Health Care as Social Investment

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Introduction

For many citizens, policy-makers, and scholars, one of the biggest achievements of our time is the welfare state. In modern societies, citizens in need of help turn to the state rather than begging on the street or having to rely on charity. To protect citizens from harm, welfare states have developed a broad range of policies and regulations and provide a variety of public services. As a socially constructed institution, the welfare state not only addresses fundamental questions such as social fairness and the basic notion of a good society but ultimately also reconciles democracy and capitalism (van Kersbergen and Manow 2017). From a technical perspective, a welfare state has been characterised by 'government-protected minimum standards of income, nutrition, health, housing and education, assured to every citizen as a political right, not charity' (Wilensky 1975 1) or, following Marshall (1950), as 'a democratic state that—in addition to civil and political rights—guarantees social protection as right to citizenship' (van Kersbergen and Manow 2017 364).

One of the welfare state's most important aims is to compensate workers once they have suffered mischance, mostly by transferring cash benefits to workers in need. Old age or unemployment compensation benefits are examples of passive compensation policies (Beramendi et al. 2015). Health care, by contrast, forms part of the increasingly relevant service dimension of the welfare state, just like education, childcare, care for the elderly, and active labour market policies. Health care is not only among the most popular branches of the

welfare state, as shown later in this section, but also among the most significant ones in terms of social spending. Public spending on health care is the second most extensive branch of social spending in the Organisation for Economic Co-operation and Development (OECD) countries, next to spending on old-age benefits, and far higher than spending on unemployment, as Figure 6.1 illustrates.

Within the OECD, spending on health care has followed an almost universal trend upwards. Before the global financial and economic crises of 2008–12, health care spending rose faster than average economic growth in most countries. During the crises, however, many countries introduced strong austerity measures such as cutting salaries or the number of employees in the health sector[1], introducing additional out-of-pocket-payments, or imposing restrictions on spending for pharmaceuticals (OECD 2018). Since 2012, health spending has tended to follow economic growth more closely (OECD 2018). Yet, despite a shift towards 'relative privatization' (Rothgang et al. 2010),[1] public finances still account for the bulk of health spending: according to the OECD (2018), two-thirds of health care spending is financed by taxes and social insurance contributions. If no further cost containment measures are taken, private and public health expenditure across OECD countries are projected to almost double from around 6 percent in the period of 2006-2010 to 12 per cent by 2060 (de la Maisonneuve and Martins 2015: 74).

[1] In Greece, one of the countries most drastically affected by the crisis, the salaries of the public healthcare workforce were cut by 15 percent, the thirteenth and fourteenth monthly salary was abolished and pension benefits were cut by 10 percent Simou, Effie, and Eleni Koutsogeorgou. 2014. "Effects of the economic crisis on health and healthcare in Greece in the literature from 2009 to 2013: A systematic review." *Health Policy* 115(2):111-19.

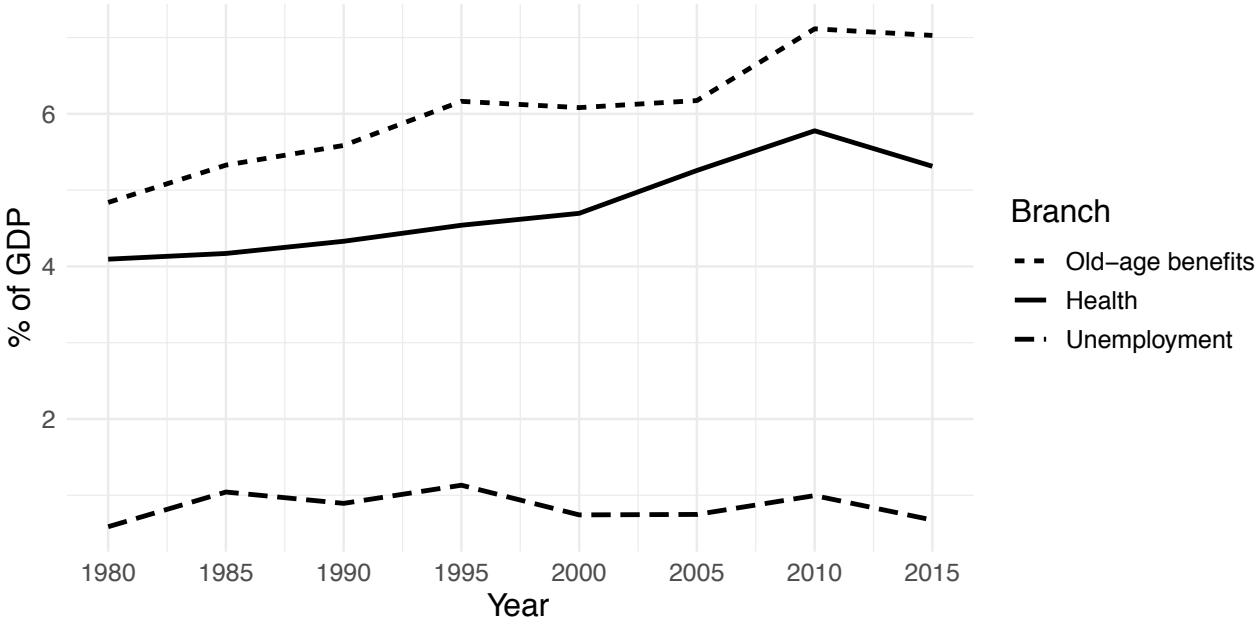

Figure 6.1 **Cross-national trends in public spending on health care, old-age benefits, and unemployment in the OECD as a share of GDP, 1980–2015**
Source: (2019)

Just as for the other branches of the welfare state, policy-makers consider this upward spending trend increasingly problematic given that the amount of resources to be poured into the health care system appears limited in times of 'permanent austerity' (Pierson 2001). Hence, since the late 1980s, when universal coverage of health risks was achieved in almost all OECD countries[2], the political debate in these societies has turned from the question of providing universal access to that of managing the cost side of health care provision. The debate focuses on controlling fees and general spending rather than excluding population segments or 'de-listing' once publicly covered benefits (Freeman and Rothgang 2010; Hacker 2004).

