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New Welfare in Health Insurances? Trends in Risk-Coverage and Self-Responsibility in Four European Countries

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Introduction

In the current economic and financial crisis, many European governments are debating cuts in healthcare costs. These debates, on the one hand, have a financial perspective, with cutting healthcare costs the highest ambition. On the other hand, they also have a moral perspective, for example when dealing with the coverage of lifestyle related health risks like binge drinking or smoking. Increasingly, the ideas of 'positive' or 'new' welfare are included in this discussion. Promoting a healthy lifestyle is stimulated or even financially rewarded in many domains of European welfare states, including healthcare (Department of Health, 2004; Jochelson, 2007; Fenger, 2009, 2011; Oliver and Brown, 2011; English, 2012).

This article sets out to explore in what ways the ideas of the social investment state and positive welfare have affected the coverage of healthcare costs in European countries. As systematic comparative information about this topic is scarce, this article fills an important knowledge gap. There is an abundance of information to be found about distinct European healthcare systems, healthcare provision structures, their financial management, level of reimbursements, out-pocket-payments and the like. However, a systematic overview of changes in health insurance coverage is lacking. This prevents an analysis of the underlying trends in European healthcare systems. Is healthcare coverage changing in European countries? And, if so, can we observe a general trend towards more preventive and pro-active coverage of health risks, as we might assume from the 'positive welfare' perspective? Or are changes in healthcare coverage more randomly distributed and inspired by financial rather than moral arguments? By answering these questions this article contributes to the overall ambitions of this themed section: exploring how the ideas of positive welfare have been implemented in practice and identifying important trends and dilemmas.

The article examines three health risks for which health insurance coverage is contested and explores the evolution of the coverage for these treatments in four different European countries. It focuses on smoking, family planning and preventive health check-ups. As healthcare systems in Europe differ considerably, it includes four countries with different healthcare systems: the UK, Sweden, Germany and the Netherlands. The empirical base of this article is formed by an analysis of written documents and websites

about healthcare coverage and healthcare systems in the four countries. In addition, we have asked experts from our own network in each of the countries for useful sources.

The article is structured as follows. In the next section, we briefly discuss the different European healthcare systems. Then we elaborate on the financial challenges of health care in the four countries, whereby we briefly outline their strategies directed at controlling health care costs. In the following section, the backgrounds of the three health risks will be discussed, showing why and how they are contested. That leads us to the core of this article: an overview of developments in healthcare coverage in the UK, Sweden, Germany and the Netherlands between 2004 and 2012. In the final section, we discuss the most important trends and dilemmas that follow from our analysis.

An overview of healthcare models in Europe

Broadly speaking, the vast majority of European health systems have their origins in either the Beveridgian or the Bismarckian model. Based on these two broad models, many authors have tried to come up with healthcare system typologies.

In this article, we take the distinction between the Beveridgian and the Bismarckian model as a starting point. The roots of healthcare services in the UK, Ireland, Spain, Portugal, Italy, Sweden, Denmark, Finland and Norway can be traced back to the Beveridgian model. Its base is universal provision of healthcare paid from general taxes, in combination with other sources of revenues. The Bismarckian model, with its roots in Prussia, forms the basis for health care systems in Germany, Austria, Belgium, the Netherlands, Luxembourg, France and Switzerland. This system is based on voluntary or compulsory health insurance of citizens. These two broad categories of healthcare typologies have been studied by many authors (see, for example, Van der Zee and Kroneman, 2007; Wagstaff, 2009). For this article we have selected four countries, equally distributed among the two broad categories: the UK, Sweden, Germany and the Netherlands. Before analyzing the developments in healthcare coverage in each of these countries in detail, we first focus on their institutional designs.

United Kingdom

The roots of the UK's healthcare system can be traced back to the Beveridge Report of 1942. Although the NHS has been subject to continual changes, its universal coverage has remained more or less constant. The overwhelming majority of the UK's population is entitled to NHS access. The NHS is the world's largest publicly funded healthcare service with an expenditure of £140.8 billion in 2010 (Adam, 2012). About 75 per cent of NHS funding comes from general tax revenues, payroll taxes (imposed on all employees) account for 20 per cent, user charges and other incomes account for 3 per cent, while the remaining 2 per cent comes from private sources (Harrison *et al*., 2011).

