*. Luxembourg: Eurostat; Senik, Claudia (2011) *The French Unhappiness Puzzle: The Cultural Dimension of Happiness*. Paris: Paris School of Economics.

General starting points: Individualistic and collectivistic approaches to happiness

Happiness has made a phenomenal entry into the high chambers of scientific inquiry. Soft social scientists are not the only ones to be thrilled about studying happiness today; hard-core economists and natural scientists are so as well.⁷ Needless to say, the search for happiness takes place in different domains and by different methods depending on the discipline of the scholar.

While a psychologist would search for signs of happiness in the dorso-lateral prefrontal cortex of the brain, using electroencephalogram and positron emission tomography,⁸ a social scientist would apply surveys and ask people how happy they feel. Although the approaches may seem very distant from each other, it has been shown that there is also a close correspondence between electrical activities in the left front of the brain – indicating happiness – and people's own opinion of their state of mind.⁹ Whereas the psychologist tries to trace electrical waves, the issue for the social scientist is to discover the societal contexts and conditions that actually cause that positive electrical brain activity in the first place.

The possible link between an individual's physiological status, social position and the characteristics of the society he/she lives in has been widely discussed by epidemiologists, and the conclusion has been that social factors – income, employment, our position in social hierarchy, social relations,

7 Veenhoven, Ruut (1984) *Conditions of Happiness*. Dordrecht: Riedel; Veenhoven, Ruut (2002) 'Why Social Policy Needs Subjective Indicators' *Social Indicators Research*, Vol. 58, Issue 1, 33–45; Layard, Richard (2006) *Happiness. Lessons from a New Science*. London: Penguin Books; Bok, Derek (2010) *The Politics of Happiness – What Governments Can Learn from the New Research on Well-Being*. Princeton: Princeton University Press; Saari 2012; see also the contribution by Carl Marklund in this volume.

8 Davidson, Richard D. (2004) 'Wellbeing and Affective Style Neural Substrates and Bio behavioural Correlates'. *Philosophical Transactions of the Royal Society B: Biological Sciences*, Vol. 359, 1395–1411.

9 Layard 2006, 11–21.

etcetera – are of importance for our health.¹⁰ Whereas an advantageous position in society has a multiplier effect leading to better education, better income and health, as well as to a longer and happier life, in a disadvantageous position harmful things tend to accumulate: low educational attainment, low income, health problems, lower experienced happiness, and life expectancy that is years behind that of people in better positions in society.

Within social sciences and between political camps there are substantial differences in the interpretations of the social prerequisites of misery and happiness. With some simplification, we can distinguish two main sets of explanations – and a vast grey area between them – that have bearing for this study. First, in the individualistic perspective, happiness is deeply regarded as an individual phenomenon that is achieved by individuals themselves. As such, individual freedom is set into focus, which also dictates the subsequent role of the national state and sets limits for state actions. In this approach, which originates with the ideas of classical liberals, the state is seen to exercise its jurisdiction through coercion that is offensive to people's autonomy. For example, the government levies taxes, which cuts into people's personal resources and limits their personal freedom and thus their possibilities to choose. Liberty begins where the state ends; liberty is only realizable in the private sphere, not in the area of public policy.¹¹ In order to maximize liberty, and hence to trigger individual happiness, the activities and tasks of the state should be limited. For example, when it comes to economic growth and prosperity, often regarded as the best determinants for a happy life, the most important issue is to create growth and a high Gross Domestic Product (GDP), whereas the distribution of prosperity is secondary. People are happy if they live in a rich country regardless of the unequal-

10 Marmot, Michael (1996) 'The Social Pattern of Health and Disease'. In Blane, David, Brunner, Eric & Wilkinson, Richard G. (eds) *Health and Social Organizations*. London: Routledge, 42–67; Marmot, Michael (2002) 'The Influence of Income on Health: Views of an Epidemiologist'. *Health Affairs*, Vol. 21, No. 1, 31–46; Kawachi, Ichiro & Kennedy, Bruce P. (2006) *The Health of Nations: Why Inequality Is Harmful to Your Health*. New York: New Press; Wilkinson, Richard G. & Pickett, Kate (2009) *The Spirit Level. Why Greater Equality Makes Societies Stronger*. New York, Berlin & London: Bloomsbury Press; Bachmans, Mona (2011) *Gender Policy and Gender Equality in Public Health Perspective*. Stockholm: Karolinska Institutet.

11 Hayek, Friedrich (1960) *The Constitution of Liberty*. London: Routledge; Nozick, Robert (1979) *Anarchy, State and Utopia*. Oxford: Blackwell.

ity concerning how the wealth in the country is distributed. This kind of political attitude supposedly underpins right-wing welfare thinking and in particular the social policy making in the US.

The second view is more collectivistic. Here, the interpretation of human beings, their happiness and other conditions of living are defined contextually, in relation to the prevailing standards in the society where they live. In contrast to the individualist approach, the collectivist tradition also pays attention to distributional issues: not only is the level of prosperity important, even more important is how evenly prosperity is distributed. Equality is better for everyone, as Richard G. Wilkinson and Kate Pickett argue in an influential book, entitled *The Spirit Level*.¹²

The overarching theme of the collectivist tradition deals with the resources and possibilities society offers to its members. This idea has been an explicit starting point in the Nordic welfare state studies and the very same idea is making a new entry in the clothing of the new social investment welfare state.¹³ The main idea has been to measure welfare with the help of the resources individuals have at their disposal. For example, in the Swedish level of living surveys, well-being was measured on nine components: health, employment, economic resources, knowledge and education, social integration, housing and neighbourhood, security of life and property, recreation and culture as well as political resources.¹⁴ The crucial point deals with the extent to which people have command over resources, while not that much attention was paid to subjective well-being. In his comparative project, Erik Allardt partially utilized the Swedish approach but shifted focus more towards the level of need-satisfaction described by the catch-

12 Wilkinson & Pickett 2009.

13 Allardt, Erik (1975) *Att ha, att älska, att vara. Om välfärd i Norden*. Lund: Argos; Allardt, Erik (1993) 'Having, Loving and Being: An Alternative to the Swedish Model of Welfare Research'. In Nussbaum, Martha & Sen, Amartya (eds) *The Quality of Life*. Oxford: Clarendon Press, 88–94; Ringen, Stein (1987) *The Possibility of Politics*. Oxford: The Clarendon Press; Erikson, Robert & Uusitalo, Hannu (1987) 'The Scandinavian Approach to Welfare Research'. In Erikson, Robert, Hansen Erik-Jørgen, Ringen, Stein & Uusitalo, Hannu (eds) *The Scandinavian Model. Welfare State and Welfare Research*. Armonk, New York & London: M.E. Sharpe, 177–193; and, more recently, Morel, Nathalie, Palme, Joakim & Palier, Bruno (eds) (2011) *Towards A Social Investment Welfare State? Ideas, Policies and Challenges*. Bristol: Policy Press.

14 Johansson, Sten (1970) *Om levnadsnivåundersökningen*. Stockholm: Allmänna förlaget; Johansson, Sten (1979) *Mot en teori om social rapportering*. Stockholm: Institutet för social forskning.

words *having*, *loving* and *being*.¹⁵ *Having* relates to material resources, *loving* pertains to an individual's social relations, and *being* refers to self-realization and self-esteem.

Despite differences in emphasis, the overarching theme in the Nordic approach is the very wide concept of welfare which includes the quality of life aspect. This approach has some conceptual linkages to Amartya Sen's interpretation of the capabilities of individuals to fulfil their own potential.¹⁶ According to this brand of social philosophy, when debating welfare we always have to take into consideration the ability to function, i.e. we should be able to make conscious life choices that we are capable of realizing. Making conscious choices is a fundament for human well-being and happiness and the very idea dates back to Aristotle's *Ethics*.¹⁷

Quite naturally, differences in the philosophical interpretation of human society lead to diverging views on how to measure well-being and its prerequisites. If everyone is the architect of his or her own fortune, there is no point in studying societal factors as determinants of happiness. It is enough to only scrutinize individual factors. At the other end of the continuum, attention is paid to the quality of the welfare state, the capacities and potentialities that the state offers to its citizens. The grey zone between disciplines and philosophical orientations is huge due to the deep divide in the main philosophical approaches on the role of the welfare state as a facilitator or inhibitor of happiness among human beings.¹⁸ The aim of the next section is to cursorily summarize previous research in the field and take a step away from the high spheres of social philosophy towards the more mundane and concrete research questions of this chapter.

15 Allardt 1975; Allardt 1993.

16 Sen, Amartya (1992) *Inequality Re-examined*. Oxford: Oxford University Press; Sen, Amartya (1993) 'Capability and Well-being'. In Nussbaum, Martha & Sen, Amartya (eds) *The Quality of Life*. Oxford: Clarendon Press, 30–53; Sen, Amartya (2010) *The Idea of Justice*. London: Penguin Books.

17 Aristotle (1955) *Ethics*. London: Penguin Books.

18 For a mental map of different approaches, see Saari 2012, 19.

Previous studies and research questions

The old adage states that it is better to be healthy and wealthy than sick and poor. There is an undeniable common sense truth in this: in most societies people are happier if they are healthy and have money than if they were poor and in ill-health. No doubt, health is good for happiness but it has also been shown that positive emotions are good for health.¹⁹ Positive feelings improve blood chemistry and have beneficial effects on health.²⁰ In this context, the concept of social capital, despite its ambiguity, has proved to be useful and has lots of explanatory power to health outcomes. Linkages exist between physical health and social capital, which are measured as trust in other people (individual trust) and trust in institutions (institutional trust). It is strongly argued that the relationship between the individual's health and trust is a causal one.²¹

Social capital is good for society as a whole and makes it function well and prosper.²² While the degree of social capital is tied to certain macro characteristics of the state: non-corrupt, effective, guaranteeing equality of possibilities etcetera.²³ At the micro level, social capital also places importance on the individual's own micro networks. As suggested by Erik Allardt, the term 'loving' reveals that the quality of social relations is of crucial importance for our well-being and happiness.²⁴ Social support gained from our fellows helps us to muddle through periods of low mood and misery. All this suggests that when analysing happiness it is important, in addition to health

19 Danner, Deborah, Snowdon, David & Friesen, Wallace (2001) 'Positive Emotions in Early Life and Longevity: Findings from the Nun Study'. *Journal of Personality and Social Psychology*, Vol. 80, No 5, 804–813.

20 Davidson, Richard D. (2000) 'Affective Style, Psychopathology, and Resilience: Brain Mechanisms and Plasticity'. *American Psychologist*, Vol. 55, No 11, 1196–1214; Davidson 2004.

21 For a detailed discussion on the issue, see for example Hyypä, Markku T. & Mäki, Juhani (2001) 'Individual-Level Relationships between Social Capital and Self-Rated Health in a Bilingual Community'. *Preventive Medicine* Vol. 32, Issue 2, 148–155; Kawachi, Ichiro, Subramanian, S. V. & Kim, Daniel (2008) *Social Capital and Health*. New York: Springer.

22 Putnam, Robert (1993): *Making Democracy Work*. Princeton: Princeton University Press; Putnam, Robert (2000): *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster; Whiteley, Paul (2000) 'Economic Growth and Social Capital'. *Political Studies*, Vol. 48, 443–466.

23 Rothstein, Bo (1998) *Just Institutions Matter. The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press; Rothstein, Bo (2003) *Sociala fällor och tillitens problem*. Stockholm: SNS.

24 Allardt 1975; Allardt 1993.

and wealth indicators, to include explanatory variables pertaining to various social factors. In our study, we shall operate on the two forms of social capital (trust in people and trust in institutions) and social relations (if the respondent has intimate friends or not).

More specifically, in this study we will ask if the impact of bad health on the happiness of immigrants is the same in different welfare state regimes of residence. Here, the hypothesis is that in all regimes bad health has a detrimental effect upon happiness, but the effect may be weaker in those welfare states that have extensive social policy programmes to cushion the immediate detrimental economic effects of sickness.

On the basis of previous studies, we expect positive and significant linkages between social trust and happiness. And if it is as Bo Rothstein argues that just institutions matter, immigrants, regardless of their origin, should display high levels of trust in those types of countries that are labelled as just, i.e. where natives also have high levels of trust in each other and in their institutions.²⁵ A contamination from the context is also hypothesized: the Nordic countries occupy the top positions in the non-corrupt state lists.²⁶ Previous studies have shown that both forms of social capital, i.e. trust in individuals and trust in institutions, are very high in the Nordic countries.²⁷ Therefore, should the contamination take place, immigrants (regardless their origin) in the Nordic countries will display higher levels of social capital than immigrants in the other countries.

When it comes to the impact of income upon health and happiness, there are two sets of explanations, absolute and relative. The first one emphasizes the impact of the absolute sum of money. This means that the level of GDP is the most important thing. Residents, be they natives or immigrants, are happier in wealthy countries: the richer, the happier. At the individual level, the absolute view states that the poor have bad health because of a lack of

25 Rothstein 1998.

26 Transparency International. Online. Available HTTP: <<http://archive.transparency.org/>>

27 Scheepers, Peer, Grotenhuis, Manfred Te & Gelissen, John (2002) 'Welfare States and Dimensions of Social Capital'. *European Societies*, Vol. 4, No. 2, 185–207; Fridberg, Torben & Kangas, Olli (2008) 'Social Capital'. In Ervasti, Heikki, Fridberg, Torben, Hjerm, Mikael & Ringdal, Krister (eds) *Nordic Social Attitudes In A European Perspective*. Cheltenham: Edward Elgar, 65–85.

money; they do not have the same possibilities to healthy nutrition as the better offs. Thus, it is absolute poverty that is detrimental for health and ill-health in turn hollows out prerequisites for happiness. The proponents of the relative interpretation argue that in addition to the absolute material conditions, there are numerous behavioural factors that are harmful to health, and most importantly, the suppressed position of the poor causes stress and other forms of psychosomatic strains, which, in a gradual manner, permanently weaken the health and reduce mental well-being. It is argued that large income differences are harmful for both health and happiness and the negative effects cannot be attributed to differences between the absolute level of wealth of the country and how wealthy the people themselves are. Also in very affluent societies inequality has corrosive effects.²⁸ If this statement is true, we should find happier people in countries with more equal income distribution.

Previous research has shown that employment is not only a source of income, but an important factor affecting our well-being. Beginning from the classical Marienthal studies, there are a vast number of studies proving the negative effects of unemployment.²⁹ These effects are not only negative in terms of income, but also affect our self-esteem, *being* is strongly built on our status in the labour markets. We can expect to find a strong negative association between unemployment and happiness, regardless of the immigrant's country of origin or country of residence.

As discussed in the previous section, the collectivist approach to welfare adheres to a large welfare state and as a rule, in this brand of thinking, the Nordic model is set as a bench mark and an ideal towards which all other countries should strive. Indeed, the goals of the modern Nordic welfare model reach further than the goal of alleviating poverty for the deserving needy. There is no doubt that the Nordic countries do try to tackle poverty and insure against income loss, but they also address a wider range of so-

28 Wilkinson, Richard G. & Pickett, Kate (2006) 'Income Inequality and Population Health: A Review and Explanation of the Evidence'. *Social Science and Medicine*, Vol. 62, No. 7, 1768–1784; Wilkinson & Pickett 2008; Wilkinson & Pickett 2009; Kawachi & Kennedy 2006.

29 Jahoda, Marie, Lazarsfeld, Paul E. & Zeisel, Hans (2002 [1933]) *Marienthal. The Sociography of an Unemployed Community*. New Brunswick: Transaction Publishers.

cial inequalities.³⁰ The goal is not only to provide people with an amount of money they can live off, but also to provide them with the opportunities to become full members of the society they are living in through their own efforts, primarily in the labour market. The view echoes Amartya Sen's ideas.

Lots of heated debate has taken place as to whether the Nordic welfare state is woman-friendly or not. An abundance of evidence from research, however, shows that this indeed is the case – the Nordic way of employment policies, organizing social services and other social policy programmes do facilitate gender equality.³¹ However, there are also more critical voices arguing that under the equality surface, there are still substantial gender inequalities and in the Nordic hemisphere women are more severely hampered by glass-ceilings than in the Liberal countries. Moreover, the segregation into male and female employment sectors is strict.³² It is not the task of this study to evaluate the correctness of these arguments as such. In this study we only want to see whether there is a linkage between immigrants' happiness and the level of gender equality prevailing in the country of residence, and whether that linkage is positive or negative. We expect to find a positive association.

One important pre-requisite for human well-being is feeling safe and free from discrimination. Immigrants may be objects of discrimination and even open hatred from the side of the native population which, needless to say, will increase feelings of insecurity. These negative encounters are linked

30 Nelson, Kenneth (2003) *Fighting Poverty: Comparative Studies on Social Insurance, Means-tested Benefits and Income Redistribution*. Stockholm: Swedish Institute for Social Research.

31 Korpi, Walter (2000) 'Faces of Inequality: Gender, Class and Patterns of Inequality in Different Types of Welfare States'. *Social Politics*, Vol. 7, No. 2, 127–191; Korpi, Walter, Ferrarini, Tommy & Englund, Stefan (2011) 'Women's Opportunities Under Different Family Policy Constellations: Gender, Glass and Inequality Tradeoffs in Western Countries Re-examined'. Stockholm: Swedish Institute for Social Research. Online. Available HTTP: <http://www2.sofi.su.se/~wko/docs/Korpi,Ferrarini,_Englund,_Paper_for_Reykjavik_Nordic_Sociology_Conferences,_August_15-17,_2012_forthcoming_in_Social_Politics..pdf> (accessed August 2012); Leira 2002; Meager, Gabriella & Szebehely, Marta (2012) 'Equality in the Social Service State: Nordic Child Care Models in Comparative Perspective'. In Kvist, Jon, Fritzell, Johan, Hvinden, Björn & Kangas, Olli (eds) *Changing Social Equality: The Nordic Welfare Model in the 21st Century*. Bristol: Policy Press, 89–117.

32 Mandel, Hadas & Semyenov, Moshe (2006) 'A Welfare State Paradox: State Interventions and Women's Employment Opportunities in 22 Countries'. *American Journal of Sociology*, Vol. 111, No. 6, 1910–1949; Mandel, Hadas & Shalev, Michael (2009) 'How Welfare States Shape the Gender Pay Gap: A Theoretical and Comparative Analysis'. *Social Forces*, Vol. 87, No. 4, 1873–1912; Datta-Gupta, Nabanita, Smith, Nina & Verner, Mette (2008) 'The Impact of Nordic Countries' Family Friendly Policies, Employment, Wages, and Children'. *Review of the Economics of the Household*, Vol. 6, No. 1, 65–89.

to a reduced well-being. Happy immigrants live in countries with low levels of discrimination.

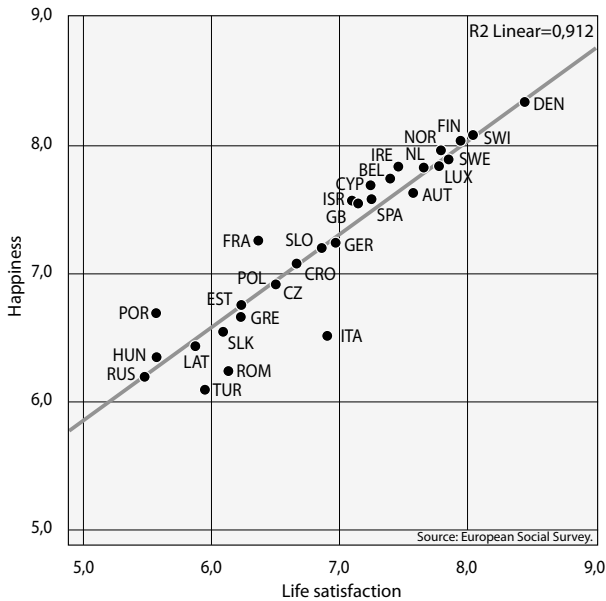
Data and methods

The data used in this study are derived from the European Social Survey (ESS). Since 2002, an ESS has been carried out at two-year intervals.³³ The latest year of observation used in this study was 2010. The size of the cross-sectional data varies from the low 579 in Iceland (2004) to the sample size of 3032 in Germany in 2010. As a rule, bi-annual national samples vary from 1500 to 2000. In the individual waves, the number of immigrants in most countries is too low and insufficient for reliable statistical analyses. In order to obtain more reliable estimates, we pooled the data for different years, i.e. we merged data for 2002, 2004, 2006, 2008 and 2010. In the pooled file thus obtained, there are a total of 228 621 respondents from 33 countries. From the merged data file we excluded those countries that had less than 50 immigrant respondents. Also Israel and Turkey were excluded. The collapsed data contain 17 837 observations on immigrants in 28 countries. The smallest sample is from Bulgaria (50 observations) and the largest one, the Swiss sample, contains as many as 1886 immigrants. Immigrant status is attached to each respondent born outside the country of residence. Since we are here interested in those who have moved into a country, we do not include second or third generation immigrants in the sample.

