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Health Care Governance: Conformity and Decline in European Health Care Systems.

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Health care is one of the core social citizenship rights with next to universal access in most industrialized welfare democracies. It is cherished by an overwhelming majority of the population. Also political opponents to other forms of social citizenship are reluctant to deny health care to citizens in need. The limited degree of moral hazard, the usefulness of a healthy workforce, and risks of contagion are three reasons for supporting elaborate health care systems. Despite the potential for strong public support welfare backlash is expected also in health care, as in all kinds of social policies, due to the pressures from "globalization", or trans-nationalization of capital, demographic shifts, high unemployment levels and European integration. With regard to the member states of the European Union, it has been suggested that the service sector of the European welfare states will be even more prone to cutbacks than cash benefits. Also institutional convergence is expected, whereby European health care systems will become more similar across countries.

The purpose of this paper is to subject the above hypotheses of welfare state decline and conformity to empirical tests. Is it possible to observe cutbacks in European health care systems and is the decline stronger than in the area of cash benefits? Does the restructuring of health care systems involve processes of convergence, whereby institutional structures of European health care systems are becoming more alike? The empirical analysis is based on health care institutional data covering 19 EU Member States for the years 1980-2006. Based on theories that link the evolution of welfare states to the emergence of modern forms of social citizenship, three basic dimensions of health care citizenship rights are identified and examined: financing, coverage, and provision. Financing concerns the share of contributions coming from public and private sources, rather than expenditure levels as such. Coverage shows the degree to which citizens are eligible for health care, whereas provision relates to the content of services that are being offered.

Social policy has recently undergone changes in most European countries. Retrenchment has been observed in connection with cash benefits, although to varying degrees cross-nationally (Korpi and Palme 2003; Nelson 2007b), whereas evidence concerning converging trends is mixed at best. The findings related to convergence of cash benefits are sensitive to measurement of institutional variation. Whereas analyses of aggregate social expenditure provide moderate signs of convergence in cash benefit programs (Castles 2004; Kenworthy 1997), institutionally informed analyses show that benefit levels and coverage rates have diverged across countries since the 1980s (Montanari et al. 2007, 2008; Nelson 2006). But

what about the changes introduced in social services, the other pillar of social policy in welfare states? Comparative studies of health care systems have so far been limited mainly to analyses of expenditure levels and the determinants for increased health care costs (Barros 1998; Blomqvist and Carter 1997; Gerdtham 1992; Hansen and King 1996; Hitiris and Posnett 1992; McCoskey and Selden 1998; Roberts 1998). Despite some disagreement concerning the magnitude of associations, most scholars seem to acknowledge a positive relationship between health care expenditure and national income. Gerdtham and Jönsson (2000) even argue that health care to some extent seems to be a luxury good. The relationship between health care expenditure and national income tend to be non-linear and progressive in character, being stronger at higher than lower levels of national income. The role of institutional structures for health care expenditure is less investigated (Hitiris and Posnett 2002), although some cross-national studies have analyzed the influence of health care organization on health care expenditure (Allen and Riemer Hommel 2006; Saltman *et al.* 2002; Wendt *et al.* 2005).

Expenditure levels do not necessarily capture the essential components of social citizenship rights (Adema 2001; Castles and Mitchell 1992; Clayton and Pontusson 1998; Esping-Andersen 1990; Gilbert and Moon 1988; Goodin *et al.* 1999; Korpi 1989; Kühner 2007). In order to more comprehensively analyze policy retrenchment and convergence patterns in health care systems we must go beyond the strict focus on expenditure levels and devote more attention to the institutional characteristics of health care systems. Institutionally oriented studies of health care systems are quite rare in the comparative welfare state literature. Thus, the analysis of institutional retrenchment and convergence processes in health care reform presented in this study is in many respects pioneering, covering a larger group of countries and a wider set of institutional indicators than normally applied in health care research (see for ex. Wendt *et al.* 2005). Hereby the study broadens the internationally recognized and important themes of welfare state backlash and convergence to the service sector of social policy, something that brings new evidence in relation to the organization of social citizenship rights. Based on welfare state theories emphasizing the importance of power relations and partisan politics for social policy change we expect countries to respond differently to the pressures for welfare state restructuring. This may have caused countries to diverge, instead of converge, especially if countries at the higher end of the health care league show less signs of retrenchment than countries at the bottom of this ranking.

The paper is organized in the following way. In the next section the issue of welfare state reorganization in terms of retrenchment and convergence is discussed. It is followed by an outline of the specific dimensions and institutional forms of health care service within a social citizenship perspective leading to a presentation of the data and methodology used in the empirical analysis. The results of the empirical analysis are then presented. The paper ends with conclusions and a discussion.

Welfare state reorganization

Welfare state developments since the mid-1970s appear to be quite different from those of preceding decades. Looking backwards, the period 1950-1975 emerges as the golden age of welfare state development. At this time countries had established elaborate systems of income protection complemented by the subsequent extension of social services. The slowdown of economic growth in the 1970s was increasingly attributed to the burdens of a too generous welfare state in political discourse. Several factors create pressures on European welfare states for social reform. The trans-nationalization of capital, the financial policy restrictions of the European Union, aging populations and the return of high unemployment levels are notable examples. The alleged need to reorganize the welfare state, especially social policies, was soon voiced also in the social sciences. Some scholars argued that maintenance, let alone expansion, of social citizenship rights had to be replaced by more social investment friendly policies (Bonoli et al. 2000; Esping-Andersen 2002; Ferrera and Hemerijck 2003; Giddens 1998; Huber and Stephens 2001; Huber et al. 2003; Jensen and Phillips 1996; Kautto and Kvist 2002; Majone 1996; Morel *et al*. 2009; Rieger and Leibfried 2003; Scharpf 2002; Scharpf and Schmidt 2000; Swank 2002). Scharpf (2002) argues that supply-side strategies, in the form of a functioning technical and logistic infrastructure, as well as social investment in human capital have become the foremost objectives of national governments with regard to macro-policy. Researchers, especially in the Nordic countries, have returned to an old theme of social investments in human capital, but concomitantly with expansion of welfare services (Myrdal and Myrdal 1934). Also some economists recognize that social stability and a well functioning labour market require social rights that challenge and to some extent counteract the allocative power of the market economy (Arrow 1963; Barr 2001; Freeman 2002). The discursive blueprints of a European social model also provide evidence of this political need (Palme 2006; Palme et al. 2009; Scharpf 2002). The extent to which the recommendations of reorganization of the welfare state are translated into national and EU-level politics is unclear.

Whereas the nature of such policy responses still needs to be explored in greater detail, it is evident that most scholars recognize that the new pressures that are building up on European welfare states in various ways constrain social policy development, something that has further stimulated an academic discussion concerning processes of welfare state decline and convergence.

Retrenchment

The slow-down of social policy expansion in Europe soon transformed into stagnation and even retrenchment, although there are differences between countries. The Nordic countries, for example, show a distinct pattern with continued expansion of social policy throughout the 1970s and 1980s, foremost in the area of family policy (Ferrarini 2006). The rollback of the Nordic welfare states nevertheless became apparent in the early 1990s (Kautto et al. 1999), when particularly Sweden (Palme 1999; Palme and Wennemo 1998) but also Finland (Kautto 2003) were severely hit by fiscal crisis.

Welfare state retrenchment has attracted great interest among scholars. Both the theoretical basis of welfare state retrenchment and the magnitude of cutbacks have been extensively discussed in the comparative social policy literature. In particular the works of Pierson (1994, 1996, 2001) have stimulated the ongoing debate about the main driving forces for welfare state change. According to Pierson the stagnation and retrenchment of welfare states since the mid-1970s is foremost related to processes of post-industrialization and the combination of slow economic growth rates and increased social expenditure. Although such structural factors certainly are important determinants for the reorganization of social policy in recent decades, governments seem to have responded rather differently to such pressures for social reform. Even though most OECD countries have introduced social policy cutbacks in recent decades, centre-right governments have gone further in this direction than left-wing cabinets (Korpi and Palme 2003). Thus partisan politics and class based action seem still to be important factors for welfare state change in the context of social policy stagnation and decline.