Many actors are involved in delivering healthcare through the NHS. Parliament can hold the Secretary of State for Health directly accountable for his department's conduct. The Department of Health is responsible for policy development, setting health priorities and controlling the overall pool of funds for the NHS. Strategic health authorities are responsible for managing healthcare and disbursing the funds to the regions. The entitlement to the NHS is free of charge for all 'ordinary residents' (see Harrison *et al*., 2011). For some treatments, the principal of cost-sharing is applied. People also can opt

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for private health care, either through employment-based care, individual-based care, or a Voluntary Healthcare Insurance (VHI).

Sweden

The Swedish public healthcare system also belongs to the family tree of the Beveridgian model. It can be characterised as a multi-level system. The central government delegates both the management and financial authorities to counties and municipalities. At the national level, the Ministry of Health is responsible for policy development and supervision among other issues such as scientific research. The regional authorities (counties) are the most important actors as they are primarily responsible for the management and delivery of primary care and specialist services in hospitals. Municipalities are responsible for elderly healthcare and social support services for disabled people such as home care services and nursing home care.

The public healthcare services are financed through different funds. The counties and municipalities use their right to levy local income taxes on their residents to finance the services. These revenues account for about 70 per cent of the funds. National taxes account for about 15 per cent of the total expenses on health care. The remaining revenues come from other sources, such as user charges (Schabloski, 2008). The entitlement to health services is free of charge for all Swedish residents. The publicly financed services also have elements of cost-sharing and out-of-pocket payments (see Anell, 2011). Additionally, people can buy supplementary care through their employers or individually.

The Netherlands

In 1941, the German occupiers pressured the Dutch government to introduce a Bismarckian-like system of health insurance (Schäfer *et al*., 2010). It consisted of private insurance for employees above a certain income level. Unemployed people or those with an income below the threshold got a compulsory basic insurance. This system remained more or less the same until 2006. Then the new Health Insurance Act introduced a single compulsory insurance scheme with competition between insurers (Schabloski, 2008).

Dutch residents are legally obliged to obtain a basic insurance package (*Basisverzekering*) as offered by the private insurers. Currently, there are about 35 competing insurers belonging to five major congregates. These insurers negotiate with healthcare providers about the price, volume and quality of care. Based on consultation with the Health Care Insurance Board, the government defines what is covered in the basic package (Schäfer *et al*., 2010). Because the basic package does not cover all costs, residents can also buy supplementary VHI to cover adult dental care, alternative medicine and the like.

The Health Insurance Act is primarily financed through two sources of revenues. First, employees and the Ministry of Health contribute to the Health Insurance Fund through income-based taxation contribution (50 per cent) and state contribution (5 per cent) for children's care. Second, adults contribute fixed community-based premiums (on average €1,100 per year) which accounts for approximately 45 per cent of all revenues (Schabloski, 2008). Additionally, most citizens have an 'own risk contribution' – a deductible amount of €350 (in 2013) to cover the first €350 of medical expenses.

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Germany

The German healthcare system has undergone many adjustments, but its basic structure with two main schemes, Statutory Health Insurance (SHI) offered by 'sickness funds' and Private Health Insurance (PHI), has remained rather the same (Schabloski, 2008). The 2007 *Gesundheitsreform* mandated universal coverage, whereby all uninsured but eligible citizens were re-enrolled to a fund. German residents can choose from numerous insurers (approximately 154 sickness funds and 45 private insurers) at any time. Self-employed and wealthy people can opt out of the SHI and buy PHI (approximately 10 per cent of the population does so).

The funding of the SHI is composed of employers' contributions, employees' contributions and premium subsidies. In 2011, the employee (or pensioner) contribution was rated at 8.2 per cent of the gross income, while the employer (or pension fund) had to top that with 7.3 per cent of the gross wage (Busse *et al*., 2011). The most important actor is the Federal Joint Committee that has SHI-wide regulatory power to assess healthcare quality and formulate in detail which services are covered. Another important actor is the Regional Association of SHI Physicians, which specifies the reimbursement for services provided by physicians within the German compulsory SHI.

Despite the fact that healthcare coverage is universalistic, patients also have to pay a fixed cost-sharing premium per visit for some services, which forms 2.85 per cent of the total healthcare revenues. Children are exempt from cost-sharing and people can also receive an amount of their contribution back if there has been no claim for one year (Busse *et al*., 2011).

