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Health Care Determinants in Comparative Perspective: The Role of Partisan Politics for Health Care Provision.

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Abstract: Health care systems differ substantially across countries in terms of service provision, which is of direct relevance for the quality and distribution of health care citizenship rights. Whereas the driving forces for the expansion and subsequent decline of social benefits have received great scholarly interest in comparative research, the determinant for health care provision is largely unexplored. In this paper we assess the role of partisan politics for health care provision in 18 OECD countries 1980-2005. Contrary to the development of many other social citizenship rights over this period, the analysis of health care provision is one of expansion rather than decline. Based on OECD Health data we propose a new strategy for measuring social citizenship rights in the area of health care policy that is based on institutional organization rather than expenditure levels. The regression framework shows that left wing government is positively related to the expansion of health care provision. Likewise, confessional parties generally have a stronger positive impact than secular right wing government.

Whereas the growth and subsequent decline of social benefits has received tremendous interest and scrutiny in the academic literature, the development of social services, the other pillar of social citizenship, is less well accounted for. This concerns the comparative analysis of health care systems, where large-scale investigations on the drivers for social change are almost absent. Partisan politics is widely believed to be closely related to the development of social citizenship, at least during the golden age of welfare state development in the immediate Post-War decades. However, in the area of health care the role of partisan politics is largely missing from the analysis, which instead seems to focus, for example, on economic development, demography and the increasing costs of medical technology.

The purpose of this study is to analyze the influence of partisan politics on health care provision in the affluent welfare democracies. Based on power resource theory we expect that left party governments have a positive impact on central dimensions of health care provision, including health employment, hospital beds and medical technology. The study includes 18 longstanding welfare democracies and covers the years 1980-2005. The empirical analysis is based on OECD Health data 2010.

The paper is organized as follows. Next is a discussion concerning the determinants for health care provision. Thereafter follows a section on data and methodological consideration, after which the results are presented. The findings are discussed at the end.

Driving forces

During the first decades after the end of the Second World War a dominating trend was to see the development of welfare states and social policy as a natural consequence of economic development, industrialization and modernization (Kerr et al. 1960; Pampel and Williamson 1988; Wilensky 1975, 1981). Cross-national differences were mostly seen as depending on cultural specificities, values or polity organization (Flora 1986; Form 1979; Wilensky 1975). In the late 1980s an alternative strand of thinking emerged, stressing the role of politics, distributive conflicts and power relations among groups of actors within countries in counteracting the effects of similar economic and technological developments. Partisan politics were held to have a determining influence on the outcome of welfare state arrangements for citizens, due to the different institutional structure of social policies (Berger and Dore 1996; Esping-Andersen 1990; Goldthorpe 1984; Hicks 1999: Huber, Ragin and Stephens 1993; Korpi 1989; Korpi and Palme 1998).

With the beginning of welfare state retrenchment from the 1980's onwards, apolitical causes have once again come into the foreground. Now "logic of industrialism" and modernization are exchanged for post-industrialism, service economy, and globalization or trans-nationalization of capital. The latter especially entails increasing pressure from national and trans-national market forces to "adapt" in terms of welfare state policies. All welfare states have to be reorganized, or at least recalibrated it has been argued (Ferrera and Hemerijck 2003; Rieger and Leibfried). One common understanding is that maintenance, let alone expansion, of social citizenship rights has to be replaced by more social investment friendly policies (Esping-Andersen 2002, 2006; Scharpf 2002). Adding common demographic trends, i.e. an ageing population and low fertility levels, countries are seen to be characterized by

"new politics" (Pierson 1996). Since the problems are the same, the solutions must consequently be similar, with no space left for national partisan politics. Furthermore, a new analytical approach, "Varieties of Capitalism" (VOC), appoints the employer organizations to be the architects of social policy arrangements in coordinated and liberal market economies respectively, in contrast to the partisan politics approach.

