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Stockholm University
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The neighbour of Sveaplans gymnasium is the high-rise Wenner-Gren Center building. From there, one has a splendid view over the architectural masterpiece by Nils Ahrbom and Helge Zimdal. (Photo: Olof Östergren)

Centre for Health Equity Studies

Denny Vågerö

ROSENBAD, SEPTEMBER 1997. It is rainy and grey outside, but in the oval conference room, underneath the prime minister's office, the mood is upbeat and the discussion lively. The Swedish Council for Social Research (SFR) had been concerned about the large differences in health within the Swedish population. Now, it had invited a number of international and Swedish experts to discuss what a national Swedish research programme on health inequalities should look like. As the discussion is drawing to its end, Sally Macintyre from Scotland puts forward her conclusion: "Sweden should put its resources into a national centre for health equity research. The researchers are out there but they are scattered around many universities and departments. Such a centre would focus Sweden's own research and allow Sweden to push forward the international research agenda in a new way". Sally Macintyre, professor of medical sociology, was head of the MRC Social and Public Health Unit, a distin-

guished research institute at Glasgow University which had been financed by the British Medical Research Council for decades. She had been following developments in Sweden since the 1980s and was well familiar with research here. She spoke with conviction that sprang from her own experience (Macintyre 1998).

The Swedish Research Council took note. Just over a year later, the research council invited all Swedish universities to apply for the privilege of hosting such a centre. The universities were asked to present a research programme for such a centre. They were also asked to specify in which way their own contributions to the centre would match, as a minimum, those supplied by the research council. All applications would be assessed by an international team of experts.

I took part in the meeting at Rosenbad. So did Finn Diderichsen, professor of social epidemiology at *Karolinska Institutet* (KI) and one of the leading researchers in this field in

Sweden. During the coffee break, following Sally's proposal, we spoke about the idea of a centre. We realized that if we applied together we would have a good chance of succeeding. A joint application from Stockholm University and *Karolinska Institutet* would be strong. Diderichsen suggested that we should include Ulf Lundberg, professor of psychology at Stockholm University, in our effort. Lundberg's research followed in the tradition of Marianne Frankenhäuser and was focused on work, stress and health.

The research literature on health inequalities had broadened considerably during the preceding years. So had the number of disciplines that took an interest in the issue. In fact, the interdisciplinarity of the field was one of its most striking features, and rightly so. It was not possible to understand how social forces and circumstances translate into health problems being unevenly distributed across society in much the same way as education, income and good jobs, without collaboration across disciplinary borders. We should accordingly build our application around our expertise in medical sociology, social epidemiology and stress psychology and draw heavily on our links to medicine, psychology and social science in general. This was the idea.

The ball had been kicked into motion. A series of meetings or brainstorming activities, took place with researchers from both universi-

ties. Many of them took place in a basement room at The Department of Social Work (*Socialhögskolan*). A grim place to spell out the future, but it worked well. Monica Åberg Yngwe was struggling to take notes and summarise these discussions. There was great consensus that the application was going to focus on how health is shaped across the life course and how social and psychological circumstances influence the distribution of health in a fundamental way. What should be the name of the proposed centre? The Pehr Wargentin Centre for Social Science and Medicine was one suggestion, in honour of Pehr Wargentin, an 18th century pioneer in population studies. However, a flash of inspiration from someone solved the problem: the name of the new centre should be the Centre for Health Equity Studies, CHESS. If you are concerned about the second S in CHESS you could read it as Centre for Health Equity Studies in Stockholm.

We asked for, and received, good support from our faculty boards and later from the two vice-chancellors at Stockholm University and *Karolinska Institutet*. Eskil Wadensjö, who was then the dean of the Faculty of Social Sciences, organized a series of meetings to establish what resources the University could muster to match the resources that we were going to apply for. A similar process took place at *Karolinska Institutet*. These discussions went very well, and a long list of positions that would be trans-

ferred to the new centre was drawn up. At the core of these were Ulf Lundberg's, Finn Diderichsen's and my own professorships. In retrospect, one might be allowed to admit that some of the commitments were not that hard to make. My own professorship in medical sociology was seen as a contribution from Stockholm University, but it had in fact been paid for by SFR itself since 1995. True, the Faculty had promised to guarantee the chair if SFR should ever withdraw, but nevertheless! Diderichsen's chair was presented as a contribution from *Karolinska Institutet*, but was in fact financed by the Swedish Public Health Institute and placed at KI through an agreement between the two. This was typical for the way the institutionalisation of the research field had happened until then – through improvised, individual-based, ad hoc solutions.