Containing health care costs in four European countries

Over the past two decades, European countries have been constantly confronted with growing health care costs. This has led to all kinds of measures aimed at cost containment, with limited success in most countries. Table 1 provides an overview of the latest OECD data on healthcare spending in the four countries.

Table 1 demonstrates the trend of growing healthcare expenditure in the four countries. This pressure is primarily attributed to two main causes (Thomson *et al*., 2009). Firstly, the share of older people as a percentage of the total population is still growing. Consequently, the needs for their healthcare are growing as well, which will put pressure on the capacity of the health systems. Secondly, today technological innovations enable things to be done that were assumed to be impossible in the past. These developments have led to increasing healthcare uses and a growth of spending on healthcare. Faced with rising healthcare costs, European policymakers have introduced many new measures to help secure the financial sustainability of health systems (Pammolli *et al*., 2008). Most common measures are forms of co-payment, doctors' fees per visit or deducible coverages. Also, reforms such as the introduction of private insurers and competition between insurers or health care providers have made their entrance (Van de Ven *et al*., 2007; Schabloski, 2008; Thomson *et al*., 2009). In addition to these more or less neutral interventions, measures have also been taken aimed at specific, lifestyle-related health risks (see Van de Ven *et al*., 2007). In the next section, we elaborate on these risks.

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Table 1 Health expenditures as a percentage of GDP

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Germany	8.3	..	9.6	9.6	9.8	10.1	10.4	10.3	10.3	10.4	10.4	10.5	10.7	10.9	10.7	10.8	10.6	10.5	10.7	11.7	11.6
Netherlands	8.0	8.2	8.4	8.5	8.3	8.3	8.2	7.9	8.1	8.1	8.0	8.3	8.9	9.8	10.0	9.8	9.7	10.8	11.0	11.9	12.0
Sweden	8.2	8.0	8.2	8.4	8.0	8.0	8.2	8.0	8.1	8.2	8.2	8.9	9.2	9.3	9.1	9.1	8.9	8.9	9.2	9.9	9.6
United Kingdom	5.9	6.3	6.8	6.8	6.9	6.8	6.8	6.6	6.7	6.9	7.0	7.3	7.6	7.8	8.0	8.2	8.5	8.5	8.8	9.8	9.6

Source: OECD Health Data 2012.

Contested care: health risks for which coverage is under pressure

There are many health risks for which coverage is taken for granted, varying from severe influenza to life-threatening forms of cancer. Even though mild forms of co-payment may apply in the different countries, there is no debate at all about whether or not these treatments should be covered by the healthcare system. However, within some European countries there are voices that advocate a limitation to healthcare provision in cases of health problems that are caused by the (supposedly) irresponsible behavior of individuals. To obtain a clear picture of the developments in the different countries, we have selected three types of healthcare that are under discussion in at least one of the countries that we have selected.

First, is the coverage of smoking cessation therapies. In some European countries, the willingness to provide cover for stop-smoking therapies is rather low. In Germany, for instance, taking up smoking is considered as an individual choice, not as a health risk (see Nguyen-Kim *et al*., 2005). From this perspective, those people who wish to quit smoking should do so at their own expense.

Second, is the issue of fertility and family planning. More specifically, this considers coverage for in-vitro fertilisation treatments (IVF) for women with fertility problems and the contraceptive pill. To some extent, limited fertility can be considered as an unforeseeable health risk which cannot be attributed to individual behavior (see ESHRE, 2008). However, there are some individual factors, most notably age, which limit women's fertility. This may give rise to a debate about a maximum age for fertility treatments. Alternatively, the use of a contraceptive pill by some is considered as an individual choice and not a health risk. Therefore, coverage for the contraceptive pill in some countries is under discussion.

Finally, preventive health checks may contribute to the early diagnosis of future health problems which imply the avoidance of future health costs. However, they can also be considered as an unnecessary and unaffordable luxury aimed at comforting individuals rather than at preventing future illnesses. Therefore, universal preventive health checks are under debate in several European countries (Hoffman and Poortvliet, 2010). In the remaining sections, we explore the current state of affairs in the coverage of these health risks and trends in the four countries.