Scientists following the power resources approach have continuously found empirical evidence of variations in social citizenship rights due to partisan politics (for ex. Ferrarini 2006; Huber et al. 1993, 2006; Korpi and Palme 1998, 2003; Nelson 2008; Montanari 2001; Palme et al. 2009). In the absence of alternatives due to economic and technological "necessities", an end state of convergence is a logical corollary. Recent institutionally informed analyses show however signs of divergence rather than convergence with regard to social citizenship rights (Montanari et al. 2007, 2008). Moreover scholars from different theoretical approaches have recently shown how countries supposedly exposed to similar pressures from national and trans-national sources have responded differently to such pressures due to varying political governance (Hacker and Pierson 2010; Jordan 2010; Kühner 2011; Schmidt 2009). It would seem that actors are taken back into social science analyses. In the case of social policies, which are the foundations of social rights, it has to be remembered that such policies just as any other policy, are enacted by political actors who have chosen or not chosen to emulate ideas or organizations originating in countries having similar problems to face (Hoberg 2001). Diffusion is never automatic, just as the definition of problems is never neutral.

In achieving the established goals of social citizenship, partisan politics is however challenged by other factors than national and trans-national market pressures, especially the level of internal degree of economic and technological development, the constitutional structure and the demographic situation. Since our analysis regards only highly developed OECD countries, the differences in GDP are minimal. In the case of larger international studies, incorporation also low and middle wage countries, the differences in GDP as a proxy for the degree of economic and technological development are of course determinant to quite another degree. The constitutional or state structure of a country is sometimes accused to hamper national social policy legislation and implementation (Immergut 1992; Pampel and Stryker 1988). It may however most fruitfully be seen as "context variable with different effects in the presence of different (political) actors" (Huber et al. 1993, p. 745). Veto points or regional authority in matters of welfare are in fact most constraining on left party incumbents in national parliaments (Huber et al. 1993). This may be particularly important for the establishment, and even more so for the implementation, of social services, which of course are locally organized.

The demographic situation and especially the proportion of old people in the population have often been held to influence social expenditure. From a social rights perspective it is however doubtful whether partisan politics would no longer determine the degree of transfers as well as social services for the old. Only USA exhibits independent strong lobby groups for retired people, while the pattern in other countries is to build associations tied to the mother party. The development to dominance of the service sector in comparison with the industrial sector in the economy has often been described as a transition to quite a new society, with floating or

no class barriers and the need for new politics. While all our eighteen OECD countries move in the direction of this transition, there are however great differences in the composition of the service sector. The Nordic countries have especially developed the so-called social service sector, which mainly consists of care work, both health care and care of old and young people Montanari 2009).

With regard to social services and health care provision, which is the object of our analysis, there is one further important "context" variable, namely the organization of the health care service in itself. We have recently developed a scheme for the analysis of social services (Montanari and Nelson 2011). Social citizenship has in fact two main components: cash benefits and services. Among the institutional dimensions developed for the comparative analyses of cash benefits (Korpi 1989), coverage and financing of health care services may be important as determinants for health care provision. For example, the pressure from the medical technology industry is often held to influence the growth of health care services, especially in terms of expenditure. This increase of medical technology may have different effects on health care provision, due to the financing and coverage of health care.

In sum we expect that partisan politics is an important driver for health care provision, despite the competing explanatory factors above. More specifically we expect that left party political power have positive effects on health care provision.

Data

There are extensive conceptual difficulties and measurement problems involved in health care research, particularly concerning the comparative analysis of health care systems (Wendt *et al*., 2009; Bevan *et al*., 2010). Numerous health care resources are liable targets for the analysis of health care provision. In this study we include three areas of outmost importance for the delivery of health care citizenship rights, namely health employment, hospital beds and medical technology (Montanari and Nelson, 2011). The measures of health care provision are from OECD Health Data 2010 covering the period 1980-2005 for 18 affluent welfare democracies.