However, the research application was duly completed and the specification of resources given by Stockholm University and *Karolinska Institutet* was spelt out in great detail. The two vice-chancellors, Hans Wigzell and Gustaf Lindencrona, signed and submitted the application in May 1999. Their signatures guaranteed the commitment of the two universities, whatever happened concerning the sponsored positions in the future. I have never felt any doubt that their commitment was genuine. CHESS has had both moral and material support from both universities ever since.

All the large universities in Sweden applied to be the host of the centre. SFR asked three leading international researchers to assess the applications, namely Sally Macintyre together with Johan Mackenbach from Erasmus University and Johannes Siegrist from Düsseldorf: one medical doctor and two social scientists, all distinguished professors with a track record in the field. In their review of our proposal, they concluded that “on the basis on their cutting-edge research plans we expect the combined centre to develop into a major (inter)national focal point in this area”. Expectations were high. The joint application from Stockholm University and *Karolinska Institutet* was chosen. CHESS was to become a reality.

The negotiations with SFR to establish CHESS followed immediately. In June 2000, a group of us who had worked on the application met SFR, represented by its chair of the board, Gabriel Romanus, and its permanent secretary at that time, Robert Erikson. They explained that SFR was willing to offer financing of four million Swedish kronor a year for six years, after which, if we were positively evaluated, they would foresee that the Ministry of Education would give a permanent grant. Our efforts to argue for a somewhat larger sum were unsuccessful. Romanus smiled. He seemed amused. Who could blame him?

The contract with SFR was signed on June 30th 2000. It was based on a negotiated agree-



The CHES library, mainly originating from the Department of Social Medicine, Karolinska Institutet, Huddinge, and donated to Denny Vågerö. (Photo: Mats Danielson)

ment between Stockholm University and *Karolinska Institutet*. According to the agreement, CHES was to be situated at Sveaplan, on the premises of the Department of Social Work (*Socialhögskolan*). This meant it was equidistant from both universities and within walking distance of both the main Stockholm University Frescati campus and *Karolinska Institutet*. Thus, we were to work in a beautiful building, which was also an outstanding example of ‘Swedish modern’ (functionalist) architecture.

We could not wish for anything better. CHES has stayed there ever since and now occupies a long corridor giving space to more than thirty people.

The issue of a fair deal between the two universities was important, and not primarily about where CHES was localised. It was an open question whether CHES should fall under the administrative umbrella of Stockholm University or *Karolinska Institutet*. That was decided at the highest level. It so happened that Stock-

holm University and KI had made another joint application to SFR at the same time. This was also successful and led to the founding of ARC, the Aging Research Centre. ARC and CHES were joint Stockholm University-Karolinska *Institutet* undertakings, but each centre would have to be administered by only one of the universities. Hans Wigzell, then still vice-chancellor of KI, was more interested in aging research than in research into health inequalities and put his weight behind ARC being under the auspices of the *Karolinska Institutet*. In the interest of fairness, CHES would then fall under the auspices of Stockholm University. And so it was.

The formal agreements between Stockholm University and *Karolinska Institutet* about joint ownership of ARC and CHES were based on the principle of power balance. And they were exact mirror images of each other. The chair of the board of CHES should be nominated by *Karolinska Institutet* and the director must be a professor employed at Stockholm University. At ARC the opposite was true. Stockholm University nominates the chair of the ARC board and the director is a professor at *Karolinska Institutet*. Each board should have an equal number of representatives from each university. Ann Fritzell at the Faculty Office had led the drafting of the agreements. The balance of power was introduced into every detail of the agreement, which guaranteed a

very smooth negotiating process. Bengt Winblad, a pioneer in aging research who became the first director of ARC, was highly impressed. He gave the negotiators from Stockholm University big hugs and explained that “I didn’t know that Stockholm University had such fantastic people”. This was Fritzell’s great moment.

Where did the research field come from?

The fact that health is unevenly distributed across social classes, occupations, regions and the two sexes has been known for a very long time. Medieval church paintings portray death dancing with the different trades or occupations in society: the farmer, the priest, the merchant, the blacksmith and so on. As early as 1766, Pehr Wargentin had analysed the Swedish Population Census for the Royal Swedish Academy of Sciences, comparing the mortality of men and women. He observed that male mortality was higher in every age group and concluded that men were the weaker sex. Abraham Bäck, another member of the Royal Swedish Academy of Sciences, observed in 1764 that “the poverty-stricken are ravaged by pestilence while few of the wealthier fall ill... When I consider the causes behind diseases and excessive mortality among the peasantry, and the worse-off in the towns, the first and foremost are poverty, misery, lack of bread, anxiety and despair” (Bäck 1765). Thus inequalities in health

seem to have deep roots in history. However, this view is not shared by everyone. Some modern economists, notably Angus Deaton, claim that they arrived with industrialization, not earlier.

