In the member states of the European Union social security and healthcare systems have become important institutions. The welfare state – of which social security and healthcare represent the core and cornerstones – may even be considered to be one of the characteristics of these European states and societies. Yet, these systems are not only very important institutions; they are also dynamic ones. During the past decades they have in fact been subject to far-reaching changes, in their practical operation but even more so in the reasoning behind them. One of the discoveries has been the possible relevance of prevention and preventive action. But before dealing with the ins and outs of prevention we need some further clarifications on social protection, its major instruments and logics.

Social protection and risk

In social protection two kinds of instruments are traditionally distinguished. On the one hand, there are replacement income schemes intended to secure an income in case primary earnings are interrupted, as, for example, in the case of unemployment, sickness or retirement. On the other hand, there are adjustment income schemes that are intended to meet exceptional expenditures, such as, for example, those connected with children or medical care. Yet, these systems are not magnanimous; they transfer income to beneficiaries only because a reason is found to do so (Gilbert et al., 1993). There are in fact two reasons – or bases of allocation as they are called – that can be distinguished:

1. Recognized social contingencies which are crucial for insurance-based schemes.
2. Need, which may open eligibility in assistance-type schemes.

Since the core social protection systems are insurance-based it is worthwhile first to have a closer look at the characteristics of insurances. The core idea of private insurance is to spread a particular risk over many shoulders on the basis of an equitable actuarial relationship. In this context ‘risk’ refers to the combined effect of two aspects, the first being the probability (P) by which a contingency will occur, and the second being the amount of damage (D) that will result when the contingency occurs. The risk (R) can then be calculated as the product of the probability and the damage.

\[ R = P \times D \]
In order to guarantee that the damage can be covered adequately when the contingency occurs, actuarial equity requires that the insurance contributions are calculated according to the risk covered. Thus the insurance technique aims at guaranteeing that every insured person may be sure of getting the real damage compensated on condition that his or her contributions may be set at a level that corresponds to the risk he or she runs. In schemes of the social insurance type, benefits are granted automatically when the envisaged social contingency occurs. With the latter as basis of allocation no test of need has to be applied by means of an income or means test. This characteristic of social insurance schemes explains the overwhelming enthusiasm with which early mutual aid initiatives and, later on, social insurances were welcomed (Rimlinger, 1971; Heclo, 1974). The second basis of allocation is need. It is used in assistance schemes. Originally this referred to private and public practices to grant help to people in need. These practices used to be of a voluntary, facultative and discretionary character. Nowadays, however, entitlement to social assistance has been operationalized in many countries within the law and the benefit levels have to some extent been standardized. Yet, the benefit amount continues to be dependent on assessed need, be it that in the end it is not need as such but income and means that are assessed. It goes without saying that schemes of the social assistance type focus on minimum income protection.

An important breakthrough: prevention

In general, social security policy and thinking have remained highly influenced by traditional social security definitions that begin with an enumeration of social contingencies and go on to describe which programmes and schemes have to be included under that cover (Pieters, 1993). Yet, the relatively one-dimensional focus on curative policy instruments has been highly criticized (Berghman et al., 2002). It is increasingly acknowledge that preventive instruments have to be taken into account as well.

Reparation and prevention

The central role which preventive action should play in social security has been revealed by Viaene by applying damage theory to social protection (Viaene, 1993). They argue that social security lies, first, in the prevention, afterwards, in the reparation, and finally in the compensation of human damage (see Table 5.1). The core of this logic is their proposition that human damage has to be kept as minimal as possible. Hence the prevention of damage should receive absolute priority over the indemnification of it. Only when a reasonable input of appropriate medical and situational instruments cannot prevent damage from arising should indemnification be pursued.

In their reasoning, indemnification refers both to the reparation of damage and to the compensation of irreparable damage. Yet, since compensation only represents a palliative, unable to remove the existing damage, reparation should always gain priority over compensation. However, when

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<th>Table 5.1 Human damage theory</th>
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<td><strong>Policy</strong></td>
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<td>Prevention (1)</td>
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these ideas are confronted with the existing social security systems, policies and budgets, one finds an illogicality. Instead of making the existing compensatory schemes as redundant as possible, in reality priority is given to the income transfer schemes, to the detriment of reparative and preventive action (Berghman, 1998).