Also the size of welfare state retrenchment has been subject to intense discussion and debate among scholars. Both Pierson (1996) and Esping-Andersen (1996) point to the resilience of welfare states for major systemic change, due in part to risks of electoral backlash. Indeed, in

core welfare state areas, such as social insurance, the basic principles governing social policy seem largely intact (Palme et *al*. 2009). However, this does not necessarily imply that more programmatic changes have been absent. For example, Montanari et al. (2007, 2008) and Nelson (2007b) show that both social insurance and social assistance have been curtailed over the last decades, either directly by deliberate reductions of benefit rates or indirectly due to an insufficient updating of benefits to changing social needs.

Another important theme in current discussions concerns the composition of welfare state retrenchment and the vulnerability of distinct policy programs for decline. For example, Clayton and Pontusson (1998) argue that cash benefits are more resistant to cutbacks than social services, such as health care. Based on an analysis of social expenditure data in Sweden, Germany, the United Kingdom and the United States, Clayton and Pontusson (1998: 96) argue that "…governments have preferred cutting the public sector to cutting entitlement programs, and it is first and foremost the service components of welfare states that have been reformed according to market principles", and thus retrenchment of the welfare state since the 1980s involves an "…anti-service bias of welfare state retrenchment". One reason for the expected greater vulnerability of social services is related to the visibility of reform initiatives; cutbacks in social services are assumed to be less transparent than those of cash benefits. In addition the effects of retrenchment in the service sector are believed to be less immediate for citizens, something that is assumed to decrease further the electoral costs associated with unpopular reform. Another reason is the enlargement and integration processes of the European Union, and specifically the probability of so called social tourism, whereby citizens from one country are expected to move across borders to take advantage of generous social policies. Social services are here believed to be more easily accessible by foreigners than major cash benefits, which often are based on gainful employment. Consequently policy makers are assumed to draw their attention to cutbacks in social services rather than cash benefits in order to circumvent potential problems of social tourism.

Although the study by Clayton and Pontusson (1998) has increased our understanding of welfare state retrenchment in several respects, the arguments in favour of greater vulnerability for social services are not fully convincing, especially when focussing on health care systems. Several circumstances that should add to the resistance of health care to major change can be mentioned. One example is that health care typically enjoys stronger support among citizens than many cash benefits, something that should increase the risk of political backlash in health

care reform. Covering public attitudes in 24 countries, Blekesaune and Quadagno (2003) show that people tend to be more supportive towards welfare state policies for the sick and old than programs targeted to the unemployed. Another circumstance is that well developed health care systems can remove barriers that hamper economic participation and thus constitute an important component of the productive welfare state (Midgley 1999). Good quality health care services are in fact also an eminent supply-side strategy of social investment in human capital (Scharpf 2002). Such integrative aspects should add further incentives for policy makers to avoid extensive cutbacks in health care. Furthermore, the organization of health care in parts of Continental and Southern Europe is based on social insurance principles, which reduce the likelihood of foreigners gaining access to the services. In comparison the problem of social tourism should be more aggravate for non-contributory and means-tested social assistance benefits, where EU legislation in part prohibits discrimination based on nationality. However, social tourism in connection with non-contributory social assistance benefits is a very limited phenomenon among the EU countries (Kvist, 2004).

In conclusion, the vulnerability of health care systems for decline is still very much an open question. Theoretically there are no univocal arguments suggesting that health care is more vulnerable to retrenchment than cash benefits. Quite the contrary, we have provided several arguments suggesting the opposite; that is, greater resistance for health care. Since the structural constraints outlined above, such as trans-nationalization of capital, European integration, demographic shifts and high unemployment levels, influence policy decisions cross-nationally, the issue of welfare state regress is closely tied to the issue of policy convergence. Below we will discuss in more detail the convergence hypothesis and how it generally is portrayed nowadays in the era of welfare state austerity and decline.

Convergence

Convergence previsions have been legion in social policy research. Earlier versions of the "logic of industrialism" theory (Kerr et al. 1960; Wilensky 1975, 1981; Wilensky and Lebeaux 1958) have been succeeded by present-day forecasts of the necessary transformation of social policy in a market-enhancing direction (Bonoli et al. 2000; Esping-Andersen 2002; Kitschelt et al. 1999; Pierson 2001; Rieger and Leibfried 2003; Scharpf and Schmidt 2000; Strange 1997). Systemic convergence of the European welfare state has been expected (Greve

1996; Taylor-Gooby 1996), also with regard to health care systems (Leidl 2001). Social scientists recognizing the existence of distinct welfare state models and social policy institutions as a result of different political choices have mostly been sceptical to a convergence thesis in the field of social policy (for ex. Esping-Andersen 1990, 1996, 2002; Goldthorpe 1984; Huber, Ragin and Stephens 1993; Kitschelt et al. 1999; Korpi 1989; Korpi and Palme 1998; Scharpf and Schmidt 2000). However, social policy institutions are path-dependent only as long as there is political support for them (Korpi 2001). Other researchers emphasize the importance to account not only for systemic changes, but also piecemeal reforms, subtle conversion of existing institutions and establishment of competing institutional structures (Cox 1998:2; Hacker 2004). For our purpose the most important aspect to recognize is that theories based on class-based action seem to predict continuing variation of social policy structures rather than convergence.

Convergence of institutional design and in the levels of cash benefits and service provision may however be politically induced at supra-national levels. For the member states of the European Union there are in fact specific political pressures towards convergence from three distinct supra-nationally established policy areas, namely: economic and financial policy, competition policy, and the Open Method of Coordination (OMC). The Broad Economic Policy Guidelines include low inflation, balancing of national budgets and exposure to competition in every field, under conditions of harmonized social regulations (EU 1996).[1] Specific for the new "constitution" of the European Union, the recently passed Lisbon Treaty, is thus that not only the norms for *procedure* of governance is established, but also that *policy content* to some extent is addressed (Gustavsson 2010). In this way the space for national variations in economic and financial policy is heavily circumscribed. Since social policy formally still is a national prerogative according to the principle of subsidiarity, any effects on national social policies are indirect results of these supra-nationally established political economy guidelines (Montanari et al. 2008).

Competition law expresses the baseline of the European Union project. In Treaty articles 81 and 82 rules to protect the internal market's neutral playing field are listed (Mossialos and McKee 2002). Apart from cartel building and other anti-competitive behaviour among

[1] EU social regulations, which mainly regard health and safety at the workplace, aim at establishing a level playing field for firms operating in the EU area, and should not be confounded with traditional social policies (Majone 1993, Montanari 1995).

companies, restrictions apply explicitly to any public procurement in sectors such as transport, education and health care. Lately these regulations have come to the forefront of public attention and have been reinforced by a series of rulings of the European Court of Justice (idem; Greer 2008). Although the formulation and implementation of health policy still remains a task of national polities, the ongoing development of the internal market as established in EU Treaties, and driven by EU institutions and specifically the European Court of Justice, is transforming the legal environment under which health systems contract employees, purchase goods, finance services, and organize themselves (Greer 2006:134, 2008: 219). Even though it is difficult to establish any causal relationships, increased European integration coincides with the marketization of service production. This transferring of services from the public to the market sphere takes many different forms. Collectively organized and provided services related to transport, communication, education and health care may be substituted by market production of the same services by outright sales or by auctioning out of service production while maintaining state financing (e.g. Esping-Andersen 2002; Ferrera and Hemerijck 2003; Scharpf 2002). In the latter process governance of state agencies are increasingly handed over to experts according to Public Management Policy (PMP) or New Public Management (NPM) theories (Clarke and Newman, 1997). The result is a fragmentation of steering and organizing collective activities, which may lead to loss of democratic involvement. In a longer time perspective, and given that patients and medical personnel are free to move around Europe demanding or offering health care services, competition might lead to a Europe-wide concentration of certain specialist health care services (Blomqvist and Larsson 2009; Rosenmöller et al. 2006). We consider this aspect to be of less relevance for primary care services.