The British, with their acute awareness of class, have produced decennial statistics on social class differences in mortality, based on censuses, since 1911. In every decade since then, a clear social class gradient in mortality has been reported; higher social classes live longer lives than lower. It was these persistent statistics that triggered the Black Report in Britain in 1977 (Department of Health and Social Services 1980). The British Labour government asked Sir Douglas Black to review the evidence about social class and health: what caused inequality in health and mortality, and what could be done about it? The Black Report was published in August 1980, under the new conservative government of Margaret Thatcher. Her government was not pleased; the health minister dismissed the report and only 250 copies were printed. The brutal dismissal of the report and all its suggestions, paradoxically, made it famous. Some years later, the shorter, paperback version of the report sold more than 100,000 copies. It triggered enormous research activity, partly because the report was a true landmark and partly because it left unresolved most of the explanation concerning how health inequalities re-emerge in every new generation in modern society.

I was present at Sir Douglas Black's first presentation of the report, before its publication at the Royal Free Hospital in London in 1979. To me, as a young sociologist, it was already clear that he had opened up a Pandora's Box. Not only were societies stratified by class and education, but this stratification also had profound implications for human health, creating inequalities in health. The Black Report quoted research from Sweden, claiming that Sweden had "probably" eradicated social class differences in infant mortality and child growth. The support for the first claim came from Sjölin's study of regional differences in infant mortality in Sweden. They showed a strong secular trend of narrowing gaps. However, this was by region and not by social class or education. The claim about disappearing growth inequalities came from a local study of school children in Malmö. Swedish researchers who noted these claims naturally wanted to examine them closer. Much later, both claims were rejected in two doctoral theses, by Maria Peck and Marit Gisselmann, both at Stockholm University. And Viveca Östberg, in her thesis, had shown that child and youth mortality in modern Sweden, for the ages 1–19, was still influenced by the social class of their parents.

The Black Report created a momentum in Sweden and provided Swedish public health researchers with a new focus on inequality in health. The research groups at Stockholm Uni-

versity and *Karolinska Institutet* that joined forces in applying for CHES had “[...] produced 11 doctoral theses in the area of health inequalities in the 1990s and just in the period 1996–1999 around 150 international scientific publications”, to quote our application for CHES.

The most important aspect of the Black Report was that it proposed a typology of explanations for health inequalities. In particular, it introduced the distinction between explanations based on selection and explanations based on social causation. In the former case, the idea was that healthy people moved up the social ladder, and that this was the way that social class differences in health came about. A large part of the discussion among researchers in the 1980s dealt with this issue. Olle Lundberg, for instance, in his doctoral thesis in 1990, noted that health in childhood had only a very marginal impact on social mobility and on the social pattern of adult disease. Most researchers would agree today.

Mainstream public health was concerned with prevention of disease, rather than with medical care. Geoffrey Rose’s pioneering book on ‘the strategy of preventive medicine’, published 1992, had had a profound impact and showed the great potential of public health once there was an understanding of how causes of disease were distributed in the population. Causes of ill health that were widespread in so-

ciety, even if relatively unimportant for an individual, could have a huge impact on the level of health and disease in society. However, at that time these causes were usually assumed to be individual behaviours or exposures at an adult age, such as alcohol drinking, tobacco smoking, salt intake or physical activity – a somewhat narrow perspective. Swedish researchers, such as Ulf Lundberg, Ingvar Lundberg and Töres Theorell, all emphasised the work environment as important for adult health. Swedish research on work and health was pioneering in this aspect.

David Barker, a British epidemiologist based in Southampton, challenged, in a big way, the assumption that adult behaviours or adult work environments were the most important causes of adult disease. In a series of more than 40 papers in the space of a few years in the 1990s, he demonstrated the importance of the early environment for later health (Barker 1992). The foetal and infancy periods were ones of ‘biological programming’ according to Barker, and what happened later in life was relatively unimportant. As a response to David Barker’s tour-de-force in publishing, Dave Leon from London, together with myself and Hans Lithell in Uppsala, had started a collaboration collecting birth data from *Akademiska Sjukhuset* in Uppsala and linking these to later census and mortality data. We wanted to replicate Barker’s studies. Working together with

Ilona Koupil, Bitte Modin and Kristiina Rajaleid, all of whom are at CHESS today, we could replicate and extend Barker's studies and confirm the importance of the foetal environment. However, Bitte Modin's thesis, the first one produced at CHESS, showed that early social factors, such as being born out of wedlock, were equally important as early predictors of adult health. Thus, early environment must be thought of as both the biological and social circumstances of a new human individual.