Developments in the coverage of smoking cessation in four countries

The Framework Convention on Tobacco Control (FCTC) is a treaty in the context of the UN's World Health Organization, signed by 168 countries worldwide including almost all European countries. In article 14 of the Convention, all signatories (168 countries) are called upon to take measures concerning smoking cessation. In general, two types of therapies can be used to assist individuals in their attempts to quit smoking: training sessions or medicines. A wide variety of training sessions have evolved in the different countries, in addition to the abundance of self-help books. Concerning medication, there are three medicines that are widely used to assist people: Zyban, Chantix and nicotine replacements.

In the UK, patients that wish to give up smoking can obtain both smoking cessation services and prescribed medications free of charge (for an overview of medications in UK

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see Kaplan, 2004). Hence, the government promotes quitting by providing different types of free-of-charge services and medicines (Bridgehead International, 2011). However, some national health services charge the patients a fixed fee per prescription regardless of the medication received. In England, for instance, the prescription charge is currently £7.20, while Scotland recently (2011) has joined Northern Ireland and Wales by abolishing prescription fees, except for English prescriptions.

The Swedish system showcases patterns of partial reimbursement for smoking cessation treatments. Although in Sweden primary care units provide help to those who want to quit smoking, the intensity of these services varies between different counties. Moreover, Sweden has a free of charge 'quit line'. Although nicotine replacement is available over the counter as the standard recognised medication for smoking cessation in Sweden, it is not reimbursed. However, medications such as bupropion and varenicline are reimbursed because they are labeled as second-line medications (Bridgehead International, 2011).

In the Netherlands, reimbursement of smoking cessation treatments has been subject to continuous adjustments the past few years. In 2009, the Minister of Health decided that such treatments should be covered by the basic insurance (*Basisverzekering*). In July 2010, a Royal Decree called the 'stop-smoking program' announced that from 2011 onwards the basic insurance would fully reimburse smoking cessation treatments once a year. However, reimbursement was deductible and only possible if a combination of treatments was used. One year later the basic insurance only reimbursed the training-part of stop-smoking treatments, whereby the insurers got the authority to decide which behavioral training was to be reimbursed. Recently, the Dutch Parliament has again amended these policies. As of 1 January 2013, individual or group sessions are reimbursable again, if such training is used in combination with medicines (STIVORO, 2012).

In Germany, stop-smoking treatments are partially reimbursable. Individual counseling is not reimbursed, while most German insurers do reimburse cognitive-behavioral group-based courses. The total cost of these courses and training sessions should not exceed the ceiling of around €100 per individual. In addition, there are different types of prescription or over-the-counter medicines available. These are not reimbursed as they are considered as lifestyle drugs and the German health authority has excluded all lifestyle drugs from coverage by insurers.

Developments in the coverage of fertility and family-planning in four countries

As indicated earlier in this article, the second health risk that we will discuss is related to family planning. Two aspects of family planning will be discussed: IVF treatments and the contraceptive pill. In this section, we will explore the developments in the coverage for these treatments in our four cases.

IVF treatment

In the UK, eligibility for IVF treatment is determined by age. Women between twenty-three and thirty-nine years are eligible for treatment. The place of treatment is restricted to the area in which the patients live. Couples have to prove that their fertility problems have lasted for at least three years. Since 2004, eligible couples have been able to receive

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up to three cycles of IVF treatment. If not eligible, women can purchase IVF treatment in private clinics.

In Sweden, IVF treatments are fully reimbursed if treatments are performed in public clinics (Fertility Europe, 2012; ESHRE, 2008; Jones *et al*., 2010). The coverage is limited to a ceiling of three cycles in most counties. Many counties have introduced policy measures aimed at reducing the number of IVF treatments (Jones *et al*., 2010). For instance, patients have to pay a fixed doctor's fee for the third treatment. Moreover, eligibility is restricted to specific age groups: women between twenty-four and thirty-seven and men between twenty-four and fifty-five. The period of unwanted childlessness should at least be three years for women under thirty-two and two years for women over thirty-two (CADTH, 2010).

In the Netherlands, from 2006 the basic insurance reimbursed three IVF treatments per ongoing pregnancy. An ongoing pregnancy is defined as a pregnancy that lasted no longer than twelve weeks. In this respect, if after week 12 a miscarriage occurs, the insured are entitled to another three treatments (Freya, 2012). In 2010, the Dutch government proposed to reduce the reimbursement to one treatment per ongoing pregnancy. After heavy protests, this proposal was reversed; but other measures have been introduced to reduce the costs of IVF in 2013. For example, women over forty-three have been excluded from reimbursement and the waiting period before starting a treatment has been extended (Dutch Ministry of Health, 2012).