The Open Method of Coordination (OMC) was launched at the European Council in Lisbon in 2000 as a new form of governance within the EU (Borrás and Jacobsson 2004; O’Connor 2005; Radaelli 2003; Szyszczak 2006; Wincott 2003). The OMC is promoting development of and standards in various fields, such as education, employment, poverty alleviation, and health care, with the explicit aim of final convergence (Carson 2004; Falkner 2005; O’Connor 2005). Although the social policy agenda of the OMC principally regards the implementation of some form of social protection in order to enhance social stability and prevent social tourism, the continuous exchange of expert-led best practices may lead to discursive consensus on institutional convergence of social policies (Schmidt 2009; Schmidt and Radaelli 2004). With regard to the level of health care in the EU member nations, the

continuous benchmarking procedures and promotion of "best practices" may have important positive effects especially for new and aspirant members (Hervey 2007; McKee et al. 2004).[2]

Due in part to the financial and political pressures related above, convergence in core dimensions of health care citizenship rights can be expected mostly to have occurred in the downward direction, especially with regard to types and degrees of health care services that are being offered, and possibly also with regard to total coverage. As to financing we would expect an increase in private expenditure, which potentially could entail a development in a downward direction for the individual holder of a social citizenship right. Increased out-of-pocket expenses may be too costly for low-income households, thus having a negative impact on health care take-up among lower income segments. Moreover, the distribution of private health insurances tend to be positively skewed toward higher income groups. In OECD countries private health insurance covers on average only 30 percent of the population. Thus, on this account an increased share of private health care expenditure in total financing may negatively affect the distribution of health care citizenship rights in society, whereby some population groups are less likely to have access to good quality health care than others (Colombo and Tapay 2004).

Health care dimensions, data and methodological considerations

Social citizenship is a bundle of rights and duties involving two main components: social benefits and services. Within the social citizenship perspective of comparative welfare state research three core analytical dimensions of cash benefits have been identified, namely coverage, benefit level and financing (Carroll 1999; Esping-Andersen, 1990; Ferrarini 2006;; Kangas 1991, 2004; Korpi, 1989; Korpi and Palme 1998, 2003; Montanari 2000, 2001;; Montanari *et al*. 2007, 2008; Nelson 2006, 2008; Palme 1990; Palme *et al*., 2009; Sjöberg 1999). Analyses of social services do so far lack an elaborated social rights perspective. One analytical challenge concerning the area of health care service is thus to identify relevant policy dimensions and to develop institutional indicators that are comparable both cross-nationally and over time. While coverage and financing remain valid for analyses of services as well, benefit level has to be replaced by the more complex dimension provision, in itself differentiated by kind as well as degree. Coverage shows the number of individuals that are eligible for a program, financing refers to the actors responsible for covering program costs,

[2] For example, individual health status and health care organization are two important dimensions in the portfolio of overarching social indicators established by the European Commission (2008).

and provision indicates the level of services in question. In this section we will moderate these three dimensions to fit the area of health care.

The empirical analysis is based on the OECD Health Data 2008, which includes a large amount of information on health care systems in the EU member countries. We restrict the analysis to the period 1980-2006 for two reasons. The first reason is a contextual one, where we limit the study to a period in which European integration has been significantly strengthened, both in content and space. This is also the period in which the pressures for welfare state reform have markedly grown, due to the global economic development and demographic shifts described above. The period 1980-2006 therefore gives excellent opportunities to analyze whether governments in different countries follow the same pattern in the restructuring of social policy. The second reason is data driven, since missing information is more frequent for earlier years in OECD Health Data 2008. For similar reason the most recent year in the empirical analysis is 2006.

Although coverage and financing are fairly straightforward dimensions of social policy, some peculiarities are worth discussing in relation to the organization of health care. As noted above, social service reform in many countries have been inspired by new public management ideas and thus introduced a market inspired relationship between organizational units that includes, for example, so-called purchaser/provider splits. Coverage in this study refers to the number of citizens eligible for health care services incurred by public funds, irrespective of whether the actual service provider is publicly or privately organized. For health care financing we distinguish between public and private expenditure for activities directly related to health care services. Indirectly related activities, such as education and training of health personnel, research and development of health care, administration of sickness related cash benefits, are not included. In addition we analyze user fees, i.e. private out-of-pocket financing paid directly by households after contact with the services. Such out-of-pocket contributions are sometimes progressive in character according to individual or household income.

Health care institutions are of course influenced by the wider welfare state arrangements (Lundberg et al. 2008; van Doorslaer et al. 2006). This influence is expected to be especially relevant for the coverage and financing dimensions. Health care systems are in fact primarily of three basic types, i.e. universal, employment related, and market oriented (Moran 2000). The former two are financed primarily by taxes or contributions. Full coverage is mostly

reached in universal systems followed by often close to full coverage in the employment related systems. Market oriented health care systems typically have much lower coverage rates and the US system is one prominent example. Such market driven health care systems are absent in Europe.

Health care provision is measured in terms of health care employment, medical technology and hospital beds. It has to be remembered that the national figures reported in the OECD Health Data 2008 do not capture the distribution of health care provision in society. Health care employment includes practicing physicians and nurses. Medical technology includes five sub-indicators: the number of computed tomography scanners, magnetic resonance imaging units, radiation therapy equipment, lithotriptors, and mammographs. Hospital beds are measured both in total and in terms of acute care beds. Acute care beds are regularly maintained, staffed and immediately available for the care of admitted patients. Missing values in OECD Health Data 2008 have to the extent possible been estimated. The study includes 19 countries: Austria, Belgium, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Poland, Portugal, Slovakia, Spain, Sweden and the United Kingdom. Due to missing values the number of countries may differ between indicators and years. No analysis includes less than 12 countries. Where break in trends are observed to be caused by the inclusion of additional cases in the analysis it is noted in the text.

In addition to health care data we also use social insurance cash entitlement data from the Citizenship Indicators Program (SCIP) (see Korpi 1989, 2001; Korpi and Palme 1998, 2003). The social insurance programs included in SCIP are all contributory in character and benefits are either paid in the form of flat-rate or earnings-related amounts. The SCIP dataset is publicly available and comprises a vast amount of quantitative indicators on qualitative aspects of social insurance systems in 18 OECD countries for the years 1930-2005 (see https://dspace.it.su.se/dspace/handle/10102/7). Entitlement levels in the SCIP database are based on a type case approach, where the social rights of individuals and typical families have been calculated based on national social insurance legislation and regulation. For Southern European EU Member States and EU Member States from Central and Eastern Europe (CEE) the SCIP database has recently been complemented by similar information on the level of

social insurance entitlements (Palme *et al*. 2009).[3] We also use social assistance data from the Social Assistance and Minimum Income Protection Interim Dataset (SaMip), which also is publicly available (Nelson 2007a). Social assistance comprises non-contributory and means-tested benefits. The main objective of social assistance is not to provide income security, but rather to prevent poverty and low income. Social assistance benefit levels in SaMip are also based on a type-case approach. We use an indicator that includes all benefits that are provided to households lacking work income and eligibility for contributory social insurances.[4]

In order to analyze the development of health care systems over the last decades we utilize two techniques; descriptive analysis of long-term developments and multi-level regression based on unbalanced panels. In the descriptive part of the empirical section we analyze both levels and cross-national variation, thus addressing questions related to welfare state retrenchment as well as institutional convergence. In the multi-level part of the empirical section we provide more formalized empirical evidence of the latest developments. Here we regress a time variable on the different dimensions of health care indicated above and estimate so-called random slope models. The restricted iterative generalized least squares (RIGLS) estimation technique is used. We are particularly interested in two distinct parts of the model. The first is the fixed effect of the time variable, which shows whether the overall trend is increasing or decreasing. The second is the covariance between the intercept and the slope of the time variable across countries, which provides crucial information concerning cross-national differences (Twisk 2003). Patterns of convergence and divergence are evaluated by comparing the covariance and the fixed effect of the time variable. Convergence is observed if the two estimates have opposite signs. Similar signs reveal divergence.

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[3] The indicator of social insurance net replacement that we use in this paper is an index of two periods of duration in receipt of benefits, one week and 26 weeks, and two family types, single person and a couple with two dependent children. For old age pensions the index is based on a single person and a couple without dependent children. Social insurance replacement rates are calculated by relating benefits to the earnings of an average production worker. Only net amounts after income tax are used in this paper. Similar procedures of calculating replacement rates is used by the OECD (see for example OECD 2007).