In principle there are two indicators for subjective well-being in the ESS. The first one is directly targeted for measuring happiness: 'how happy would you say you are?' The respondents could express their happiness on a continuous scale that runs from 0 'extremely unhappy' to 10 'extremely happy'. The ESS also contains a question relating to life satisfaction: 'how satisfied are you with your life as a whole nowadays?' The response alternatives were analogous to the happiness question. 0 indicates extreme dissatisfaction, while 10 indicates the highest possible level of satisfaction with one's life. We can assume that while happiness is more limited a concept and measures

33 For a closer description, see European Social Survey. Online. Available HTTP: <<http://www.europe-socialsurvey.org>> (accessed August 2012)

Figure 1. Happiness and life satisfaction.



Source: European Social Survey.

a mental state of mind, satisfaction with life comes closer to traditional welfare studies and reflects more broadly the respondents' satisfaction with the actual circumstances in which they are living.

Figure 1 constitutes a preamble to the subsequent, more detailed study. As can be seen, the Nordic countries, together with Switzerland, top the league when the questions on happiness or the more general dimension of life satisfaction, are concerned. At the other end of the continuum we find – perhaps not that surprisingly – the Post-Socialist countries and poorer Southern European countries displaying significantly lower levels of happiness. The correspondence between the two variables is very high. At the individual level, the correlation coefficient (r) is $.70^{**}$, and at the aggregate country level, it is as high as $.98^{***}$. Correlations are almost exactly the same if we look at the

native population or immigrants separately. A preliminary conclusion of this first inspection is that happy and satisfied immigrants are found in countries where the natives, too, are happy and satisfied (see Figure 2).

To gain a more robust measure for subjective well-being, we merged the two variables and constructed an additive index $((\text{happiness} + \text{life satisfaction})/2)$. The new variable also varies between the low 0 (very unhappy) and high 10 (very happy). For the sake of simplicity we call the additive index 'happiness'.

As indicated above, in welfare research it is a common practice to cluster countries in welfare state regimes reflecting the underpinning rationale and institutional characteristics in national social policy solutions. On the basis of this family resemblance countries of residence are here grouped into five welfare clusters: The Post-Socialist regime (Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Poland, Russia, Slovenia, Slovakia and Ukraine); the Southern European regime (Cyprus, Greece, Portugal and Spain); the Anglo regime (Ireland and the UK); the Central European regime (Austria, Belgium, France, Germany, Luxembourg, Netherlands and Switzerland) and the Nordic cluster (Denmark, Finland, Norway and Sweden).³⁴

When classifying the regime of birth, a sixth regime 'Other' has been added to catch all those respondents coming from countries outside the European hemisphere (also Turkey and Israel, that are included in the ESS, are classified as 'others').³⁵ These clusters will be used, on the one hand, to evaluate how happy immigrants emigrating from different welfare regimes are, and on the other, the regimes of residence will be used when analysing how explanatory factors perform in various contextual settings. The background characteristics of the regimes are depicted in Appendix Table A1.

Before proceeding further, a few words about the methods applied are warranted. When describing and discussing the construction of variables, we preliminarily make references to the relative importance of our key vari-

34 Iceland (a country that displays a very high level of happiness) was left out of the analysis because of the insufficient number of immigrant respondents.

35 Design weight is used in regression models when operating with countries, while data are weighted by population weight when analysing data regime-wise. For clustering countries, see Castles, Leibfried, Lewis, Obinger & Pierson 2010.

ables. This importance is measured by multilevel models where we have included the country and the variable in question into the analyses. Application of this kind of multilevel modelling provides us with possibilities to preliminarily evaluate the magnitude of the variance that the variable in question explains within and between countries. The coefficients are given in Appendix Table A2 and are occasionally discussed in the text.

Social capital is measured by two dimensions. The first dimension pertains to individual trust and is a combination of three separate statements: 'Most people can be trusted or you can't be too careful.' 'Most people try to take advantage of you, or try to be fair.' 'Most of the time people are helpful or mostly looking out for themselves.'

Respondents could give their answers in a continuum where 0 indicated the lowest trust and 10 the highest. With the help of principal component analysis the three questions were collapsed into one dimension (analysis resulted in one component) 'personal trust' that consists of factor loadings of those three questions. The second dimension 'institutional trust' is as well a combined factor of three questions on trust in the country's parliament, trust in the legal system of the country and trust in the police. The scale was the same (0 to 10) as in previous questions, and also here factor analysis was used to get one indicator. The higher the value, the stronger the trust. Both factors perform very well. While personal trust explains 30 per cent of the within country and almost 10 per cent of the variation between countries, trust in national institutions explains more than 40 per cent of the variation in happiness within a country and some 10 per cent of the between country variance (Appendix Table A2). Preliminarily we can conclude that trust is a very important precondition for happiness and just institutions matter.³⁶ Indeed, the macro-level correlation between the non-corrupt index and trust in people is 0,82** and trust in national institutions as high as 0,86**. One can discuss whether social capital is a personal characteristic attached to an individual or whether it is a country level factor that should be linked to the quality of the state. Here we have treated social capital as an individual level variable.

36 Rothstein 1998; Rothstein 2003.

The quality of social relations is based on a question pertaining to whether a respondent has a close person with whom to discuss intimate and personal matters. The variable is dichotomous (0 = has a close person/s; 1 = does not have a close person/s). Respondents' experiences on discrimination are asked dichotomously ('Are you a member of a group discriminated against in this country?'). Two other subjective welfare indicators, i.e. health status and feeling safe were dichotomized. We recoded the health status into 'Bad health', value 1 consisting of the original alternatives 'very bad' and 'bad' and 'fair', whereas 'good' and 'very good' were assigned a value 0. The same kind of procedure was applied to feeling safe. The ESS asked whether the respondent feels safe when walking alone after dark in a local area. 'Very unsafe' and 'unsafe' responses were grouped into 'Feeling unsafe' (value = 1) and the rest got the value 0.

Unfortunately, income data in the ESS are not ideal: income is categorized into 10 income groups, and in richer countries into 12. However, the groups do provide some possibilities to evaluate the economic position of the respondent. As such, the original variable is a categorical measure of a household's absolute income level. As can be seen in Appendix Table A2, the variable is a powerful explanatory factor both when it comes to the within country variance (between individuals living in the same country) or to the variance between countries (variances explained are 18 per cent and 6 per cent, respectively).

By recoding the original income variable it is possible to rank households according to their income and to use those rankings as proxies of nationally organized deciles, quintiles or quartiles. Here we grouped the respondents into quartiles to obtain more observations in each quartile. Although the relative placing of the individual is of importance, the effect of the absolute level seems to be stronger (Appendix Table A2). However, instead of absolute income levels we use quartiles in regression models, and after the individual level factors are controlled for, we regress country dummies against national GDP per capita data which are an indicator of the overall level of prosperity of the country.

In addition, we include a third income variable into the analyses. The ESS also asks the respondents to provide their own perception on their present income. Answers were reanalysed into a new dichotomous variable called 'economic difficulties'. Value 1 was given to all those who said that they have difficulties in coping on their incomes, and those with no problems getting on were assigned a value 0. Preliminarily, one can already say that the subjective experience of economic difficulties, together with self-evaluated health, is one of the most important explanatory factors for happiness. Indeed, experiences on economic hardship explain as much as 45 per cent of variations in happiness within countries and 10 per cent between countries. For the health problems, the corresponding shares of explanation are almost as high (Appendix Table A2).

The variables discussed above all pertain to individual level characteristics and they have a close correspondence to the variables used in the Nordic level of living surveys. In order to take into consideration contextual factors, we include a number of country level variables. To complement analyses of the significance of monetary living conditions, GDP per capita (in Euros modified by Purchasing Power Parities in 2006 prices) is included. The GDP is used as a general measure of the prosperity of the country. As discussed above, it may be worthwhile to include some country-level indicators on social inequalities. Therefore, the Gini coefficient, social security spending as a percentage of the GDP (indicating the state involvement in guaranteeing social protection to residents),³⁷ relative poverty rate (60 per cent poverty line) and Gender Inequality Index (GII) are used as contextual variables against which OLS-regression coefficients of country dummies are projected. If we are to believe Wilkinson and Pickett, a negative correlation (after controlling for individual level variables) between happiness and inequality can be expected. Correspondingly, there should be a negative linkage between the GII and happiness, whereas the happiness and prosperity of nations should

37 Eurostat. *Expenditure on Social Protection as % GDP*. Online. Available HTTP: <http://epp.eurostat.ec.europa.eu/statistics_explained/images/0/0f/Expenditure_on_social_protection_as_%25GDP.PNG> (accessed August 2012)

go hand in hand.³⁸

In subsequent analyses, regression models are used for the total sample of all immigrants and regime-wise subsamples to see if there are differences in how the explanatory variables listed in Appendix Table A2 perform in different welfare state settings. From the regression model on the total immigrant sample we derive coefficients for each country (countries are included into the models as dummies). Using Sweden (that many analysts regard as *the* welfare state) as a reference, a positive regression coefficient for a country indicates a greater level of happiness in the country in question and a negative value a lower level of happiness than in Sweden when individual level characteristics are controlled for. Finally, the country coefficients are depicted against the most important country-level variables to see if there are connections at the macro level. We visualize interactions between happiness, gender, regime of origin, regime of residence and some other key variables by plots from univariate linear models (LM) which are handy devices to present rather complicated two and three level interactions in easily interpretable and understandable graphs.

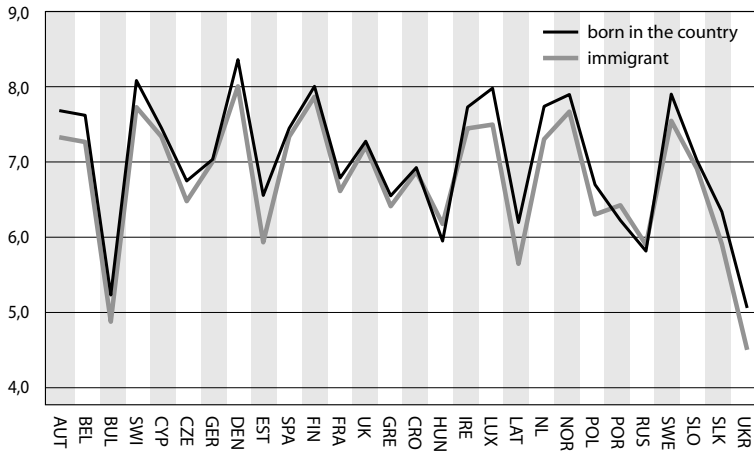
Happy immigrants live in happy countries

Previous studies have shown that the level of happiness is lower among immigrants than native residents.³⁹ Although there are numerous interesting reasons for that, the issue falls outside the scope of this study. Here we only take a cursory glance over the situation. In Figure 2, the levels of happiness are portrayed separately for immigrants and for the native population. The main story of the graph is that happy immigrants tend to live in countries with happy natives and most probably the same factors inhibit or generate happiness among both natives and immigrants. The overall level of happi-

38 Indicators are for the year 2006 which is in the middle of our observation period. A better strategy would have been to take an average for the entire observation period. However, all the indicators used here are rather sticky and changes in them are slow. Therefore, the choice to use the 2006 values instead of averages for 2002–2010 does not affect the results. Data are taken from United Nations Development Programme (UNDP). Going Beyond GDP, UNDP Proposes Human Development Measure of Sustainability. Online. Available HTTP: <<http://hdr.undp.org/en/>> (accessed August 2012)

39 Senik 2011.

Figure 2. Happiness (combined happiness and life satisfaction) among natives and immigrants in Europe.



ness is high in Denmark, Switzerland and Finland followed by Norway and Sweden. In these countries also the immigrants say that they are happy. Also Ireland and Austria, together with the Low Countries – Belgium, Luxembourg, and the Netherlands – are happy countries, but differences between natives and immigrants are substantial, comparatively speaking.

Table 1 gives a summary of the importance of each individual explanatory variable when the other variables are controlled for. The two indicators of social trust are statistically significant in all country-settings, as expected. Whereas unemployment, bad health and experienced economic problems are also significant regardless of the regime, the importance of the other variables depends on the sample of countries. For example, income quartile is significant in the total sample, in Post-Socialist countries and in Central Europe, but not significant in the other regimes. Correspondingly, while having no friends and experiences of discrimination are important in the Southern European regime, they play no major role in the Anglo regime. When it comes to the origin of the immigrants, those who emigrated from

a Post-Socialist country into some other Post-Socialist country are significantly less happy than the non-European immigrants. Whereas Central-European emigrants seem to be happy in another Continental country or in South Europe, they are not that happy if their destination happens to be the Anglo regime. In relation to non-European immigrants, the Anglo movers are happiest in a Southern European country.

Our interim conclusion so far could be that there are some regime-dependent differences in the explanatory power of the whole model – as indicated in the Adjusted R squared – and while some variables (health, experienced economic difficulties, unemployment and social capital) are robust to welfare regimes, some other variables (e.g. gender, age, income quartile, feeling unsafe, and regime of origin) are more context sensitive.

On average, although the level of happiness is the highest in the Nordic hemisphere, the picture is much more thrilling than simply that. Table 1 showed that immigrants coming from the same regime of origin display different levels of happiness depending on their regime of residence. In Figure 3 – which is a result from LM models where other variables are controlled for – we have visualized three-way interactions, i.e. regime of residence*regime of origin*gender. Based on this, some interesting regime and gender patterns appear. Whereas Southern European males express low levels of satisfaction in the Anglo countries, they are satisfied in the North, as are other Northerners and men from Eastern Europe. Female immigrants from the Nordic regime express the highest levels of happiness in the Anglo countries, Southern European women are not that happy in the Nordic countries, and Eastern European and non-European female immigrants are happy in the South.

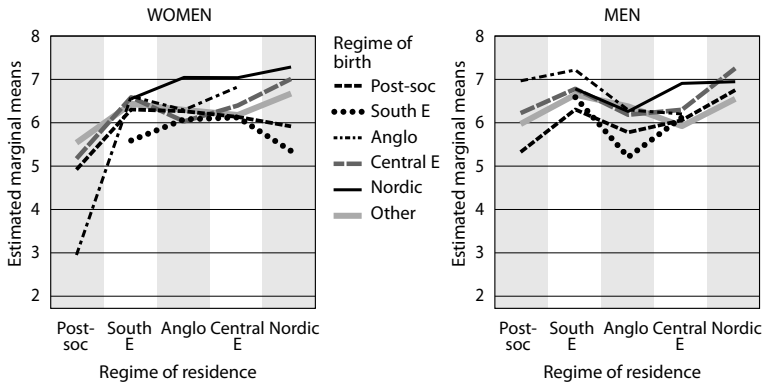
A number of cultural and language factors may contribute to these results. As can be seen in Appendix Table A1, while the share of non-European immigrants is the largest in Anglo and Southern European regimes, the share of Nordic immigrants is the largest in the Nordic hemisphere and immigrants in the Post-Socialist countries tend to have moved in from another post-socialist country or from outside Europe. These factors may have some ramifications for the level of happiness among immigrants. Due to lingual

Table 1. Unstandardized OLS regression coefficients for happiness in different welfare state regime settings.

	<i>All countries</i>	<i>Post Socialist</i>	<i>South</i>	<i>Anglo</i>	<i>Central Europe</i>	<i>Nordic</i>
<i>Constant</i>	8,247***	7,827***	9,708***	8,105***	7,852***	8,604***
<i>Gender</i>	0,096**	0,155**	-0,196*	0,070	0,234***	0,079
<i>Age</i>	-0,038***	-0,032**	-0,068***	-0,036**	-0,045	-0,058**
<i>Age squared/1000</i>	0,402***	0,282	0,613***	0,494***	0,453***	0,658**
<i>Economic difficulties</i>	-1,001***	-1,090***	-0,842***	-1,041***	-0,977***	-0,769***
<i>Quartile</i>	0,050***	0,178***	0,018	0,009	.139***	0,076
<i>Bad health</i>	-0,684***	-0,612***	-0,474***	-0,534***	-0,611***	-0,666***
<i>Unemployed</i>	-0,402***	-0,702***	-0,288*	-0,640***	-0,301***	-0,504*
<i>No friends</i>	-0,533***	-0,777***	-0,851***	-0,205	-0,607***	-0,789***
<i>Feeling unsafe</i>	-0,092**	-0,474***	-0,058	-0,229**	0,088	-0,241
<i>Discrimination</i>	-0,317***	-0,345***	-0,614***	-0,291**	-0,248***	-0,265
<i>Trust in people</i>	0,306***	0,273***	0,221***	0,331***	0,270***	0,417***
<i>Trust in institutions</i>	0,381***	0,370***	0,227***	0,355***	0,370***	0,248***
<i>Regime of origin</i> <i>(non-European = reference)</i>						
<i>Post-socialist</i>	-0,196***	-0,340***	0,006	-0,279	-0,029	-0,094
<i>Southern</i>	0,157*	0,613	0,053	-0,398*	0,158	-0,283
<i>Anglo</i>	0,230***	-0,263	0,787**	-0,91	0,352	-0,081
<i>Central Europe</i>	0,208***	-0,084	0,288*	-0,280*	0,277***	0,083
<i>Nordic</i>	0,201**	0,614	0,215	1,111	0,176	0,038
<i>Adj. R squared</i>	0,305	0,302	0,222	0,258	0,247	0,228

Note: age squared was divided by 1000 in order to make coefficient visible.

Figure 3. Happiness, gender, regime of birth and the regime of residence in Europe.



resemblances, those moving within Scandinavia understand each other (the Finns are an exception) as do the Irish moving to Britain and vice versa. Many Central European movers belong to a same lingual group (French or German). When it comes to the impact of language, we can assume that the English-speaking countries are in the best position. Since English is today's *lingua franca* and immigrants already speak English when they enter the country be it Britain or Ireland, and British or Irish emigrants are also understood in their new country of residence as well. Many other countries, belonging to a group of smaller, more isolated languages, say Finland or Hungary, face bigger language-related problems with people moving in as do the Finns and Hungarians when moving out from their home countries. A closer analysis on the impact of language and culture falls beyond the scope of this study.

We can also visualize some other interactions that are concealed behind the regression coefficients in Table 1. In principle, we could again control for other variables and inspect how happiness varies when we move from non-unemployed to unemployed, from healthy to sick persons and from better-offs to those who have problems in getting on with their present income. The story from all of these graphs would be more or less the same: in all the regimes bad conditions significantly hollow out happiness and the

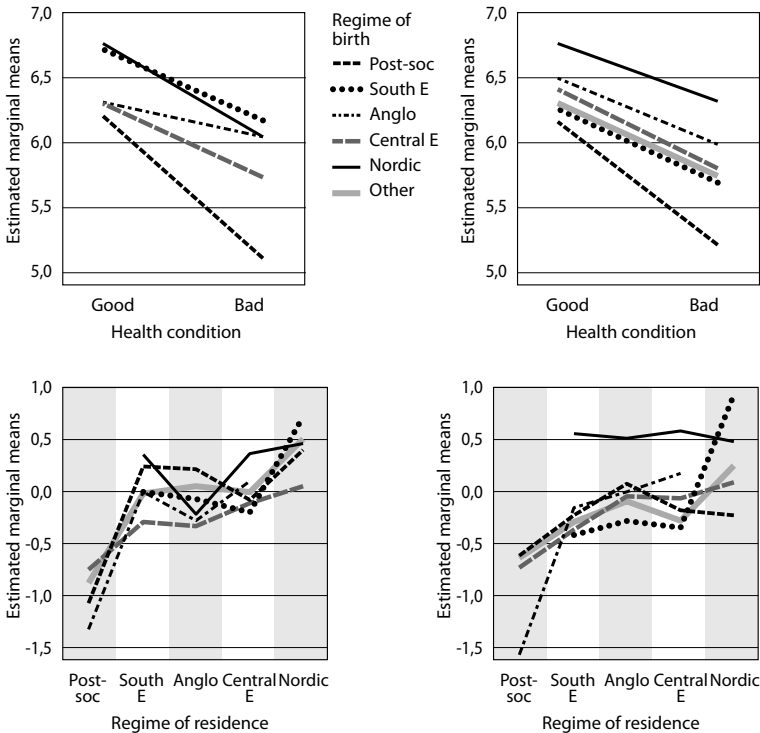
hollowing out effect is the biggest in the Post-Socialist regime, while the effect is not that steep in the Nordic countries and in the Southern European regimes. That kind of visualization is presented in the upper left-hand panel in Figure 4. Instead of presenting similar plots for economic hardship and unemployment, we focus on the interaction between origin and health (upper right-hand panel). While there were no differences between the Nordic and Southern European countries when we analysed the regime of residence, the regime of origin inspection shows that immigrants originating from the Nordic countries have, in comparison to other immigrants, higher levels of happiness depending on whether they are sick or not. The lowest level of satisfaction and the deepest hollowing out effects are found in the Post-Socialist countries.