The upward trend in spending on health has several explanations. For one, technological progress makes medical services more expensive. In medical services, progress is defined by 'product' rather than 'process' innovation, meaning that innovation adds more products, resulting in higher costs rather than savings. Personal services such as medical attention are

also much less subject to rationalisation than are material goods. Rather, they are characterised by the 'cost disease of personal services' (Baumol 1967) by which the price of personal services increases at a faster pace than average prices. Medical services become a luxury good for which demand increases with increasing wealth. This means that as people become wealthier their relative demand for material consumption goods such as cars, mobile phones, or clothing decreases, whereas their relative demand for medical services increases. In addition, the health market is characterised by uncertainty, risk aversion, and issue complexity, which empowers precisely those actors (i.e. medical doctors) that have an interest in high spending (Hacker 2004).

Spending for health care is also driven by the same demographic trends that drive spending on old-age pension benefits: The ageing of post-industrial societies in the OECD increases the number of multimorbid, chronically ill patients in need of treatment, a factor that is exacerbated by the self-reproducing effect of successful treatment: successful treatment leads to more demand as survivors need further treatment or might need treatment in later stages of life (Freeman and Rothgang 2010).

Cost containment is further complicated by the popularity of health care among the population. Public provision of health care is among the most popular branches of the welfare state, arguably because of the universality of health care risks and the perception of the ill as deserving (Van Oorschot and Roosma 2015). As shown in Figure 6.2 based on data from the International Social Security Programme (ISSP) Role of Government V (RoG V) module (2016), a majority of the public across the selected OECD countries demands more public spending on health care. Furthermore, in all but one country (Switzerland), the share of respondents in favour of more public spending on health care is higher than the share of citizens in favour of higher spending for old-age provision.

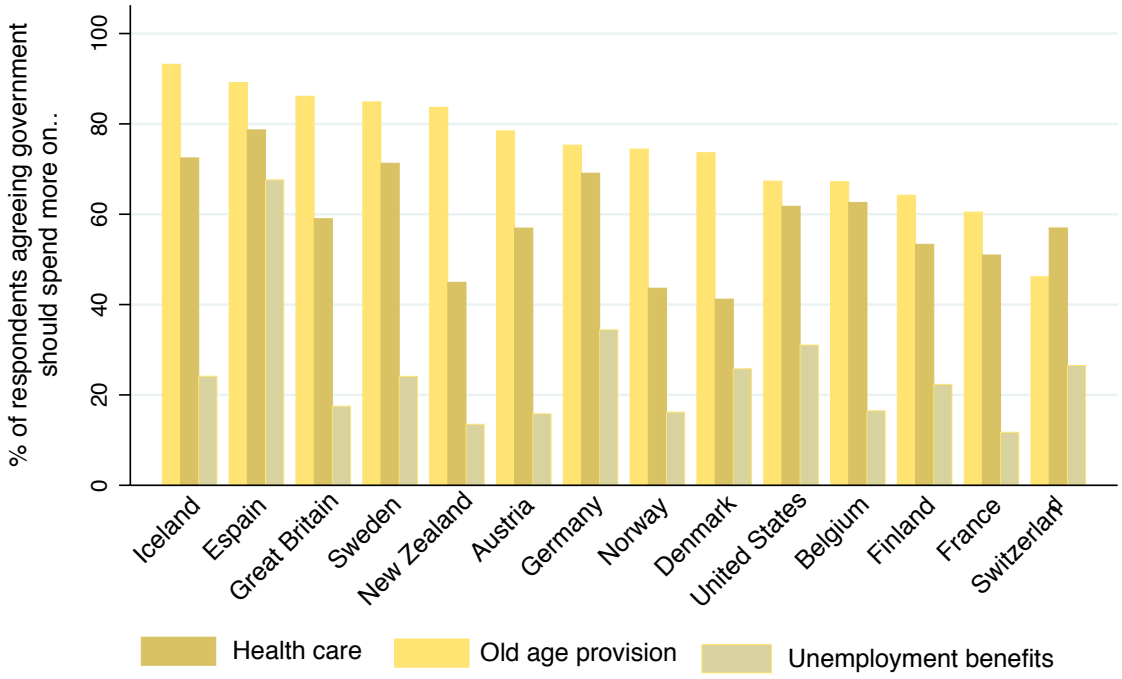

Figure 6.2 **Public support for higher government spending on selected welfare state branches**
Source: ISSP (2016)

The twin pressures of rising demand and limited availability of resources are not unique to health care.[3] Other branches of the welfare state struggle to adapt to the new economic and social contexts as well. While earlier arguments expected international factors such as globalisation to lead to a downward pressure and welfare state retrenchment in the form of a 'race to the bottom' (Garrett 2001), the direction of social policy reforms rather points to a modernisation of the welfare state, a development best exemplified in the discussion about a social investment turn (Esping-Andersen et al. 2002; Garritzmann, Häusermann and Palier 2017; Hemerijck 2018; Jenson 2009). Social investment policies are 'policies that both invest in human capital development and that help make efficient use of human capital, while fostering greater social inclusion' (Morel, Palier and Palme 2012 2).

Reconsidering social investment's three functions (stock, flow, and buffer) and its emphasis on capacitating social justice, human capital development, and efficient use of human capital, this chapter argues that health care plays a crucial role in the new social investment welfare state. To underpin this argument, the next section outlines the position of health care within comparative welfare state research, emphasising that the literature proposed different explanations for the origins and cross-national variation of health care systems and of social protection systems. On that basis, the role of health care in the debate about a social investment welfare state is then explained. The final section summarises the argument for raising the profile of health care and highlights the implications it has for policy-making and governance.

<A> Health Care in Welfare State Research and Policy Analysis

The cross-cutting variation in the organisation of health care provision and the different underlying explanations for this variation are two reasons why the analysis of health care is still not fully integrated in the comparative welfare state research that underpins much policy-making and analysis (but see Bambra (2005) and Reibling (2010) for attempts to link health care and welfare typology research). To understand why this is significant, it is important to first review the main insights of the research field as it seeks to explain cross-national variation in social protection provision, highlighting its inherently political nature. I will then discuss how these approaches apply to the analysis of health care and discuss alternative explanations for cross-national difference in the provision of health care.