Health employment includes practicing doctors and nurses, whereas hospital beds are measured both in total and in terms of acute care beds. Medical technology includes four items: the number of computed tomography scanners, magnetic resonance imaging units, radiation therapy equipment, lithotriptors and mammographs. All indicators are measured as fractions of total population. It should be noted that it is not possible with this data to assess the distribution of health care provision in society, which may differ depending on the overall organization of health care. There are essentially three different health care systems in place among the OECD countries: universal health care, social insurance based health care and private health care (Schieber and Poullier, 1987).

Table 1 shows the mean values of health care provision for the period 1980-2005 in our sample of countries. Since the levels often differ between the individual indicators, the data is standardized according to z-scores. Health care provision is the average score of health

employment, hospital beds and medical technology. In order to bring some order to the data and for reasons of convention, countries are grouped according to the overall organization of welfare states, using Esping-Andersen's (1990) well known categorization of liberal, conservative and social-democratic welfare state regimes. However, it should be noted that there is a high degree of overlap between the categorization of welfare state regimes and type of health care system, particularly between the universalist health care systems of the Nordic countries and the social insurance based health care in many Continental European countries. Some notable differences between the general trademarks of the three welfare state regimes and the organization of health care should also be mention. This discrepancy is perhaps most notable concerning the universalist principle, which is common both to the Nordic and the Anglo-Saxon countries, with the exception of the United States. There is also some resemblance between the organization of countries into different welfare state regimes and health care provision, although individual countries may deviate from the broader pattern. Health care provision is on average clearly lower in the liberal than in the social democratic welfare state regimes. The highest scores tend to be found among the conservative regimes.

[Table 1 about here]

The independent variables are from various sources. The political variables of government composition are from Korpi and Palme (2003) and updated to 2005. We distinguish between left, confessional and secular centrist/right wing parties in the cabinet. Left parties include social democrats and parties to their left. European Christian Democratic parties are included in the confessional category, whereas the remaining parties belong to the secular centrist/right

wing group. In order to control for the institutional interplay between different dimensions of health care citizenship rights we also use a measure of health care coverage and health care expenditure. Both variables are based on OECD Health data 2010. Health care coverage captures the share of citizens eligible for health care services financed by public funds, irrespective of whether the actual service provider is a public or private actor. Health care expenditure is measured as percentage of the GDP. The measure on constitutional structure and veto points is from the Comparative Welfare State Dataset (Huber *et al*., 2004). This additive index includes six items: federalism, presidentialism, bicameralism, popular referenda, judicial review and proportional representation in parliament. Index scores can vary between 0 and 8. The degree of post-industrialism is measured by the proportion of the population 15 to 64 employed in the service sector. This indicator is from the OECD Labour Force Statistics. The demographic burden of aging populations is measures by the percentage share of the population above 64 years. Statistics on the size of the elderly population are downloaded from OECD stat. Economic development is measured by the GDP per capita in constant purchasing power adjusted US dollars. This data is from the OECD National Accounts series.

Table 2 shows the mean values of the various independent variables for the period 1980-2005 in our sample of countries. Not surprisingly, left governments have had strongest foothold in cabinet among the social democratic welfare state regimes, whereas the conservative countries have been strongly influenced by Christian-democratic doctrines. Likewise, secular centrist/right wing governments have been prominent in the liberal welfare state regimes. Health care coverage only shows modest variations across countries. Complete coverage is

reached in countries with universalist health care systems, including the Nordic countries and Australia, Canada, Ireland, Italy, Japan, New Zealand, and the United Kingdom. Countries with insurance based health care systems reach on average nearly complete coverage over the period, in part by the often gradual implementation of compulsory health insurance schemes. In this category we find several conservative welfare state regimes of continental Europe, including Austria, Belgium, France, Germany, the Netherlands and Switzerland. Health Expenditure is on average highest among the conservative welfare state regimes, followed by the liberal and social democratic countries. The growth and size of health expenditure is one of the most frequently discussed themes in health economics, including causes such as economic development, population age structure and health care institutional organization (Gerdtham and Jönsson, 2000). Concerning the latter, for example, primary care gatekeepers and reimbursement methods are suggested to be negatively associated with health expenditure (Gerdtham *et al*., 1998). The exceptionally high level of health expenditure of the highly privatized system in the United States has been related to malpractice litigation and premiums, adding to defensive medicine (Hellinger and Encinosa, 2006). Another supposed reason is higher medical care prices in the United States compared to the rest of the OECD (Anderson *et al*., 2005).