Figure 4 also contains a graphical presentation of the relationships between social capital (institutional trust in the lower left-hand panel), regime of origin and the regime of residence. These two graphs show how the level of social capital – one of the most important explanatory factors of happiness – varies between various immigrant groups in different destination clusters. Immigrants, whatever their origin, trust in the Nordic institutions. It is intriguing that while the Nordic immigrants display high levels of trust in other people (the right-hand panel) regardless of their regime of residence, the level of the Northerners' trust in institutions vary depending on the regime of residence. These results indicate that there is a kind of contamination effect from 'just' institutions.⁴⁰

Now it is time to take a look at the country level variables and try to see whether we can find any relationship between happiness and a number of macro level indicators (due to space considerations we do not graphically present results for all macro level inspections). Mimicking a simple two-stage approach, the rationale in Figure 5 is that after controlling for the key individual level variables we can project regression coefficients for country dummies obtained in the first equation in Table 1, and assume that if, for example, the Gender Inequality Index (GII) is somehow related to female

40 Rothstein 1998.

Figure 4. Interactions between happiness, bad health and regime of residence (upper left-hand panel) and regime of origin (upper right-hand panel) and interactions between levels of social capital (lower left-hand panel: trust in institutions; and lower right-hand panel: trust in people).



happiness, that should be revealed when we regress country dummy coefficients on GII, as done in the upper left-hand panel.

The correlation between GII and country coefficients is strong ($-0,75^{**}$ for women that are portrayed in the graph and $-0,69^{**}$ for males) and although it will shrink if we omit the Post-Socialist countries, it still remains significant ($r = -0,48$). The result gives qualified support for the ideas of the

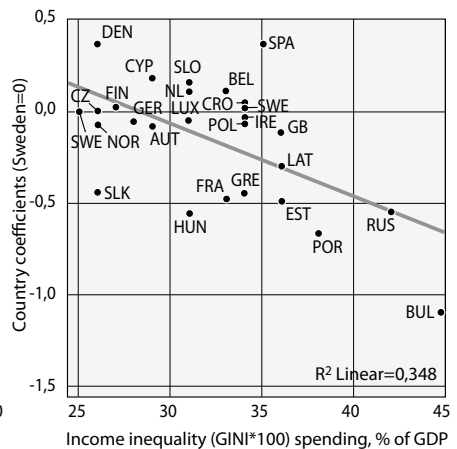
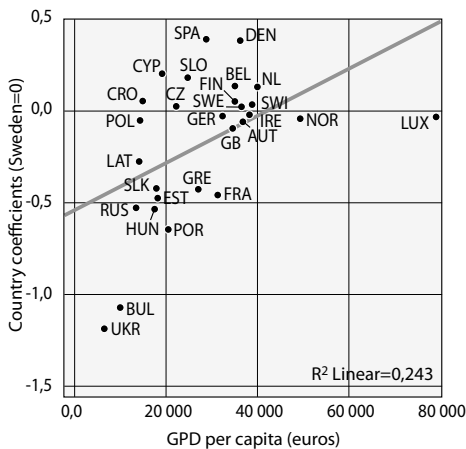
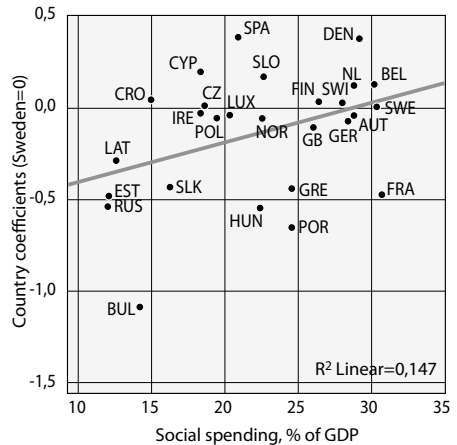
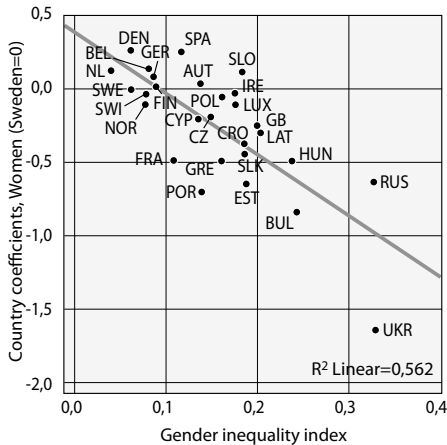
woman-friendly welfare state – that also seems to make men happier.⁴¹ This simple inspection gives rather strong support to the ideas that some countries and clusters of countries may be more women-friendly than others.

The other correlations also run in the expected direction but they are substantially smaller and the relationships will be further reduced by the omission of the poorer countries. The correlation between social spending and happiness goes down from 0,38* to insignificant -0,10 if the Post-Socialist regime is omitted. There seems to be slight support for Wilkinson's and Pickett's kind of arguments. The lower right-hand panel depicts the relationship between income inequality and happiness ($r = -.59^{**}$) but this relationship is also sensitive to the inclusion or omission of the Post-Socialist countries. While the correlation coefficients between happiness and relative income poverty are -0,39* for the total sample and -0,22 for West Europe, the measure of material deprivation, i.e. an index constructed by Eurostat to measure the lack of necessities, yields a much higher coefficient in all samples ($r = -0,69^{**}$ for all countries and -0,52* for the richer countries, the pictures of poverty are not displayed here).

The correlation between country coefficients and GDP per capita is modest but nevertheless it gives qualified support for the 'absolutist' views – there is a tendency that happiness and national wealth are linked to each other. The results were fortified in multilevel analyses. GDP per capita and material deprivation appeared to be mutually exclusive in regression models. If material deprivation and GDP were simultaneously included in the models, the material deprivation variable became significant and down-played the importance of GDP (sig. = ,259). However, if the deprivation index was omitted, GDP got significance (sig. = ,002) as well as non-corrupt state (sig. = ,000), gender inequality (sig. = ,000) and social security spending (,039). It is important to pinpoint that at the national level all the variables used here are linked to each other: countries that spend much on social security display low levels of poverty, income inequality and inequalities between genders. Consequently, they are the least corrupt states and all these features are important macro-level ingredients for a happy life.

41 Cf. Bachans 2011.

Figure 5. Unstandardized coefficients for country dummies (individual level characteristics controlled for) depicted against some country level characteristics.



Conclusions

The aim of this chapter was to analyse happiness among immigrants living in the European hemisphere. We used the basic ideological underpinnings of the Nordic welfare state as its platform. The goal of social policy making in Scandinavia has been to offer residents a wide set of possibilities to master their own lives. The idea has links to Amartya Sen's philosophical thinking on capabilities. Everyone has to be offered a wide set of capabilities in order to be able to more or less fully participate in the life of the surrounding society. In the Nordic level of living studies, capabilities have been in the disguise of resources that individuals can command to master their lives. The idea has been that if there are sufficient resources they will produce high levels of material well-being which in turn produce satisfaction and happiness. *Having, loving and being* are at high levels in the Nordic countries.

Thus, whereas the state in the Nordic discourse has been seen as a facilitator for a good and happy life, in liberal Hayek-inspired thinking the state is often regarded as a malevolent and alien force, depriving the individual of freedom and hence, circumscribing individual happiness. In this brand of thinking, distributional issues are not seen as being that important. The most important thing is to increase the level of material welfare, which is also the best guarantee for happiness. In the collectivist tradition, much emphasis is laid on relative differences, and huge relative differences are seen as being harmful not only to the worst-offs but to everyone.

Our humble results perhaps point more to the collectivist tradition: the happiest and most satisfied immigrants were found in countries with large and efficient welfare states and, comparatively speaking, small income and other social differences. Such social conditions create institutional settings that generate and fortify trust or social capital, if you like. However, there was a strong indication that the absolute income level is important as well, and the impact, no doubt, is the strongest among those who are living in economic scarcity. In addition to experienced economic problems, bad health and unemployment appeared to be associated with lower levels of happiness. But the strength of that negative association varied between welfare state regimes. Also the importance of other explanatory variables was to some extent context-bound.

Earlier studies have shown that the most important determinant of happiness and a good life is the degree of social capital the individuals have. That is very much true for immigrants, too. Those who have high levels of social capital display high levels of happiness as well. This perhaps is not that novel a finding. The novelty in our study is in the inspection of various interactions between the backgrounds of immigrants and their country and welfare regimes of residence. For example, when it comes to the Nordic emigrants, i.e. those who have emigrated from their own country, they seem to have a higher level of social capital, and hence, they seem to be happier than emigrants/immigrants from other regimes. Furthermore, the Nordic immigrants tend to maintain their trust in people wherever they reside, but their level of trust in institutions changes depending on their country of residence. Correspondingly, those immigrants moving to the Nordic countries display higher levels of institutional trust and higher levels of happiness than immigrants in other regimes – something that hints towards a contamination effect from just and trustworthy institutions. Happy immigrants live in happy countries.

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APPENDIX 1

Table A1.

Summary characteristics of immigrants in different welfare state regimes.

	<i>Post-Socialist</i>	<i>South Europe</i>	<i>Anglo</i>	<i>Central Europe</i>	<i>Nordic</i>
<i>Happiness (mean / st.dev.*)</i>	5,50/2,28	7,06/1,82	7,22/1,77	6,98/1,96	7,68/1,76
Individual characteristics					
<i>Gender; share of women (%)</i>	58,8	50,6	52,5	53,4	54,0
<i>Age (mean / st.dev.)</i>	51,8/18,1	38,3/14,1	44,2/17,4	43,8/16,6	46,3/17,4
<i>Economic difficulties (%)</i>	64,6	38,9	21,7	26,9	16,0
<i>Unemployed (%)</i>	4,5	13,3	5,5	8,8	6,8
<i>Bad health (%)</i>	69,0	26,1	23,3	35,1	26,7
<i>No intimate friend (%)</i>	15,3	10,1	9,8	9,9	10,0
<i>Feeling unsafe (%)</i>	48,2	20,7	33,5	25,8	19,3
<i>Discrimination (%)</i>	11,4	20,2	16,3	17,2	15,3
<i>Trust in persons (mean / st.dev.)</i>	-0,45/1,1	-,23/0,9	-0,14/0,9	-0,03/0,9	0,48/0,9
<i>Trust in national institutions (mean / st.dev.)</i>	-0,88/1,0	0,01/0,9	0,11/0,9	0,97/0,9	0,42/0,9
Regime of origin (%)					
<i>Non-European (%)</i>	46,9	69,1	67,7	53,0	49,7
<i>Post-socialist (%)</i>	49,1	12,8	7,5	20,9	12,6
<i>South Europe (%)</i>	0,1	3,2	4,2	12,4	1,6
<i>Anglo (%)</i>	0,1	2,6	10,3	1,7	2,7
<i>Central Europe (%)</i>	3,8	11,7	9,4	11,5	8,3
<i>Nordic (%)</i>	0,1	0,7	0,9	0,5	25,1
Country level data					
<i>Gini coefficient / st.dev.</i>	37,8/5,02	33,0/2,21	33,82/0,75	29,8/2,84	25,0/2,57
<i>Poverty (%) / st.dev</i>	19,3/6,2	18,2/1,2	17,8/1,5	13,8/1,4	12,0/0,9
<i>GDP per capita (2006) /st.dev.</i>	11750/4212	27259/2853	35118/667	33739/3758	38580/5590
<i>Gender Inequality Index / st.dev.</i>	0,31/0,05	0,13/0,01	0,20/0,01	0,09/0,02	0,07/0,01
<i>Social spending (% of GDP) / st.dev.</i>	15,0/4,2	22,9/2,1	22,9/3,7	27,7/3,1	27,4/3,2
<i>Non-corrupt state index/st.dev.</i>	5,0/1,7	5,9/1,0	8,1/0,6	8,3/0,6	9,2/0,3

* standard deviation; Gender Inequality Index (GII) is a composite measure reflecting equality achievements between genders in three dimensions: health, empowerment and labour market. The higher the value the larger the gender disparity. World-wide the GII values vary from the low 0,05 in Sweden to 0,7 in Sierra Leone. The non-corrupt state index varies from 10 = very clean to 0 = highly corrupt. In 2006 the world-wide variation was from the high 9,6 in Finland to the low 1,6 in Chad.

Table A2.

Within country and between country variance explained by individual explanatory variables; multilevel model including the country and the variable in question (in per cent).

<i>Variable</i>	<i>Variance explained within countries</i>	<i>Variance explained between countries</i>
<i>Gender</i>	0,0	0,1
<i>Age</i>	3,5	0,3
<i>Economic difficulties</i>	44,9	10,0
<i>Income (quartile)</i>	10,4	5,1
<i>Income (absolute)</i>	17,6	6,1
<i>Bad health</i>	39,3	9,9
<i>Unemployed</i>	0,1	1,8
<i>No intimate friend</i>	6,8	2,6
<i>Feeling unsafe</i>	13,5	1,4
<i>Discrimination</i>	0,3	1,4
<i>Trust in people</i>	30,1	7,8
<i>Trust in national institutions</i>	43,9	9,3
<i>Regime of origin</i>	11,0	0,6

Public health and solidarity – How to succeed in the population-based prevention of alcohol problems

PEKKA SULKUNEN & TRYGVE UGLAND

Introduction

Traditional welfare state research has aimed to explain levels and distributions of objective well-being in terms of services and equality policies. Even recent interest in subjective indicators of well-being by economists such as Joseph Stiglitz, Amartya Sen and Jean-Paul Fitoussi have looked at them from the perspective of risks posed by structural, external factors.¹ Much less attention has been paid to a second type of risk, namely that produced directly by consumption. We can call this internal risk.² Our own desires and choices are threats against which we must protect ourselves. The facts are well known. In developed countries, the five most important causes of the total health burden are tobacco, blood pressure, alcohol, cholesterol and overweight, all related to lifestyle. Across the whole world, including the developing countries, the most important factors are otherwise the same but include underweight, unsafe sex, and unsafe water; in other words indica-

1 Stiglitz, Joseph E., Sen, Amartya & Fitoussi, Jean-Paul (2009) *Report by the Commission on the Measurement of Economic Performance and Social Progress*. Paris: Commission on the Measurement of Economic Performance and Social Progress.

2 Sulkunen, Pekka (2011) 'Autonomy Against Intimacy: On the Problem of Governing Lifestyle-Related Risks.' *Telos*, Vol. 156, 99–112.

tors of extreme inequality of resources appear at the top of the list.³ These risks, too, are the making of human societies, not of nature itself.

Once we observe this, we also observe how poor the track record of health and welfare policy is in this area. This incapacity is a recent phenomenon. History is full of examples of society successfully controlling the consumption and desires of individuals, including sexuality, media culture, food, drugs, and alcohol. Alcohol control has in fact had been one of the first areas of social policy exercised by the emerging nation states in the late nineteenth and early twentieth centuries. Severe measures, including prohibitions, individual rationing systems, state monopolies, high taxes to keep prices up, restrictions on selling hours, and outlets have been used throughout the industrialized world.

In the individualized modern society today, such measures are incompatible with the dominant principles of justification of the social order, which include the freedom of consumers to follow their preferences, and the freedom of the market to satisfy them. Total prohibitions or controls targeted at problem users or specific risk groups – on the basis of particularistic criteria such as ethnicity, gender, or class – would be experienced as violations of equity norms and requirements of self-responsibility.

Alcohol policy has a history of evolution from rigorous state-imposed controls towards increasing freedom of the market and the consumer in most industrialized countries since the turn of the twentieth century. This evolution has been accompanied by increasing consumption and by growing rates of harm to health and society. A balance between freedom and harm has been sought by different means, for example trying to modify behaviour towards less risky drinking patterns, but most of the attempts have either failed or been experienced as excessively normative and biased to favour the dominant middle class (male) culture.

3 World Health Organization (WHO) (2002) *World Health Report*. Geneva: World Health Organization; Babor, T. F., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E., Rehm, J., Room, R. & Rossow, I. (2003) *Alcohol: No Ordinary Commodity – Research and Public Policy*. Oxford and London: Oxford University Press.

The Total Consumption Model

The Total Consumption Model (TCM) has been a solution that satisfies both sides of the balance, at least in theory. According to this model, even moderate drinkers influence the prevalence of alcohol problems in any population, because they are the vast majority, and problems like accidents, petty crime and violence sometimes occur in relatively controlled drinking occasions. But even chronic health problems typically associated with long-term heavy drinking co-vary with moderate consumption. It is very difficult to reduce heavy use without also affecting moderate drinking, as the distribution of alcohol use has been observed to be very stable across populations and over time. The model recommends universal preventive measures to regulate the average consumption, such as price increases and availability restrictions, instead of measures directed at persons at high risk. Such measures increase the cost of alcohol in terms of time and money, but leave the choice to the consumers, and equally to all consumer groups.

This model has served as a leading policy doctrine among experts in the area of public health and alcohol for several decades. It has been the guideline of the European Alcohol Action Plans since 1993, and it has been validated and elaborated on several occasions since it was introduced almost 40 years ago.⁴ However, its implementation in actual policy-making has been rare. Business interests, the difficulty of justifying restrictive availability and tax measures, and the low esteem of public health interests in comparison to economic and fiscal interests, have been obstacles to its implementation.

The differences in how countries utilize and implement the findings of the TCM can partially be explained as depending on the temperance history and drinking patterns of the country in question. Although all the Nordic countries have had similar drinking patterns, strong temperance movements, and severely state-regulated alcohol markets, only Sweden, and to some extent Norway, have applied the TCM for any significant period of time. This chapter will show that there are also positive preconditions, em-

4 Bruun, Kettil, Edwards, Griffith, Lumio, Martti, Mäkelä, Klaus, Pan, Lynn, Popham, Robert E., Room, Robin, Schmidt, Wolfgang, Skog, Ole-Jørgen, Sulkunen, Pekka & Österberg, Esa (1975) *Alcohol Control Policies in a Public Health Perspective*. Helsinki: The Finnish Foundation for Alcohol Studies.

bedded in the TCM itself, for its application in actual policy. They are less connected to alcohol-related harm, drinking cultures and even to temperance traditions than to the mode of governance. The model presupposes a policy-maker governing a delimited population, individual consumer autonomy, and a strong link between expertise and health policy.

This chapter will analyse four cases, comparing France with three Nordic countries, Finland, Norway and Sweden, where attempts to frame alcohol policy as a restriction of total consumption in a population have been successful, at least for a while; more so in Sweden and France than in the other two cases. Two factors are likely to explain this: early medicalization of the alcohol problem, and a strong appeal to social solidarity by advocates of this policy. The more research-based applications of the model in Norway and Finland, by comparison, have not gained strong popular support, but for opposite reasons. In Norway, the temperance tradition has continued in almost all political parties and been associated with nationalism as the country has otherwise been integrated to the global world. Technocratic epidemiological arguments were not very much needed. In Finland, the temperance movement had become incapacitated as a stake-holder in alcohol policy at the moment when the public health argument was most needed.

The analysis of Norway, Sweden and Finland presented in this chapter is based on several studies already published. The French case is based on our original research, including press material, official documents and personal interviews of key participants in the policy process. This research has never before been published, and therefore it is offered here to the reader in greater detail than the Nordic cases.

Background: Alcohol policy and the temperance issue

With regard to alcoholic beverages, the TCM implies political restrictions on the free market and consumer choice. Therefore it would seem natural to assume that temperance history and the strong presence of socialist political parties would explain its implementation in some countries, whereas countries with less prominent anti-alcohol traditions and dominant market-liberal political attitudes would be less inclined to accept it as the alcohol

policy guideline. The cultural traditions of alcohol use, the political role of women, the Protestant religion and the dominance of the rural population are all related to the temperance history of the late nineteenth and early twentieth century. Therefore, one would assume that these factors should also be relevant determinants of whether the TCM will gain popular acceptance or not.⁵

At a closer look, however, the relationships between these background factors and alcohol policy are very complex. In countries where the socialist working-class parties carried the anti-alcohol flag until the first decades of the twentieth century, the alcohol policy regimes remained more restrictive of the market and consumer freedom than in countries where the socialist platform dismissed the alcohol issue early on. This holds, for example, for comparisons between Belgium and Germany or France, between Scotland and England, and between the other Nordic countries and Denmark, the second of these pairs of comparison having been more liberal in their alcohol policy regimes than the first, in which the socialist parties maintained the alcohol issue on their agendas longer. However, in the period after the Second World War, when alcohol regimes gradually became liberalized in the Nordic countries, the alcohol issue became politicized along the left-right dimension only for a very short period of time; and again inconsistently, in the 1970s. Then socialist parties accepted stronger state regulations than liberal or conservative parties, which labelled TCM-oriented alcohol policy as a 'socialist plot', for example in Finland.⁶

Temperance history is related to Protestantism in an interesting way. Anglo-American Protestant movements associated with Calvinism (Methodism, Baptism) are especially critical of drinking, which partly explains why the strongly Lutheran Denmark has had a less alcohol-critical policy

5 Johansson, Lennart (2000) 'Sources of the Nordic Solutions'. In Sulkunen, Pekka, Sutton, Caroline, Tigerstedt, Christoffer & Warpenius, Katariina (eds) *Broken Spirits: Power and Ideas in Nordic Alcohol Control*. Helsinki: Nordic Council for Alcohol and Drug Research (NAD), 17–43.