Much later, in January 2006, David Barker visited CHESS and gave a well-attended seminar. His presentation upset some people by more or less dismissing the importance of adult nutritional intake and physical activity. Heart disease, cancer and obesity all had their roots very early in life, was his point. Of course, he understood that adult exposures had an impact. This was his style of arguing, his way of making a point which was difficult to take for some.

A bitter conflict was looming between researchers about which period of life was most important for adult disease. It was resolved by the gradually growing insight that both early life and adult life were important and, furthermore, that they may interact. Being obese in adult life, for instance, was especially hazardous if you were born with a low birth weight. Low birth weight babies tended to do worse in school and were thus less likely to be

upwardly mobile in society. People's lives unfolded in such a way that early experience influenced and modified the force of later experiences.

These insights also threw a different light on the Black Report's selection explanation. If someone was upwardly mobile due to his/her good childhood health or cognitive ability, the likelihood is that the good health or cognitive ability in childhood was itself a result of earlier social processes acting already in the foetal or infancy period. 'Health selection' could therefore be seen as just another form of 'social causation'.

There were many other theoretical problems with the Black Report. Raymond Illsley and I had in 1995 summed up the first decade of discussions of the report (Vågerö & Illsley 1995). By then, a consensus was emerging that the social distribution of health and mortality was a result of social forces acting upon the human body, from conception up to old age. In addition, most people agreed that health was likely to influence a person's social achievements and career in some way. Thus health achievements and social achievements unfolded together, mutually influencing each other during the course of life. That consensus solved several theoretical conflicts which had previously dominated the field.

On May 12th 1999, when Stockholm University and *Karolinska Institutet* submitted their



The CHES corridor.
CHES offices are
converted classrooms,
ready to be changed back
to their original purpose
on request. (Photo: Mats
Danielson)

joint proposal for a Centre for Health Equity Studies in Stockholm, our programmatic platform reflected all the above discussions synthesized into a programme. Nevertheless, the evaluators were conscientious. In a letter, they asked us to specify “the priorities among our plans”. In November 1999, Finn Diderichsen and I spelt out those priorities in the following way: Firstly, to achieve “a creative interdisciplinary environment” by exploiting the different competencies of people with widely different academic backgrounds; secondly, to study the emergence of health inequalities by 1) focusing on contextual influences, including social policies; 2) exploring “the short and long term influence of the early social environment for health’ and 3) examining ‘how control of life circumstances, specifically at work, in the home and during other activities [...] influence psycho-biological mechanisms”. The evaluators accepted our priorities and the new research centre thus had its first research programme approved and financed.

CHES – the first years

The contract with SFR was signed on June 30th 2000. I was appointed the first director of CHES, and took up the position from July 1st 2000. In front of me I had a six year contract with SFR, granting us 24 million SEK to spend over six years, but no staff and no activity yet. The contract also stated that a number of positions should be guaranteed by resources

from the two collaborating universities. For me, this was a great sense of freedom and opportunity.

Six months later, in January 2001, the first researchers moved into the new premises at Sveaplan. Seven people, all from my own research group and funded by previous external grants, formed the core of the centre. Ulf Lundberg and Britt af Klintberg, both from the psychology department, moved in with three colleagues in March and April 2001. Diderichsen’s research group was to be a central element of the centre, but during the spring of 2001 Diderichsen, quite unexpectedly, left us. This was a difficult moment. He had fallen deeply in love with a Danish woman, married and moved to Copenhagen where he took up a new professorship. We wished him good luck, of course, but his departure delayed considerably the move of public health scientists from KI to CHES. Eventually, though, the public health group at KI was integrated with CHES. In the spring of 2002, three doctoral students in public health science were appointed and financed (Gloria Macassa, Maria Kölegård Stjärne and Monica Åberg Yngwe). Their supervisors at KI (Johan Hallquist and Bo Burström) became affiliated with CHES; all five became important members of the new research environment. Ingvar Lundberg, occupational epidemiologist from KI, also joined us for a time.

The director of CHESS was also a member of the board, working under its supervision. To chair the board, *Karolinska Institutet* nominated Kerstin Hagenfeldt, professor emerita at KI, who was duly appointed. Among the other members of the first board were Joakim Palme from Stockholm University and Christer Hogstedt from KI. Stig Wall, Gunnar Ågren, Lena Sommestad and Gabriel Romanus were appointed by SFR, and Viveca Östberg (later) represented the staff. Affiliated members were Finn Diderichsen and Ulf Lundberg. This was a formidable group of people.

The board held its first meeting on October 2nd, 2000. This dealt with how CHESS was to be built up: the balance between its role as a research centre and as a network coordinator. What kind of posts should be created and what questions were of strategic importance? At the following board meeting, in November 2000, we decided to advertise two professorships in health equity studies. One of those was to have a public health science perspective and the other a social science perspective.