Esping-Andersen's (1990) classical typology of 'worlds of welfare capitalism' is based on three dimensions of welfare state analysis (decommodification, stratification, and primary

provider of welfare[4]). As noted, the core explanation for this cross-regime variety is political: it is the result of conflict between social groups and their different political powers. Specific patterns of party competition and the power of political movements such as the labour or the women's movement closely correspond to the distinct worlds of welfare capitalism (Esping-Andersen 1990). More precisely, the dominance of liberal/conservative, social democratic, or Christian democratic parties in the respective political systems and their power in government are crucial in explaining why welfare states differ across countries (Allan and Scruggs 2004; Döring and Schwander 2015; Huber and Stephens 2001a; Manow, Palier and Schwander 2018a). Box 6.1 provides a brief overview of the main types of welfare states and political configurations that influence them.

Box 6.1 begins here

Box 6.1 **Main 'worlds of welfare capitalism'**

Liberal: Secular-liberal or conservative parties dominate the party competition in the Anglo-Saxon world, for example, Canada, United Kingdom, and the US, also because the majoritarian rules of electoral competition disadvantage the left (Döring and Manow 2017). The result of the conservative dominance is a residual system of social protection, which directs the middle class to search for market solutions. Accordingly, those who can afford it buy services such as education, health care, childcare, and additional social protection in the form of private insurance on the market (Ansell and Gingrich 2013; Esping-Andersen 1990; Huber and Stephens 2001b; Iversen and Stephens 2008).

Social democratic: This type of welfare state is the result of the hegemonic position of social democratic parties in the Scandinavian political systems, which built the welfare state according to egalitarian ideas with the support of strong and encompassing trade unions. A

generous, mainly tax-financed welfare state not only pays out generous cash benefits but also offers comprehensive public services such as schooling, industrial retraining, and public early childhood education and childcare. As Esping-Andersen (1990) emphasises, these encompassing public services were what guaranteed the support of the middle class for the welfare state and turned the welfare state into a highly legitimised 'people's home'.

Conservative: The conservative or corporatist welfare states, shaped by the pivotal Christian democracy in continental Europe (Huber and Stephens 2001b; Manow 2004) is a social insurance state, administered by a mix of private and public stakeholders and with a strong emphasis on cash transfers rather than public services to protect its citizens (Esping-Andersen 1990).

Southern Europe: Although not originally considered a distinct type, scholarly consensus considers Southern Europe a fourth welfare regime type (Bonoli 1997; Ferrera 1996; Guillen 2002; Leibfried 1993; Manow, Palier and Schwander 2018b). The Southern welfare regime appears distinct—among other reasons—for its strongly segmented labour markets and fragmented welfare states offering generous protection for insiders while providing only very little protection for other social groups (Manow, Palier and Schwander 2018a). For instance, Italy did not broaden its unemployment protection scheme until 2015, and social assistance schemes were expanded only very recently in Southern Europe. This patchy expansion of the welfare state is explained by the strong polarisation of the political system between a revolutionary left and a conservative Christian democracy, which made attempts to overcome occupational fragmentation in favour of universal social insurance schemes impossible (Ferrera 1996 31; Watson 2008). Universalism was implemented only where no vested worker interests were affected, namely, in health care.

End of Box 6.1

Though highly influential in the analysis of welfare states and their origins, functions, and governance, the framework has not fully taken into account variation in how health care provision is organised (even though health risks are one of the oldest and most universal social risks) and the effect of this variation on access to health care and outcomes such as health inequalities. One explanation for this scant consideration is that the fundamental 'equality versus market' conflict on which the welfare state is centred in this framework does not directly apply to variations in health care systems.[5] How health care is organised does not affect distributive conflicts between social classes in the same way as the organisation of other social protection measures such as old-age pensions, unemployment compensation systems, or disability schemes does. In particular, it does not touch vested interests of traditional stakeholders such as trade unions and employer associations. This is seen as a reason why Southern European countries with their strong and radical trade unions and left-oriented parties have developed universal, non-contributory but tax-financed national health care systems just as have liberal countries such as the UK or Canada where the left is historically much weaker (Manow 2015).

Accordingly, existing classifications of health care systems are not based on political power constellations or on their distributive implications but rather on the source of financing and the distinction between private or public ownership of facilities (Freeman and Rothgang 2010) or the number of payers combined with the ownership of facilities (Hacker 2004). Others include not only the financing but also the regulation and the type of providers of health care services (Reibling 2010; Wendt 2009; Wendt 2014). The most common typologies such as that differentiating between national health service systems, social insurance systems, and the rare type of private systems therefore are based on different criteria than the worlds of

welfare capitalism typology. Furthermore, they cut across it, with national health services tending to be found in the countries of the Scandinavian type, Southern Europe, and the UK, and social insurance in continental and Central Europe, except Switzerland.

The second reason for the shadowy existence of health issues in analyses of the welfare state is that expansion and variation in health care provision are much less driven by political factors such as the strength of the labour movement or government partisanship that are at the heart of many conflict-based approaches. Thus, health care does not fit in the common theoretical frameworks.[6] As shown in Figure 6.3, based on data from ISSP(2016), the traditional explanations for within-society variation do not seem to apply: support for more public spending on health care is much less stratified by educational attainment than is support for more spending on other typical social policy programmes such as old-age provision and unemployment benefits that have strong distributive implications.