6 Anttila, Anu-Hanna & Sulkunen, Pekka (2001) 'The Inflammable Alcohol Issue: Alcohol Policy Argumentation in the Programs of Political Parties in Finland, Norway and Sweden from the 1960s to the 1990s'. *Contemporary Drug Problems*, Vol. 28, 49–86.

tradition than Sweden and Norway.⁷ In the post-war decades the rural dry option was adopted mostly in regions where these churches have been prominent.⁸ Yet many examples can be given of countries where religion does not seem to play a role, such as Catholic Poland with a relatively strong temperance tradition, and – for this chapter most relevant – the Catholic but officially non-religious state of France, where the TCM has played an important role. France is also a case in point concerning women's political roles, as they gained voting rights in national elections only in 1945.

As to the prominence of the rural population, the early temperance movements that in the late nineteenth and early twentieth century represented the avant-garde of modern ideals of individual autonomy gradually became conservative rural traditionalists⁹. In most Western countries, anti-alcohol attitudes have therefore become associated with moral conservatism. Again, however, the post-war alcohol policy history is contradictory. For example, in Finland the rural population was larger than in the other Nordic countries, yet alcohol policy liberalization was more radical than in Sweden or Norway. In Norway, on the other hand, earlier dry rural areas had started to strive for off-licenses and restaurants for competitive reasons.¹⁰

Drinking patterns are even less consistently related to the implementation of the TCM than religion, politics, women's political rights or the size of the rural population. Finland, with a high rate of arrests for drunkenness, and the UK with a high rate of binge drinking, are examples where restrictive alcohol policies could be expected to appear, compared to milder drinking patterns in Sweden or France. Instead, both the UK and Finland have been reluctant to adopt the TCM and the market regulations that it implies, compared to Sweden and France.

7 Eriksen, Sidsel (1993) 'Drunken Danes and Sober Swedes? Religious Revivalism and the Temperance Movements as Keys to Danish and Swedish Folk Cultures'. In Stråth, Bo (ed.) *Language and the Construction of Class Identities. The Struggle for Discursive Power in Social Organisation: Scandinavia and Germany after 1800*. Gothenburg: Gothenburg University, 55–94.

8 Johansson 2000; Andersen, Jan (2000) 'Municipalities Between the State and the People'. In Sulkunen, Pekka, Sutton, Caroline, Tigerstedt, Christoffer & Warpenius, Katariina (eds) *Broken Spirits: Power and Ideas in Nordic Alcohol Control*. Helsinki: Nordic Council for Alcohol and Drug Research (NAD), 183–197.

9 Sulkunen, Pekka & Warpenius, Katariina (2000) 'Reforming the Self and the Other: The Temperance Movement and the Duality of Modern Subjectivity'. *Critical Public Health*, Vol. 10, No. 4, 423–438.

10 Andersen 2000.

Overall, the match between the usual background factors of temperance history and the application of the TCM is poor. In an earlier article we have shown one reason for this.¹¹ The emergence of the TCM as an alcohol policy guideline *was not at all an offspring of temperance politics*; it was an antidote to its moralistic undertones and normativity. In the mind of its early developer, Professor Kettil Bruun, TCM-based alcohol policy increases the cost of alcohol in time and money to the consumers but leaves it up to them to make decisions on their consumption, given the known risks to health, wealth and welfare. Policy was to avoid individual discrimination and other moral stands, and to treat all individuals in the same way, neutrally.

To get a better view of the preconditions for successful applications of the TCM we need to take a look at the kind of policy approach it represents in the field of lifestyle-related risk prevention.

Biopolitics and the pastoral welfare state

The total consumption framework was invented in France by the demographer Sully Ledermann in the 1950s. The context was the extraordinary loss of male lives in and between the two world wars. He argued that the biggest factor of the high mortality rate was not war but the very high consumption of alcohol in France. Ledermann proposed that the distribution of alcohol consumption is skewed and has a relatively constant form. Therefore, when the average consumption rate in a population increases, also the number and consumption level of problem drinkers, and consequently the prevalence of drinking problems, will increase even more. Therefore, the objective of alcohol policy should be to regulate the total consumption of a population, by means of taxation, by regulating opening hours and by controlling the network of outlets for alcoholic beverages.

Ledermann's work was almost forgotten for over a decade, but it was rediscovered by Canadian researchers in the 1960s, and later in other coun-

11 Sulkunen, Pekka & Warsell, Leena (2012) 'Universalism Against Particularism. Kettil Bruun and the Ideological Background of the Total Consumption Model'. *Nordic Studies On Alcohol And Drugs*, Vol. 29, 217–232.

tries.¹² The Nordic countries became involved in this research for immediate policy reasons. Alcohol consumption was increasing and health care and alcoholism treatment systems were unprepared for the mounting problems and costs incurred to the public. The approach found its way back to France in the late 1980s in the context of the Évin Law (passed in 1990). The European Regional Office of the World Health Organization in Copenhagen became instrumental in diffusing the message to policy makers across Europe.

The population argument is a continuation of a long historical development in which the life of the population became the object of state power in modern societies. As Michel Foucault has argued, the modern process shifts the emphasis of power to the size of the population, its health, hygiene, sexuality and mental fitness, instead of disciplining deviant or rebellious individuals.¹³ Increasingly also civilized manners and ways of thinking were conceived as products of good government. The populations of national societies were not only the objects of national states; they were also the source of the states' sovereignty. The people, *le peuple*, *das Volk*, *folket*, *kansa*, was thought to act on itself through the institutions of parliamentary politics that were expected to reflect not only the people's needs but also its common will. Nation states are societies with geographic boundaries, independent political institutions, a more or less shared culture – and a population.

Ideologically the TCM represents the type of governance that Michel Foucault has described with the metaphor 'pastoral power'.¹⁴ Pastoral authority, the shepherd, knows the herd and its needs, leads it from one meadow to another, and cares for the lost sheep. It is an inclusive and universalistic form of power that assumes a high degree of solidarity among the members of the flock. These metaphors perfectly describe the welfare state until the last third of the twentieth century because they stress that the function of social policy was, besides the well-being of the population, the

12 de Lint, Jan & Schmidt, Wolfgang (1971) 'Consumption Averages and Alcoholism Prevalence: A Brief Review of Epidemiological Investigations'. *British Journal of Addiction*, Vol. 66, 97–107; Popham, Robert (1970) 'Indirect Methods of Alcoholism Prevalence Estimation: A Critical Evaluation'. In Popham, Robert (ed.) *Alcohol and Alcoholism*. Toronto: University of Toronto Press.

13 Foucault, Michel (1976) *Histoire de la sexualité 1. La volonté de savoir*. Paris: Gallimard; Foucault, Michel (1991) 'Governmentality'. In Burchell, Graham, Gordon, Colin & Miller, Peter (eds) *The Foucault Effect*. Chicago: University of Chicago Press, 87–104.

14 Foucault 1991, 87–104.

consolidation of social order by treating all citizens in the same way. In the welfare state literature this is called the universality principle.

To succeed, such an approach cares for the population while leaving it to individuals themselves to weigh their pleasures against the risks. However, two further conditions must be met. First, there must be a centralized state that represents the generalized interest of the population in terms of the commonly accepted good, in this case the health, well-being and security of the population, instead of only particular interests or values of particular groups. This centralized power must draw its legitimacy from the will of the people, expressed through parliamentary elections. Second, it must be based on transparent scientific evidence to prove that it works, and it must have measurable objectives to demonstrate that it attains the goals set for it. The second requirement implies that the TCM is justified on the basis of expert knowledge. No one individual, from his or her own experience, can judge whether price increases actually have an impact on alcohol-related harm *rates in the population*, even if personal evidence on *individuals' reactions* is available to everyone. This must be demonstrated with statistical knowledge. Even less can individuals observe from their own experience how the consumption-harm relation can be expected to react when policy measures are implemented. This requires expert knowledge about the regularities of the consumption distribution, risk functions and methods of aggregating the burden of harm, not only in one population but across several populations in time and place. In the next two sub-sections we shall examine how these preconditions were met, first in the three Nordic countries Norway, Sweden and Finland, and then in France.

The Nordic cases

The total consumption model landed in a fertile soil in the Nordic countries with their state alcohol monopolies, not only because of the increasing alcohol-related problems but also for general ideological reasons related to the societal context. The Nordic welfare states were in the process of consolidation, albeit Finland was somewhat behind the others. Welfare states, especially in the Nordic context, were national projects that continued the

nation-building process of the late nineteenth and early twentieth century.¹⁵

Nordic alcohol policy in the mid-twentieth century was a prime example of the gradual shift from discipline to concerns about the health and welfare of the population.¹⁶ Rigorous state control of drinking by the state has been relaxed in three waves. The first occurred in the 1950s and can be called the civilizing wave, with increasing consumption levels and a gradually liberalizing availability policy. The second was the wave of welfare state liberalism, and the total consumption approach became part of that approach in the 1970s and 1980s. The increasing availability of alcohol from both off- and on-premise outlets was frozen in all countries, and although political concern was expressed about rising alcohol problems, otherwise the policy reactions varied between them. The third occurred as a consequence of the evolving new consumer society in the 'crazy decade' of the 1980s, when non-socialist coalition governments were in power, the monetary market was liberalized, public services were outsourced and credit-based consumption boomed.¹⁷ Also alcohol markets were liberalized, and this turn became a challenge to the total consumption approach. On-premise availability increased drastically. Moreover, the state-owned off-licences (monopoly stores in effect) increased in number and were modernized, wine columns started to appear in the printed media, beer societies were founded, and all three countries faced the need to adjust their alcohol policy systems in light of European Union (EU) rules. However, each country reacted differently in terms of implementing this new policy.¹⁸

The dominant idea of the *first wave of liberalization* was that since prohibitions did not work, drinking behaviour should be civilized and controlled by individuals themselves autonomously. The civilizing discourse was lib-

15 Sulkunen, Pekka (2009) *The Saturated Society: Governing Lifestyles and Risks in Consumer Culture*. London: Sage, ch. 4.

16 Mäkelä, Klaus & Viikari, Matti (1977) 'Notes on Alcohol and the State'. *Acta Sociologica*, Vol. 20, 155–179.

17 Mjøset, Lars (2011) 'Nordic Political Economy after Financial Deregulation: Banking Crises, Economic Experts and the Role of Neoliberalism'. In Mjøset, Lars (ed) *The Nordic Varieties of Capitalism*. Bingley: Emerald Books, 365–420.

18 Sulkunen, Pekka (2000) 'The Liberal Arguments'. In Sulkunen, Pekka, Sutton, Caroline, Tigerstedt, Christoffer & Warpenius, Katariina (eds) *Broken Spirits: Power and Ideas in Nordic Alcohol Control*. Helsinki: NAD-Publication, 72–90.

eral in the sense that it purported to replace the polarity of drinking versus abstinence by more nuanced images of alcohol use, borrowed from European, especially French bourgeois culture. To achieve this, alcoholic beverages should be allowed in the legal market, but under supervision by state monopolies and other government control agencies. The main motivation of the policy was the fear of the drunken worker.¹⁹ The *viina*, *renat* or *brennevin* (distilled white grain spirits) was the drink of intoxication, revolt and uproar as well as the cause of social misery, especially grave on the family and its welfare that depended on the man's reliability and sense of responsibility (*skötsamhet* in Swedish). It was believed that if working-men would drink wine instead of spirits, the drinking pattern and the sociability around it would also become tamed according to the self-controlling bourgeois model. The monopolies gave advice on the proper way of serving drinks, informed the customers about the origins and characteristics of different 'wine cultures' and favoured 'mild' beverages in their pricing policies.

Consequently, availability restrictions were gradually lifted in the Nordic countries, which culminated in the licensed sale of medium beer in grocery stores in Sweden and Finland in 1966 and 1969 respectively. Furthermore, age limits for buying alcoholic beverages were lowered in all three Nordic countries. This reinforced the increasing long-term trend in alcohol consumption that could be observed throughout the Western world. This trend was widely believed to be a natural consequence of modernization that alcohol policy could not prevent without perverse effects.²⁰

In the Nordic countries serving regulations, selling practices and the individual controls exercised over problem drinkers were selective and unfair towards the working class, the rural population and women.²¹ The *second wave of liberalization* of the 1970s in Nordic alcohol policy incorporated

19 Peltonen, Matti (1991) 'Kieli vai kulttuuri? Väittely suomalaisesta viinapäästä keväällä 1948'. *Alkoholipolitiikka*, Vol. 56, 8–25.

20 Sulkunen, Pekka (1983) 'Alcohol Consumption and the Transformation of Living Conditions. A Comparative Study'. In Smart, Reginald G. (ed.) *Research Advances in Alcohol and Drug Problems*, Vol. 7. London: Plenum Publishing Corporation, 247–297; Sulkunen, Sutton, Tigerstedt & Warpenius 2000.

21 Järvinen, Margareta (1991) 'Kontrollerade kontrollörer – Kvinnor, män och alkohol'. *Nordisk alkoholtidskrift*, Vol. 8, 143–152; Peltonen 1991.

the total consumption approach as a reaction to such biases but also as a continuation of the civilizing policy. Although the TCM reacted against the rising overall consumption level and its harmful consequences (and was therefore a backlash movement as regards market and consumer freedom), it was ideologically liberal as it reacted against the discriminating and inequitable methods of the civilizing policy that still carried strong disciplinary overtones. It stressed solidarity and the need to sacrifice part of the consumers' freedom and convenience even among moderate drinkers for the benefit of the public good.

In contrast, *the third wave of liberalization* of Nordic alcohol policy from the early 1980s onwards emphasizes the romantic ethos of individual difference and happiness. It gives priority to individuals' desires over social needs. It became dominant later, when restrictions of the marketplace were again relaxed and a series of price and tax cuts began.

Sweden

The start of the first liberal wave in Sweden culminated in the discontinuation of the Bratt system in 1955. Paradoxically, this was considered a victory for the conservative temperance movement, which considered the system of personal monthly quotas to be a permissive alternative to total prohibition, and felt that the referendum of 1922 was a defeat for their cause.²² The Bratt system, even after its repeal, continued to have the support of the alcohol liberals, arguing that the personal allowance was, from the point of view of educating the Swedish people, much better than the personal control that replaced it, with blacklists, checks at purchase and other individual controls.²³

For the temperance folk, the repeal of the Bratt system was a double-edged sword. The consumption level increased rapidly, and a substantial tax increase was implemented as a counter-measure in 1957. Already at this point the Swedish temperance movement saw the reduction of total con-

22 Bruun, Kettel (1985) 'Maktens centrum – centraladministrationen'. In Bruun, Kettel & Fränberg, Per (eds) *Den svenska supen. En historia om brännvin, Bratt och byråkrati*. Stockholm: Prisma, 74–114.

23 Sulkunen 2000, 74.

sumption as the best policy line,²⁴ and still in the wake of new liberalization measures the argument was that ‘misusers are recruited from among moderate consumers – therefore zero consumption is best.’²⁵ Although divisions between conservative and more lenient wings of the temperance lobby – those close to the labour unions and students – were tense, the common ground was firm: less is better.

The last move of the first liberal wave in Nordic alcohol policy was again led by Sweden with its medium beer reform of 1965. Allowing medium-strength beer to be sold outside the monopoly in ordinary grocery stores was of course a controversial idea, but the justifications used to support it were strongly consensual. The civilizing alcohol policy that aimed to achieve a society without alcohol-related harm was felt to be discriminating against the working class, rural people, women, youth and minorities. The number of blacklisted people went up to 20 000, and however neutral the selection mechanisms appeared on the surface, the actual sales practices in the monopoly were not. On the eve of the reform, a media storm was raised by the Torvald Nilsson case. He was a construction worker who wanted to buy seven bottles of vodka in working clothes. He was given two bottles of wine. The next day he dressed up in a jacket, white shirt and a tie: no questions were asked about his vodka bottles. The justification of the reform was unanimously solidarity and equality first, reducing alcohol-related harm second.²⁶

A number of adverse consequences followed, notably an increase in the consumption level. The government appointed an expert committee, whose report was an amalgam of the continued civilizing harm-reductionism (‘deglorifying alcohol’) and a set of proposals to keep consumption low.²⁷ Although in this sense it was a backlash against the first wave of liberalization, the ideological principles of justification remained liberal and within the

24 Tigerstedt, Christoffer (2000) ‘Discipline and Public Health’. In Sulkunen, Pekka, Sutton, Caroline, Tigerstedt, Christoffer & Warpenius, Katariina (eds) *Broken Spirits: Power and Ideas in Nordic Alcohol Control*. Helsinki: Nordic Council for Alcohol and Drug Research (NAD), 135–152.

25 Sulkunen 2000, 74.

26 Sulkunen 2000, 76.

27 SOU 1974:92. *Alkoholpolitik: betänkande*. Stockholm: Liber Förlag/Allmänna förlaget.

pastoral regime of power. It employed measures of inclusion and solidarity that aimed at the whole population, not bad individuals.²⁸ From 1977 rules tightened for sales hours and alcohol serving in theatres and concerts, the number of monopoly shops was frozen, the medium-beer was repealed, and an advertising ban on alcoholic beverages was passed.

From 1980 onwards expert reports commissioned by the government declared the TCM as the official doctrine, repeated in later reports and preliminary work for legislation:²⁹ ‘The total consumption model needs to be theoretically developed and completed as a foundation for a comprehensive alcohol policy. The principal goal is to reduce total consumption.’³⁰ Like in Norway, the argument relied on both universalism and solidarity. Government reports in 1991 insisted that alcohol-related harm affect not only alcoholics but ‘all of us’. The question is about caring for our fellow citizens, and the more Swedish people drink, the more harm will be caused to the whole society. Even the contagion argument proposed by researchers was used:³¹ If moderate drinkers increase their consumption, the excessive users will find themselves in more situations where alcohol is used and therefore increase their consumption.³² In contrast to the earlier doctrine dominant in socialist discourse, attributing alcohol problems to bad social conditions – the so-called symptom theory that saw drinking-related misery only as a side effect of poverty and dissatisfaction – the causal connection was now made clear:

That the alcohol question should be placed within a social context does not mean that it is just an expression for dissatisfying social conditions. Alcohol plays therewith an independent role in creat-

28 Tigerstedt 2000, 104.

29 Samordningsorganet för alkoholfrågor (SAMO) (1980) *Om alkohopolitiken. Förslag från Samordningsorganet för alkoholfrågor*. Stockholm: Liber Förlag/Allmänna förlaget; Sutton, Caroline (1998) *Swedish Alcohol Discourse. Constructions of a Social Problem*. Uppsala: Studia Sociologica Upsalien-sia, 45, 100.

30 SOU 1994:24. *Svensk alkohopolitik – en strategi för framtiden*. Stockholm: Fritzes; quoted in Tigerstedt 2000, 105.

31 Sulkunen, Pekka (1976) ‘Drinking Patterns and the Level of Alcohol Consumption: An International Overview’. In Gibbins, Robert J., Israel, Yedy, Kalant, Harold, Popham, Robert E., Schmidt, Wolfgang & Smart, Reginald G. (eds) *Research Advances in Alcohol and Drug Problems*, Vol. 3. New York: John Wiley & Sons; Skog, Ole-Jørgen (1985) ‘The Collectivity of Drinking Cultures: A Theory of the Distribution of Alcohol Consumption’. *British Journal of Addiction*, Vol. 81, Issue 3, 83–99.

32 Sutton 1998, 104–119.

ing and exacerbating problems. Heavy consumption of alcohol is far from always a symptom of poor social integration.³³

Two factors concerning the actors in the Swedish case deserve special attention. First, the alcohol monopoly *Systembolaget* itself very prominently promoted the TCM. From about 1988 onwards it published several brochures for its customers on the importance of public retail monopoly and availability restrictions. One of them was titled: *Why Must We Suffer for the Sake of a Few Alcoholics, and Seventeen Other Questions*. One of these argued in a straightforward manner: 'The more alcohol that is sold, the more Swedish people lose...'³⁴

The man behind this policy was *Systembolaget's* Director General (1982–1999) Gabriel Romanus, a liberal (*Folkpartiet*) Member of Parliament, former Minister of Social Affairs, and an ardent supporter of restrictive alcohol policy, also internationally well-known in this role. The Liberal Party in Sweden has traditionally been the most active in temperance politics, and the fact that its representative was chosen to serve in the key position in the alcohol control system is a strong indication of the national concern about alcohol as a social and health problem. One reason why the principal commercial outlet for alcoholic beverages could take such a position against its own business interests was that *Systembolaget* only controlled retail sales, not wholesale or production. Its control policy position was a reaction to the liberal trend against state monopolies: it underlined the special and problematic nature of alcohol as a consumer item, and thus the importance of public control over its distribution.