Not only in social security policies but also in social security thinking, the importance of preventive actions has remained highly undervalued. Yet, the existing social security schemes do not enhance social security; they only help mitigate the level of social insecurity that has emerged. Social security consists first of all in making available work opportunities that may guarantee an appropriate income level and healthy living conditions. Only in the second place should the traditional curative social security and healthcare provisions play a role. The past decades have made it abundantly clear that labour opportunities are of the utmost importance in this connection. Yet, the elaboration of active employment policies is far from easy. Nevertheless, elaborating these kinds of preventive social security policies seems unavoidable in order to safeguard the broader societal function of the social protection system (Berghman, 2002).

The basic social policy chain

This function may best be explained by pointing to the logical chain that underpins social policy. This logical chain holds that we educate and train people so that they may be adequately inserted into the (paid) labour market. Such an insertion would give them the opportunity to gain a primary income. This income in turn enables them to have command over resources to guarantee their social participation. Yet, when this logical chain is interrupted due to unemployment, incapacity to work or old age, social protection systems operate to provide replacement income in order not to endanger social participation. Meanwhile restorative actions like healthcare, work mediation, retraining and even partial re-employment schemes are activated with an aim to secure a quick reinsertion into the labour market, restoring the logical chain. When both of these reinsertion devices and the income protection schemes are inadequate, however, the risk of social exclusion – of deficient social participation – materializes (Berghman, 1997).

Thus, so far as the core replacement income schemes are concerned, and as is illustrated in Figure 5.1, social security basically operates as a bypass mechanism in those cases where insertion into the labour force is no longer possible or desirable. In such cases its aim is to mend the chain by guaranteeing the availability of (replacement) income in order to safeguard social participation. One may even argue that replacement income schemes all cover the same basic social risk, i.e. incapacity to work. In the case of unemployment the risk materializes because there is no work; in the case of sickness and invalidity because there is no work capacity. Taking into account the way pension schemes were introduced, they must be classified as a particular form of invalidity scheme in which incapacity to work is presumed as soon as the pensionable age is reached and hence any proof of incapacity is no longer used as an entitlement condition. Prevention in social protection should then in the first place focus on limiting the prevalence and consequences of ‘incapacities to work’.

![Figure 5.1 Basic social policy chain.](image-url)
Prevention in social protection

The most logical and efficient policy approach, according to human damage theory, would be to aim for prevention first, then for reparation and only finally for compensation. However, in this section a more subtle picture emerges. It is pointed out that prevention can be achieved at not just one, but at three stages in the basic social policy chain (see Figure 5.1). The first stage of prevention coincides with the concept of prevention as in human damage theory and aims at preventing social contingencies such as unemployment, illness and disability from happening. In terms of the insurance formula it aims at lowering the probability ‘P’. This will henceforth be called primary prevention. The second stage of prevention coincides with the concept of repair in human damage theory: it intervenes after the social contingency has occurred, but aims at restoring the original situation as swiftly as possible, thereby limiting the damage ‘D’ in the insurance formula. It is also prevention, as it prevents further damage caused by longer term exclusion from the labour market. It is therefore called secondary prevention. Third, prevention may also be achieved via the bypass mechanism in the basic social policy chain, by providing compensation for the damage done. This is called tertiary prevention, because it avoids further downward spirals of social exclusion.

Primary prevention policies

The prevention of unemployment and labour market exclusion requires an understanding of the mechanisms causing it. These mechanisms are the subject of debate among economists. For an overview we refer to O’Sullivan and Sheffrin (2003). Generally speaking, three strategies may be discerned: (1) Focusing prevention at the supply side, for example, by changing the characteristics and skills of labour supply; (2) Focusing prevention with respect to the functioning of the labour market, for example, by diminishing existing labour market institutions, and (3) Focusing prevention at the demand side, for example, in a Keynesian sense by boosting job creation.

With respect to the first strategy, there is wide consensus that initial education is a decisive factor in the prevention of unemployment at the individual level. The higher educated earn more than the lower educated and also have lower chances of unemployment (Psacharopoulos and Patrinos, 2004; OECD, 2010). However, will investment in initial education also lead to lower unemployment at the aggregate level? The answer to this question is less clear, because general efforts to raise educational skills may result in an inflation of degrees. Still, most agree that a highly educated labour force is a major advantage in actual knowledge-based societies and in view of the rapid technological changes and restructurings facing current economies (see the discussion on the transitional labour market in Schmid and Gazier, 2002). In particular, initial education provides workers with the skills required to be able to learn new things and to adjust swiftly in later life (de Koning, 2007a).