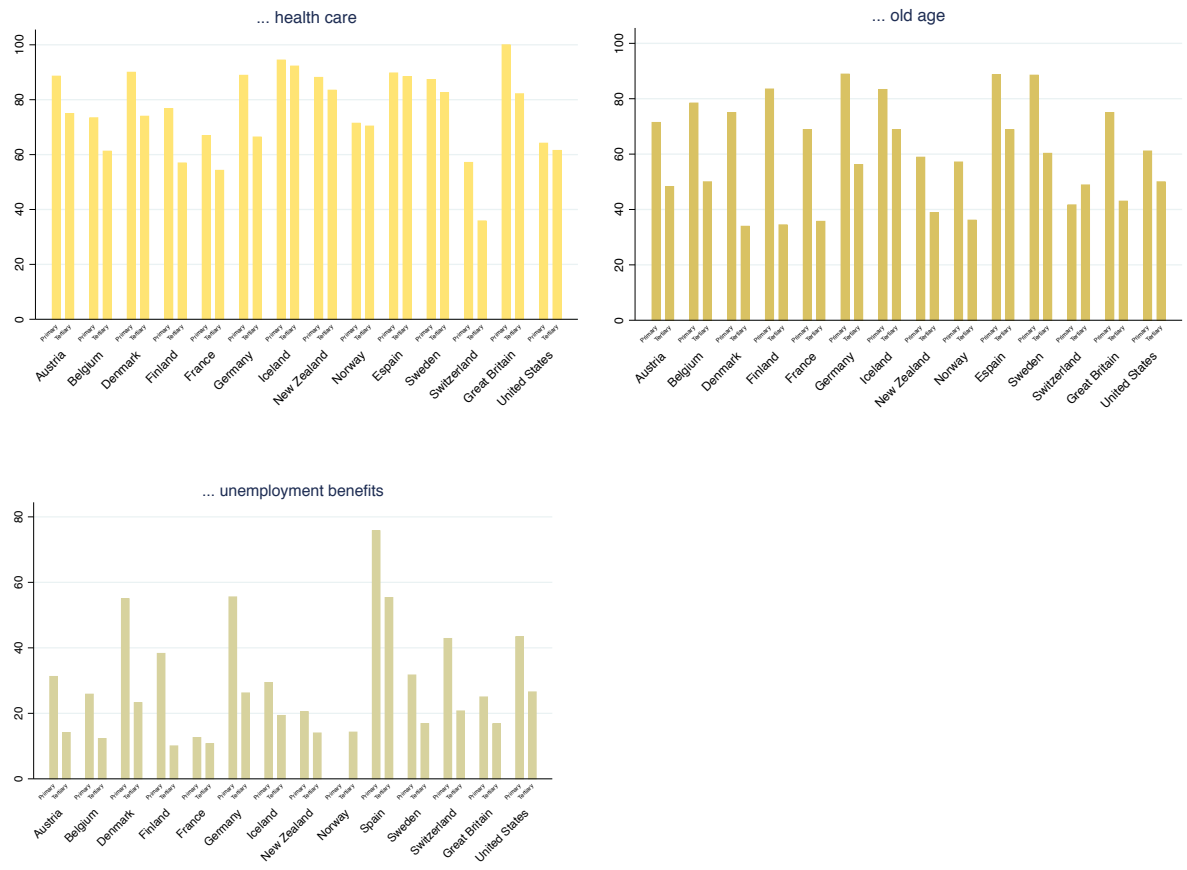

Figure 6.3 **Public support for additional spending on different welfare state branches according to education levels**
Source: ISSP (2016)

Rather, variation in health care systems is much more driven by institutional factors, in particular the extent to which veto players limit the decision-making power of governments, as historical institutionalists such as Immergut (1992) or Hacker (2004) highlight.

Immergut's seminal book (1992) on health care policy-making in France, Sweden, and Switzerland in the first half of the twentieth century starts from the observation that the government's ideological approach towards health care and the interests of the medical profession do not differ in the three countries. This rules out party-political factors and different demands of interest groups as explanations for cross-national differences. Instead, the conflict is between the governments that want available and affordable care for their citizens and the elite physicians who oppose state interference in their professional affairs, for

instance regarding price controls. Thus, the variation in health care structures is attributed to the institutional power that the well-organised physicians have over the political process, in other words, their veto power or—in Immergut's terms—their 'access to veto points'. In Switzerland, for example, the availability of binding referendums provides physicians strong veto power. With the federal government's role in health provision restricted, the original system of government subsidies to private insurance schemes to make them more affordable has remained in place, much to the advantage of the medical profession. France takes the intermediate position: the parliament of the Fourth Republic (1946–58, the decisive period in the construction of the health care system) was accessible to the lobbying efforts of interest groups resulting in a universal public insurance scheme with government-controlled fees for general practice and salaried hospital physicians. In Sweden, the strong concentration of political power within the executive branch isolated the government from pressure from interest groups, and elite doctors had no access to veto points once the decision to move towards a national health system had been decided.

If we generalise Immergut's argument, polities with a large number of veto points (such as federalism, the separation of power between the executive and legislative, or direct democratic institutions) will favour the opponents of government intervention in health care. It is therefore not surprising that no federal state has implemented a national health service and that the US as the 'most veto-point ridden polity of all rich democracies' has remained the only rich democracy without universal health coverage (Hacker 2004 697).

Adding to the relevance of institutions is a phenomenon called *path dependency* (Pierson 1996; Pierson 2000) by which early institutional choices have long-term stabilising effects that are difficult to reverse. Most countries began to intrude into the doctor–patient relationship by subsidising non-governmental insurers, rather than financing services. These

policies created important vested interests in a pluralist financing structure and reinforced doctors' preferences for fee-for-service payment. How extensive and long-lived these arrangements were had crucial effects on the types of systems countries retained (Hacker 1998). The longer it took the national government to replace private or occupational insurance, the more likely a country ends with a decentralised health care system in which private insurance plays a larger role: the delay allows the formation of a powerful interest group of private stakeholders (Hacker 1998). The case of the US illustrates the argument perfectly: since private insurance has essentially replaced public insurance, it has become politically nearly impossible to expand public insurance at the expense of private insurance.

Hacker (2004) emphasises not only the structure of the political system but also the hierarchical versus decentralised financing structure of medical systems for the extent and type of change to health care systems. This is particularly true in the effort to contain costs. Structural cost containment reforms are most likely to be enacted in countries with concentrated executive power, that is no or a very limited number of veto points, and with a hierarchical financing structure of the medical system, such as in Britain, Sweden, or Denmark (Hacker 2004: 709ff). In countries with dispersed political authority such as Germany or the US it is highly difficult to overcome the veto points for major policy change; yet the fragmentation of the health care system may actually facilitate smaller-scale reform by leaving room for shifting coalitions of interest. Most difficult are reforms in countries with highly dispersed political authority and hierarchical financing structures such as Canada, where neither the political system nor the medical system provides favourable conditions for change (Hacker 2004).