[Table 2 about here]

Constitutional veto points are much more frequent in several liberal and conservative welfare states than in the social democratic ones. The service sector is on average greatest in the social democratic welfare state regimes, followed by the liberal and conservative counterparts. The

share of the population above 64 years is on average highest in the social democratic welfare state regimes, likewise economic development. Next thereafter we find the conservative welfare states followed by the liberal countries. Notably, economic development in the United States is quite exceptional compared to the other countries.

Analytical Techniques

The empirical analyses are based on unbalanced panel data with no less than 207 observations spread unequally across the 18 countries and the years 1980-2005. The number of observations for a single country is no less than five. OLS regressions based on cross-sectional panel data are likely to produce incorrect standard errors for the regression coefficients. In this study we follow common procedures to adjust for these errors by computing cluster robust standard errors of the regression coefficients (Chung and Muntaner, 2006; Huber *et al*., 2006; Acemoglu *et al*., 2008;).[1] The robust estimator provides correct standard errors in the presence of heteroskedastic error terms across countries (Long and Ervin, 2000), while the cluster option report valid standard errors also in presence of within unit correlation over time, something that includes autocorrelation (Moller *et al*., 2003). In order to control for the effects of non-included characteristics of countries we use fixed effect models. This procedure is accomplished by the inclusion of a full set of country dummy variables in the regression models.

[1] Panel corrected standard errors (Beck and Katz, 1995) are often used to adjust for heteroskedastic and contemporaneously correlated error terms across panels. However, this estimator requires a perfectly equal spacing of observations across the data matrix, something that not applies to the data used in this study.

Cluster robust standard errors require that there are no contemporaneous effects and correlated errors between countries. This assumption might be violated if an unmeasured factor influences the outcome for all countries at a specific point in time. Severe global financial crises of the magnitude recently experienced and beginning in 2008 is one example. We expect such contemporaneous correlations to be less problematic here, especially since health care provision shows a steady increase in most of our countries throughout the period (Montanari and Nelson, 2011). Despite the advantage the cluster robust estimation technique, we also utilize OLS standard errors to illustrate the differences in the size of the standard errors relevant for hypotheses testing. Although the regressions are based on pooled cross-sectional and time series data, the results are sensitive to the influence of single countries. We have therefore continuously checked for observations that deviate from the broader pattern. Substantial changes to the results after the exclusion of single countries are noted in the text.

Results

The empirical test of the partisan politics hypothesis is accomplished in two steps. First we analyze health care provision at the more aggregate level. Thereafter the aggregate index of health care provision is disaggregated into the constitute components, thus analyzing health employment, hospital beds and medical technology separately. *Table 3* shows the results from a series of fixed effects OLS regressions of health care provision on various independent variables in 18 OECD countries, 1980-2005. Both cluster robust standard errors and OLS standard errors are reported. Evidently, the cluster robust standard errors provide a more conservative test of statistical significance of the variable effects. The main result is that left wing governments have a statistically significant positive effect on health care provision.

Regressions are made with and without the variable measuring constitutional structures and veto points of countries' political systems, which very seldom change over time. The constitutional structure variable hardly impacts the parameter estimates of left wing governments. However, after the inclusion of veto points, the positive effect of confessional governments disappears by statistical terms. Among the other variables only the size of the service industry has a statistically significant effect on health care provision. In this particular case the effect is positive.