In Germany, prior to 2004, four cycles of IVF were automatically reimbursable for 100 per cent on SHI. Since 2004, SHI has only covered 50 per cent of IVF costs up to a maximum of three cycles (Rayprich *et al*., 2010). The average out-of-pocket payment for a couple is between €1,500 and €1,800 per treatment. Recently, Germany introduced age limitations for married couples: only women between twenty-five and thirty-nine and men between twenty-five and forty-nine are eligible. In addition, non-married couples, HIV positive patients and treatments involving third parties are excluded from coverage to further cuts the costs of care (ESHRE, 2008 and Rauprich *et al*, 2010).

Contraceptive pill

In the UK, contraceptive pills are available free of charge from all contraception clinics, specific health clinics and GPs (Jenkins, 2011). As there appear to be no plans to change this, we may conclude that coverage of contraceptive pills in the UK has remained stable over time. The issue is not contested in this country.

Since the 1980s, prescribed contraceptive pills have been available at subsidised rates in Sweden. The healthcare authorities in almost all counties cover 25 per cent to 75 per cent of the sticker price (CFRR, 2009; Madestam and Simeonova, 2012). Subsidised pills are only available for young women aged up to twenty-four. Swedish public health clinics do offer free contraceptive counseling for young people (Madestam and Simeonova, 2012).

In the Netherlands, age-based eligibility criteria were introduced for contraceptive pills in 2011. Reimbursement for women under eighteen remained free of charge. Women between eighteen and twenty-one can obtain contraceptive pills at a subsidised rate,

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which is deductible. The basic insurance does not cover for contraceptive pills for individuals aged twenty-one or older.

In Germany, prescribed contraceptive medicine is available at subsidised prices for women under the age of twenty (PPFA, 2012). But they must pay a 10 per cent co-payment for the price of each contraceptive drug if the sticker price is higher than €5. The maximum amount of the co-payment does not exceed €10 (CFRR, 2009). Women over twenty pay the full sticker prices (Riesberg and Wörz, 2008).

Developments in the coverage of preventive health checks in four countries

Preventive health checks (PHC) include various components of preventive medical examination varying from blood tests to Magnetic Resonance Imaging (MRI). This section explores the coverage of preventive health checks in the four countries.

All citizens in the UK are entitled to general health check-ups through their GPs. During this check-up, a variety of checklists are covered. This entitlement covers all children under five for regular assessments, all adults if they have not visited a GP for three years and older people if they have not visited a GP for a year. Moreover, the NHS Health Check Programme (2012) provides free of charge preventive check-ups for everyone between the ages of forty and seventy-four concerning the risks on heart disease, stroke, diabetes and kidney disease. In addition, there are specific screenings for groups of residents, such as NHS Breast Screening which covers all women between the ages of fifty-three and seventy.

In Sweden, preventive services are covered through primary care, vaccinations, health examinations and consultations at both municipal and regional levels (Hohman and Chaua, 2006; Anell *et al*., 2012; Glenngård, 2012). However, the patients do have to pay a fixed price for each visit to a GP or medial specialist. Specific groups, such as young people under the age of twenty and pregnant women, are exempt from co-payments. Women are offered regular check-ups during the entire pregnancy (Holland *et al*., 2006; Anell *et al*., 2012). As in the UK, Sweden does have specific preventive programs, such as a screening program aimed at detecting breast cancer for women between forty and seventy-four.

Hoffman and Poortvliet (2010) distinguish between at least five types of preventive health check-ups in the Netherlands, provided by either the GP, the insurer, the employer, a private clinic, or at one's own initiative. However, the basic insurance does not cover the costs of preventive health check-ups (Hoffman and Poortvliet, 2010). Preventive health check-ups are covered by most supplementary insurances. The trend is that occupational health services endorse preventive health policies. In this respect, many employees participate in collective supplementary insurance through their employers at reduced prices (Hoffman and Poortvliet, 2010).