Although variation in health care systems is examined by some analysts, especially institutionalists like Immergut and Hacker, health care is still treated rather as an orphan in

discussions on social protection (Hacker 2004). Yet, health care is an essential part of social protection. This is particularly evident in newer perspectives on the welfare state that do not consider social policy as 'politics against the markets' (Esping-Andersen 1985), that is, as extractions that had to be wrested from the forces of capitalism by the agents of organised labour in a political battle. Instead they see social policy as a productive factor for the economy that is in the interest of both employers and employees. This is the perspective that the social investment approach takes. The following briefly outlines the concept of social investment as well as its main goals and policy focus before elaborating on the role of health care within the social investment perspective.

<A> Investing in a healthy population: Health care as social policy

As the advanced industrialised societies transitioned from the industrial to the post-industrial era, the traditional welfare state with its strong emphasis on protecting the income and job of the male breadwinner has taken flak from both neoliberal economists and progressive social scientists. While the neoliberal dogma rests on the belief that a generous welfare state implies efficiency loss and is irreconcilable with economic growth, proponents of a 'new welfare state' have taken issue with the dysfunctionalities of the traditional welfare state in terms of equality and economic efficiency (Hemerijck 2017). In a post-industrial society, the male breadwinner employment-based social insurance welfare state would increasingly foster suboptimal life chances among large parts of the population. Consequently, a new welfare state is needed (Esping-Andersen et al. 2002).

These visions of a new welfare state are based on the presumption that social policy can be a 'productive force' if it invests in a competitive and productive population that is able to

perform the complex tasks required by the knowledge economy (Jenson 2009; Vandenbroucke, Hemerijck and Palier 2011). Just as the traditional welfare state was built to ease the transition from a feudal to an industrial society by addressing social risks that would inevitably arise (van Kersbergen and Manow 2017), social investment policies help ease the transition from an industrial, Fordian economy to a post-industrial, individualised, and knowledge-based economy and the resulting new social risks (Bonoli 2007; Garritzmann, Häusermann and Palier 2017; Hemerijck 2018; Jenson 2009). With their emphasis on human capital development, activation, and social inclusion (Bonoli 2014; Hemerijck 2015), social investment policies aim at 'preparing instead of repairing' (Morel, Palier and Palme 2012). In terms of policy theory, social justice was reconceptualised from 'distributive fairness' in a Rawlsian sense (1971) to 'capacitating' social justice in the tradition of Sen (1992) and Nussbaum (2000) by which entitlements and services should enable individuals to act as 'autonomous agents' (Morel and Palme 2017). Hence the normative claim of social investment rests on concrete needs and capabilities for social participation, which is why social investment policies focus strongly on social inclusion and inclusive growth.

Health is an inherent part of social investment as some of the crucial aims of social investment are closely linked to health issues. Indeed, a vicious circle links poverty, education, and health. On the one hand, ill health leads to marginalisation, poverty, and—for children—lower learning outcomes. Investing not only in health but also particularly in reducing health inequalities consequently contributes to social cohesion and reinforces employability thereby making active employment policies more effective and ultimately contributing to higher productivity and economic growth. Poverty, marginalisation, and low education, on the other hand, also lead to ill health (Bambra 2011; McNamara et al. 2017; Nordahl et al. 2014) see also Bambra, Chapter 5 in this Report). More precisely, social investment fulfils three interdependent functions—stock, flow, and buffer (Hemerijck

2015)—along which the final discussion of how health care is related to social investment policies is structured.

First, social investment policies raise the quality of the stock of human capital and capabilities. Investment in human capital development starts with early child development among pre-school children continuing to universal access to high quality of school education, but also includes lifelong learning and retraining for adults with a job and for those in need of a new one. Access to health care is essential for a productive workforce and raises the quality of human capital and capabilities (Boyer 2002). Inequalities in health pose a significant challenge for social investment welfare states (Diderichsen 2016). This is particularly evident in the persistent and—given their traditions of social investment and relatively free and equal access to health care—surprisingly high health inequalities in the Nordic countries (Hurrelmann, Rathmann and Richter 2011; Mackenbach 2012). Policies that attack health issues early on, such as the fight against child obesity, are therefore key to a social investment strategy. In Finland, for instance, social investment begins already before a child's birth and continues to adulthood: free maternity and child health clinics, free maternity packages, free or heavily subsidised day care services, free meals from kindergartens to colleges, and free education from pre-primary schools to universities. Consequently, family background plays a smaller role in educational results in Finland than it does in many other European countries (Bouget et al. 2015).

The second function of social investment policies is to ease the flow between different labour market and life course transitions via activating policies. But such policies need to take into account that health inequalities are also about different consequences of being ill in terms of survival, disability, and participation (Diderichsen 2016). As such, activation policies should involve not only economic incentives and instruments for retraining and education but also

efforts to revive functional abilities as well as to adapt the demands of working life to fit individuals' functional limitations, and thereby improve their ability to actually work (Diderichsen 2016). In the Nordic countries, for instance, the target groups for activation policies were expanded after the economic crisis of the 1990s to include now also people in need of disability benefits or with a variety of health and/or social problems (Dolvik et al. 2015; Pedersen and Andersen 2014). The disability scheme in Denmark was reformed in 2013 with the aim of giving people individual, tailor-made assistance to come back to work. These rehabilitation programmes could combine labour market activities, health treatment, and social help, and require close cooperation among these policy sectors and with the education sector (Pedersen and Andersen 2014). Such cooperation is all too often lacking, with recent reforms often increasing fragmentation rather than fostering coordination between the different actors.

Third, social investment also has a protective aim. Strong minimum income safety nets function as buffers, which are particularly relevant in fighting poor health outcomes as well as for preventing the negative outcomes of poor health for children. Family and general minimum income benefits are crucial safeguards to ensure that children of poor families lack no basic necessities and grow up in a secure and healthy environment in which they can develop (Bouget et al. 2015 23), thereby preventing particularly the intergenerational transmission of poverty. For instance, the Danish Social 2020 strategy seeks to extensively reform of social, education, health, and employment policies as well as introduce targeted measures to improve conditions for people in vulnerable situations (Bouget et al. 2015 15). Regulative policies might also function as buffers to a certain degree: employment protection policies generally counteract labour market inequalities between healthy and unhealthy people, but in times of severe recession such as the 2008–12 period additional programmes are needed to protect vulnerable groups (Reeves et al. 2014).