Another important question in this respect is whether prevention of unemployment through investment in initial education is cost-effective. Generally speaking, the rate of return from initial education tends to be high with benefits exceeding costs, both for individuals and for society (OECD, 2010). The benefits arise because unemployment can be avoided, and because education leads to higher earnings and more derived taxes for governments. A further important finding in this literature is that the rate of return to investments in human capital is highest at pre-school age and declines rapidly afterwards (Heckman, 2006). This is because both cognitive and non-cognitive abilities of children are more malleable at young ages. Proper early education and high-quality childcare facilities start off an upward spiral of cumulating advantages by facilitating later learning...
Moreover, the returns on investments in early education are higher for children with the lowest socio-economic background (Currie, 2001; Cunha et al., 2006). Early interventions targeted at disadvantaged children have much higher returns than later interventions such as reduced pupil–teacher ratios, public job training, convict rehabilitation programmes, tuition subsidies or expenditure on police.

Another part of the debate has focused on the question of whether labour market institutions intended to protect workers (e.g. minimum wages, unemployment benefits), push the wages of workers above the market-clearing level and thus lead to unemployment. Yet, the idea that plain deregulation is a panacea for unemployment has increasingly been abandoned. For example, Nickell and Layard (1999) have shown that the positive correlation between generous unemployment benefits and the unemployment rate is offset by active labour market policies (ALMPs). Moreover, the unemployment rate seems to be influenced in important ways by product market regulation and fiscal and monetary restrictions (e.g. Krueger and Pischke, 1997). Blau and Kahn (2002) have integrated much of this literature by arguing that it is an interaction between macro-economic demand shocks and labour market institutions that causes unemployment. Prevention policies should hence be adjusted accordingly. In a sense, this is what active labour market policies do, as they embody a wide range of programmes (Kluve et al., 2007): training programmes, wage placement or self-employment subsidies, job creation schemes in the public sector, and services and sanctions that support job search efficiency. The ALMPs will be further discussed under secondary prevention, since many of these schemes address the already unemployed.

Secondary prevention policies

Although ALMPs have become the new buzzword of the latest decades and spending on this type of policies has increased substantially, their effectiveness is debatable (Kluve et al., 2007; OECD, 2007; Crepon and van den Bergh, 2016). We refer to Chapter 32 in this handbook for a more extensive discussion of the problems occurring with ALMPs. The major conclusion of ALMP programme evaluations is that the effectiveness of the programmes depends on the details of the programme concerned. First, it depends strongly on the type of programme involved: while job search assistance and monitoring are particularly effective, public job creation schemes are not (de Koning, 2007b). Second, it depends on the way in which the programme has been implemented: it is important to keep the programmes well targeted (and hence small scale), of short duration and closely monitored (Martin and Grubb, 2001). Third, the effectiveness depends on the characteristics of the participants: they tend to work for women, but not for (out-of-school) youths.

Even if ALMPs are successful and lead to (re)integration on the labour market, there is no guarantee that they also entail genuine social integration. This is because labour market participation neither locks out working poverty nor precarious labour market conditions. There is some evidence that jobs created especially to reduce unemployment run a higher risk of being bad jobs (e.g. Martin and Grubb, 2001). In other words, there is a fundamental problem with the exclusive focus on jobs and labour market integration in primary and secondary prevention policies. A more integrated policy approach is needed that besides education and employment also includes aspects of child, family, health, housing, care and well-being policy.

Tertiary prevention policies

From the above discussion it is already clear that primary and secondary prevention do not always work. In fact, societies are usually confronted with a residual group of unemployed who
Prevention: social security and healthcare

cannot easily be activated (Van Berkel and Hornemann, 2004). Thus, when employment policy and ALMPs fail, there is still a need for a compensatory policy. The latter type of policy is usually not considered to be preventive policy, but here we argue why it should be. In particular, social benefits can prevent the start of a downward spiral of social exclusion. Social exclusion is indeed often the result of cumulating and mutually reinforcing economic and social disadvantages (Gallie and Paugam, 2000). Furthermore, replacement incomes have a preventive effect on longer term unemployment, because they support individual investments in job search by decreasing the constant worries of daily survival. Yet, at the same time, high and unconditional benefits (i.e. so-called passive policies) may generate unemployment and productivity traps (de Koning, 2007b). However, the tightening of eligibility conditions raises a number of normative issues. In particular, they cannot be justified when it is not certain whether activated individuals are in a position to respond adequately to such prevention policies (Dubois, 2011). This may not be the case, for example, when a lack of aggregate demand is driving unemployment, when individuals have to deal with discrimination on the labour market or when they are faced with problems beyond their own control, such as handicaps or complex situations of social exclusion from which they can rarely escape on their own initiative.