The second factor that helped Sweden to adopt and maintain a strong adherence to the TCM was the role of researchers. The state commissions of 1974, 1980 and 1994 were manned not only by medical scientists but by epidemiologists, sociologists, a criminologist, and academic researchers of social work and social policy.³⁵ Evidence for the TCM itself cannot be ob-

33 SAMO 1980, 10, 29; quoted in Sutton 1998, 105.

34 Sutton 1998, 105.

35 Sutton 1998, 112–113.

served without statistical studies, and to be convincing, aggregate information of alcohol's harm and cost to the whole society is necessary.

The tenacity of the Swedish policy is further stressed by the fact that both Social Democrats and Conservative Governments have supported it, and therefore the Swedish alcohol policy has had strong parliamentary support. Even the third wave of alcohol policy liberalism, with radical romantic overtones stressing consumers' freedom and 'modernization' since the mid-1980s did not succeed in shattering the state-control of the market that the TCM implies.³⁶ The Swedish adjustment of alcohol regulations to comply with EU rules occasioned by the European Economic Area (EEA) Agreement from 1994, and full EU membership from 1995 was conservative, minimizing the necessary changes despite challenges against the monopoly system.³⁷

Norway

Norwegian alcohol researchers were among the first in the world to rediscover 'the Ledermann curve'. As early as 1972 elements of the TCM were introduced in a governmental report and it has had a dominant role in public policy documents ever since.³⁸ However, it is widely believed that the model had little impact on actual policies, only the justification changed.³⁹ In a governmental report from 1987, Norwegian alcohol policy is justified in the following way:

We know progressively more about the harmful health and social effects of alcohol – not only for the heavy consumers, but for each and every consumer and for the society as a whole. We should therefore much more than before direct the attention towards the collective consequences viewed from a public health perspective.⁴⁰

36 Sulkunen 2000, 84–85.

37 Ugland, Trygve (2000) 'European Integration and the Corrupting Gaps of the Systems.' In Sulkunen, Pekka, Sutton, Caroline, Tigerstedt, Christoffer & Warpenius, Katariina (eds) *Broken Spirits: Power and Ideas in Nordic Alcohol Control*. Helsinki: Nordic Council for Alcohol and Drug Research (NAD), 185–198.

38 Hauge, Ragnar (1998) *Norsk alkohollovgivning gjennom 1000 år*. Oslo: Rusmiddelsdirektoratet, 238–239.

39 Hauge 1998, 239.

40 Our translation. Sosialdepartementet [Ministry of Social Affairs] (1987) *Stortingsmelding nr 17 (1987–1987) Alkohol og folkehelse*. Oslo: Sosialdepartementet, 5–6.

One influential view is that Norwegian alcohol policy has always been based on the principle of solidarity even before the TCM was introduced, because of the strong presence of the temperance movement.⁴¹

In contrast to Finland and Sweden, Norway had a kind of civilizing wine policy in place already during the 'prohibition' that only involved spirits and fortified wine. To illustrate the more pragmatic attitude towards beer and table wine, the state alcohol monopoly – *Vinmonopolet* – was established by a parliamentary decision in 1922, in the midst of the prohibition period between 1919 and 1926.

However, the same concern about alcohol problems that was felt in Finland and Sweden during the second backlash wave of liberalism, led to an advertising ban in 1975. On the other hand, no major response to the rising consumer culture during the third wave of liberalization occurred, until tax reforms and the adjustments to EU legislation in connection with Norway's adoption of the EEA Agreement in 1994. However, these changes aroused little political fervour. The negotiations between Norway and the EU concerning the retail monopoly were cautious on both sides; to question *Vinmonopolet's* role as protector of public health and social welfare would have issued negative signals to an already EU-sceptic population that was thinking in terms of national sovereignty and self-determination versus EU domination.⁴²

The widely accepted interpretation of researchers is that Norwegian alcohol policy has been strongly influenced by the nationalistic temperance movement and its presence across the political spectrum, the exception being the utmost neo-liberal right within *Høyre* and the populist *Fremskrittspartiet*.⁴³ The expert doctrine represented by the TCM has however been, albeit strongly supported by the research community, far less important than in Sweden as a guideline in actual policy-making. Also, the liberalization that took place in Norway was gradual rather than abrupt like in

41 Brofoss, Knut (1996) 'Alkoholpolitikken i Norge'. In Pedersen, Willy & Waal, Helge (eds) *Rusmidler og veivalg*. Oslo: Cappelen Akademisk Forlag, 34–38.

42 Uglund 2000, 129.

43 Hauge, Ragnar (1986) *Alkoholpolitikken i Norge*. Oslo: Statens Edruskapsdirektorat; Hauge 1998; Tigerstedt 2000, 105; Sulkunen 2000, 86.

Sweden and Finland. This incremental logic is illustrated by the fact that, despite numerous amendments, the Alcohol Act of 1927, which was established immediately after prohibition, remained in effect until 1989, when a new comprehensive Alcohol Act was adopted.

Finland

Finnish researchers started to work on the TCM as a reaction to an alcohol policy crisis created by the first, civilizing wave of alcohol policy liberalization.⁴⁴ Following Sweden's example, medium beer was released from the state monopoly to grocery stores in 1969. In addition, rural municipalities were allowed to have restaurants and monopoly stores in their area (with the consent of the local council), public drunkenness was decriminalized, advertising rules were relaxed and some other minor reforms were implemented. The consequent rise in the consumption level, from a little over two to almost six litres of 100 per cent alcohol per capita within a few years surprised everyone. Beer gradually became a national drink, instead of vodka; wine consumption stayed at a low level, but unruly behaviour in the streets increased, arrests for drunkenness did not go down and many other harm indicators showed alarming trends.

The response among the research community was to turn to the TCM. With some trouble the management of the monopoly, as well as the ministries controlling it, were convinced of the need to control the total consumption; the number of outlets was frozen, price increases (moderate) were implemented, the advertising ban was introduced in 1975, and in general, attitudes towards alcohol liberalism became more critical. About 70 rural communities withdrew their consent to sell medium beer in their area.⁴⁵

A new state committee was commissioned to make a long-term plan, led by Heikki Koski, Director General of the monopoly, *Alko*.⁴⁶ This committee was the only one in Finland who explicitly drew on the TCM as the theoretical guideline for its proposals. They included price increases, lower-

44 Sulkunen & Warsell 2012.

45 Sulkunen 2000, 84.

46 Alkoholikomitea [Alcohol Committee] (1978) *Alkoholikomitean mietintö*. Helsinki: Valtion painatuskeskus.

ing the alcohol content of beers (there were three classes: 'mild' beer below 2.25 per cent vol., medium beer below 4.7 per cent, and strong up to 5.2 per cent), maintaining the ban on advertising, freezing the number of outlets and some other minor measures. None of these were implemented – the third wave of alcohol liberalism was already setting in, together with the turf of deregulating the credit market and the consequent consumption boom.⁴⁷ The alcohol policy climate was increasingly opposed to regulation, starting from the media and gradually turning into popular opinion and also policy.

The opinion favouring the release of wine from the monopoly went up from a quarter to two thirds 1984–1996, the consumption level went up from 7.9 to 9.5 litres in 1985–1990, the number of fully-licensed bars and restaurants went up from 1585 to 4274 in 1980–1997, monopoly shops were modernized, and advertising was reintroduced in 1995.⁴⁸ The EU negotiations resulted in a drastic reorganization of the monopoly, which now retained only its retail functions, separated from production, imports and wholesale. Medium beer was allowed in kiosks and service stations, at sports occasions, regulations on serving alcohol as well as selling hours were relaxed. The sale of 'wine' from factory outlets was allowed.⁴⁹ Many of these changes in excess of the legal EU requirements were made directly in the parliament, without preparatory work, in a spirit of revolutionary freedom following the victorious referendum to join the EU, which for supporters meant modernization, cosmopolitanism, and a final blow to Russo-friendly foreign policy. After these events, the TCM has hardly been mentioned in governmental policy programmes.

Comparison between Sweden, Norway and Finland

The overall picture is that alcohol policy changes in Norway have been gradual and perhaps even less politicized than in Sweden and Finland. Sweden has experimented with reforms both ways, Finland going consistently

47 Vartiainen, Juhana (2011) 'The Finnish Model of Economic and Social Policy – From Cold War Primitive Accumulation to Generational Conflicts'. In Mjøset, Lars (ed.) *The Nordic Varieties of Capitalism*. Bingley: Emerald Books, 53–88.

48 Sulkunen 2000, 87.

49 Ugland 2000.

towards a free market. The TCM has been and still is an important policy guideline in Sweden but relevant only in Finnish and Norwegian alcohol research, not in policy.

Two related factors seem to explain the differences. First, the role of the temperance movement had almost disappeared in Finland at the moment when the welfare-state based TCM was introduced. The movement was incorporated into political parties and lost autonomy as a stake-holder in specific alcohol policy issues. It took more than 10 years before the remaining bodies of temperance organizations realised that the TCM might serve their cause, but then it was too late. This is important, because the Finnish power structure is very dominated by corporatist bodies rather than the parliamentary institutions. The employers, labour unions, the Finnish Bank, together with the sitting government, have played decisive roles in economic and social policy. In contrast, lifestyle policies in general have not had a strong stake-holder structure at the national level. Issues around alcohol policy have either been subsumed to other policy concerns such as state finances, western orientation in foreign policy, and other fragmented policy interests such as the media and sports on advertising and sponsoring; decentralized production, imports and wholesale interests; and the food retail structure based on two major chains covering over 80 per cent of the total turnover. The alcohol monopoly has lost its role as a central national actor and the research expertise it once had at its disposal in the policy field has been removed and decentralized.

The contrast with Norway is interesting. Whereas in Finland, the public health lobby in the alcohol issue was weakest when it was most needed in the middle of 'the crazy 1980s', the temperance movement has remained an active stake-holder role in Norway within the party structure itself. Weak majority coalitions, even minority governments during a long period of 1986–1997 were unwilling to rock the boat, especially as the alcohol policy issue was closely connected with the EU membership question that divided all major parties.⁵⁰ Thus there has been less need for using the TCM as a

50 Mjøset, Lars & Cappelen, Ådne (2011) 'The Integration of the Norwegian Oil Economy into the World Economy'. In Mjøset, Lars (ed.) *The Nordic Varieties of Capitalism*. Bingley: Emerald Books.

policy guideline to support the restrictions to the overall mild liberalization trend domestically. The increasing number of outlets, especially in rural areas, has resulted from local competitive interests, not from political decisions at the national level. However, the Norwegian temperance movement is still very active in its promotion of the TCM internationally. For instance, the Norwegian Policy Network on Alcohol and Drugs (ACTIS) – which replaced the Norwegian Temperance Alliance (*Avholdsfolkets Landsråd*) when it was dissolved in 2003 – has maintained a permanent lobby office in Brussels since 1995, due to the strong impacts of the EU integration process on Norwegian alcohol policies.⁵¹

Sweden, therefore, is the only Nordic country where the TCM has actually served significant policy goals. Two factors stand out as explanations for this. First, the temperance movement, also spread across the political spectrum, has maintained its stake-holder role at national level politics. Secondly, the alcohol policy debate has remained in parliamentary hands at the national level, infused with independent expert knowledge through the political state committees that actually participate in the formulation of policy. An important feature of this expertise is that it has largely been represented by the medical, epidemiological and social science community in the policy-making bodies and activities. For example, in the 1980s about every third medical doctor signed a petition to re-introduce the rationing system in order to reduce alcohol-related harm and keep the consumption level in control.⁵²

The French case

If the TCM has been difficult to implement in the Nordic countries with strong temperance traditions, unruly drinking patterns, and a centralized welfare state exercising pastoral power over the population, it might be even less likely that a country like France with a much longer history of daily alcohol consumption, an immense alcohol and serving industry and an in-

51 Uglund, Trygve (2011) *Alcohol on the European Union's Political Agenda: Getting Off the Policy Roller-Coaster?* Oslo: Norwegian Institute for Alcohol and Drug Research.

52 Tigerstedt 2000, 98–99.

dividualistic, state-sceptic culture, would adopt such an approach to care for the well-being of its citizens. In circumstances where the availability of alcohol is very high and it is present everywhere, it might be expected to be very difficult to demonstrate that policy can have an impact on consumption, and, even more difficult to convince consumers that it can reduce harm.

Nevertheless, in September 2001 the French Minister for Health, Bernard Kouchner, presented a new alcohol action plan, based on the idea that a reduction in the total consumption of alcohol is required if alcohol-related problems should be minimized. This policy document was not unique. It reflects and redefines a long public health tradition in the French alcohol policy arena. As is well known, the epidemiological basis of the total consumption framework was originally laid in France in the 1950s in the work of the epidemiologist and demographer, Sully Ledermann.⁵³ Since then, it has repeatedly been floated as the policy argument in alcohol control efforts, disappearing occasionally only to surface again. Minister Kouchner's policy paper continues the legislation pressed through the parliament in 1989–1991 by Claude Évin, then Minister for Social affairs. The so-called *Loi Évin*, the Évin Law, marked the most radical restrictive reform in alcohol and tobacco policy in Western Europe in the second half of the twentieth century, aiming at a quasi-total prohibition of advertisement and sponsoring, and introducing serious cuts in the availability of these products, especially for young people. The law created an enormous public debate in the media from the preliminary stages of the legislative process until the evaluation report of 1999, which declared that the law was a legal failure and needs to be rewritten completely.⁵⁴ Still the law continues to be implemented, with possibly reinforcing effects on a development in which alcohol consumption has been declining and awareness of alcohol-related risks increasing for over a half-century.

53 Ledermann, Sully (1956) *Alcool, alcoolisme, alcoolisation*. Institut national d'études démographiques. Paris: Presses universitaires de France.

54 Commission nationale d'évaluation (1999) *Évaluation de la Loi Évin*. Paris: Commission nationale d'évaluation.

The historical background

Although still amongst the leading alcohol consumers in the world, the level of consumption by the French has declined since the 1950s. This was also the period when the first initiatives to control the consumption were taken at the political level. During his short period as Prime Minister (June 1954–February 1955), Pierre Mendès-France introduced more than 20 decrees and proposals related to the objective of reducing the production and consumption of alcohol in the French society. For instance, his government proposed new restrictions in relation to the *bouilleur de cru* system, a set of fiscal measures to encourage production of sugar instead of alcohol, and regulations to favour milk in relation to wine. A government bill to reinstate a ban on the advertising of *pastis* and whisky was presented to the Parliament, as was a proposal to ban the sale of aperitifs between five and 10 o'clock in the morning.⁵⁵

Perhaps most important in the long run, Mendès-France established the High Committee for the Study and Information on Alcoholism (*Haut Comité d'Etudes et d'Information sur l'Alcoolisme*) with Robert Debré as its president in 1955. This committee was an agency of the Prime Minister, and its main tasks were to provide information on alcohol-related problems, to fund research and to provide initiatives in order to reduce alcohol abuse in society.

All in all, the Mendès-France actions represented a comprehensive approach towards the fight against alcoholism in France. Although most of his proposals were defeated, the attention concerning alcohol related problems was raised, and this attention was institutionalized through the High Committee for the Study and Information on Alcoholism. Public awareness about the risks related to alcohol use increased and has ever since been an important factor in the historical decline in alcohol consumption in France.⁵⁶

55 Prestwich, Patricia E. (1988) *Drink and the Politics of Social Reform: Antialcoholism in France Since 1870*. Palo Alto, CA: The Society for the Promotion of Science and Scholarship.

56 Sulkunen, Pekka (1989) 'Drinking in France 1965–1979. An Analysis of Household Consumption Data'. *British Journal of Addiction*, Vol. 84, No. 1, 61–72; Aigrain, Pierre, Boulet, Daniel, Lambert, Jean L. & Laporte, Jean P. (1991) *La consommation du vin en France en 1990*. Montpellier: INRA.

Despite these initiatives, the public health interest in relation to alcohol did not manage to make a consistent and continuous impact in the French society, as the economic and market interests seemed to dominate the arena during the next decade. However, the public health interests never disappeared completely, and their balance with commercial and economic interests has been unstable. The Minister for Social affairs, Maurice Schumann, expressed his opinion on the subject in 1968, when he claimed that 'alcoholism is the worst and most poorly fought of all our social diseases [*fléaux*]'. Legislation allowing random breath testing in traffic in the early 1970s was the most important – and probably effective – consequence of this concern.⁵⁷

The public health point of view became more visible again during the 1980s. On request from President Giscard d'Estaing, Professor Jean Bernard presented a new report on alcohol prevention, education and treatment in 1980. Since a total ban on alcohol advertising at that time was not a viable option, the legislation that was proposed merely intended to regulate alcohol advertising in a manner that had already been implemented on tobacco a few years earlier.

The Évin Law

Law no. 91–32 of 10 January 1991 is the official name of what has become known as the Évin Law. Its objective is to reduce the harm related to tobacco and alcohol in society. The Évin Law focuses on advertising and sponsoring, education, as well as the supply side in relation to tobacco and alcohol products. Its background documentation refers explicitly to the need to reduce alcohol consumption among the whole population.

The law has been in effect since 1 January 1993. It prohibits direct or indirect advertising of alcoholic drinks on television and cinema, in stadiums, public and private sports grounds, swimming pools, competition arenas and all areas used by youth associations or for education. Advertising was authorized in the original law on radio only within certain specified time slots, on billboards or notices only in zones of production. Advertising is permit-

⁵⁷ Prestwich 1988.

ted, however, within sales outlets and in the press, except for publications aimed at young people.

The content of the advertising messages is strictly limited to product information concerning the alcohol content, origin, the categorization (*denomination*), ingredients, the name and address of the producer, the agents and distributors, modalities of merchandizing (packaging etcetera), and the manner in which it is supposed to be consumed (*mode de consommation*).⁵⁸ Specifically, the permitted announcements must not include any encouragement to minors. It is forbidden to give, distribute or send documents or objects naming an alcoholic drink to those under age. Lastly, advertisements for alcoholic drinks must include a health warning stating that alcohol abuse is dangerous to health.

A specific aim of the legislation was to avoid the possibilities of indirect advertising that had been extensively used under previous legal restrictions. Sponsoring involving advertisements for tobacco and alcohol products was completely banned, which violated serious interests in mass media sports, especially soccer and Formula 1 racing, but was felt necessary because of the widespread use of indirect advertisement before.

In the controversy, the alcohol lobby argued that tobacco and alcohol should not be combined in the same law since the nature of the problem is completely different in the two cases. The wine lobby attempted to exclude French quality wines (*appellation d'origine contrôlée* – AOC) from the law.⁵⁹ The negotiations that ensued introduced a number of compromises and minor amendments in the law that later proved fatal to its intent. Also, a number of issues were to be ruled by the ministry later on by decrees, which also proved to be a problem for the implementation of the law. The advertising industry announced that the limits of the law would be pushed as far as the letter would allow as regards the content of the regulations.⁶⁰

58 Haut Comité d'études et d'information sur l'alcoolisme (1990) *Actualités*, No. 3–4.

59 Sénat. *Compte rendu officiel*, No. 60, 12 October (1990). Assemblée Nationale. *Seconde session ordinaire de 1989–1990 (92e séance)*. *Compte rendu integral*, 2867.

60 Bureau de Vérification de la Publicité. 16 April 1992.

The campaign

From the point of view of this chapter, the process that led to the adoption of the law was even more interesting than the outcome. The initiative came from five prestigious professors of medicine, Gérard Dubois, Claude Got, François Grémy, Albert Hirsch and Maurice Tubiana. Their campaign was carefully planned, and the outcome has been presented as the first lobby victory within the public health sector in France.⁶¹

The background of their initiative can be traced back to 1984, when the High Committee for the Study and Information on Alcoholism presented a proposal for a ban on the advertising of alcoholic drinks directed towards adolescents. However, possible restrictions on alcohol advertising were challenged by the new media situation. As a response to pressure from the new commercial television channels, the restrictions of beer advertising were relaxed in 1985 and again in 1986. Then Prime Minister Jacques Chirac announced that although alcohol advertising could be banned in public television by an administrative decision, a ban in the commercial TV channels would require a new law.⁶² In 1987, this initiative was formalized in a new law (*Loi n° 87-588* 30 July 1987), often referred to as the *Loi Barzach* after the then Minister for Health, Michèle Barzach, herself a medical doctor by training. This law banned alcohol advertising on TV for the first time in France, but made an exception for beer.