<A> Conclusion: A Case for Renewing Interest in Health Care from a Distributive Perspective

This chapter argues that health care must be an inherent part of social policy, in particular in the social investment framework. The social investment perspective takes a more dynamic perspective on how social policy interacts with fertility, education, and labour decisions to enhance not only aggregate productivity but also well-being and life chances: unequal opportunities and unrealised human potential result in a waste of human capital and constitute a barrier to economic growth (Hemerijck 2017). Given its preparing orientation, the social investment welfare state tends to be more service oriented than the old, industrial one and therefore better equipped to deal with the new social risks emerging in a post-industrial social and economic order (Morel et al. 2012). This can be seen in the main policy foci of the social investment approach: core policy areas are childhood education and care policies, education, lifelong learning, upskilling and training, active labour market policies, family policies to prevent child poverty and to reconcile work and family live. Reconsidering the three functions of social investment (stock, flow, and buffer) and its emphasis on capacitating social justice and the development and efficient use of human capital, the relevance of health care within the social investment framework is easy to see. In addition, fostering people's employability and bringing them into good, productive, and healthy work ease the financial pressure on health care systems by increasing the stock of active population that is contributing to financing the health care system by either their social contributions or income taxes.

Although health issues are often high on the agenda of policy-making discussions and health care is frequently mentioned as a social investment policy in the academic literature, it is very

rarely considered in policy analysis. In some of the most recent academic volumes (see Bonoli and Natali 2012; Hemerijck 2018; Midgley, Dahl and Wright 2017) on the new welfare state, health care is referred to only in passing, and none of them dedicates a chapter, or even a section within a chapter, to the analysis of health care governance, the effects of policy reforms on health outcomes or similar questions. Hence, while the social investment approach adopts a life course perspective that emphasises the need for state intervention at different transitional moments of an individual's life and the preventing dimension of state intervention, the scholarly literature has not fully considered the importance of health care to achieving the aims of social investment.

Universal access to high quality health care is a safety net not in the form of cash transfers for the weakest members of society but in the form of reducing health inequalities between social groups. Here, a social investment approach with its emphasis on preparing and educating might contribute to fighting health inequalities. Countries with high levels of income inequality also have lower average levels of population health (Hurrelmann, Rathmann and Richter 2011). Yet, above a certain limit further increases in wealth have only a limited effect on the health of a country's population (OECD 2009 6). In that case, a Matthew effect of increasing wealth takes place: only the already privileged groups achieve health benefits from increases in wealth, whereas the health of the less privileged improves only minimally. This means that, if economic growth intensifies existing income inequalities that translate into unequal life chances and health outcomes, social inclusion and capacitating social justice cannot be achieved. The limited effect of additional material resources on health outcomes suggests that other factors such as psychological, social, or cultural variables might be more relevant in affecting health outcomes (Hurrelmann, Rathmann and Richter 2011; Ross et al. 2000). With its focus on cognitive and social development and education, the social

investment state might well contribute to closing the gap and provide a route out of health inequality.

References

Allan, James P., and Lyle Scruggs. 2004. "Political Partisanship and Welfare State Reform in Advanced Industrial Societies." *American Journal of Political Science* 48(3):496-512.

Ansell, Ben, and Jane Gingrich. 2013. "A Tale of Two Trilemmas: Varieties of Higher Education and the Service Economy." Pp. 195-224 in *The Political Economy of the Service Transition*, edited by Anne Wren. Oxford: Oxford University Press.

Bambra, Clare. 2005. "Cash Versus Services: 'Worlds of Welfare' and the Decommodification of Cash Benefits and Health Care Services." *Journal of Social Policy* 34(02):195-213.

—. 2011. "Health inequalities and welfare state regimes: theoretical insights on a public health 'puzzle'." *Journal of Epidemiology and Community Health* 65(9):740-45.

Baumol, William J. 1967. "Macroeconomics of Unbalanced Growth: The Anatomy of Urban Crisis." *American Economic Review* 57(3):415-26.

Beramendi, Pablo, Silja Häusermann, Herbert Kitschelt, and Hanspeter Kriesi. 2015. *The Politics of Advanced Capitalism*. Cambridge: Cambridge University Press.

Bonoli, Giuliano. 1997. "Classifying Welfare States: a Two-Dimension Approach." *Journal of Social Policy* 26(3):315-72.

—. 2007. "Time Matters: Postindustrialization, New Social Risks, and Welfare State Adaptation in Advanced Industrial Democracies." *Comparative Political Studies* 40(5):495 - 520.

—. 2014. "Social Investment Policies in Times of Permanent Austerity." in *XVIII ISA World Congress of Sociology (July 13-19, 2014)*: Isaconf.

Bonoli, Giuliano, and David Natali. 2012. *The Politics of the 'New' Welfare States*. Oxford: Oxford University Press.

Bouget, Denis, Hugh Frazer, Eric Marlier, Sebastiano Sabato, and Bart Vanhercke. 2015. "Social Investment in Europe: A study of national policies " *EUROPEAN COMMISSION: EUROPEAN SOCIAL POLICY NETWORK (ESPN)*.

Boyer, Robert. 2002. *La croissance début de siècle*. Paris: Albin Michel.

Database, OECD Social Expenditure. 2019. "http://www.oecd.org/social/expenditure.htm." *Accessed January 29th, 2019.*

de la Maisonneuve, Christine, and Joachim Oliveira Martins. 2015. "The future of health and long-term care spending." *OECD Journal Econ Studies*:61-96.

Diderichsen, Finn. 2016. "Health inequalities – a challenge for the social investment welfare state." *Nordisk välfärdsforskning | Nordic Welfare Research* 1(01):43-54.

Dolvik, Jon Erik, Tone Flotten, Jon E. Hippe, and Bard Jordbald. 2015. "The Nordic model towards 2030 - A new chapter?": Fafo.

Döring, Holger, and Philip Manow. 2017. "Is Proportional Representation more Favourable to the Left? Electoral Rules and their impact on Elections, Parliaments and the Formation of Governments." *British Journal of Political Science* 47(1):149-64.