We advertised in international media and received 17 applications in all. The appointments panel worked fast. In December 2001, Olle Lundberg took up the professorship in health equity studies with a social science perspective. Lundberg came from the Swedish Institute for Social Research at Stockholm University (SOFI). We had worked together for more than

a decade already. Ilona Koupil was appointed professor of health equity studies with a public health science perspective. She took up her position from September 2002. Koupil came from the Department of Epidemiology at the London School of Hygiene and Tropical Medicine; the ‘trop shop’ as it was affectionately called by both friends and foes. She had previously worked with me, Dave Leon and Hans Lithell as a PhD student in Uppsala.

In the spring of 2001, the board decided to establish two more senior research positions: one in behavioural medicine the other in ‘sociology, in particular social stratification and inequality’. Thus CHESS was joined by Gunilla Krantz from the Nordic School of Public Health and Johan Fritzell from SOFI. Fritzell’s position was immediately upgraded to a professorship.

At the end of 2002, the first phase in the creation of CHESS was concluded. There were ten well-qualified researchers and seven PhD students from three disciplines, all working under the same roof. The atmosphere was open and lively and with a minimal amount of hierarchical relations.

A hard question and a difficult crisis

CHESS was supposed to be a national and international research node. The first network conference was held in October 2002. Its theme was: “Health inequalities: why do they persist

in modern societies?” The assumption, as already spelt out in the Black Report, was that health inequalities should disappear with economic and social progress. It was, however, clear that health inequalities were anything but a mere relic of the past. Instead, they seemed to be re-generated in each new generation. Three plenary speakers attempted to answer this puzzle: Sara Arber from Guildford, Anton Kunst from Rotterdam and Olle Lundberg from CHESS. It was a hard issue to tackle. Much of the European research of the last two decades has dealt with this question.

The same question was asked again a decade later. In January 2013, an international symposium organized by the Royal Swedish Academy of Sciences asked: “Health inequalities in modern welfare states – do we understand present trends?” By then, we had learnt that not only do health inequalities persist, but also that they are getting larger in many (most?) countries. Increasing gaps in life expectancy between those with low and high education in the Nordic countries were a concern and a puzzle.

The attempted answer at the latter symposium was threefold: 1) patterns of consumption (alcohol, tobacco, poor food) have changed for the better much faster among the highly-educated than among the more poorly-educated; 2) the erosion in later years of social protection provided by the welfare state took its toll on

lower social classes and those outside the labour market; and 3) the shortcomings of national states when it comes to coping with global pressures on labour markets, incomes and tax regimes have resulted in increasing social and economic inequalities in general.

These were tentative answers and the fundamental question still awaits clarification and resolution. Health inequalities mirror social inequalities; these also seem to have deepened in recent decades. Thus health inequalities research has good reason to be aware of what is going on in neighbouring research fields focusing on social inequalities, such as those which address economic inequalities or unequal educational or job opportunities.

The contract with SFR had stipulated that CHESS's performance should be evaluated in 2004, more than half way through the six-year contract. But even before 2004 a Nordic group, led by Finn Kamper-Jørgensen, had been busy evaluating Nordic public health research at large. In spite of its tender age, CHESS was included and the group concluded, in February 2004, that “CHESS provides an important focus, ensuring that Sweden remains internationally central within inequalities in health research over the coming decades”. We were pleased and looked forward to the SFR evaluation with confidence. Sally Macintyre, Johan Mackenbach and Johannes Siegrist were asked again. Their review was a careful discussion of

strengths and weaknesses at CHESS, and reflections on areas to develop further, such as the understanding of income dynamics and closer ties to some medical disciplines. They concluded that “CHESS has made an excellent start” and recommended continued funding. They advised SFR that “funding decisions be made as quickly as possible in order to reduce planning blight”. However, exactly this point was to develop into the first major crisis in CHESS’s history.

One sentence in the contract became disputed. It gave me sleepless nights for a period and led to an exchange in the Swedish parliament. It is this: “If the evaluation of CHESS is positive, SFR will facilitate the permanent transfer to Stockholm University of financial resources corresponding to SFR’s annual contributions”. This was understood by us to be a commitment of the Ministry of Education to long term financing, conditional upon the evaluation. The Aging Research Centre had an identical clause in its contract, and was given an equally positive evaluation from its review panel. Both evaluations were unambiguous, but the promise in our contracts was not. The government’s legal experts explained, but not until 2005, that the paragraph in question was not binding. SFR did not have the mandate to promise such a thing. Thus, the financing of CHESS and ARC would cease when the present contract had run out on December 31, 2005. However,

as a good-will gesture, SFR (now called FAS) would make a smaller commitment after the contract had run out, phasing out its support gradually by cutting 25% each year during 2006–2009.