[4] Social assistance refers to an index of the benefit package of a single person, a lone parent, and a two-parent family. Social assistance is standardized for wage development, something that makes it possible to assess the long-term value of benefits and compare the development of social assistance to the development of other types of benefits, such as social insurance. Similar standardization is used by Nelson (2007b) in a study on the vulnerability and resistance of social assistance and social insurance to cutbacks

Results

European health care systems are constantly subject to reform pressures as described above. Most European governments and policy makers have also introduced changes of relevance for health care citizenship rights. In this section we analyze both changes in the level and cross-national dispersion of core institutional dimensions of health care in a number of European welfare democracies. We begin by looking at financing, and thereafter health care coverage and provision.

Health Care Financing

The growth of health care expenditure in recent decades has introduced a shift in financing responsibilities. *Figure 1* shows changes in private health care expenditure (standardized for 1980 levels) and out-of-pocket health care expenditure (standardized for 1990 levels) as percentages of total health care expenditure in 19 EU countries 1980-2006. Out-of-pocket expenses are one component of private health care expenditure, the other one being private health insurance (Saltman 2003, Wendt 2005). Due to the large amount of missing values in OECD Health Data, out-of-pocket expenditure is shown from 1990 and onwards only. Also the coefficient of variation is shown, which measures the amount of cross-national variation in the data. It is evident that private financing of European health care systems has become more important over the years. Between 1980 and 2009 the share of private health care financing increased on average by about 22 percentage points. The decline around 1990 is due to breaks in the series and the subsequent inclusion of the Czech Republic and Poland in OECD Health Data 2008. Although public health care financing still accounts for the largest share of total health care expenditure in Europe, the private part of health care financing is on average at a level of 22 percent in 2009 (not shown here). In absolute terms this share amounts to about 1.9 percent of GDP, which can be compared to 1.4 percent of GDP in 1980.

[Figure 1 about here]

Cross-country averages of course conceal differences between individual countries, which sometimes can be substantial. For example, private health care financing is around or slightly above 30 percent of total health care expenditure in Greece, Poland, Portugal, Hungary and Spain. At the other end of the distribution, with levels of private health care financing below

20 percent of total health care expenditure, we find Sweden, Denmark, Slovakia, the United Kingdom, the Czech Republic and Luxembourg; countries dominated by universal health care systems. Private health care financing has increased most dramatically in Sweden and the CEE countries. Between 1990 and 2006 private health care expenditure more than doubled in Sweden, from about 8 to 19 percent of total health care expenditure. Since 1990 the CEE countries increased private expenditure by no less than 60 percent. Austria, Greece and Portugal show changes in the opposite direction and here private health care expenditure has decreased by about 13 percentage points, something that probably is due to the efforts in the 1980s and 1990s to make the essentially insurance based health care systems more universal in character (Saltman and Figueras 1997).

Several European countries are struggling with escalating public health care expenditure. Two means to control or reduce public expenditure that have been practiced among the EU member states are increased competition among health insurance providers and strengthened personal responsibility for user charges (Saltman and Figueras 1997). Although comparative analyses of out-of-pocket expenses are somewhat problematic due to the large number of missing values in OECD Health Data, the overall tendency in the transformation of health care financing is quite clear. Out-of pocket expenditure has increased in most European countries, particularly in the early 1990s but also at a more moderate pace in subsequent years. Out-of-pocket expenditure constitutes the lion share of private health care expenditure in most European countries, reaching an average of about 70 percent of private health care expenditure in 2006 (not shown here). Its size in total health care expenditure increased from about 11 to 16 percent between 1990 and 2006. Thus, one major trend in health care financing seems to be the increased burden placed on households to finance services directly at the time of contact with the health care system. From an equity point of view the trend towards an increased reliance of out-of-pocket expenses is worrying. Out-of-pocket expenses tend to be more regressive in nature than private health insurance premiums, at least in Europe where private health insurances mostly are complementary or supplementary to public financing sources. An increased share of out-of-pocket expenses in the private part of health care financing is mostly of benefit for higher than lower income groups. In comparison, public financing sources are mostly progressive in nature and thus of greater interest to lower income strata (De Graeve and Van Ourti 2003). However, there is substantial cross-country variation, both in terms of levels and trends in the share of out-of-pocket expenditure. For example, the share of out-of-pocket expenditure is particularly high in Hungary, Italy, Poland, Portugal and

Slovakia reaching more than 20 percent of total health care expenditure and more than 80 percent of private health care expenditure. At the lower end we find France and the Netherlands, with of out-of-pocket expenditure less than 10 percent of total health care expenditure and less than 30 percent of private health care expenditure.

It is difficult to observe any clear overall trend of increased or decreased cross-national dispersion in the share of out-of-pocket expenditure for the period 1980-2006. At the end of the period cross-national variation in out-of-pocket financing is approximately at the same levels as in the early 1990s. The general increase in private health care financing gives clear evidence of convergence, whereby the share of private health care expenditure across countries is more similar today than two decades ago. Notably, cross-national variation in private health care financing seems not to be particularly sensitive to the inclusion of the Czech Republic and Poland in OECD Health Data 2008. The ambition here is not to establish any causal claims for convergence of European health care systems, i.e. whether any trends in the organization of health care are due to particular transnational reform pressures. Nevertheless, it is interesting to note that increased European integration over the last two decades at least is associated with greater institutional conformity in health care financing structures across the EU member states. The hypothesis of indirect convergence and emulation of European health care financing due to European integration cannot therefore be disregarded, although the exact causes of convergence is still largely obscure. One preliminary investigation into the causes of convergence would be to compare developments of EU member states to that of non-EU member states (Nelson, 2008). Based on such country groupings Wendt *et al*. (2005) observe somewhat stronger convergence patterns for total health care financing among EU member states than among OECD countries in general. However, in order to explain certain outcomes simple cross-tabulations are not enough. We also need to control for other potential causes for converging health care systems. Both globalization and demography, for example, may influence European health care systems differently from those of other welfare states. Such an elaborate investigation into the causes of health care convergence is beyond this study to undertake.

Health Care Coverage

Most European citizens have access to health care and European health care systems thus have very high coverage rates. Coverage in European countries is to a large extent related to

the fundamental structure of health care systems, whether eligibility is universal or insurance based (Schieber and Poullier, 1987). Universal health care systems with full coverage were often established in Europe before the 1980s and as a result health care coverage is very stable among the countries here studied. Over the last two decades the share of eligible citizens in total population only fluctuates a couple of percentage points around the 1980 baseline. For example, in 1980 the average coverage rate of the 19 EU member states was 95.8 percent. The corresponding figure for 2005 is 97.0 percent. Over these years the dispersion of coverage rates across the EU member states is extremely stable, with changes only in the fourth decimal of the coefficient of variation for 1980 and 2005.

Due to developments in the Netherlands the average coverage rate increases to 98.9 percent in 2006. The Netherlands used to be a European outlier in terms of health care coverage, with rates fluctuating around 60 percent between 1980 and 2005. As part of a major and nationwide restructuring of health care services, whereby health care eligibility became statutory, coverage was substantially extended. In the new system all Dutch citizens are required to purchase private health insurance (Hassenteufel and Palier 2007; Palier and Martin 2007). Nowadays almost all or about 99 percent of Dutch citizens are eligible for health care. The Dutch reformation substantially influences cross-national dispersion of health care coverage rates in Europe. In the sample of 19 EU member states the coefficient of variation of health care coverage is reduced by nearly 80 percent, from 0.09 in 2005 to 0.02 in 2006, due to the Dutch case.