[Table 3 about here]

Next we turn to an analysis of the separate components of health care provision. *Table 4* shows the results from a series of fixed effects regressions of health employment, hospital beds and medical technology on various independent variables in 18 OECD countries 1980-2005. The number of observations is clearly lower than in the analysis of health care provision above, something that makes it more difficult to establish statistical significant relationships. In addition the statistical analysis becomes more sensitive to developments of individual countries. Nonetheless, left wing governments seem to have positive effects on health employment, especially after Belgium is excluded from the analysis. From a political perspective Belgium is an exceptional case due the strong reliance on coalition governments to varying extent involving members from left wing, confessional and secular centrist/right wing parties. In addition the health employment is much higher than in Belgium than in most other Continental European countries. The close connection with EU level bureaucracy in Belgium may be one reason for high levels of female employment in general (Montanari,

2009), and health employment in particular.[2] After exclusion of Belgium, the positive coefficient for confessional governments is substantially increased and statistically significant. The inclusion of veto points in the regression does not impact the parameter estimates of the partisan politics variables to any serious extent. Also for health employment the size of the service sector has a positive and statistically significant effect.

[Table 4 about here]

The effect of partisan politics changes from positive to negative when the focus of analysis is shifted from health employment to hospital beds. However, only the negative effect of confessional governments is statistically significant. The downsizing of the number of hospital beds may not necessary be a sign of retrenchment, since there seems to be a general trend in many countries to increase the relative size of specialized nursing care, community-based health or social care services, particularly in the European countries. This major restructuring of health care is probably related to several factors, including budgetary considerations, changed treatment and care options, and new prescription drugs (Healy and McKee, 2002; Sheppard and Iliffe, 2005). Also the negative effects of economic wealth, measured by GDP per capita, and the share of the elderly population, are statistically significant, irrespective of the inclusion of the constitutional structure variable. Concerning the latter variable, the number of veto points seems to be positively related to hospital beds. This might indicate the presence of greater degrees of path dependency in countries with veto

[2] It should be noted that OECD Health data lack information on the number of practising nurses. Thus, for Belgium the analysis of health employment is solely based on the number of practising doctors.

points political systems, something that makes major health care reforms of the sort above more political troublesome.

Turning to medical technology, we find that the partisan politics variables have opposing effects. Left wing governments are positively related to medical technology, whereas confessional parties seem to be negatively associated. However, only the positive effect of left wing governments is statistically significant, when Australia and Austria are excluded from the analysis.[3] The influence of left parties in government is much stronger in Australia than in many of the other liberal welfare state regimes, whereas the level of medical technology is clearly below average. The influence of left parties has been comparatively strong also in Austria, while scoring somewhat below average on medical technology. The positive effect of left wing governments disappears when veto points are included in the regression model, at least by conventional statistical standards. However, it should be noted that the p-value of the effect for the left wing government variable is about 0.07, when the constitutional structure variable is included. Both the constitutional structure and health coverage are negatively associated with medical technology, whereas the share of elderly persons has a positive relationship.

Discussion

[To be added]

References

[3] The coefficient for the left wing government variable is negative also when only Australia is excluded from the analysis. However, the p-values in this analysis is about 0.08.

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Table 1. Means of Health Care Provision, Health Employment, Hospital Beds and Medical Technology.

Welfare State Regime	Provision	Health Employment	Hospital Beds	Medical Technology
Liberal				
Australia	-.2840	-.2321	-.2600	-.4535
Canada	-.4038	-.1921	-.4541	-.6167
Ireland	-.3466	m.d.	-.2119	-.5970
New Zealand	-.4303	-.6040	-1.2506	-.2883
United Kingdom	-.2401	-1.1325	-.9473	-1.0760
United States	-.2668	-.4478	-.6942	-.7963
Mean	*-.3286*	*-.5217*	*-.6364*	*-.6380*
Conservative				
Austria	.5040	.3989	.9244	-.0084
Belgium	.7123	1.0514	.4088	m.d.
France	.0556	m.d.	.0556	m.d.
Germany	.7683	.4872	1.0494	m.d.
Italy	.3114	m.d.	.2382	-.1509
Japan	.5505	-1.2325	3.0971	1.5653
Netherlands	-.5836	-.2597	-.6083	-.5678
Switzerland	.7025	1.7241	-.3043	1.6900
Mean	*.3776*	*.3616*	*.6076*	*.5056*
Social Democratic				
Denmark	-.2661	.0672	-.7654	-.0582
Finland	.1273	.4264	-.3677	.2920
Norway	-.1579	.3596	-.6754	m.d.
Sweden	-.2511	-.0520	-.4958	m.d.
Mean	*-.1370*	*.2003*	*-.5761*	*.1169*

Note: All indicators are composite indices based on z-scores.