I know very little about what went on between the Ministry of Social Affairs, under whose auspices SFR/FAS operated, and the Ministry of Education, responsible for the long-term research financing of universities. Some harsh words, I guess. I suspect that it was the Ministry of Education that rocked the boat. When this information reached the vice-chancellors of Stockholm University and *Karolinska Institutet*, they reacted strongly. Kåre Bremer and Harriet Wallberg-Henriksson were both upset. In a pointed letter to the Minister of Education, Leif Pagrotsky, the two vice-chancellors wrote on June 1, 2005:

SU and KI assume that the original agreement shall be respected and that both universities will receive permanent resources...

And if this was not possible for some reason:

...we will have to reassess and cut down these activities. There is no possibility to finance the present levels of activities from the resources now available to the universities.

This was in fact a threat to close down both CHESS and ARC, or at best to radically cut their resources and positions. Rune Åberg, the



View of the Sveaplan building from the hallway outside the CHESS entrance. (Photo: Mats Danielson)

new permanent secretary of SFR/FAS met the leadership of Stockholm University and *Karolinska Institutet* for a heated discussion, which took place in CHESS's library at Sveaplan in June 2005. This occasion is difficult to forget. Rune Åberg had a hard time. He concluded that CHESS and ARC were the first two victims of the philosophy of giving large strategic grants to universities without any financial commitment after the contract time. This was of course very true.

Gabriel Romanus, on the very same day, fought the issue in the Parliament. Romanus, previously chairman of the board of SFR, was now a member of the Swedish parliament. He raised the question of long term financing of CHESS, ARC and SoRAD there, triggering a long debate. Romanus had been part of the negotiating process leading up to the creation of CHESS and ARC and knew the situation very well. He tried to get Leif Pagrotsky to make a commitment, but with no luck. That the minis-

try cannot have a view on the research priorities of the universities was Pagrotsky's dull and disappointing response. To me and my colleagues this sounded quite illogical considering that the same government had started the whole process by its call to SFR to develop "a national program for research into inequalities in health", as it had been formulated nine years earlier in the 1996 Government Bill on research. In fact, the fundamental research question of why we have (growing) health inequalities in modern Sweden played no role whatsoever in the response from the minister of education. The institutional memory did not even go back nine years (Interpellation 2004/05:663).

There we were. A chilling message had been delivered, the implication of which was surely that we had to rethink our existence as an independent research centre. Neither FAS nor the Ministry of Education would change their minds. What could we do? I and Olle Lundberg, who had been deputy director of CHES since 2002, gradually developed a plan of action: we would have to apply for new strategic grants of similar size to the old grant. At the same time, we would try to convince both Stockholm University and *Karolinska Institutet* to increase their direct contributions to CHES, arguing that we had done well so far and that we had been an asset to both universities. Thirdly, we should explore our new contacts with the World Health Organisation

where I had just been appointed a member of its Commission on Social Determinants of Health. If all this failed, we would have to cut down on staff and to begin administer a sinking ship. This gave me many restless nights.

In 2006, we applied to become a 'FAS-Centre', the new strategic grant opportunity that SFR/FAS had created. We also argued in the board of the Faculty of Social Sciences, of which I was a member, that budget allocations should be more responsive to scientific output. CHES had a large scientific output, but this did not make any difference at all regarding how much money the faculty allocated to us. We had many discussions with Eskil Wadensjö, faculty dean, about how to secure CHES's existence at the University. We spoke, similarly, to the vice-chancellor of KI, Harriet Wallberg-Henriksson, and her staff. Members of CHES's board such as Chairperson Kerstin Hagenfeldt and Robert Erikson, now vice chairperson, were a great support in this.

In the end, we were lucky on all battlefronts. We managed to get a new strategic grant from FAS for ten years from 2007–2016. It gave us 55 million SEK in all, 5.5 million per year. The Faculty of Social Sciences at Stockholm University was also responsive. Our grant from the faculty grew to match the annual grant from FAS. *Karolinska Institutet* had lowered their contributions to CHES as a response to the broken promise in the contract with SFR, but

now they were back on board with an increased annual grant again. This was evidently the Matthew principle in action: if you win one grant, you are more likely to win the other one as well. Thirdly, our new work for the WHO gave us a small but important grant directly from the Ministry of Social Affairs. Thus, during the autumn of 2006, things were starting to look very bright again. CHESS had a long term grant covering ten years, several smaller external grants and a renewed commitment from both universities on a higher level than previously.