Prevention in healthcare

Finally, let us see how prevention works out in that other part of social protection, namely the adjustment schemes, with healthcare as the main and instructive representative. Healthcare academics and policy makers increasingly acknowledge that they can no longer rely on treatment-oriented strategies alone, but that new strategies are needed to prevent disease. While traditional preventive interventions, such as pure water and food, hygiene and vaccinations, have been fully exploited in Western countries, recent programmes in healthcare reflect a preventive approach in the form of more individualized prevention programmes, such as lifestyle interventions, risk factor screening and ‘personalised medicine’. Many costly and disabling conditions – cardiovascular diseases, cancer, diabetes and chronic respiratory diseases – are linked by common preventable risk factors, such as smoking, unhealthy nutrition, physical inactivity and excessive alcohol. Moreover, it has been suggested that preventive interventions targeted at lifestyle-related risk factors have the potential of not only increasing public health but at the same time lowering healthcare expenditures (OECD, 2005; Topol, 2015) or reducing mortality either at low cost or at a cost saving (Maciosek et al., 2006). With the shift from treatment to prevention, preventive action in healthcare is considered to combine the best of both worlds: sound healthcare spending with a healthier population.

Lifestyle prevention: evidence and debate

The emphasis on investing in prevention programmes in healthcare has been accompanied by the development of so-called ‘prevention policies’ (Dubois, 2011) – i.e. insurance policies constructed to give incentives to investments in prevention or to promote desirable behaviour and thereby reduce reliance on insurance. Some health policy academics have suggested assigning larger responsibility for health to individuals to contain costs through rewarding healthy lifestyles in health insurance. In particular, health insurance premiums are related to smoking and body mass index (BMI) as an indicator of obesity, and insurers have increasingly turned to policies that rely on co-insurance and deductibles or various forms of incentive-based healthcare plans and bonus policies to financially ‘nudge’ people towards good behaviour (ter Meulen and Maarse, 2008; Schmidt et al., 2010). Apart from rewarding healthy lifestyles, prevention policies
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can also be directed towards targeting bad lifestyle behaviour in insurance. In the Netherlands, the Health Care Insurance Board and the Council for Public Health and Care recently introduced the idea of a sharpening of individual responsibilities in healthcare. Those who lead a poor lifestyle (smoking, alcohol, obesity) should pay more in insurance premiums, it is argued. Yet the elaboration of ‘personalized’ prevention programmes in healthcare and prevention policies is far from self-evident. For example, it is questionable whether prevention programmes and incentives work at the individual level. Over the years, many studies have shown how prevention programmes could reduce disease burden and mortality. However, there is a great deal of evidence that these policies fail to change people’s lifestyles in the long run because unhealthy living habits are strongly predicted by a person’s socio-economic position and social circumstances (Marmot, 2010). In addition, the effectiveness of prevention policies, such as incentives in health insurance, is the topic of current academic and policy debate. Some studies indicate that co-insurance may influence individuals’ lifestyle choices. For example, Bhattacharya and Sood (2005) suggested that increased co-insurance may help reduce the prevalence of obesity. Conversely, other studies indicate the scarce and contradictory empirical evidence of the effects of prevention policies in promoting healthier lifestyles. Moreover, some sources indicate that prevention programmes may lead to unintended side-effects. One of these side-effects is the danger that focusing on prevention may actually reinforce existing socio-economic inequalities (Schmidt et al., 2010). By offering prevention programmes and incentives, the initial advantage of the well educated and well paid may tend to beget further advantage, and disadvantage those in most need of health improvements, creating widening gaps between haves and have-nots. While these incentives may be voluntary, for some lower income people they may feel obligatory if the only way to obtain affordable insurance is to meet the targets of these incentives. “To them, programs that are offered as carrots may feel more like sticks” (Schmidt et al., 2010).

Cost savings?