Because beer advertising was still allowed, the five professors were not content with this law, arguing that the 'dangerousness of alcohol does not depend on the amount of water that surrounds it'. Professors Dubois and Got were at that time members of the High Committee for the Study and Information on Alcoholism. Claude Got left the High Committee as a protest, which received considerable attention in the media. Together with Grémy, Hirsch and Tubiana they decided to launch a campaign to get a new and more restrictive law on alcohol advertising. The medical professional societies, the deans of medical faculties and important personalities among the medical professions including some Nobel Prize winners joined in to make

61 Personal interview with Gérard Dubois on 12 October 1992.

62 Personal interview with Laurence Nart (*Direction générale de la santé*) on 9 October 1992.

it known to the Minister for Health that alcohol is still the number one public health problem in France.⁶³ This was done in the form of a petition that also included a subscription to collect money for paid advertising on the issue.⁶⁴

When Claude Got was commissioned to prepare a new policy paper on the prevention of AIDS in 1988, he decided with his close colleagues to also address public health issues that were regarded as even more important, namely traffic accidents, smoking and alcoholism.⁶⁵ The process towards the Évin Law picked up speed in 1989, when the five professors were commissioned to prepare a white paper on these three issues by the Minister for Social affairs, Claude Évin. In this paper, they raised the need for firmer actions in order to reduce the harm resulting from alcohol consumption. Their proposal for the new legislation included a wide range of public health issues: screening for certain cancers, reducing the number of traffic fatalities, and excessive use of psychotropic drugs, which is high in France.

The Minister for Social Affairs accepted the proposals from the five professors on tobacco and alcohol, and decided to present a new law before the Parliament in May 1990. The new law was presented using the procedure of urgency. After a very intensive debate on alcohol – the legislation concerning tobacco was less controversial – the law was passed by the National Assembly on 27 June 1990, and with some modifications by the Senate on 16 October the same year. The Senate, however, excluded the restrictions on alcohol advertising. The revised text then went back both to the National Assembly and the Senate, where the final text was adopted in December 1990 and became law in January 1991. In the Assembly, the Socialist Party voted in corpore for the legislation presented by the socialist minister, but in the Senate the socialists were first opposed. The communists were against the legislation throughout the process, whereas the bourgeois parties were divided. Despite the amendments that were adopted in this process, the final legislation was for the most part in line with the proposal of the five professors.

63 Personal interview with G. Dubois on 12 October 1992. Active support was given by the internationally reknown and prestigious professor of haematology and cancerology Jean Bernard, Member of the Academie de France and Academie des sciences. *Le Monde*, 18 April 1990.

64 Personal interview with G. Dubois, 12 October 1992.

65 Personal interview with Claude Got on 29 October 1992.

An important part of the campaign was an article bearing the title 'No to a ministry of disease!' that appeared in *Le Monde* the day after the white paper was published.⁶⁶ The authors claimed that 'the government should not hesitate in implementing a public health policy, and not delay measures that have a general interest and the support from the majority of the population and of the politicians'. The media approach was combined with active lobbying in the political arena. An opinion poll commissioned in 1989 by the Catholic newspaper *La Croix l'Événement* that opened their columns to the campaign showed that 69 percent of the population supported a ban on tobacco advertising, and 61 per cent supported a ban on alcohol advertising.⁶⁷

The total consumption framework was central in the argumentation of the five professors, and a number of references were made to the work of Ledermann in the background material, as well as in the document prepared by the Ministry of Social Affairs to introduce the legislation to the public.⁶⁸ The universalism of the population argument was an important part of the campaign. The restrictions on advertising and availability that they proposed in the name of the public good concern everyone in the same way. It is important that especially the media to which all are exposed regardless of their will should be free of advertising. A further aspect of the universalism is the solidarity argument involved. The professors published a second article just before the bill was presented to the Assembly, writing that:

The 100 million premature deaths caused by alcohol and tobacco are not randomly distributed. The life expectancy of a manual worker at the age of 35 is eight years less than his male counterpart belonging to the upper middle class. These inequalities are largely explained by the superior capacity to manage alcohol- and tobacco-related risks

66 Dubois, Gérard, Got, Claude, Hirsch, Albert, Grémy, François & Tubiana, Maurice (1989) 'Non au Ministère de la Maladie!'. *Le Monde*, 15 Nov.

67 Dubois, Gérard, Got, Claude, Grémy, François, Hirsch, Albert & Tubiana, Maurice (1990) 'État est en retard sur l'opinion'. *La Croix l'Événement*. 10 Jan.

68 Ministère de la Santé et de la Protection sociale [Ministry of Social Affairs] (1989) *L'action politique dans le domaine de la santé publique et de la prévention. Propositions de Gérard Dubois, Claude Got, François Grémy, Albert Hirsch et Maurice Tubiana*. Paris: Ministère de la Santé et de la Protection sociale.

by social groups that are in a favourable familial and educational environment.⁶⁹

In their public articles, the professors employed the rhetorical format of the pending narrative, placing themselves on the side of the public good against the threatening private interests. The scene is set, the characters of the plot are positioned, the task of the protagonist is defined, but the solution of the story is pending⁷⁰ – and depending on the support of the public: the readers.⁷¹ However, they also wanted to get around the political elite, resorting to the classical method of French intellectual movements since the Dreyfus Affair – the petition:⁷²

The group prepared, we had an idea, and since we had the support of the Nobelists etc., we said, yes, let's make a petition to the people: destroy the politicians! The politicians are intermediaries, elected by the people. When you turn directly to the people, you ignore the politicians, which is for them the most disagreeable thing. So we made an appeal to people in *Le Monde* asking them to subscribe and to send us money.⁷³

The new and strange aspect of this self-definition is not that intellectuals represent themselves as vanguards of the people; what is striking is that this time the vanguards did not come from the margins of intellectual life – the literary circles and the artists, but from what according to Pierre Bourdieu's analysis is the most legitimate centre of the intellectual field.⁷⁴

But the margins were against. A group of social workers who were at the time in the process of establishing their own national network of '*alcolo-*

69 Dubois, Gérard, Got, Claude, Hirsch, Albert, Grémy, François & Tubiana, Maurice (1990) 'Un honneur pour notre démocratie'. *Le Monde*, 29 Mar.

70 A pending narrative is a semiotic structure where the setting of the story is ready, with threats, objectives, and heroes, but the narrative does not unfold to the end, as if the solution would depend on the support of the audience. Pending narratives are typically used in persuasive texts such as editorials.

71 Sulkunen, Pekka & Törrönen, Jukka (1997) 'The Production of Values: The Concept of Modality in Textual Discourse Analysis'. *Semiotica*, Vol. 113, Issue 1/2, 43–69.

72 Ory, Pascal & Sirinelli, Jean-François (1986) *Les intellectuels en France de l'Affaire Dreyfus à nos jours*. Paris: Armand Colin.

73 Personal interview with G. Dubois on 9 October 1992.

74 Bourdieu, Pierre (1986) *Homo Academicus*. Cambridge: Cambridge University Press.

gists' as a counterbalance to the medically dominated and temperance-affiliated treatment community, decided to rally with the industry and the media that opposed the law.⁷⁵ They considered the initiative to be hypocritical, and argued that it was paternalistic to attack the advertising and availability of alcohol, while the real issues of poverty, exclusion and education were not addressed. The working class and ordinary people should be educated and given the opportunity to appreciate wine and to avoid the risks of alcoholism.⁷⁶ The group calls itself *Alcoologie plurielle* and publishes a review bearing that name. The review and other activities of the group are supported financially by the French distilling industry, but it is also significant that the 'pluralism' of the group contrasts with the traditional medically-oriented French anti-alcoholism movement Association Nationale de Prévention de l'Alcoolisme (ANPA) and its commitment to total abstinence in treatment. *Alcoologie plurielle* collaborates closely with ex-drinkers' associations but is in favour of moderation rather than abstinence. The group argued that the Évin Law is scape-goating the producers, the advertising industry and the drinkers, and is not based on firm evidence on the impact advertising has on drinking problems; rather, it represents neo-prohibitionism. Instead, alcohol advertising should be taxed to support treatment institutions and self-help organizations. Emphasis should be placed on regional rather than national structures and institutions.⁷⁷

In sum, the Évin Law was a victory for the public health lobby over the alcohol and advertising industries, and France has adopted the most restrictive legislation on alcohol advertising in the EU. Like the beverage laws that were adopted by the Mendès-France government (*Code de Boissons*), the public health interests had won a more or less unexpected victory. The campaign fought by the five professors of medicine was crucial in this process, infused with references to the values of the modern welfare state: universalism, solidarity and justice as well as science and health.

75 A counter 'manifest' was signed and published in July 1990 by the Breton regional activist G. Caro and by P. Zolotareff, together with a number of psychiatrists, treatment personnel and some social scientists.

76 Personal interview with P. Zolotareff on 15 October 1992.

77 'Loi Évin – le débat se poursuit'. *Alcoologie Plurielle*, No. 9. Nov. 1990, 6–13.

Attacks and resilience

The Évin Law has been highly controversial throughout its existence, and its implementation has been systematically maimed not only by the alcoholic beverage industries, but, to an even higher degree, by advertising and the media. One of its immediate effects has been to deprive the press of about one fifth of its advertising revenue.⁷⁸

With respect to alcohol, the controversies over the Évin Law have led to a number of important modifications following lobbying pressures. The legislation has been watered down in relation to alcohol advertising, distribution and sponsoring. The evaluation, much delayed from what was intended, argued that the law is excessively ambiguous and leads to a waste of resources in continuous court cases on what is and what is not allowed in alcohol advertising.

The initiative by Health Minister Kouchner – himself a medical doctor and co-founder of *Médecins Sans Frontières* (MSF) – in 2001 was a decisive step towards consolidating the Évin law, suggesting that the established objective of promoting ‘moderate alcohol consumption’ should be replaced by ‘low alcohol consumption’. The argument is based on the recommendations of the WHO and scientific literature. It claims that the idea of moderate drinking has to be abandoned because this notion allows individuals to define for themselves what is moderate drinking. These individual definitions are said to be too often above what is epidemiologically defined as low risk. The traditional focus on problem drinkers must be replaced by a ‘new focus’ on speeding up the process of reducing the total consumption and on heavy drinking occasions. And furthermore: To speak to the total population in order to reduce the total consumption does not mean to address an abstract population but to put into place means which are aimed at different segments of population and its different consumption patterns.⁷⁹

The Évin Law is assumed to play a key role in connection with this new strategy, and the ambition is to strengthen the law. It is claimed that the ideas behind the Évin Law are good, but it has not worked practice. The

78 Dorozynski, Alain (1995) ‘France Dilutes Tobacco and Alcohol Advertising Ban’. *British Medical Journal*, Vol. 310, Issue 6985, 962.

79 *Stratégie d’action alcool. Stratégie d’action alcool: Intensifier la prévention et le traitement des problèmes de santé liés à la consommation d’alcool*. Paris: Direction générale de la Santé, 2001.

response to the evaluation report of October 1999, which underlined the incoherence between the legislative dispositions and the present regulations were to strengthen the law by eliminating the number of exceptions in the area of publicity within sports, as well in the fields of culture and science.⁸⁰

The arguments presented in favour of the Évin Law not only rely on the TCM but, even more interestingly, closely resemble the rhetoric of Pastoral power, especially the principles of universalism and solidarity. The essential factor in its success was that it was backed by the expert authority of the medical community. The medical community has always been in an important role in promoting that awareness, ever since the foundation of the French association against the abuse of alcohol in 1872. Like in Sweden the 'medicalization' of the problem did not first and foremost concern treatment but prevention. In France, the focus of attention was placed especially on the *bouilleurs de cru* (traditional distillers) and the cheap alcohol that they made available to the people.⁸¹ The Évin Law successfully maintained the health promotion image of a restrictive alcohol policy by combining alcohol and tobacco.

The Évin Law marks, however, an important change in the French debate over alcohol. In the earlier phases of its history, this conflict has been very complex politically. The medical profession has not been prone to turn towards socialism, not even in the social democratic sense. Neither has the socialist party and even less the French communist party been unanimous in its support of a public health-oriented alcohol policy. On the contrary, the socialists have had a stronghold in the viticulture regions, and consequently their attitudes towards restrictive attempts have tended to be negative. The process around the Évin Law has markedly changed this. Like in the Nordic countries, alcohol policy has become a left-right political issue only in the course of the last quarter of the twentieth century. This may make it even more vulnerable to political tides than before.

80 Stratégie d'action alcool 2001.

81 Nourrisson, Didier (1987) *Alcoolisme et antialcoolisme en France sous la Troisième République*. Vol. 2. Paris: Haut Comité d'études et d'information sur l'alcoolisme.

Conclusions

The comparisons we have made in this chapter concerning the Total Consumption Model in alcohol policy demonstrate that the viability of the public health approach in lifestyle regulation policy depends not only on epidemiological arguments *per se* but on the match between the social philosophy in which it is formulated and the political context in which it is applied. The public health concern in the alcohol question has for long been severe in France, and it was strongly surfacing in the Nordic countries in the crazy 1980s, when consumption levels were already high and rising still. Yet the TCM gained force only in France and Sweden, among the countries studied in this chapter. In Norway it was strong among researchers but less needed in policy implementation, since the anti-alcohol attitudes continued to be built into the political apparatus, amalgamated with the EU issue. In Finland, the corporatist power structure has tended to downplay the prominence of lifestyle regulation policy at the expense of economic and interest-based social policy concerns. The parliamentary political structure has been weak, leaving the alcohol field open to particular interest lobbies precisely when the public health argument was most needed. Even the parliament was carried away by the liberal gusto of the crazy 1980s, when it passed the reforms of the alcohol regime to adapt it to the EU-membership in 1994.

The population argument is part of the 'bio-political' discourse that has been characteristic of modern national societies in the course of the twentieth century. The responsibility of the state has been not only to correct deviant individuals but to place emphasis on the public good, the well-being of the population, solidarity, and the values of rational and scientifically-based central planning. In the French case, the attractiveness of the population argument and its success in justifying the initial formulations of the Évin Law was based on two of its properties. Firstly, it holds an expert position – only research can provide the necessary evidence on the relationship between the number of deaths and the consumption of alcohol in the population. Secondly, it appeals by its universalism, and by the argument of solidarity that it implies. It applies to every citizen in the same way by restricting the choice itself, and only makes an argument about the consequences of drinking at

the population level rather than against indulging in the pleasures of drinking by individuals. Both of these values are well adapted to contemporary modern and pluralistic societies, where it would be very difficult to agree on whose drinking and what kind of drinking should be permitted or rejected, and where the calculation of risks rather than guarding over behaviour is the proper role of experts.

But the comparisons also show that these two aspects of the epidemiological argument are also its weaknesses. The statistical relationship between total consumption and the prevalence of problems is not obvious to the public, and evokes the issue of trust in a world impregnated with suspicion for hidden agendas. The struggle against total consumption is never only a technical matter but always also involves priorities, and some priorities necessarily imply a sacrifice of others. Pastoral power implies the notion of the public good and its priority over private gain. The idea of the public good can only be enforced if it is made to appear as the will of the nation through parliamentary processes, and the population becomes not only the object of governmental power but also its source. The temperance history at the turn of the century therefore does not explain the success of prioritizing public health in this matter, unlike the liberalism of the Finnish case, and the determination of the French policy show. Rather, it seems to matter to what extent public health experts and advocates are able to join forces at the national level in the central institutions of parliamentary power. The fragmentation of the Finnish corporatist stake-holder structure and the parliamentary structure in Sweden and France are extreme points on a scale.

The similarities between France and Sweden documented in this chapter can also be identified in their relationships with the EU. It has for instance been illustrated how the French and Swedish governments have actively supported each other in discussions and disputes over alcohol policy questions at the EU-level.⁸²

Our analysis shows that the conditions for the successful use of the TCM are unique, precarious and probably exceptions, rather than the rule in the contemporary world. On the other hand, French public health policy shows

82 Ugland, Trygve (2003) 'A Case of Strange Bedfellows in the EU: An Institutional Perspective on the French-Swedish Cooperation on Alcohol Control'. *Scandinavian Political Studies*, Vol. 26, No. 3, 269–286.

that there is no absolute reason why the values of solidarity and the public good could not stand up to private interests and individualism even today, but there is no guarantee of their success either.

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The return of happiness – the end of utopia? Rankings of subjective well-being and the politics of happiness¹

CARL MARKLUND

Introduction

In July 2011, the General Assembly of the United Nations unanimously adopted Resolution 65/309. Entitled ‘Happiness: towards a holistic approach to development’, the Resolution recognized ‘the need for a more inclusive, equitable and balanced approach to economic growth’ with the aim of promoting ‘sustainable development, poverty eradication, happiness and well-being of all peoples’ in line with the Millennium Development Goals. Member States were invited to elaborate measures that can better capture the importance of the pursuit of happiness and well-being with a view to guide future public policy. The Resolution also called upon Members States as well as regional and international organizations to develop new indicators and to share information on these at upcoming sessions of the UN General Assembly.²

Following the aims spelled out in the Resolution, the world’s first *World Happiness Report* was released in early April 2012. Commissioned by the ‘United Nations Conference on Happiness’ – also a global first – the report begins by noting that ‘happier countries tend to be richer countries’. According to the report, the happiest countries in the world are clustered in

1 The author wishes to thank Anna Alanko, Nicholas Aylott, Inga Brandell, Yonhyok Choe, Pauli Ket-tunen, Klaus Petersen, Hannele Sauli, Varda Soskolne, Michael Kuur Sørensen, and Jaakko Turunen for valuable comments and critique on an earlier draft of this chapter.

2 United Nations (2011) Resolution 65/309. Online. Available HTTP: <http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/65/309> (accessed October 2012)

Northern Europe, with Denmark, Norway, Finland, and the Netherlands at the top. The least happy countries are all in Sub-Saharan Africa, with Togo, Benin, Central African Republic, and Sierra Leone registering the lowest self-reported happiness.³

But it is not just wealth that makes people happy, the report underlines: Political freedom, strong social networks, and absence of corruption are – if taken together – more important factors than income in explaining well-being differences between the top and bottom countries, according to the authors. At the individual level, good mental and physical health, job security, and stable families are crucial, as well as having ‘someone to count on.’⁴ ‘Behaving well’ makes people happier, too. In addition, the report also tracks differences between different groups with regard to happiness. In advanced countries, for example, women are generally happier than men, while the situation is more mixed in poorer countries. Happiness is lowest in middle age. The report confirms that mental health is the biggest single factor affecting happiness in any country. Yet, only a quarter of mentally ill people get treatment for their condition in advanced countries and still fewer in poorer countries.⁵

On average, the report states, the world has become ‘a little happier in the last 30 years.’ However, as living standards rise, self-reported happiness has increased in some countries, but not in others.⁶ Apparently, happiness does not rise in tandem with economic growth.⁷ Several recent studies suggest that affluence and wealth has a tendency to generate new sets of problems which are detrimental to self-reported happiness.⁸ This observation has also been connected with the widespread notion that wealthy Westerners have become relatively unhappier throughout the past half century.⁹

3 Helliwell, John F., Layard, Richard & Sachs, Jeffrey D. (eds) (2012) *World Happiness Report*. New York: The Earth Institute, Columbia University.

4 See also Marmot, Michael & Wilkinson, Richard (eds) (2003) *Social Determinants of Health: The Solid Facts*. Copenhagen: WHO Regional Office for Europe.

5 Helliwell, Layard & Sachs 2012, 74.

6 Frey, Bruno S. & Stutzer, Alois (2002) ‘What Can Economists Learn from Happiness Research?’ *Journal of Economic Literature*, Vol. 40, No. 2, 402–435.

7 Layard, Richard (2005) *Happiness: Lessons From A New Science*. London: Penguin.

8 Offer, Avner (2006) *The Challenge of Affluence*. Oxford: Oxford University Press; Lane, Robert E. (2001) *The Loss of Happiness in Market Democracies*. New Haven: Yale University Press; James, Oliver (1998) *Britain On the Couch: Why We Are Unhappier Compared to 1950 Despite Being Richer*. London: Arrow Books.

9 James 1998; Simonson, Nisse (2008) *Varför mår vi så dåligt när vi har det så bra?* Stockholm: Brombergs; Eriksen, Thomas Hylland (2008) *Storeulvsyndromet: Jakten på lykken i overflodssamfunnet*. Aschehoug & Co.