Source: OECD Health Data 2010.

Table 2. Means of Health Care Provision and independent variables in 18 OECD Countries, 1980-2005.

Welfare State Regime	Left Government	Confessional Government	Secular Government	Health Coverage	Health Expenditure	Const. Veto Points	Service Sector	Population Above 64 Years	GDP per Capita (Thousands of US$ PPPs)
Liberal									
Australia	0.50	0.00	0.50	1.00	7.22	5.00	0.48	11.64	2.52
Canada	0.00	0.00	1.00	1.00	8.95	5.00	0.50	11.74	2.54
Ireland	0.14	0.20	0.66	1.00	7.07	1.00	0.36	11.11	2.15
New Zealand	0.45	0.00	0.55	1.00	7.17	0.93	0.45	11.30	1.97
United Kingdom	0.33	0.00	0.67	1.00	6.77	2.00	0.48	15.60	2.28
United States	0.00	0.00	1.00	0.85	12.79	8.00	0.52	12.33	3.06
Mean	*0.24*	*0.03*	*0.73*	*0.98*	*8.33*	*3.66*	*0.47*	*12.29*	*2.42*
Conservative									
Austria	0.50	0.39	0.12	0.99	8.70	2.00	0.40	15.33	2.54
Belgium	0.36	0.36	0.28	0.99	8.37	2.13	0.40	15.67	2.44
France	0.57	0.00	0.43	0.99	9.25	3.00	0.43	14.17	2.27
Germany	0.30	0.48	0.22	0.95	9.61	5.00	0.36	16.30	2.31
Italy	0.28	0.45	0.22	1.00	8.11	2.53	0.32	16.44	2.27
Japan	0.04	0.00	0.96	1.00	7.05	3.00	0.45	14.85	2.32
Netherlands	0.22	0.36	0.42	0.80	8.33	1.00	0.46	13.15	2.53
Switzerland	0.29	0.28	0.44	0.99	9.32	6.00	0.54	14.96	2.97
Mean	*0.32*	*0.29*	*0.39*	*0.96*	*8.59*	*3.08*	*0.42*	*15.11*	*2.46*
Social Democratic									
Denmark	0.33	0.02	0.65	1.00	8.69	1.00	0.61	15.16	2.54
Finland	0.37	0.01	0.43	1.00	7.61	1.00	0.43	14.17	2.28
Norway	0.54	0.12	0.34	1.00	8.09	1.00	0.53	15.45	3.11
Sweden	0.78	0.02	0.20	1.00	8.62	1.00	0.53	17.34	2.52

Mean	*0.51*	*0.04*	*0.41*	*1.00*	*8.25*	*1.00*	*0.53*	*15.53*	*2.61*

Source: OECD Health Data 2010, Huber *et al*., (2004), OECD National Accounts, Korpi and Palme (2003), OECD stat.

Table 3. Fixed Effects OLS Regressions of Health Care Provision on Various Independent Variables in 18 OECD Countries, 1980-2005.