Second, the popularity for prevention programmes in healthcare is often based on the argument that these prevention programmes are ‘cost saving’. However, it is debated whether prevention programmes actually ‘pay off’ treatment costs in healthcare. Evidence on the cost issue has accumulated since the 1970s, when cost-effectiveness analysis (CEA) was first applied to health and medicine. Some reports claim that effective prevention programmes would save the state billions of euro or dollars (Levi et al., 2008; Flack et al., 2007), while others predict the reverse (Kahn et al., 2008; Russell, 2009; Cohen et al., 2008). Most recent cost-effectiveness studies advocate a careful assessment of the costs and savings associated with health prevention. It initially costs more to deliver preventive services; the savings the resulting health benefits will incur over time are less clear (Woolf, 2009; Merkur et al., 2013). Whether any preventive measure saves money depends on the particular intervention and the specific population in question. For example, drugs used to treat high cholesterol yield much greater value for money if the targeted population is at high risk for coronary heart disease, and the efficiency of cancer screening can depend heavily on both the frequency of the screening and the level of cancer risk in the screened population (Russell, 1993).

In an overview article on the economic argument for disease prevention, Woolf (2009) highlighted the role of methodological issues (e.g. in regard to the choice of criteria and incorporation of particular cost categories) in economic evaluations of preventive healthcare interventions. In general, some factors enhance the economics of prevention in ways that often elude disease care. For example, addressing a single risk factor (e.g. smoking) can influence outcomes across multiple diseases, from pre-term birth to lung disease and cancer. The long time horizon
that poses a challenge for prevention is also an opportunity for ‘compounding’ health benefits. Addressing obesity in today’s children will alter the prevalence of many diseases they will encounter decades later, a return on investment that may be profound. Another issue is the choice of inclusion criteria, such as unrelated medical costs in life years gained when asserting the cost-effectiveness of preventive interventions. In a recent study, Rappange et al. (2010) argue that although preventive interventions may reduce illnesses and expenditures related to risk factors, they will increase illnesses and expenditures unrelated to those risk factors primarily in gained life years. However, these unrelated costs are often not included in the cost-effectiveness of prevention studies. Yet, they have been demonstrated to outweigh the savings on related illnesses for the important risk factors. Obesity and smoking, for example, not only cause morbidity but may also reduce life expectancy. Preventive interventions may thus reduce this risk of premature death and subsequently extend life. During these life years gained, as a consequence of other, unrelated diseases, people may consume additional healthcare. Or, as the former Dutch minister of health, Dr Els Borst, said: ‘Dementia is something we witness in people of ages normally not reached by smokers and obesity.’ These additional expenditures due to unrelated diseases in these life years gained may offset savings from avoiding risk factor-related diseases. As such, effective preventive interventions may increase rather than decrease healthcare costs.

Value for money

However, while the cost-saving argument for prevention intervention may be controversial, the investments themselves may still be worthwhile (Rappange et al., 2010). A related argument often claimed in this context is that preventing sickness has value in human terms that economics cannot capture (alone). Even if prevention and treatment cost the same per QALY (the quality-adjusted life years measurement), patients prefer the former to avoid the ordeal of illness. Other societal benefits of improved health (e.g. workforce productivity and corporate competitiveness, and the ripple effects these trends bring to households, education, crime and other societal outcomes) are among the intangibles that typically go unmeasured in cost-effectiveness studies. Prevention, then, like other care, does not have to be cost saving in order to be attractive (Cohen and Henderson, 1991). Such a requirement would implicitly hold prevention ‘to a higher standard of cost-effectiveness than other medical care’ (Russell, 1993). Thus, beyond the debates having to do with the ‘cost of prevention’, we can detect a change in perspective from a narrow health economics perspective of ‘cost savings’ of prevention to a broader societal perspective of ‘value for money’. It is increasingly acknowledged that the question of whether prevention ‘pays of’ treatment is not the right question. Instead it is argued that healthcare policy makers should focus on the proper question of whether prevention offers value for money. Preventive interventions do not necessarily have to alleviate the financial burden on healthcare systems in order to be eligible for funding, but rather, like other interventions, demonstrate good value for money (Cutler et al., 2006). Prevention, then, may be a relatively cost-effective means of improving public health. In this respect, Rappange et al. (2010) reiterate the argument that saving money is not the primary aim of healthcare. Rather, they say, the aim is to optimally enhance health with the available resources. Focusing exclusively on the input side of the balance between costs and benefits may be considered a rather restrictive view, ‘as it ignores the value of the output of prevention and health care and may consequently lead to underinvestment in these areas’ (Brouwer et al., 2007). Thus, as Goetzel (2009) succinctly put it: ‘Instead of debating whether prevention or treatment saves money, we should determine the most cost-effective ways to achieve improved population health.’
Back to basic questions