While increasing income thus has a direct and positive impact upon self-reported happiness in poor countries, the correlation is weaker in rich countries, as growth itself appears to generate problems of adaptation and adjustment. Thus, economic growth and level of income does not necessarily improve self-reported happiness, as first scientifically observed by American economist Richard Easterlin.¹⁰ The so-called ‘Easterlin paradox’ observes that richer individuals may be happier than poorer persons at any particular time, but that society as a whole does not become happier as it becomes richer. The most common explanation for the Easterlin paradox is that people compare themselves to others: When the economy as a whole improves, individuals’ relative status remains unchanged as those who gain the most quickly adapt to their new higher income while the gains may not have been evenly shared.¹¹

Yet another aspect of the paradoxical relationship between income, wealth, and happiness is identified by the authors of the *World Happiness Report*. They observe that various ‘societal factors’ may have ‘counteracted any benefits felt from the higher incomes,’ noting that ‘[u]ncertainties and anxieties are high, social and economic inequalities have widened considerably, social trust is in decline, and confidence in government is at an all-time low’.¹² By inference, social policies that target the improvement of social conditions and generate social equality – or a less competitive work culture and excluding labour market, one may add – may thus have a positive impact upon self-reported happiness, which in turn can have positive effects upon the economy.¹³

Happiness is thus not necessarily a primarily private affair, but something which is inextricably linked with economical, political, and social structures

10 Easterlin, Richard (1974) ‘Does Economic Growth Improve the Human Lot?’ In David, Paul A. & Reder, Melvin Warren (eds) *Nations and Households in Economic Growth: Essays in Honor of Moses Abramovitz*. New York: Academic Press, 89–125; Easterlin, Richard (1995) ‘Will Raising the Incomes of All Increase the Happiness of All?’. *Journal of Economic Behavior and Organization*, Vol. 27, 35–47.

11 Helliwell, Layard & Sachs 2012.

12 Helliwell, Layard & Sachs 2012.

13 Greve, Bent (ed.) (2010) *Happiness and Social Policy in Europe*. Cheltenham: Edgar Elgar; Saari, Juho (2012) *Omnellisuuspolitiikka – Kohti sosiaalisesti kestäväää Suomea*. Helsinki: Kalevi Sorsa Säätiö; Wilkinson, Richard G. & Pickett, Kate (2009) *The Spirit Level – Why More Equal Societies Almost Always Do Better*. London: Penguin.

and hence, human agency. But the Easterlin paradox is not unanimously accepted by happiness researchers, and the complex relation between income, wealth, and happiness as delineated in the *World Happiness Report* remains at the core of contest in contemporary happiness research.¹⁴

Taking this observation as its point of departure, this chapter analyzes the ‘return’ of happiness in public debate, looking at the tension between happiness as an (il)legitimate goal of politics and happiness as an (ir)relevant study object of science. It first looks at how happiness was marginalized as a political and scientific category in Western public discourse after the Second World War. It then analyzes its initially slow return from the 1970s and onwards to today’s dramatically rising interest in happiness rankings by international organizations and national governments alike.

While there is an emerging literature on the business appropriation of happiness, its scientific-cum-political utilization has not yet been analyzed in any greater detail. With a few exceptions, most studies have been primarily concerned with the quality of the scientific evidence presented in support of the claims to measure what scholars call ‘subjective well-being’ (SWB).¹⁵

By contrast, this chapter does not discuss the methods and results of these rankings, most of which are easily accessible and subject to lively debate among social statisticians.¹⁶ Instead, it asks why these rankings are being produced to begin with and what they may entail for public policy.

14 Most notably, it has been criticized by Ruut Veenhoven, whose statistics show a strong correlation between happiness and income, both on the societal and the individual level, see Veenhoven, Ruut (2008) *World Database of Happiness: Continuous Register of Scientific Research on Subjective Appreciation of Life*. Rotterdam: Erasmus University; Gasper, Des (2007) ‘Uncounted or Illusory Blessings? Competing Responses to the Easterlin, Easterbrook and Schwartz Paradoxes of Well-Being’, *Journal of International Development*, Special Issue: Human Security, Well-Being And Sustainability, Vol. 19, Issue 4, 473–492.

15 Dolan, Paul, Peasgood, Tessa & White, Mathew (2008) ‘Do We Really Know What Makes Us Happy? A Review of the Economic Literature on the Factors Associated With Subjective Well Being’, *Journal of Economic Psychology*, Vol. 29, 94–122; Thin, Neil (2012) *Social Happiness: Theory Into Policy and Practice*. Bristol: The Policy Press.

16 For a comprehensive overview of different rankings of happiness and SWB and their different means and ends, see European Communities (2009) *Beyond GDP—Measuring Progress, True Wealth and the Well-being of Nations*. Luxembourg: Office for Official Publications of the European Communities. Online. Available HTTP: <http://www.beyond.gdp.eu/proceedings/bgdp_proceedings_full.pdf> (accessed October 2012)

Scepticism towards happiness

While the recent concern with well-being has generated high-profile initiatives of governments and international organizations alike, scientific interest in measuring happiness is not new. Early and largely theoretical efforts to quantify happiness were made by enlightenment philosophers and utilitarian liberals, perhaps most notably evidenced by Jeremy Bentham's concept of the 'felicific calculus'.¹⁷

Nevertheless, in bringing the explicit concept of happiness back into the scope of global governance, the *World Happiness Report* marks a new departure from a long tradition of scepticism towards happiness in the social sciences. Western social sciences have largely viewed happiness as emotional, personal, and highly subjective.¹⁸ Hence, social scientists tended to regard it as either irrelevant or found alternative ways of conceptualizing it. When used – although sparingly, as noted by Easterlin¹⁹ – it was most often as a vague analogy to 'welfare' in welfare economics, primarily in theoretical discussions of the difference between 'wealth' and 'welfare'.²⁰

Yet, the subject matter of happiness – the match between needs and human satisfaction – never ceased to be of interest to social scientists. But that interest had to be channelled through proxy concepts such as well-being, satisfaction with life, and quality of life. Partly, this purging seems to have been the result of the success and influence of American behaviourism on modern psychology and social science. With its insistence upon only researching those phenomena which can be empirically observed – i.e. actions and behaviour of humans and conditions of environment and heredity – behaviourism had by the mid-1950s established a firm consensus on social 'cause and effect' and psychological 'stimulus and response' as the preferred paradigm of Western social science.

17 Bentham, Jeremy (1907 [1780/1789]) *An Introduction to the Principles of Morals and Legislation*. Oxford: Clarendon Press.

18 McMahon, Darrin M. (2006) *Happiness: A History*. New York: Atlantic Monthly Press.

19 Easterlin 1974.

20 Pigou, Arthur Cecil (1912) *Wealth and Welfare*. London: Macmillan; Little, I. M. D. (1950) *A Critique of Welfare Economics*. London & New York: Clarendon Press; Mishan, E. J. (1968) 'Welfare Economics'. In *International Encyclopedia of the Social Sciences*, Vol. 16. New York: Macmillan, 504–512; Eckaus, Richard S. (1972) *Basic Economics*. Boston: Little, Brown.

In so doing, behaviourism also bypassed the problem of subjectivity of (dis)satisfaction by deploying an objective standard of (dis)satisfaction through the concept of ‘needs’, e.g. Abraham Maslow’s ‘hierarchy of needs’ with physiological needs at the bottom, followed by needs for safety, love, esteem, and ‘self-actualization’ on the top. Since happiness could not be tied to any particular set of cause and effect or stimulus and response it could neither be empirically connected with the fulfilment of concrete needs nor be observed experimentally. Thus, the category of happiness thus remained something of a ‘blind spot’ for modern social science until methods for public opinion polling were being more widely applied by social psychologists in the 1960s.

In an early effort to address the scientific blindness *vis-à-vis* human happiness, American public opinion scholar Hadley Cantril collected data in 1957–1963 from 14 countries – both capitalist and communist societies, rich and poor – asking open-ended questions about what people want out of life and what they would need for their lives to be completely happy.²¹ Despite the vast socio-economic and cultural disparities among the countries, people’s responses were strikingly similar, ranking level of living, happy family life, personal and family health, work, emotional stability, personal worth, and self-discipline as the most important factors, in that order. According to Cantril’s findings, factors such as war, civil rights, political liberties, and social equality, mattered less, but this did not mean that respondents valued these factors less. It only meant that the interviewees tended to regard these factors as largely exogenous.²²

Another example of explicit social science interest in happiness dates from a collaborative Nordic sociological project in the early 1970s, where subjective happiness was directly connected with material welfare and included in the questionnaires used for sampling perceptions of welfare in

21 The 14 nations included in the original study cover Brazil, Cuba, Dominican Republic, Egypt, India, Israel, Japan, Nigeria, the Philippines, Panama, Poland, the United States, West Germany, and Yugoslavia. The study employed a ‘Self-Anchoring Striving Scale’, asking the respondent to define hopes and fears for self and the nation. Cantril, Hadley (1965) *The Pattern of Human Concerns*. New Brunswick, Rutgers University Press.

22 Easterlin, Richard (2004) ‘The Economics of Happiness.’ *Daedalus*, Vol. 133, Issue 2, 26–33.

the Nordic countries. Yet, the study used the abstract, existential, and hence rather depersonalized question of whether the respondent finds that 'Life is happy', the answer to which need not necessarily tell the researcher much about the actual SWB of the respondent.²³

Despite these early attempts at approaching explicit notions of happiness scientifically, 'satisfaction with life' proved the most popular analytical category throughout the 1960s and 1970s. Part of its appeal rested in its connection to then current theories on 'development', largely understood as the fulfilment of material needs, commensurate with 'objective well-being' (OWB) and often treated as synonymous with 'standard of living'.²⁴

However, as standard of living gradually evolved into a rhetorical weapon in the Cold War struggle between capitalism and communism, alternative and supposedly more neutral concepts such as 'quality of life' had to be developed. Quality of life proved politically attractive, as most clearly indicated by US President Richard Nixon's state of the union address in January 1970 and the Quality of Life review process as established in October 1971. The political appropriation of this concept clearly reflected the shift from 'materialist' to 'post-materialist' values which could be registered throughout the politically tumultuous and economically insecure 1970s.²⁵

Rankings of happiness

Over the past decade, however, the explicit concept of 'happiness' has begun to reappear more frequently in scholarly literature and university textbooks across a number of disciplines, alongside the expanding and progressively more inclusive concept of 'well-being'.²⁶ While academic interest in developing statistical methods for conducting surveys and rankings of SWB found a platform in the journal *Social Indicators Research*, founded in 1974, *The Journal of Happiness Studies* has since 2000 catered for the more specific

23 Allardt, Erik (1975) *Att ha, att älska, att vara: Om välfärd i Norden*. Lund: Argos.

24 Gasper, Des (2005) 'Subjective and Objective Well-Being in Relation to Economic Inputs: Puzzles and Responses'. *Review of Social Economy*, Vol. 63, Issue 2, 177–206.

25 Inglehart, Ronald (1977) *The Silent Revolution*. Princeton: Princeton University Press.

26 Huppert, Felicia & Linley, P. Alex (eds) (2011) *Happiness and Well-being: Critical Concepts in Psychology*. New York: Routledge.

interest in the subject matter of happiness. Today, 'happiness research' has been established as an independent field of multidisciplinary academic research, including economics, psychology, sociology, and management studies.²⁷

Alongside the development of the academic discipline, one of the most high-level initiatives has been undertaken by the Organisation for Economic Cooperation and Development (OECD) from the beginning of the 2000s. Using substantive analysis and surveys, the OECD has sought to address the limits of official statistics in measuring the progress of societies' material living conditions, quality of life and sustainability. In 2001, the OECD launched its so-called Better Life Initiative to this end.²⁸ In 2011, the Better Life Initiative released a report entitled *How's Life? Measuring Well-being* as part of its ongoing work to promote 'Better Policies for Better Lives'.²⁹

Together with the launching of the so-called 'Your Better Life Index', the release of the report has been widely noted in the media as a step towards going 'beyond GNP' by measuring and valuing 'happiness' as an independent social objective alongside the more traditional economic measures according to which societies are usually ranked.³⁰ In a related undertaking, the OECD-sponsored Global Project on 'Measuring the Progress of Societies' seeks to develop progress indicators as well as to create a community working together to determine how to measure the well-being of societies. To ensure legitimacy and authority, it includes representatives of NGOs, governments, and researchers worldwide. The OECD World Forum in Istanbul in June 2007 made the 'Measuring and Fostering the Progress of Societies' its core topic:

27 Layard 2005; Martin, Paul (2005) *Making Happy People: The Nature of Happiness and its Origins in Childhood*. London: Fourth Estate.

28 Organisation for Economic Co-operation and Development (OECD) (2011) 'Better Life Initiative: Measuring Well-being and Progress'. Online. Available HTTP: <<http://www.oecd.org/statistics/betterlifeinitiative/measuringwell-beingandprogress.htm>> (accessed October 2012)

29 OECD (2011) *How's Life? Measuring Well-being*. Online. Available HTTP: <<http://wwwwww.uni-klu.ac.at/nwohlgem/makrooekonomik/topics/How%20is%20life.%20measuring%20wellbeing.pdf>> (accessed October 2012)

30 OECD (2012) 'Better Life Index'. Online. Available HTTP: <<http://www.oecdbetterlifeindex.org>> (accessed October 2012)

Is life getting better? Are our societies making progress? Indeed, what does 'progress' mean to the world's citizens? For a good portion of the 20th century there was an implicit assumption that economic growth was synonymous with progress: an assumption that a growing GDP meant life must be getting better. But we now recognise that it isn't quite as simple as that. Access to accurate information is vital when we come to judge our politicians and hold them accountable. But access to a comprehensive and intelligible portrait of that most important of questions – whether or not life has got and is likely to get better – is lacking in many societies.³¹

At the World Forum, the Istanbul Declaration was signed by representatives of the European Commission, the OECD, the Organisation of the Islamic Conference, the United Nations, the United Nations Development Programme and the World Bank. The Declaration states that:

A culture of evidence-based decision making has to be promoted at all levels, to increase the welfare of societies. And in the 'information age', welfare depends in part on transparent and accountable public policy making. The availability of statistical indicators of economic, social, and environmental outcomes and their dissemination to citizens can contribute to promoting good governance and the improvement of democratic processes. It can strengthen citizens' capacity to influence the goals of the societies they live in through debate and consensus building, and increase the accountability of public policies.³²

Noting that '[o]fficial statistics are a key "public good" that foster the progress of societies', the Declaration 'urge[s] statistical offices, public and private organizations, and academic experts to work alongside representatives of their communities to produce high-quality, facts-based information

31 OECD (2008) *Statistics, Knowledge and Policy 2007: Measuring and Fostering the Progress of Societies*. Paris: OECD Publishing.

32 Istanbul Declaration (2007) Online. Available HTTP: <http://www.wikiprogress.org/images/Istanbul_Declaration.pdf> (accessed October 2012)

that can be used by all of society to form a shared view of societal well-being and its evolution over time.³³

In November 2007, this largely OECD-driven quest for ‘a shared view of societal well-being’ resulted in a conference in the European Parliament in Brussels on the topic ‘Beyond GDP – Measuring progress, true wealth, and the well-being of nations’, jointly organized by the European Commission, European Parliament, Club of Rome, WWF and OECD.³⁴ The conference sought to initiate the selection and inclusion of various new indexes purporting to measure happiness and well-being in official statistics, providing a ‘Virtual Indicator Exhibition’ where some 20 complementing and competing indexes were presented. In gathering the authors of these indexes, it also provided a platform for a general discussion on the political applicability of these measures, i.e. for making and shaping policy initiatives.

At the conference, a basic dividing line emerged between those who view these new measures as a complement to GDP and those who argue that these measures should also contribute to a shift in (inter)national policy objectives, away from promoting free market liberalism in favour of global equality, justice, and welfare. Neither side turns openly against the order of priority held by the other. Instead, the debate is focused on the degree to which ‘societal well-being’ or ‘happiness’ can at all be measured with any accuracy. While the policy implications remain rather underdeveloped in these discussions, the evidence presented by both sides appear to support a link between happiness and welfare policies, as long as the latter are adequately provided for.³⁵

Through evaluation of policy outcomes and peer pressure, the OECD has been instrumental in promoting policy diffusion and norm entrepre-

33 Istanbul Declaration 2007.

34 European Communities (2009), *Beyond GDP—Measuring Progress, True Wealth and the Well-being of Nations*. Luxembourg: Office for Official Publications of the European Communities. Online Available HTTP: <http://www.beyond-gdp.eu/proceedings/bgdp_proceedings_full.pdf> (accessed October 2012); see also Costanza, Robert, Hart, Maureen, Posner, Stephen & Talberth, John (2009) *Beyond GDP: The Need for New Measures of Progress*. Boston: The Frederick S. Pardee Center for the Study of the Longer-Range Future.

35 The argument can be found in a more developed form in Frey, Bruno S. & Stutzer, Alois (2007) ‘Should National Happiness Be Maximized?’ *Institute for Empirical Research in Economics University of Zurich Working Paper*, No. 306. Online. Available HTTP: <<http://www.iew.uzh.ch/wp/iewwp306.pdf>> (accessed October 2012)

neurship in a wide variety of different policy areas.³⁶ Since 2008 and onwards, its advocacy for including happiness in official statistics appears to win ground internationally. In the USA, for example, similar ideas have been expressed by advisers of President Barack Obama's administration. In their 2008 book *Nudge: How to Improve Decisions About Wealth, Health, and Happiness*, economist Richard H. Thaler and lawyer Cass R. Sunstein (until August 2012 head of the US Government's Office of Information and Regulatory Affairs, OIRA) argue that individuals are frequently led astray from making the decisions which would improve their SWB by following the wrong cues. A measure of 'libertarian paternalism' – which is distinct from paternalism according to Thaler and Sunstein in that it does not prohibit, but rather attempt to 'nudge' people's decisions in certain, presumably favourable directions – can, the authors suggest, improve general levels of happiness by reframing the 'choice architecture' of a given society.³⁷

In December 2011, a panel of experts in psychology and economics – including Daniel Kahneman, psychologist and Nobel laureate in economics and prolific writer on the topic of well-being and 'hedonic psychology' – began convening in Washington D.C. to try to define reliable measures of SWB.³⁸ The panel enjoys the explicit support of President Obama's chief economic adviser and chair of the Council of Economic Advisers, Alan B. Krueger, who has previously proposed a method for generating a national statistic covering 'the flow of emotional experience during daily activities'.³⁹

Mainly funded by the US Department of Health and Human Services and organized by the non-profit National Academies, the panel has been

36 Recent examples where the OECD has influenced member state policies include anti-corruption, educational policy, investment policy, labour market policy, and tax policy.

37 Thaler, Richard H. & Sunstein, Cass R. (2008) *Nudge: Improving Decisions about Health, Wealth, and Happiness*. New Haven: Yale University Press; see also Sunstein, Cass R. (2010) *Law and Happiness*. Chicago: University of Chicago Press.

38 Kahneman, Daniel, Wakker, Peter P. & Sarin, Rakesh (1997). 'Back to Bentham? Explorations of Experienced Utility'. *The Quarterly Journal of Economics*, Vol. 112, No. 2, 375–406; Kahneman, Daniel, Diener, Ed & Schwartz, Norbert (eds) (1999) *Well-Being: The Foundations of Hedonic Psychology*. New York: Russel Sage Foundation; Whoriskey, Peter (2012) 'If you're happy and you know it ... let the government know'. *The Washington Post*. Online. Available HTTP: <http://articles.washingtonpost.com/2012-03-29/business/35450353_1_gross-national-happiness-alan-krueger-measure> (accessed October 2012)

39 Krueger, Alan B. & Kahneman, Daniel (2006) 'Developments in the Measurement of Subjective Well-Being'. *Journal of Economic Perspectives*, Vol. 20, No. 1, 3–24.

promoting the message that a more accurate measure of happiness is a helpful tool for evaluating the success or failure of a range of government policies. As such, it could help analyze citizen preferences and government policy priorities with regard to trade-offs between health benefits, education, employment, and higher income levels, besides probing the complex and changing relationships between these human needs and policy goals. It might also detect extremes of inequality or imbalances in how people divide their time between work and leisure. If deemed reliable, the measures under development by the panel could become part of official US statistics, including that of the US Census Bureau and the Bureau of Economic Analysis. If so, the USA would become ‘the latest country to clamber aboard a happiness bandwagon’, as noted by *The Economist*.⁴⁰

The happiness discourse is by no means reserved by ‘progressive’ actors such as the current US administration. Conservatives on both sides of the Atlantic, have also been keen to appropriate the happiness discourse. In 2008, former French President Nicholas Sarkozy convened a commission, consisting of Joseph Stiglitz, Amartya Sen, and Jean-Paul Fitoussi, stating that ‘time is ripe for our measurement system to shift emphasis from measuring economic production to measuring people’s well-being’. The Commission on the Measurement of Economic Performance and Social Progress – also known as the Stiglitz-Sen-Fitoussi Commission – concluded in September 2009 that a broad range of measures and indicators about people’s well-being and societal progress should be used alongside more standard economic measures such as GDP.⁴¹ In 2009, the French government started publishing its own happiness indicator, in line with OECD recommendations.