Also developments in other countries deserve some comment. Only Greece and Italy made the transition towards full coverage during the observation period. Greece went from a coverage rate of 88 percent in 1983 to 100 percent in 1984. For some people, however, full coverage in Greece simply means access to public hospitals, since the development of public primary care facilities are far from meeting the demand for such services (Cabiedes and Guillén 2001). Health care in Italy achieved full coverage in 1980, a few years earlier than Greece. Portugal was the first among the southern European countries to introduce universal health care and full coverage was reached already in the 1970s. Spain does still not have full health care coverage, although substantial extensions to eligibility were introduced in the 1990s. In continental Europe we find countries moving in the opposed direction with strengthened insurance based principles. In Germany, for example, health care coverage shows a slow but steady decline since the early 1980s, after a couple of decades associated

with stable increases. Reforms in the former centralized economies of central and eastern Europe are largely triggered by intense political pressure to replace elements of the previous authoritarian regimes. Progress is often slow due to various financial and political obstacles (Saltman and Figueras 1997). Nevertheless, both the Czech Republic and Hungary have full health care coverage. Together with Denmark, Finland, Ireland, Sweden, and the United Kingdom full coverage is reached in about half of the 19 EU countries in 2006. In eight European countries with insurance based health care systems approximately less than 5 percent of the total population lacks health care. Included here are Austria, Belgium, France, Luxembourg, the Netherlands, Poland, Slovakia, and Spain. Germany is an outlier by European standards having a coverage rate of 90 percent.

The stability of health care coverage in Europe since 1980, with the exception of the Dutch case primarily, does not, of course, imply that European health care systems are immune against cutbacks. Whereas eligibility and coverage are closely related to the basic principles governing access to European health care systems, resulting in complete or nearly full coverage throughout Europe, more gradual reforms may have affected the level of services provided. One way to analyze this dimension of European health care systems in closer detail is to explore levels and dispersion of health care provision.

Health Care Provision

One of the most challenging aspects of the comparative study of health care systems concerns the establishment of indicators of health care provision that describe the content and the more qualitative aspects of health care service. Since most comparisons of health care systems are based on financing and expenditure data the analysis of health care provision provides important crucial information about the level and development of European health care systems (Castles, 2004; Comas-Herrera, 1999; Leidl, 2001; OECD, 1996). Analyses of cash social benefits show that developments in social expenditure do not necessarily correspond to developments in the content of social policy, such as social assistance benefit levels (Nelson 2008). The link between health care expenditure and health care provision may similarly be weak among European countries.

Figure 2 shows health employment, hospital beds and medical technology for the years 1980-2006 in the 19 EU countries. Due to the large amount of missing values in OECD Health

Data, developments in medical technology are analyzed from 1990 and onwards. The values for each indicator are standardized according to levels in 1980 and 1990 (technology). Whereas health employment and medical technology increase almost continuously over the period, the indicator of hospital beds has declined. The improvement of medical technology reflects the fast and consistent growth of the biomedical and pharmaceutical industrial sectors (Clemente et al. 2008; Saltman et al. 2002), being an important driver for increasing per capita health care expenditure (Newhouse 1992; Okunade and Murthy 2002). Whereas the increase of health employment and medical technology to some extent can be interpreted in qualitative terms and as improvements in health care provision, albeit we do not know whether access to the services is equally distributed in society, it is more difficult to judge whether the trend towards less hospital beds is a sign of retrenchment or not.[5] Although the number of total hospital and acute care beds gives some indication of the availability of hospital care, one should recognize that most EU countries as part of a major restructuring of health care services have reduced the number of acute care beds almost continuously since 1980 at least and increased the number of patients subject to specialized nursing care. Alternatively patients are treated at home with the assistance of community-based health and social care services. There are several reasons for this re-organization of health care services, including both cost-cutting pressures and changes in treatment and care options, such as the availability of new prescription drugs (Healy and McKee, 2002).[6]

[Figure 2 about here]

[5] OECD statistics do not distinguish between full-time and part-time employment, which would be highly relevant for nurses (Montanari 2009). Health employment may thus have increased less than here indicated in terms of hours of service.

[6] Although the possibility of being treated at home instead of staying in hospital may be desirable, there are some indications that reformations are mainly driven by factors associated with cost-control rather than the quality of treatments. In some countries, such as the United Kingdom, the downsizing of hospitals seems even to have gone too far and at the turn of the new millennium worries were raised that the number of beds did not reach current demands (Healy and McKee, 2002). The money saved by closing or downsizing hospitals is not necessarily reallocated and used for the treatment of those who were moved from institutions and into the community; appropriate alternative care may not be provided (Mechanic and Rochefort 1990). The reformation of Swedish psychiatric care in the mid 1990s is one illustrative case, where many municipalities lacked alternative caring facilities necessary to comply with the decentralization of health care from the county to the local level (The National Board of Health and Welfare 1999). There is also some evidence that early discharge of patients from hospitals increases the overall length of treatment (Shepperd and Iliffe 2005) and the likelihood of being readmitted to hospitals (Amstrong *et al*. 2008).

Despite that the three indicators of health care provision have developed quite differently over the years, the overall trends place some doubts on arguments of substantial cutbacks in service provision in EU member states. *Figure 3* shows the index of health care provision (with and without medical technology), an index of contributory social insurance replacement rates and an index describing the level of social assistance benefits. It is evident that health care provision has not necessarily suffered from serious retrenchment in recent decades. In fact, we can observe quite the opposite. Between 1980 and 2006 the index of health care provision increased by about 25 percent, even though the 1980s is more characterized by stability or even a slight decline. Much of this increase is due to the exceptional increase of medical technology since 1990. If medical technology is excluded from the index of health care provision the increase is more modest and around 16 percent since 1990. Also the slight decline in health care provision in the 1980s disappears when medical technology is excluded from the index. Thus, health care provision does not seem to be particularly prone to cutbacks. Rather it is cash benefits that have suffered from cutbacks and retrenchment in the last decades, quite contrary to previous claims. Social insurance replacement rates have declined on average by about 10 percent between 1980 and 2005. The decline for social assistance benefit levels is on average almost up to 20 percent for the shorter period 1990-2005.

[Figure 3 about here]

Since European integration has not resulted in substantial downsizing of health care services we cannot assume to observe any downward convergence in health care provision. Instead the development may translate into upward convergence, whereby countries with less elaborate health care systems are catching up on countries ranked higher in the welfare league. For example this is the type of convergence envisioned by Hervey (2007) and McKee *et al.* (2004) due to the introduction of the OMC. If the opposite applies a fanning out pattern occurs, showing patterns of divergence in health care provision, where countries with a more elaborate welfare state introduce more improvements in health care than countries in the lower rank of the welfare league.

Figure 4 shows cross-national dispersion in the index of health care provision for the 19 EU countries 1980-2006. Included in the figure are separate series for health employment, hospital beds and medical technology. Quite contrary to common expectation about the development of European welfare states the period of improvements in health care provision

since 1980 is more associated with divergence and greater cross-national variation than convergence. The EU countries are becoming less similar on all three indicators of health care provision studied here. Medical technology varies most extensively across countries, followed by hospital beds and health employment. The inclusion of the Czech Republic and Poland around 1990 causes the index of health care provision to rise sharply. Even though the dispersion in the index of medical technology describes somewhat of a roller coaster pattern, the overall trend is an increase in the coefficient of variation between 1990 and 2006. Hospital beds shows the clearest and most stable pattern of divergence. In particular developments in the 1980s made countries more different in terms of the number of hospital beds; something that continued to characterize cross-national variation also during subsequent years, albeit with less strong signs of divergence. Health employment shows more diversified long-term changes. The coefficient of variation for health employment describes a U-turn pattern, with decreased variation in the 1980s and early 1990s and increased dispersion the following years. In the 1980s health employment therefore converged, whereas the 1990s and the first years of the new millennium are characterized by divergence.

[Figure 4 about here]

The descriptive analysis of health care systems above shows that the "Europeanization" hypothesis of greater similarities between European health care systems is not fully supported. Of the three dimensions of health care analyzed in this paper, only private health care financing shows clear signs of convergence for the period 1980-2006. Increased out-of-pocket expenditure does not translate into greater similarities in the financing of European health care systems, nor is it possible to find any convergence tendencies in health care coverage. Also the argument that European integration most likely leads to cutbacks in service provision rather than downsized cash social benefits is hard to support with empirical data. Based on the results presented above cash benefits have suffered from welfare state retrenchment since 1980, whereas health care provision has been improved.