Our research programme, which led to the ten year grant (and to our position as an official ‘FAS-centre’) had the title: “Human society as a life-long determinant of human health”. Its leading research question is familiar to the reader by now: “Why are inequalities in health generated anew in every new generation and in every society?” It was by far the best and most comprehensive research programme that we have formulated so far. The mood had changed at CHESS. We were moving forward again.

Social determinants of health – knowledge into practice

At CHESS’s very first board meeting, Gunnar Ågren, then head of the Swedish Public Health Institute, had asked in what way our research results could be useful for practical public health purposes. If I remember right, we did

not have a very good answer. As researchers, we wanted to do research, and we hoped someone else would understand how to translate our research results into action on the part of governments, communities or individuals.

Public health has always had a very strong commitment to collective action by local or national governments. This has been most evident in dealing with epidemics, during which all governments around the world have taken coercive powers. In the past, sea ports could be closed; today it is airports, as during the bird flu epidemic. Cattle could be slaughtered en masse, as during the mad cow disease fear, or people could be coerced into being vaccinated, as during the swine flu epidemic. In contrast, governments have had much less clout when it comes to preventing chronic, non-communicable disease such as cancer, circulatory disease or mental health problems. These have often been seen as individual responsibility, full stop.

Nevertheless, Simon Szreter, a Cambridge historian, had argued with good evidence that the mortality decline in Britain during the 19th century was driven by local political reforms led by a “battling public health ideology” that achieved sanitary reforms, clean water, better housing and improved living conditions in general. Perhaps a modern version of this is what Gunnar Ågren had in mind? We do know enough to have better policies. I knew that the question of how social policies may influence



Entrance to CHES offices from the mail hallway of the Sveaplan building. (Photo: Mats Danielson)

health had long been preoccupying two of my colleagues who joined CHES from the Swedish Institute for Social Research (SOFI), Olle Lundberg and Johan Fritzell. Was there an opportunity to do serious research into this?

In March 2005 I received a phone call from Richard Poe at the World Health Organisation in Geneva. He told me that I had been nominated to be a member of the 'Commission on Social Determinants of Health', a three year commitment if I accepted. Twenty people were going to be appointed directly by the Head of WHO, Dr Lee Jong-wook. The issue was global health inequalities: what can we do about them. Global health inequalities

were appallingly large, with a life expectancy difference of almost 40 years between the best and the worst country at that time. The head of WHO feared that WHO was losing its leading role in world health affairs; other UN agencies were becoming more active in health, such as the World Bank, and even more so corporate actors such as the Gates Foundation. The Commission would work as an independent think tank and report directly to him. No strings attached. The Commission's advice, if accepted, would become WHO policy. The first meeting was going to be in three weeks' time in Santiago de Chile, hosted by the president of Chile, who would also be a

member of the Commission. Could I come? I was given 24 hours to think it over, but accepted straightaway. As it turned out, this appointment opened many doors for CHES for years to come.

Michael Marmot, professor of epidemiology in London and knighted “for services to health inequalities research” was to chair the Commission. I had worked with Marmot previously and know him well. In the Santiago meeting we discussed the possibility for CHES to study the importance of social policies for health. I was well prepared after discussions with my colleagues at CHES. Marmot wrote a letter to the Swedish public health minister at that time, Morgan Johansson. Could Sweden perhaps support the Commission by financing a study of how social policies influence health in modern industrial states? Johansson responded positively, and offered to host one of the Commission meetings in Stockholm. Thus, CHES was asked by the WHO Commission to produce a report, based on new research, examining the importance of Nordic welfare state policies for the health of their populations. This opened up a new line of research for CHES.

The ‘NEWS project’ (Nordic experience of welfare states and public health) started. It engaged many people at CHES: Olle Lundberg, Johan Fritzell, Monica Åberg Yngwe, Maria Kölegård Stjärne and Lisa Björk were behind the final report (2008). This was based on con-

tributions from many people; CHES’s Nordic network was especially important. The project combined data from two sources: the Human Mortality Data Base, held in Rostock, and the SCIP data base at Stockholm University. The SCIP data base (Social Citizenship Indicators Project) was a hidden treasure at Stockholm University. It had been developed and extended by Walter Korpi’s research group over the decades and offered comparable data on social rights, pension rights, social insurance system indicators and benefit levels for 18 OECD countries for most of the 20th century. Through ‘pooled cross-sectional time series analysis’ the group was able to conclude that generous social policies towards families and children were strongly linked to low levels of child poverty and low infant mortality rates. Furthermore, generous policies in terms of basic pension rights were linked to better survival among the elderly. Even if causality was not proven by these studies, they represented the beginning of a more systematic exploration of how social and economic policies in a country may change the health chances of its population. The WHO Commission subsequently came to embrace ‘social protection across the life course’ as one of its main recommendations for better and more equal health in all countries. The Lancet, in an editorial, praised the work.