In 2011, also the British Coalition Government began surveys, asking respondents ‘Overall, how happy did you feel yesterday?’ and ‘Overall, how satisfied are you with your life nowadays?’ More specifically, the connection

40 ‘Happiness – No Longer the Dismal Science?’ *The Economist*, 6 April 2012. Online. Available HTTP: <<http://www.economist.com/blogs/feastandfamine/2012/04/happiness>> (accessed October 2012)

41 Stiglitz, Joseph E., Sen, Amartya & Fitoussi, Jean-Paul (2009) *Report by the Commission on the Measurement of Economic Performance and Social Progress*. Paris: Commission on the Measurement of Economic Performance and Social Progress.

between happiness and sustainability has been underlined by a UK government initiative entitled the Sustainable Development Commission (SDC). In cooperation with Earthscan, the SDC proposed ways in which to refocus public policy in line with the principle of 'prosperity without growth'. This interpretation could favour an increased attention to sustainability and an emphasis upon 'downshifting' or 'descaling' the economy.⁴² The SDC was set up by the Labour Government in June 2000 as a non-departmental public body responsible for advising the government on sustainable development and related issues. The SDC was closed by the Coalition Government in March 2011, but its reports have since been cited favourably by British Prime Minister David Cameron, noting 'it's time we focused not just on GDP but on GWB – general well-being'. Along similar lines, British economist Richard Layard has argued that General National Happiness (GNH) could positively complement GDP.⁴³

In addition to these governmental initiatives, there have also been numerous attempts at measuring SWB launched by universities, research institutions, think tanks, and NGOs. While these rankings usually either pool together variables which are already measured by traditional indexes or rely upon interviews and surveys where the informants state their own perception of their SWB, they are often represented in the media as claiming to chart happiness. As such, they signal a new type of interest in SWB which goes a long way towards 'rehabilitating' the concept of happiness in public debate. For example, the reference objects of these rankings have recently shifted from various qualified and limited notions 'perceived' quality of life or 'self-reported' or 'avowed' happiness to make direct and explicit references to happiness.

Paradoxes of happiness

While these rankings all factor in non-material concerns, the authors of these indexes usually do not claim that these new measures should replace

42 Jackson, Tim (2009) *Prosperity without Growth. Economics for a Finite Planet*. London: Earthscan.

43 The modern formulation of the idea of GNH finds its origin in a conservative context, having first been proposed by the King of Bhutan in 1972, see Ura, Karma & Galay, Karma (eds) (2004) *Gross National Happiness and Development*. Thimphu: The Centre for Bhutan Studies; Layard 2005.

the traditional economical measures which have dominated the assessment of societies. Instead, the addition of social factors through the notion of SWB should simply prevent it from becoming solely deducible from economic and material factors.⁴⁴ But how much importance should be given to the one or the other? Is it possible to weigh these factors against one another in an accurate manner? And are they really distinct from one another, after all? A number of different paradoxes or tensions emerge when the concept of happiness is introduced as a parameter for assessing socio-economic conditions as well as policy outcomes.

Progressives highlight that the societies which tend to register the highest levels of SWB are characterized by a high level of economic equality and social security, as exemplified by the Nordic countries.⁴⁵ Indeed, several surveys report the Danes as being the most satisfied.⁴⁶ Several studies have suggested that the universalistic welfare state has been a decisive factor for the high levels of SWB and public trust recorded in the Nordic countries.⁴⁷ This would apparently favour a universalistic welfare state of the Nordic model which combines economic growth with social redistribution, in addition to placing a strong focus upon democracy and sustainability.

These interpretations have troubled self-designated neoliberal observers for a variety of reasons. First, there is scepticism regarding the inclusion of rankings of SWB in the work of various international organizations. Second, there has been a neoliberally-slanted criticism which claims that the notion of legitimate needs could imply a limiting of free choice in consumption and

44 Diener, Ed & Seligman, Martin E. P. (2004) 'Beyond Money—Towards an Economy of Wellbeing'. *Psychological Science in the Public Interest*, Vol. 5, No. 1, 1–31; Costanza, Robert, Fisher, Brendan, Ali, Saleem, Beer, Caroline, Bond, Lynne, Boemans, Roelof, Danigelis, Nicholas L., Dickinson, Jennifer, Elliott, Carolyn, Farley, Joshua, Gayer, Diane Elliott, Glenn, Linda MacDonald, Hudspeth, Thomas, Mahoney, Dennis, McCahill, Laurence, McIntosh, Barbara, Reed, Brian, Rizvi, S. Abu Turab, Rizzo, Donna M., Simpatico, Thomas & Snapp, Robert (2007) 'Quality of Life: An Approach Integrating Opportunities, Human Needs, and Subjective Well-Being'. *Ecological Economics*, Vol. 61, Issues 2–3, 267–276; Brown, Kirk & Kasser, Tim (2005) 'Are Psychological and Ecological Well-Being Compatible? The Role of Values, Mindfulness and Lifestyle'. *Social Indicators Research*, Vol. 74, No. 2, 349–369; Abdallah, Saamah, Thompson, Sam & Marks, Nic (2008) 'Estimating Worldwide Life Satisfaction'. *Ecological Economics*, Vol. 65, No. 1, 35–47.

45 Wilkinson & Pickett 2009.

46 Greve 2010.

47 Rothstein, Bo (2011) 'Social tillit, lycka, korruption och välfärdsstat'. In Holmberg, Sören, Weibull, Lennart & Oscarsson, Per (eds) *Lycksalighetens ö*. Göteborg: SOM-institutet, 65–84.

production and hence an infringement upon the free market forces. Third, there is a tendency to question the link between the welfare state and happiness on the one hand and the link between sustainability and happiness on the other.

The criticism has unfolded in two different directions in response to the progressive challenge posed by the new happiness discourse to free market liberalism. One direction has actually 'joined the choir'. Legatum Institute, for example, a think tank based in Washington D.C., has pointed out that the contemporary policies of the Nordic welfare states which generate favourable ratings for the Nordics are just as liberal and economy-oriented as the policies of those societies which score worse. The difference lies in the determination and skill by which Nordic governments have implemented necessary reforms in the welfare systems, thus saving the welfare state while reframing the 'Nordic model' of the past into a new 'Nordic Way' of the future which has recently won the praise of liberal newspaper *The Economist*.⁴⁸

Another concern has been the accuracy of the measures. Neoliberal critics frequently criticize the evidence provided by happiness researchers. In 2007, the same year as the OECD launched its 'Beyond GNP' conference, researchers associated with the Cato Institute, another Washington-based think tank, argued that the data provided by happiness researchers show that 'neither higher rates of government redistribution nor lower levels of income inequality make us happier, whereas high levels of economic freedom and high average incomes are among the strongest correlates of SWB'.⁴⁹

The problem rests with the diverging interpretation of the causal mechanisms behind the weak correlations that the rankings point to: Not only is happiness research troubled by competing methodologies and conflicting research objectives, neoliberal critics and other sceptics argue. Happiness itself does not appear as 'a simple empirical phenomenon but a cultural and

48 'The Next Supermodel: Politicians from both Right and Left Could Learn from the Nordic Countries'. *The Economist*. 2 Feb. 2013. Online. Available HTTP: <<http://www.economist.com/news/leaders/21571136-politicians-both-right-and-left-could-learn-nordic-countries-next-supermodel>> (accessed February 2013)

49 Wilkinson, Will (2007) 'In Pursuit of Happiness Research: Is It Reliable? What Does It Imply for Policy?' *Policy Analysis*, No. 590, 2–41. Online. Available HTTP: <<http://www.cato.org/sites/cato.org/files/pubs/pdf/pa590.pdf>> (accessed October 2012)

historical moving target', defined differently by different individuals at different points in life – indeed, a central argument of liberal critics of the welfare state for a long time.

Politics or rhetorics of happiness?

Happiness research has thus far failed to establish a singular 'shared view of societal well-being' as called for by the OECD. The question is whether the rather natural and seemingly neutral quest for such a shared view could translate from rhetorics into politics, and what kind of politics that would be.

The differences between different factors in explaining happiness and SWB appear marginal in most rankings. This observation has led social psychologists to launch the 'set-point theory' according to which most people have a stable level of SWB, to which they return after various positive as well as negative experiences. This individual set-point is supposedly more determined by personality than income, wealth, health, or equality. If SWB is mostly determined by factors beyond the reach of politics or even human agency, it would follow that public policy with the aim of improving happiness would carry little hope of actually increasing SWB, just as the so-called 'bell curve paradox' would rule out the aggregated effects of education on overall levels of intelligence in a given society. A set-point theory of happiness would thus rather support a neoliberal interpretation than a welfare state interpretation of public policy.⁵⁰

But if we accept the correlation between happiness and the welfare state as evidenced by the high rankings for the Nordic societies, the possibility of a politics of happiness would seem clear enough: It would simply be a question of providing for the basic social goods (education, employment, empowerment, and environmental protection) on a universal basis through the means of public participation to secure the possibility for as many as possible to independently pursue their own ideas of how to achieve happi-

50 Bruni, Luigino & Porta, Pier Luigi (eds) (2007) *Handbook on the Economics of Happiness* Cheltenham: Edward Elgar; Easterlin 2004; Inglehart, Ronald & Klingemann, Hans-Dieter (2000) *Genes, Culture and Happiness*. Boston: MIT Press.

ness.⁵¹ It would then be a rather basic and very practical question of setting up systems of social care which as far as possible address social conditions which are known to correlate with unhappiness and deteriorating mental health, rather than some utopian attempt at downscaling the economy or to 'maximize happiness' for all through some ambitious scheme of 'social engineering'.

However, it must also be observed that the universalism of the welfare state may produce potential tensions, too. The principle of universalism secures some measure of equality which translates into public trust and SWB as well as legitimacy of the welfare state. To be able to afford this universalism, however, the welfare state requires a rather high level of productivity to allow for a comparatively high level of both private and public consumption. This means that a substantial source of stress and dissatisfaction will likely remain inbuilt into the system.⁵²

The levels of stress among the employed, well-integrated, and more or less well-paid middle classes are reportedly on the rise, not only in the West generally, but in the Nordic countries, too. This generates growing demands for mental health care and crowding out scarce resources for those who already suffer from unemployment, poverty, social exclusion, and/or mental problems – whose well-being in turn is imperilled by the rising requirements for employability.⁵³ If the happiness discourse would be embraced by the universalistic welfare state, the latter would also need to accommodate the rather different needs of both these groups. Medical definitions would become even more important than they are today. Where do we draw the line between the happiness which should be the concern of the individual and the unhappiness which should be the concern of society as a whole?

This issue is complicated by the suggestion that the welfare state – in the Nordic countries as well as elsewhere – is undergoing a transformation

51 See discussion in European Communities (2009); Frey & Stutzer 2007.

52 Bunting, Madeleine (2005) *Willing Slaves: How the Overwork Culture is Ruining Our Lives*. London: Harper.

53 For a discussion, see Fallov, Mia Arp (2011) 'Constructing the Capacity of Employability, and the Government of Inclusion'. In Blomberg, Helena & Kildal, Nanna (eds) *Workfare and Welfare State Legitimacy*. Helsinki: Nordic Centre of Excellence NordWel, 125–160.

towards a more neoliberal mode of governance by gradually and piece by piece abandoning the principle of universalism, so that it becomes a question of interpretation whether the eventual success of the Nordic welfare model is rather the result of whatever traditional welfare state is left or follows from the competition state reforms, which, according to some, may spell the end of traditional welfare policies.⁵⁴

The increasing attention to the immaterial factors for happiness and SWB unfold in parallel with the current economic recession. The ‘softer’ measures of economic and social performance of societies do indeed seem to reflect some of the post-materialist values which have become more widely accepted during the last decades, in Western Europe, the USA, and increasingly also in Southeast Asia. It would be politically sound for both conservative and progressive politicians to rhetorically embrace more post-materialist values in a time of crisis, while retaining a focus upon traditional economic policy goals in actual policies, just as Nixon once sought to channel counter-culture sentiments in the USA during the high-tide of radicalism in the early 1970s while conducting relatively traditional economic policies.

Assuming that the Easterlin paradox holds some truth, governmental interest in SWB may then increase when economic figures point downward or when income disparity is on the rise. Similar rhetorics have, for example, been utilized by various South East Asian governments, notably by the Chinese Government invoking the concept of *xiaokang* [‘basic well-being’] during the rapid growth of the 1990s or by the Thai Government in the wake of the Asian financial crisis in 1997, as citizens were encouraged to focus on ‘sufficiency economy’ and to moderate their consumption rather than to expect increased governmental relief or press for an expansion of welfare programmes in times of need.⁵⁵

54 Blomberg, Helena & Kildal, Nanna (eds) (2011) *Workfare and Welfare State Legitimacy*. Helsinki: Nordic Centre of Excellence NordWel; Heiskala, Risto & Kantola, Anu (2010) ‘Vallan uudet ideat: hyvinvointivaltion huomasta valmentajavaltion valvontaan’. In Pietikäinen, Petteri (ed.) *Valta Suomessa*. Helsinki: Gaudeamus, 124–148.

55 Noy, Darren (2011) ‘Thailand’s Sufficiency Economy: Origins and Comparisons with Other Systems of Religious Economics’. *Social Compass*, Vol. 58, No. 4, 593–610.

The inclusion of happiness and SWB by conservative governments and traditionally free-trade-oriented international organizations can also channel public criticism away from economic failure, rising income disparity, and welfare state retrenchment. So it has been suggested that former French President Sarkozy's embracing of the new happiness agenda was designated to compensate for criticism in the context of the lowering of the French credit rating in 2011. In any case, the conservative appropriation of the happiness discourse is not very likely to herald massively increased government spending on public goods.

Conclusion

The new rankings of happiness have had some political impact, as witnessed by the high-level interest from the UN and the OECD as well as national governments. The close relationship between political agency and scientific knowledge production, especially the political function of statistics is well-known: Numbers, rankings, and scientific verifiable knowledge have long been considered a precondition for the turning of various social problems into targets of evidence-based policy making (EBP).⁵⁶ But, as of yet, this interest remains on the level of political rhetoric. Even if the social statisticians working with official statistics may perceive an increased pressure from governments and international organizations to conform to the new norms, a pressure which can be said to be 'political', the happiness discourse appears rather 'under-politicized' for now.

Yet, the popular reception of rankings and measures has actualized an essentially political struggle between different interpretations of happiness rankings and research. Through its vague and non-committal character, the happiness discourse can be bent for different political purposes. For some, the happiness discourse can be used as an argument for the expansion of the welfare state to also include more qualitative social services with more ambitious aims in terms of health and happiness. For others, it can be used

56 Piironen, Ossi & Erkkilä, Tero (2009) 'Politics and Numbers: The Iron Cage of Governance Indicators'. In Cox III, R. W. (ed.) *Ethics and Integrity in Public Administration*. Armonk, N.Y.: M.E. Sharpe, 125–145.

to drive home the point that we are all individually responsible for our own happiness. Still others may use the happiness discourse to promote an environmentalist agenda of descaling, downsizing, redistribution, and extended regulation of the financial markets in the interest of sustainability.

It may perhaps seem paradoxical that happiness returns as a political concern at a point in time when politics is widely thought to have been replaced by the market and public policy-making is supposedly supplanted by 'post-political regulation'.⁵⁷ The idea that individual happiness can be measured is strangely familiar with the idea that individual happiness could, for all of its complexity, be made into a political objective in its own right – indeed, a most utopian idea in itself. This would appear even more puzzling, since utopian or visionary ideas are supposedly in short supply today, both on the left as well as on the right.⁵⁸

Proponents argue that there is a demand for better measurements due to the rather natural interest in ascertaining a better balance between OWB and SWB – between economical and social concerns – when evaluating policy effects and designing new policy measures. At the same time, the causality between various policies and the reported SWB in a particular society remains elusive at best, national social statisticians warn, beyond the subjective character of happiness to begin with. Yet, the way in which the goal of individual happiness is articulated ties in with societal well-being is an important issue if we are interested in how the limits of politics are being changed and re-negotiated under conditions of globalization, post-modern values, and post-political regulation.⁵⁹

For now, it remains a question for debate whether the rising interest in

57 For a discussion of the concept of 'post-political regulation,' see Garsten, Christina & Jacobsson, Kerstin (2013) 'Post-Political Regulation: Soft Power and Post-Political Visions in Global Governance'. *Critical Sociology*. Online. Available HTTP: <<http://crs.sagepub.com/content/early/2012/06/22/0896920511413942>> (accessed February 2013)

58 For the notion of 'end of utopia,' see successive discussions in Marcuse, Herbert (1970) 'The End of Utopia'. In Marcuse, Herbert, *Five Lectures: Psychoanalysis, Politics, and Utopia*. Boston: Beacon Press, 62–82; Habermas, Jürgen (1986) 'The New Obscurity: The Crisis of the Welfare State and the Exhaustion of Utopian Energies'. *Philosophy and Social Criticism*, Vol. 11, No. 2, 1–18; Bauman, Zygmunt (1999) *In Search of Politics*. Cambridge: Polity; Berghahn, Klaus L. (2008) 'The End of Utopia?' *Telos*, No. 143, 171–180.

59 Cf. Inglehart, Ronald (1997) *Modernization and Postmodernization: Cultural, Economic, and Political Change in 43 Societies*. Princeton: Princeton University Press.

happiness will be politicized and, if so, to what degree and with what consequences. A first political implication is that these rankings do not only answer to a perceived need for knowledge, but also contribute to sustain and expand this need. This need will either be filled by 'pseudo-science' marginalizing official statistics, or official statistics will have to adapt to the demand, even if official social statisticians may be wary and skeptical of political pressure to expand the scope of their discipline.

Indeed, identifying, measuring, and ranking performance is not only a way of generating better knowledge about social conditions and policy outcomes with a view of improving both. It is also a means of communicating a message to the electorate and to shape public opinion. Rankings, even if they do not necessarily herald a new start for welfare state policies, do signal at least a symbolic response on the part of international and national policy-making elites to widespread popular concerns with life satisfaction, health, and environment beyond the scope of individual economy.

Second, it may today simply not be possible for politicians to focus singularly on economic growth as the primary policy objective, despite the current crisis. Cynics may remark that this would be rather fitting, since market performance is more volatile and appears less susceptible to political control now than in the past. It would hence be unwise for politicians to make themselves too dependent upon economical performance as the single most important parameter of policy evaluation. Novel concerns with 'soft issues' can be used to offset growing dissatisfaction with faltering economic policies and demonstrable weakness of politics. Nordic countries, for example, rank nicely in the statistics, while social inequalities are on the rise, indicating that overall performance may be good even if the least privileged members of society fare ill or do not share the benefits of stability and growth.

A third political implication, or rather symptom, is that the concern with rankings corresponds to the 'evacuation of politics' in evidence in contemporary governance in a multitude of policy fields, such as care, education, and unemployment policies.⁶⁰ Overarching social conflicts and party po-

60 See for example discussions on neoliberal governance in educational policies in Giroux, Henry A. (2008) *Against the Terror of Neoliberalism: Beyond the Politics of Greed*. Boulder: Paradigm.

litical contests are reduced as economic and social problems are isolated into targets for specialized policy administration.⁶¹ In the ‘political void’ that is left, global non-political organizations increasingly take up the role of visionaries, norm-entrepreneurs, and policy promoters, exactly through producing and disseminating new knowledge, new standards, and new best practices in a general movement towards post-political regulation. For all of its concern with accountability and transparency, it is of interest to note how post-political governance is tasking itself with yet more complex policy goals, identifying categories that, strictly speaking, cannot be as accurately and unambiguously quantified, compared, and evaluated as the traditional policy goals of work, security, justice, growth, and equality.

This raises the question whether contemporary discourses on happiness will serve to expand the duties of public policy to include more immaterial notions of welfare or to limit the reach of politics, further pointing to the responsibility of the individual for her own happiness. Due to this tension in the recent attention to happiness, the primary political importance of the recent rankings of SWB does not seem to concern their eventual ability to actually measure happiness but rather to rhetorically challenge the primacy of economy as the single most important basis for public policy and to underscore the social component of economic performance.

As such, it answers to a utopian drive in an era of utopian exhaustion. It is paradoxical, as the increased political and scientific interest in the vague and causally under-determined phenomenon of happiness can go in two directions: It may either divert attention away from the economy in order to further strengthen its grips on our public policies, or – quite on the contrary – further emphasize the need for alternative, non-monetary yardsticks by which to assess the well-being in the contemporary welfare state.

61 For a discussion, see Mair, Peter (2000) ‘Partyless Democracy? Solving the Paradox of New Labour?’, *New Left Review*, No. 2, 21–35; Mair, Peter (2006) ‘Ruling the Void? The Hollowing of Western Democracy’, *New Left Review*, Vol. 42, 25–51.

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The aim of this volume is to analyze how the recent attention to subjective well-being and happiness may affect welfare state policies, looking at both Nordic and international experiences. While the Nordic welfare states typically score well in rankings of happiness, the volume asks whether all is well in the welfare state. Rather than assessing whether happiness research manages to capture the multiple factors which underpin subjective well-being, the contributions probe the relationship between the general discourse on subjective well-being and the welfare policies designed to support those members of society who are in greatest need.

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