In order to provide formalized evidence of health care developments we will finalize this section by applying a multilevel framework to the study of welfare state retrenchment and policy convergence. *Table 1* shows the results from a series of multi-level regression models using health care financing, provision and coverage as dependent variables and a time variable as independent variable. Since the nominal values differ across the various indicators,

the size of the parameter estimates is not comparable across models. The results confirm the findings from the descriptive analysis above. The increases of private and out-of-pocket expenditures are associated with convergence, indicated by different signs of the fixed effect of time and the covariance between intercept and time in the random slope model (denoted *b* in table 1). For example, the fixed effect of time for the first random slope model is .2352, which indicates that private health care expenditure has a tendency to increase over time. The covariance between the intercept and time is -4.752, showing that countries with higher levels of private health care expenditure on average have steeper negative slopes, thus creating a fanning in pattern whereby the size of private health care expenditure is becoming more similar across countries. For out-of-pocket expenditure in the second random slope model the parameter for the time variable is close to, but not statistically significant. If we recapture the results from the descriptive analysis above, cross-national variation of out-of-pocket expenditure shows a curve-linear pattern where it was difficult to observe any clear overall tendency towards convergence. However, since the standard errors in the random slope models only are approximations it may here be more appropriate to rely on tests specifically designed for the random part of the model. For example, the deviance test or the likelihood ratio test shows whether the random slope model fits the data better than the random intercept model (models *a* in table 1) (Snijders and Bosker 1999). In all the models in table 1 the deviance test is strongly significant, indicating that the random slope models indeed explain more of the institutional variation in health care than the random intercept model.

[Table 1 about here]

The tendencies of convergence disappear when we move from expenditure to provision. The index of health care provision and the indicators on health employment and hospital beds show signs of divergence over the period 1980-2006. For all three indicators both the parameter estimates of the fixed effect of time and the covariance between the intercept and time are negative. The interpretation is a general decline in the indices and that countries with lower intercepts tend to have the steeper negative slopes, thus describing a downward fanning out pattern of divergence. The index of health care technology deviates from this pattern since the fixed effect of time and the covariance have opposite signs on the parameter estimates. Here the parameter estimate of the fixed effect of time has a very large standard error, which probably is due to the large amount of missing values in the composite parts of the medical technology index. The standard errors are large also in the model including health care

coverage as dependent variable. The slight tendency towards convergence in this model disappears if the Netherlands is excluded from the analysis.

Discussion

In this paper we have made a preliminary analysis of health care developments in a large number of EU member states. In addition to the same reform pressures as non-European OECD countries are facing, such as economic globalization and the aging of populations, intrinsic pressures for reform of social policy are building up also within the increased European cooperation. Although many of these pressures do not directly involve the organization of social policy, one common assumption in the comparative welfare state literature is reformations of social benefits and services in a downward direction. Since the structural pressures often are assumed to affect all EU countries alike, albeit perhaps to differing extent, it is plausible that long-term developments in the organization of health care services should show patterns of downward convergence.

In the empirical section we analyzed three core dimensions of health care services: financing, coverage, and provision. We show that developments of health care services differ in important aspects from that of cash benefits, where quality often has been reduced. Since we did not find any stronger evidence for cutbacks and retrenchment efforts introduced in health care provision, the hypothesis concerning greater vulnerability for social services is not supported by empirical data. This preliminary finding brings new input into the discussion about welfare state developments in eras of welfare state retrenchment and decline. There are many factors that may explain the greater resistance to cutbacks of health care services. One factor may be that health care services often receive strong popular support. One may recall that even the conservative Prime Minister Thatcher in the 1980s failed to fundamentally change health care service in the United Kingdom. Another factor may be that health care systems are less affected by economic downturns than cash benefits. The demand for health care is probably less influenced by business cycles than that of social transfers and benefits, which means that the need for reforms due to movements in caseloads are less apparent for health care services.

Nor did we observe any stronger convergence in the organization of health care. Countries have only become more similar in terms of private health care financing, whereas other

dimensions such as health care provision tend to diverge. The influence of European integration on health care systems seems therefore to be rather limited, at least concerning the dimensions and indicators of institutional organization used in this study. Of course, issues related to social service provision is very difficult to measure and analyze empirically in large-scale comparative studies. The index of health care provision construed in this paper may be one way forward to more closely and accurately study more complex dimensions of health care in a comparative perspective. To this extent the analyses presented above provide some pioneering results.

There are still important dimensions of health care service that calls for more detailed analysis. The regulation of the medical profession is one example that concerns qualifications of medical personnel and conditions of professional performance (Moran 2000). The independence of members of the medical profession did gradually decrease during the last century through political intervention circumscribing the range and forms of exercise (Nordgren 2000; Scott 2000), a trend which however is now being partly reversed through the privatization of provision also in countries with tax-financed health care. A more detailed analysis of the components of medical technology and pharmaceuticals used in health care services as well as its distribution across and within countries would also be of interest. Are all citizens, or holders of social insurance, eligible for every kind of treatment, or are especially costly services reserved for those with an additional private insurance?
Another possible extension of this study is to focus more explicitly on the introduction of purchaser-provider splits, or quasi-markets, in countries with tax-financed social services. This relatively new innovation in health care governance has resulted in the appearance of private for-profit firms, as well as non-profit organizations, as the actual providers of services, alongside the traditional exclusive public sector providers (Anell 2005; Blomqvist 2004; Burau et al. 2009; Checkland et al. 2009; le Grand and Bartlett 1993; Ovretveit 2003). In countries where social services are organized as a collective employment related insurance service, for-profit firms have always been the dominant form of providers (Mossialos and Dixon 2002). The introduction of quasi-markets in tax-financed health care systems has entailed fervent academic and political debates, with regard to the effects on total health care expenditure, as well as on equity in access to health care. This re-organization of health care has been justified in terms of cost containment and greater efficiency, albeit recent studies question the economic advantages (Herr 2008; Lindqvist 2008; Shafrin 2009; Silverman and Skinner 2004). Precise contractual regulation and adequate payment methods are

recommended, measures which in turn require increased control activity by the financing part, thus contributing to already escalating health care expenditure (Blomqvist 2004; Duggan 2000; Gerdtham 1998; Hughes Tuohy; Lindqvist 2008).[7] It is also argued that equitable access to health care may be jeopardized by the introduction of choice and competition inherent in market-driven provision of health care services: by cream-skimming on part of the providers, and by less information and habit to make choices on part of low educated patients (Hunter 2009). Also in this case strong regulatory contracts are the recommended solution (Le Grand 2009).

Great political interest is presently shown for the possible effects of patient mobility. Formally, EU citizens are free to demand health care services anywhere in the European Union, a freedom which is actively promoted by the EU Commission. The issue is if permission has to be granted aforehand by the home country local authorities, which are responsible for payments. We do not consider this to be a prominent cause of future convergence in any of the dimensions of health care services analysed here. The possibility to demand health care in foreign environments will probably also in the future be an option only for well educated and well situated persons. Language, cultural values and epistemic identity are of paramount importance in the relationship between patient and medical professionals.

Despite the future directions of the European social models the above discussion illustrates the great need for continued analyses of European health care systems and to create comparative benchmarks against which individual countries can be evaluated. This work entails both conceptual considerations regarding institutional measurement of the sort applied in this study and theoretical assessments of the latest claims concerning the causes and consequences of institutional variation. This study clearly shows that large-scale comparative welfare state research can and should be broadened to encompass not only developments in cash benefits, but also the evolution of social services and health care.

[7] For primary care services the main payment methods are capitation, in which payments are made for every patient on the doctor's list, sometimes differentiated according to Diagnosis Related Groups (DRG) or complexity of the patient's medical problems, and fee-for service, in which payment is received for every visit, independent of kind of problem. For hospital care the main payment methods are per-diem reimbursement, and patient care completed. Systems with primary care "gatekeepers" control access to specialist care.