	Cluster Robust Standard Errors		OLS Standard Errors	
	Model I	Model II	Model III	Model IV
Left Gov.	0.185*	0.183*	0.185**	0.182**
	(0.085)	(0.083)	(0.058)	(0.058)
Conf. Gov.	0.625*	0.586	0.625**	0.586**
	(0.291)	(0.300)	(0.131)	(0.134)
GDP	-0.010	-0.010	-0.010	-0.010
	(0.014)	(0.014)	(0.008)	(0.008)
Health Cov.	0.131	0.087	0.131	0.087
	(0.287)	(0.310)	(0.425)	(0.426)
Health Exp.	-0.231	0.662	-0.231	0.662
	(7.827)	(7.775)	(2.967)	(3.048)
Service Ind.	1.797**	1.725**	1.797**	1.725**
	(0.355)	(0.380)	(0.536)	(0.538)
Pop. > 64 years	0.138	0.141	0.138**	0.141**
	(0.105)	(0.103)	(0.017)	(0.017)
Const. Struct.		-0.071		-0.071
		(0.139)		(0.056)
Constant	-2.667**	-2.180	-2.667**	-2.180**
	(0.722)	(1.316)	(0.452)	(0.593)
No. Obs.	381	381	381	381
R^2	0.749	0.750	0.749	0.750

Note: **p<.01 *p□<0.05. Country dummies are not shown.

Table 4. Fixed Effects OLS Regressions of Health Employment, Hospital Beds and Medical Technology on Various Independent Variables in 18 OECD Countries, 1980-2005.

	Health Employment	Health Employment[2]	Health Employment	Health Employment[2]	Hospital Beds	Hospital Beds	Medical Technology	Medical Technology[3]	Medical Technology[3]
Left Gov.	0.242[1]	0.280*	0.280*	0.280*	-0.072	-0.084	0.023	0.184*	0.165[1]
	(0.132)	(0.115)	(0.115)	(0.809)	(0.067)	(0.063)	(0.107)	(.072)	(0.080)
Conf. Gov.	0.144	0.809**	0.809**	0.809**	-0.346*	-0.277*	-0.206	-0.229	-0.233
	(0.475)	(0.206)	(0.206)	(0.206)	(0.155)	(0.128)	(0.273)	(0.241)	(0.244)
GDP	0.050	0.046	0.046	0.046	-0.063**	-0.064**	0.023*	.017	0.017
	(0.027)	(0.029)	(0.029)	(0.029)	(0.019)	(0.018)	(0.009)	(0.009)	(0.009)
Health Cov.	-0.428	3.275	3.275	3.275	-0.092	0.006	-0.895**	-0.937**	-0.877**
	(2.887)	(1.817)	(1.817)	(1.817)	(0.156)	(0.133)	(0.286)	(0.255)	(0.262)
Health Exp.	6.522	-4.416	-4.416	-4.416	2.872	0.620	4.470	3.133	2.750
	(8.664)	(4.993)	(4.993)	(4.993)	(3.827)	(2.631)	(7.057)	(7.752)	(7.948)
Service Ind.	3.121**	3.613**	3.613**	3.613**	0.352	0.543	0.244	0.593	0.403
	(0.670)	(0.642)	(0.642)	(0.642)	(1.066)	(1.171)	(0.578)	(0.543)	(0.567)
Pop. > 64 years	-0.026	-0.024	-0.024	-0.024	-0.206**	-0.226**	0.200**	0.206**	0.208**
	(0.031)	(0.043)	(0.043)	(0.043)	(0.026)	(0.027)	(0.025)	(.022)	(0.023)
Const. Struct.			0.0615	0.061		0.185**			-0.138**
			(0.070)	(0.070)		(0.036)			(0.023)
Constant	-2.667**	-5.882**	-6.373**	-6.373**	3.229**	2.146**	-2.499**	-2.339**	-1.168
	(0.722)	(1.605)	(1.703)	(1.703)	(0.515)	(0.359)	(0.677)	(0.773)	(0.950)
No. Obs.	284	258	284	284	289	289	207	171	171
R^2	0.841	0.832	0.832	0.858	0.969	0.972	0.939	0.942	0.944

Note: **p<.01 *p□<0.05. Country dummies are not shown. All regression models use Cluster Robust Standard Errors. [1]p<0.1. [2]Excludes Belgium. [3]Excludes Australia and Italy.

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