The global WHO Commission published its report in the autumn of 2008. Since then,

CHESS researchers have been involved in several follow-up reviews at European, national and local levels, such as the ‘European Review of Social Determinants and the Health Divide’ commissioned by the European office of WHO in Copenhagen; the English Marmot Review, commissioned by the British government; the Norwegian Review on Health Inequities, commissioned by the Norwegian Health Ministry and the Commission for a socially sustainable Malmö, commissioned by the City of Malmö.

These reviews represent the most important efforts so far to translate the knowledge from our research field into practice. Many of us have also lectured widely, both in Sweden and abroad, about this experience. The Master’s Programme in Public Health at CHESS, which has been operating since 2008, has benefitted hugely from this engagement. Talking about CHESS engagement in the above reviews and commissions in December 2013, I could see Gunnar Ågren in the audience, nodding approvingly.

CHESS has for a long time been interested in the importance of the early environment for adult health and social achievement. Jenny Eklund, Anders Hjern, Ilona Koupil and Bitte Modin all worked to understand this. One of the recommendations, which has been common to all reviews following the original WHO Commission report, is that governments should focus on giving all children a good start in life. School and preschool, in particular, have been

in focus. It is perhaps not a coincidence that schooling has moved to the forefront in Swedish political life recently. The PISA study of 2014 pointed to shortcomings in the school results of children in Sweden. Two years earlier, the psychological well-being of school children had been in focus. An international symposium at the Royal Swedish Academy of Sciences concluded that children who were left behind their peers in learning to read in the first year at school were especially vulnerable later in school. The importance of school, school achievement and peer relations in the school class, and of teacher/pupil relations for children’s wellbeing and social status, has been a strongly emerging research field at CHESS.

Inequalities start early and become formative for the rest of life. The work of Viveca Östberg, Bitte Modin, Ylva Almqvist and Anton Lager has helped to transform the academic discussions about school, school achievement, and health and wellbeing in the short and long run. One particularly intriguing finding is that peer status and peer relations in a school class seem to have long term effects on both later educational achievement and adult mental wellbeing.

In 2013, CHESS could announce a new professorship in social paediatrics, financed by *Karolinska Institutet*. Anders Hjern was appointed and has joined forces with Östberg’s group. This is now a creative and dynamic research area.

Generation shift and new developments

One of the last strategic decisions that I took part in as director of CHESS was to launch an international ‘Master’s Programme in Population health’, today renamed as ‘Public health’. The board of CHESS discussed this in several meetings, realizing that it was a watershed decision. It encouraged us to take up this new task. The first students, around 25 persons, started in the autumn of 2008; half of them had a Swedish back-



The Sveaplan building from behind.

ground, the other half were foreign students. Monica Åberg Yngwe and Jenny Eklund guided them skilfully through the two-year programme. In 2014, the fourth generation of master’s students started their course work. The master’s students, most of them bright and engaged, have changed CHESS in positive ways. Some of them have continued to take up PhD studies with us.

In 2013, the Faculty of Social Sciences was given rights to award PhD degrees in ‘public health science’. The new discipline was going to be a shared responsibility between the Stress Research Institute and CHESS. This year, five PhD students in public health science have been admitted. To support this, a new professorship in public health science was advertised in June 2014.

I left as a director at the end of 2008 and consequently left the board at the same time. I can confess in retrospect that the only time when I was somewhat nervous about what we had achieved at CHESS and what we were planning to do in the future was in the run-up to board meetings. The board was the effective power holder, if it so desired. Yet the board was immensely supportive. Kerstin Hagenfeldt in particular took great care to make sure we were all right and that things went well. Later, in 2006, Nina Rehnqvist became the chair of the board. She filled the same role. She has stayed as chair of the board until today and been able to oversee the many new developments.

Thus, a new generation of CHES researches took over from 2009. Olle Lundberg became the new director, Viveca Östberg deputy director, Monica Åberg Yngwe was director of studies and later deputy director. Bitte Modin became head of CHES's postgraduate school and Jenny Eklund the new director of studies with Mikael Rostila as her deputy. Susanna Toivanen and Mikael Rostila, who both received their PhD degrees during the first years of CHES, now edited a volume of contributions around 'unfair health' for the broader Swedish public. All this has been a pleasure to watch from the ringside, without me ever feeling an urgent need to step inside the ring again.

CHES has matured and I have no doubt that it will continue to thrive and flourish. Stockholm is one of the best places in the world in which to do health research. Our human society influences people's life chances and health in a fundamental way, both historically and in the present. To study this empirically results in gaining theoretical insights, which in turn can lead to a better way of organizing our human affairs: what could be more fun or important?



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