Döring, Holger, and Hanna Schwander. 2015. "Revisiting the left cabinet share: How to measure the partisan profile of governments in welfare state research." *Journal of European Social Policy* 25(2):175-93.

Esping-Andersen, Gosta. 1987. "Citizenship and Socialism: Decommodification and Solidarity in the Welfare State." Pp. 78-101 in *Stagnation and Renewal in Social Policy: The Rise and Fall of Policy Regimes*, edited by G.; M. Rein and L. Rainwater Esping-Andersen. Armonk, NY

London, England: M. E. Sharpe, INC.

Esping-Andersen, Gøsta. 1985. *Politics Against Markets: The Social Democratic Road to Power*.
—. 1990. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.
Esping-Andersen, Gøsta, Duncan Gallie, John Myles, and Anton Hemerijck. 2002. *Why We Need a New Welfare State*. Oxford: Oxford University Press.
Ferrera, Maurizio. 1996. "The Southern Model of Welfare in Social Europe." *Journal of European Social Policy* 6(1):17-37.
Freeman, Richard, and Heinz Rothgang. 2010. "Health." Pp. 367-77 in *The Oxford Handbook of the Welfare State.*, edited by Francis G. Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger, and Christopher Pierson. Oxford: Oxford University Press.
Garrett, Geoffrey. 2001. "Globalization and government spending around the world." *Studies in Comparative International Development* 35(4):3-29.
Garritzmann, Julian L, Silja Häusermann, and Bruno Palier. 2017. "The World Politics of Social Investment." *LIEPP Working Paper n° 64, March 2017*.
Guillen, Ana. 2002. "The Politics of Universalisation: Establishing National Health Services in Southern Europe." *West European Politics* 25(4):49-68.
Hacker, Jacob S. 1998. "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy." *Studies in American Political Development* 12(1):57-130.
—. 2004. "Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform." *British Journal of Political Science* 34(4):693-724.
Hemerijck, Anton. 2015. "The quiet paradigm revolution of social investment." *Social Politics: International Studies in Gender, State & Society* 22(2):242-56.
— (Ed.). 2017. *The Uses of Social Investment*. Oxford Oxford University Press.
—. 2018. "Social investment as a policy paradigm." *Journal of European Public Policy* 25(6):810-27.
Huber, Evelyn, and John D. Stephens. 2001a. *Development and Crisis of the Welfare State. Parties and Policies in Global Markets*. Chicago: University of Chicago Press.
—. 2001b. "Welfare State and Production Regimes in the Era of Retrenchment " in *The New Politics of the Welfare State*, edited by Paul Pierson. Oxford: Oxford University Press.
Hurrelmann, Klaus, Katharina Rathmann, and Matthias Richter. 2011. *Health Inequalities and welfare state regimes. A research note*.
Immergut, Ellen M. 1992. *Health politics: interests and institutions in Western Europe*. Cambridge: Cambridge University Press.
ISSP. 2016. "Role of Government V." https://www.gesis.org/issp/modules/issp-modules-by-topic/role-of-government/2016/. Accessed December 9th, 2018.
Iversen, Torben, and John D Stephens. 2008. "Partisan politics, the welfare state, and three worlds of human capital formation." *Comparative Political Studies* 41(4-5):600-37.
Jenson, Jane. 2009. "Lost in translation: The social investment perspective and gender equality." *Social Politics: International Studies in Gender, State & Society* 16(4):446-83.
Leibfried, Stefan. 1993. "Towards a European Welfare State? On integrating poverty regimes into the European Community." Pp. 133-56 in *New Perspectives on the welfare state in Europa* edited by Cathrine Jones. London: Routeledge.
Mackenbach, JP. 2012. "The persistence of health inequalities in modern welfare states: the explanation of a paradox." *Social Science Medicine* 75(4):761-9.

Manow, Philip. 2004. "'The Good, the Bad, and the Ugly' – Esping-Andersen's Regime Typology and the Religious Roots of the Western Welfare State." *MPIfG Working Paper 09/12* 04/3.
—. 2015. "Workers, farmers and Catholicism: A history of political class coalitions and the south-European welfare state regime." *Journal of European Social Policy* 25(1):32-49.
Manow, Philip, Bruno Palier, and Hanna Schwander. 2018a. "Introduction: Welfare Democracies and Party Politics — Explaining Electoral Dynamics in Times of Changing Welfare Capitalism." Pp. 1-26 in *Welfare Democracies and Party Politics Explaining Electoral Dynamics in Times of Changing Welfare Capitalism*, edited by Philip Manow, Bruno Palier, and Hanna Schwander. Oxford: Oxford University Press.
—. 2018b. *Welfare democracies and party politics: Explaining electoral dynamics in times of changing welfare capitalism*. Oxford: Oxford University Press.
Marshall, Thomas H. 1950. *Citizenship and Social Class: And Other Essays*. Cambridge: Cambridge University Press.
McNamara, Courtney L., Mirza Balaj, Katie H. Thomson, Terje A. Eikemo, Erling F. Solheim, and Clare Bambra. 2017. "The socioeconomic distribution of non-communicable diseases in Europe: findings from the European Social Survey (2014) special module on the social determinants of health." *European Journal of Public Health* 27(suppl_1):22-26.
Midgley, James, Espen Dahl, and Amy Conley Wright. 2017. *Social investment and social welfare. International and critical perspectives*. Cheltenham, UK: Edward Elgar Publishing.
Morel, Nathalie , and Joakim Palme. 2017. "A Normative Foundation for the Social Investment Approach?" Pp. 150-59 in *The Uses of Social Investment* edited by Anton Hemerijck. Oxford, United Kingdom New York, NY: Oxford University Press.
Morel, Nathalie, Bruno Palier, and Joakim Palme. 2012. *Towards a social investment welfare state? Ideas, policies and challenges*. Bristol: The Policy Press.
Nelson, Moira, and Johan Sandberg. 2017. "From perspectives to policy contingencies: Conditional cash transfers as social investments." *Global Social Policy* 17(1):21-37.
Nordahl, Helene, Theis Lange, Merete Osler, Finn Diderichsen, Ingelise Andersen, Eva Prescott, Anne Tjønneland, Birgitte Lidegaard Frederiksen, and Naja Hulvej Rod. 2014. "Education and Cause-specific Mortality: The Mediating Role of Differential Exposure and Vulnerability to Behavioral Risk Factors." *Epidemiology* 25(3):389-96.
Nussbaum, Martha Craven. 2000. *Women and Human Development : The Capabilities Approach*. Cambridge: Cambridge University Press.
OECD. 2009. *Health at a Glance 2009. OECD Indicators*: Éditions OCDE / OECD Publishing.
—. 2018. "Policy Brief „Focus on Spending on Health: Latest trends". http://www.oecd.org/health *Accessed January 29th, 2019.*
Pedersen, L, and S. K Andersen. 2014. "A time of reforms. Regulation of labour market and welfare since 1990. Danish country report." Oslo: Fafo.
Pierson, Paul. 1996. "The New Politics of the Welfare State." *World Politics* 48(2):143-79.
—. 2000. "Increasing Returns, Path Dependence, and the Study of Politics." *The American Political Science Review* 94(2):251-67.
—. 2001. "Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies." Pp. 410-56 in *The New Politics of the Welfare State*, edited by Paul Pierson. Oxford: Oxford University Press.
Rawls, John. 1971. *A Theory of Justice*. Cambridge, Mass.: The Belknap Press of Harvard University Press