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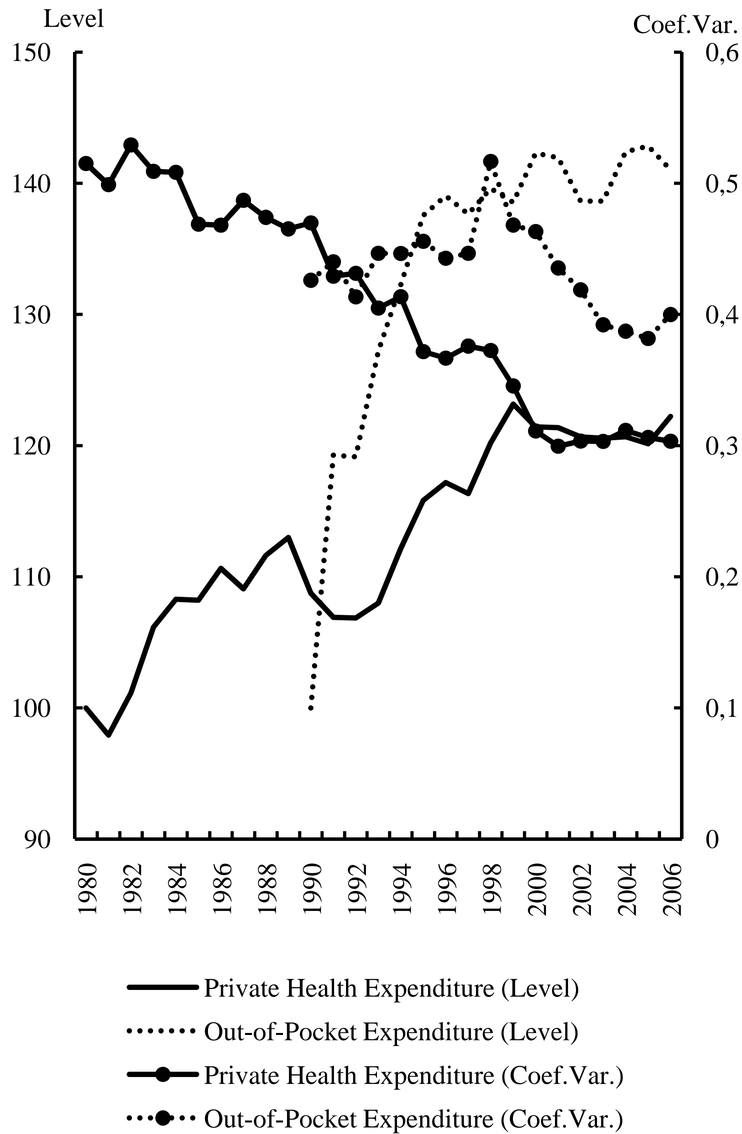
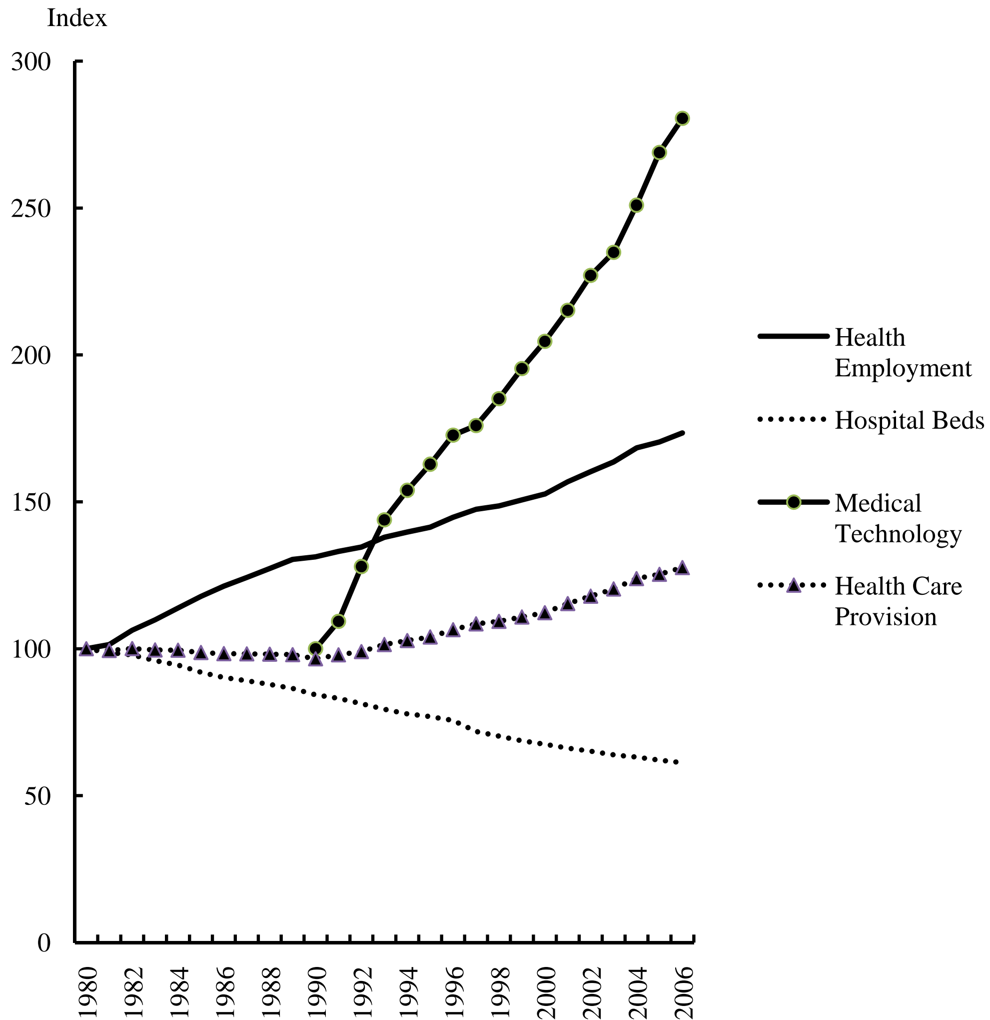
Figure 1. Private Health Care Financing in 19 EU Member States 1980-2006. Private Health Expenditure and Out-of-Pocket Expenditure as Percentage of Total Health Expenditure.



Note: Levels Index 1980=100 (Private Health Expenditure) and Index 1990=100 (Out-Of-Pocket Expenditure). Coef.Var. = Coefficient of Variation.

Source: OECD Health Data 2008.

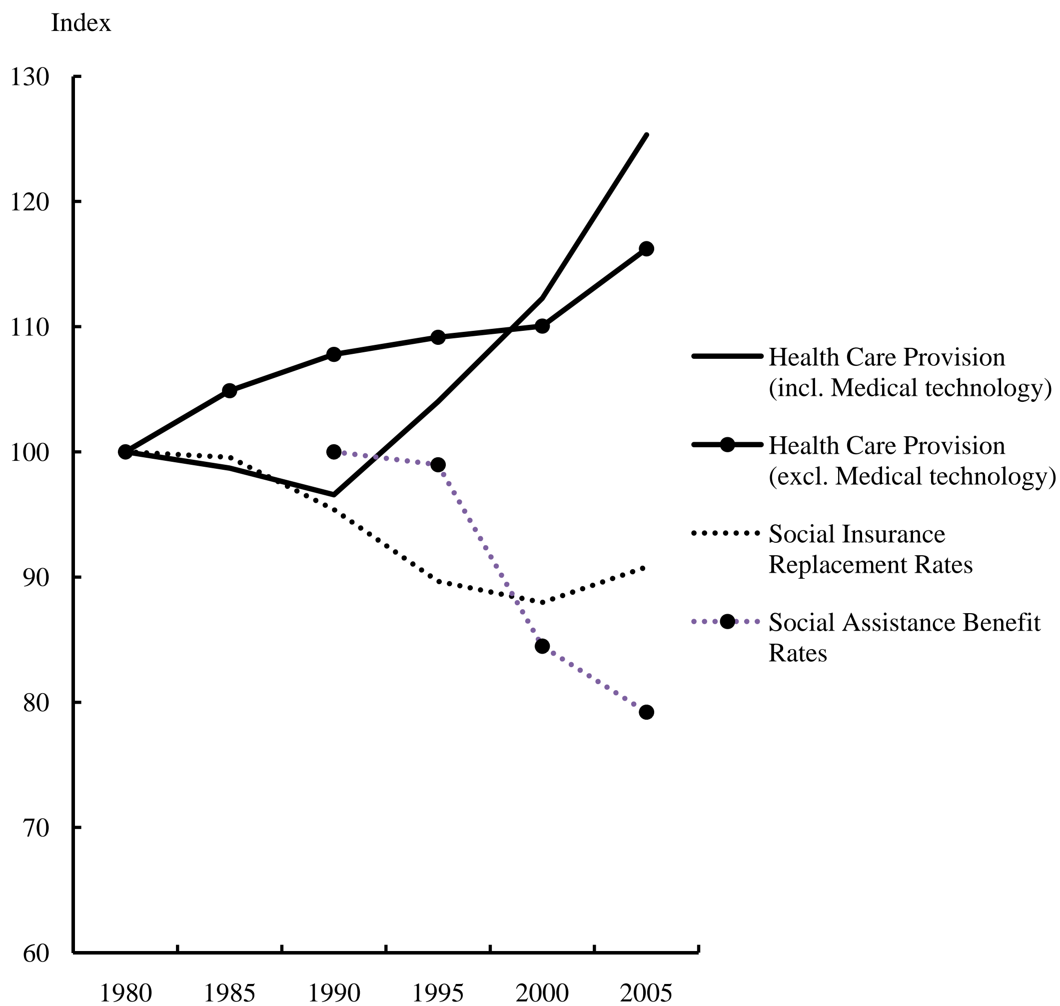
Figure 2. Levels of Health Care Provision in 19 EU Member States 1980-2006, Index 1980=100.