In Germany, the statutory insurance reimburses the cost of preventive health check-ups (Blümel, 2012). At the present time, German insurers provide check-ups and screenings, immunisation, primary prevention and exercise. People can save on their health insurance premiums by participating in these programs (Augurzky *et al*., 2012). The government advises its citizens aged thirty-five and older to undergo a health check-up every two years. About 17 per cent of the target group actually do undertake a preventive health check-up.

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Table 2 An overview of coverage for medical treatments in four countries

	Smoking cessation		Fertility		Preventive health check
	Training	*Medicines*	*IVF*	*Contraceptive pill*	*GP or Specialised clinic*
UK					
Current situation	Free of charge services	Full reimbursement (prescription fee)	Coverage up to 3 cycles	Free of charge	Universal coverage
Trend	Stability: promotion of cessation	Stability: promotion of cessation	Reducing treatments by age and area codes limits, etc.	Stability	Stability
Sweden					
Current situation	Free of charge Quitline and clinic attendance	Partial reimbursement	Coverage up to 3 cycles	25% to 75% reimbursement	Universal coverage
Trend	Decrease regional difference	Decrease regional differences	Reducing treatments by age limits and clinics, etc.	Stability: subsidised only for those under 24	Stability
Netherlands					
Current situation	Once a year, deductible	Not any more, VHI is needed	3 cycles per targeted pregnancy	Not anymore for women older than aged 21	No reimbursement
Trend	Continuous adjustments	Reimbursement 2013	Reducing treatments by age limits	Not anymore for women older than aged 21	VHI: partially
Germany					
Current situation	Partial reimbursement	No reimbursement	50% reimbursement up to 3 cycles	Subsidised	Different types of reimbursement for aged 35 or older
Trend	Group based courses are more and more reimbursed, but up to a ceiling	Increasingly exclusion of so-called lifestyle drugs by law	Increased out-of-pocket payment, reducing treatments by age limits, etc.	Target group: women under age 20	Increasingly promoted by insurers and government

Conclusions

The aim of this article was to explore how the ideas of the social investment state get shape in the coverage of health treatments that mirror the ambitions of the social investment strategy. Table 2 provides a brief overview of our main findings.

This analysis has uncovered three important conclusions about the ways in which the ideas of positive welfare and the social investment state have found their ways into the healthcare systems in different European countries.

Firstly, the analysis clearly shows the normative and ideological implications of decisions concerning the coverage of health treatments. Although many reforms seem to be inspired by financial considerations, their moral implications should not be underestimated. This is obvious in the case of family planning. Positions in the public debate about the coverage of IVF treatments, specifically in Germany and the Netherlands, focus on the question of whether low-fertility is to be considered as an illness, a consequence of individual choices or couples' lack of patience (Rauprich *et al*., 2010; Freya, 2012). Therefore, we tend to conclude that even more so than in the other cases of this themed section, positive welfare in the case of healthcare inevitably forces authorities to take a position in cases of moral dilemmas.

Secondly, this article has sought to explore to what extent the ideas of the social investment state have been introduced in the area of healthcare and healthcare insurances. Based on this explorative analysis, we conclude that the image is dynamic and fragmented. There is no clear trend toward more social investment or preventive healthcare in our cases, neither within nor between countries. In the area of healthcare, decisions about coverage seem to be primarily based on financial considerations. How these decisions affect individual decisions about lifestyle seems to be only a secondary issue.

Thirdly, the article has explored general trends in the coverage of healthcare costs in four European countries. Despite the abundance of healthcare indicators and national case studies, it appears hard to identify comparable policies and coverage. To some extent, this may also explain the considerable differences in coverage between some of the countries we have analysed. For instance, what are the reasons that the upper limit for coverage of IVF treatments in European countries varying between thirty-seven (Sweden) and forty-three (the Netherlands)? And, perhaps even more importantly, what are the consequences of differences and similarities in the costs of healthcare and the health situations of citizens? A comparative overview of healthcare coverage may facilitate a European dialogue about the difficult normative decisions that need to be taken.

Our final conclusion underlines the importance of our analysis for this themed section and the issue of positive welfare in general. Welfare reform, including health care reform, is hardly ever an objective, neutral intervention in the welfare state. Redistributive effects and moral implications are almost inevitable. These first explorations in the dynamics of health care coverage in four European countries clearly illustrate the need for further, more detailed, empirical analyses of the redistributive and moral effects of the ideas of positive welfare and social investment.

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