Finally, the introduction of personalized lifestyle prevention programmes in healthcare and prevention policies triggers debates on its normative implications and fundamental questions on the legitimacy of social security. In this sense, some authors suggest how these programmes may reflect a more fundamental shift from collective to individual responsibility for health (Ter Meulen and Maarse, 2008; Feiring 2008; Prainsack and Buyckx, 2017). With the shift to preventive medicine, illness has ceased to be a fatality or a social contingency and is increasingly considered as an individual responsibility – something for which we can, or even must, be responsible in taking preventive actions. This has led to the idea of the sharpening of individual rights and responsibilities in healthcare, illustrated in policy initiatives targeting lifestyle behaviour by shifting the financial costs to the individual. Often these prevention policies in health insurance are justified by arguments that individuals have responsibility for their health or lifestyles (Schmidt, 2008). To what extent it is reasonable to expect that individuals can be responsible for their health and change their lifestyles in response to prevention policies raises substantial issues about individual responsibility and solidarity (Feiring, 2008; Van Hoyweghen et al., 2006). In challenging the ‘deservingness criteria’ for healthcare, preventive actions and policies pose important questions for the legitimacy of social security systems. The importance of these normative questions suggests that arguments and distinctions drawn from political philosophy should play a more prominent role in the debate on the shift towards an active welfare state and the introduction of prevention policies in insurance. For example, an extensive discussion about for which lifestyle choices it is reasonable to hold individuals liable could enhance the efficiency, and thereby also the legitimacy, of prevention policies in insurance to the benefit of both the individuals insured and society at large (Schmidt, 2016).

Conclusion

If, as the human damage theory holds, social security resides in the first place in making available work opportunities to guarantee an appropriate income level and in healthy living conditions, we cannot limit ourselves to the traditional curative social security instruments of income transfer schemes and healthcare facilities. The insurance logic which points to the importance of the probability/prevalence and damage factors and the basic logical chain has shown where the alternatives may be found. Primary and secondary prevention should be activated. After this, tertiary prevention by compensatory and curative instruments can play its role. Developments in social policy thinking during past decades have prepared us for policy shifts whereby a preventive approach became feasible. The EU has very much promoted this through its Lisbon and 2020 strategies (Marlier et al., 2010).

In retrospect, however, a preventive approach is not unproblematic. As with other policy innovations, preventive policies tend to pose new questions and call for a well-balanced approach since, so far as the income guaranteeing part of social protection is concerned, the results are in fact mixed. Labour market institutions and educational policies seem crucial for primary prevention indeed, but questions arise on their cost-effectiveness and macro-level results. Secondary prevention by ALMPs raises similar reservations and points to doubts about its contribution to genuine social integration: jobs are not necessarily good and safe jobs. In healthcare the traditional preventive policies of pure water and food, hygiene and vaccination are complemented by more individualistically oriented interventions aiming at healthy lifestyles. Their promotion can be of the ‘carrot’ style, but may turn out to represent a ‘stick’ approach. Whether they are cost saving is unsettled and rather difficult to assess, but in the end the question is whether they are worthwhile in themselves and thus offering value for money.
All this leads to a triple conclusion. First of all it was right to enlarge the social policy scope by complementing the traditional curative instruments by preventive and re-integrative actions and services. Yet, in doing so, it appears that there is a need for shared responsibilities: between compensatory and preventive measures, but also between all instances involved: the individual citizen, employers, services like labour mediation offices and schools, and the state. Second, prevention has its limits. It is not the panacea for the problems left behind by the traditional, curative approach, and certainly not a full guarantee for efficacy and cost-effectiveness. Its input should rather be conceived of and assessed in the much broader policy realm to which it is called to contribute. Finally, however, to the extent that contingencies can be prevented, the veil of ignorance that inspires insurances is lost. Social contingencies represent no longer socially accepted fatalities. This poses normative questions on the legitimacy of insurance-based policy schemes and calls for fundamental discussions on private and collective responsibilities. Social policy is then in need of inspiration by social philosophy.

Notes
1 The first author of the chapter in the first edition, Jos Berghman, sadly passed away on 6 October 2014.
2 A QALY gives an idea of how many extra months or years of life of a reasonable quality a person might gain as a result of treatment (particularly important when considering treatments for chronic conditions) (source: www.nice.org.uk).

References