Note: Health employment includes practising Doctors and Nurses. Health care beds includes total and acute health care beds. Medical technology includes computer tomograph scanners, MRI units, radiation therapy equipment, lithotriptors, and mammographs. Health care provision is an additative index comprising health employment, health care beds and medical technology. Medical Technology is measured from 1990 and onwards.

Source: OECD Health Data 2008.

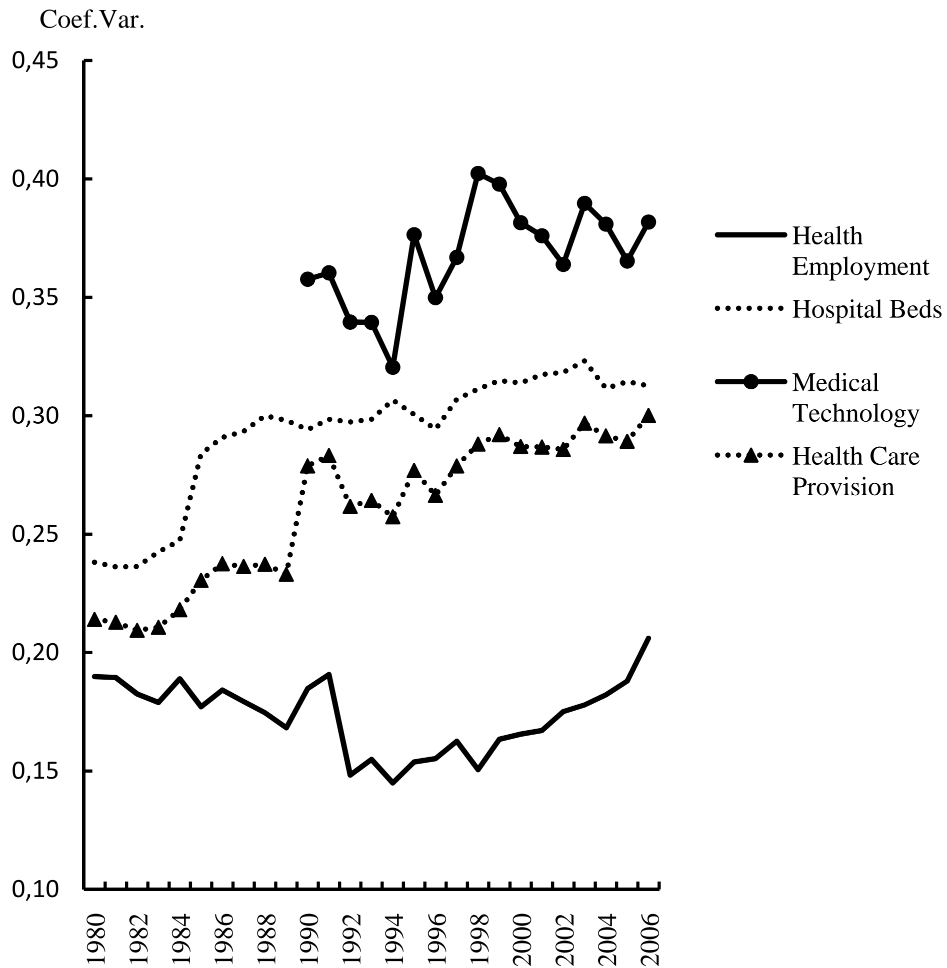
Figure 3. Index of Health Care Provision, social insurance replacement rates and social assistance benefit levels in 19 EU Member States 1980-2006, Index 1980=100.



Note: Index of health care provision includes health employmen, hospital beds and medical technology. Social assistance is indexed according to 1990-levels.

Source: OECD Health Data 2008.

Figure 4. Dispersion of Health Care Provision in 19 EU Member States 1980-2006.



Note: Health employment includes practising Doctors and Nurses. Health care beds includes total and acute health care beds. Medical technology includes computer tomograph scanners, MRI units, radiation therapy equipment, lithotriptors, and mammographs. Health care provision is an additative index comprising health employment, health care beds and medical technology. Coef.Var. = Coefficient of Variation.

Source: OECD Health Data 2008.

Table 1. Multilevel Regression of Health Care Financing, Provision and Coverage in 19 EU Member States, 1980-2006 (Standard Errors Within Parentheses).

	I:a Private Health Expenditure	II:a Out-of-Pocket Expenditure	III:a Health Employment	IV:a Hospital Beds	V:a Medical Technology	VI:a Health Care Provision	VII:a Health Care Coverage
Fixed Effect							
Intercept	20.590*	13.968*	7.317*	7.203*	4.591*	6.624*	96.196*
	(2.133)	(1.393)	(.222)	(.444)	(.414)	(.232)	(1.873)
Time	.106*	.085*	-.048*	-.029*	.006	-.036*	.050*
	(.024)	(.023)	(.004)	(.004)	(.008)	(.004)	(.014)
Random Effects Intercept							
Country	83.061*	30.983*	.827*	3.668*	2.840*	.943*	65.458*
	(27.137)	(10.446)	(.275)	(1.189)	(.941)	(.311)	(21.370)
Year	13.163*	7.313*	.458*	.269*	1.219*	.445*	5.433*
	(.914)	(.597)	(.031)	(.019)	(.089)	(.029)	(.360)
Deviance	2411.850	1613.517	984.148	748.572	1269.806	1063.419	2247.486
	I:b	II:b	III:b	IV:b	V:b	VI:b	VII:b
Fixed Effect							
Intercept	17.914*	10.685*	7.401*	7.176*	4.122*	6.598*	96.392*
	(3.207)	(2.620)	(.358)	(.460)	(.705)	(.334)	(2.050)
Time	.2352*	.235**	-.052*	-.027**	.027	-.034*	.041
	(.103)	(.118)	(.017)	(.014)	(.026)	(.014)	(.036)
Random Effects Intercept							
Country	190.060*	106.363*	2.345*	3.866*	8.579*	2.055*	77.836*
	(63.185)	(39.756),	(.789)	(1.294)	(3.001)	(.687)	(25.859)
Year	.187*	.218*	.005*	.003*	.012*	.004*	.020*
	(.064)	(.081)	(.002)	(.001)	(.004)	(.001)	(.008)
Covariance							
Intercept*Time	-4.752*	-3.3956	-.084*	-.033	-.261*	-.065*	-.565
	(.458)	(1.655)	(.033)	(.029)	(.104)	(.026)	(.350)
Random effect Time							
Country	6.452*	3.730*	.157*	.072*	.625*	.220*	4.346*
	(.458)	(.313)	(.011)	(.005)	(.047)	(.015)	(.294)
Deviance	2204.844	1468.426	594.718	286.336	1066.891	792.865	2182.049
Δ Deviance (model a-b)	*207.006*	*145.091*	*389.430*	*462.236*	*202.92*	*270.554*	*65.437*

*** do not know. Coverage not significant covariance when the Netherlands is corrected for.