Reeves, Aaron, Marina Karanikolos, Johan Mackenbach, Martin McKee, and David Stuckler. 2014. "Do employment protection policies reduce the relative disadvantage in the labour market experienced by unhealthy people? A natural experiment created by the Great Recession in Europe." *Social Science & Medicine* 121:98-108.
Reibling, Nadine. 2010. "Healthcare systems in Europe: towards an incorporation of patient access." *Journal of European Social Policy* 20(1):5-18.
Ross, Nancy A, Michael C Wolfson, James R Dunn, Jean-Marie Berthelot, George A Kaplan, and John W Lynch. 2000. "Relation between income inequality and mortality in Canada and in the United States: cross sectional assessment using census data and vital statistics." *BMJ* 320(7239):898-902.
Rothgang, Heinz , M Cacace, Loraine Frisina, S Grimmeisen, Achim Schmid, and Claus Wendt. 2010. *The State and Healthcare: comparing OECD countries.* . Basingstoke: Palgrave Macmillan.
Sen, Amartya. 1992. *Inequality re-examined*: Harvard University Press.
Simou, Effie, and Eleni Koutsogeorgou. 2014. "Effects of the economic crisis on health and healthcare in Greece in the literature from 2009 to 2013: A systematic review." *Health Policy* 115(2):111-19.
van Kersbergen, Kees, and Philip Manow. 2017. "The welfare state." Pp. 363-80. in *Comparative Politics*, edited by Daniele Caramani. Oxford Oxford University Press.
van Oorschot, Wim. 2006. "Making the difference in social Europe: deservingness perceptions among citizens of European welfare states." *Journal of European Social Policy* 16(1):23-42.
Van Oorschot, Wim, and Femke Roosma. 2015. "The social legitimacy of differently targeted benefits." *ImProvE Discussion Paper 15/11, April 2015*.
Vandenbroucke, Frank, Anton Hemerijck, and Bruno Palier. 2011. "The EU needs a social investment pact." *Observatoire Social Européen Paper Series, Opinion Paper* 5.
Watson, Sara. 2008. "The Left Divided: Parties, Unions, and the Resolution of Southern Spain's Agrarian Social Question." *Politics & society* 36(4):451-77.
Wendt, Claus. 2009. "Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare." *Journal of European Social Policy* 19(5):432-45.
—. 2014. "Changing Healthcare System Types." *Social Policy & Administration* 48(7):864-82.
Wilensky, Harold L. 1975. *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures*. Berkley: University of California Press.

Endnotes

[1] Rothgang et al. (2005) also observe a convergence in spending patterns between advanced industrialised societies mainly due to a catch-up process of latecomer countries since the 1980s.
[2] The US represents a partial exception insofar as, in light of the patchy and highly unequal access to a very expensive health care system, the political debate revolves around expanding access to health care as much as around containing costs.
[3] Yet the debate about cost containment is not as loud as similar debates for old-age protection or unemployment compensation schemes, which is most likely due to the popularity of the health care system (see Figure 6.2), the relative universal distribution of health risks (i.e. everybody fears and anticipates needing health care in later stages of life), and the fact that health risks are perceived to be outside the control of an individual. Health care recipients are therefore deemed to be 'deserving' of need (in contrast to 'undeserving' unemployment or social insurance recipients) (Van Oorschot 2006). van Oorschot, Wim. 2006. "Making the difference in social Europe:

deservingness perceptions among citizens of European welfare states." *Journal of European Social Policy* 16(1):23-42.

[4] *Decommodification* denotes 'the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance' Esping-Andersen, Gosta. 1987. "Citizenship and Socialism: Decommodification and Solidarity in the Welfare State." Pp. 78-101 in *Stagnation and Renewal in Social Policy: The Rise and Fall of Policy Regimes*, edited by G.; M. Rein and L. Rainwater Esping-Andersen. Armonk, NY
London, England: M. E. Sharpe, INC., while *stratification* refers to the extent to which the welfare state interferes with the existing social order.

[5] Generally, the 'worlds of welfare capitalism' typology suffers from an over-emphasis on cash benefits, which are relevant for protecting citizens. But welfare states are as much about the delivery of services, such as health, education, and social care, of which health care is among the most important Bambra, Clare. 2005. "Cash Versus Services: 'Worlds of Welfare' and the Decommodification of Cash Benefits and Health Care Services." *Journal of Social Policy* 34(02):195-213.. Moreover, health outcomes also cut across welfare state typologies Hurrelmann, Klaus, Katharina Rathmann, and Matthias Richter. 2011. *Health Inequalities and welfare state regimes. A research note*..

[6] In addition, many sociologists and political scientists in the field of welfare state analysis were predominantly concerned with the redistributive capacity of the welfare state for different social classes and the impact on income equality, whereas economists focus on the economic cost dimension associated with social protection.