

# Public health care in the balance: Exploring popular support for health care systems in the European Union

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## Public health care in balance

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# Public Health Care in the Balance: Exploring Popular Support for Health Care Systems in the European Union

*J. Gevers, J. Gelissen, W. Arts and R. Muffels<sup>1</sup>*

## 1. Introduction and research question

Health care systems are important elements of western European welfare states. Earlier research indicates that public health care has always been warmly welcomed and supported by the public, even in periods of retreat of the welfare state due to retrenchment policies. Using data from 1973, Ardigó (1995) reviewed comparative evidence on the public opinion concerning health services in seven European countries and the United States. He found that citizens considered good medical care 'very important' and its provision an 'essential' responsibility of the government. Even though the welfare state was said to suffer from a legitimacy crisis from the mid-70's onwards; the results of the survey showed no traces of this crisis. Neither did the results of a profound trend-study on welfare attitudes by Coughlin (1980). Despite a considerable ambivalence among the public towards some programs, his findings clearly showed that some of the most expensive and extensive elements of the welfare state, such as old-age pensions and health care, were invariably popular. Because his findings revealed no evidence of a health care backlash, Coughlin (1980: 74-75) concludes, that even though national approaches to the provision of health care vary in their organisation, coverage, funding and circumstances under which care is provided, public attitudes towards government provision of health care show a surprisingly constant pattern of popularity across nations.

Currently, all European Union member states provide or guarantee health care to their populations. In all countries, coverage is nearly 100 percent of the population, except in Germany, the Netherlands, Ireland and Portugal where a part of the population has to rely on private insurance or has to cover the costs themselves. However, as pointed out by Taylor-Gooby (1996), these health care systems are, in spite of many differences in their set-up, facing common problems: a combination of demographic shifts, technological advances and rising public expectations increasing the costs of provision.

The ageing of the population and, closely related, the growth of chronic diseases and the increasing need for care; technological developments in health care, many of which increase costs directly or indirectly and the lack of incentives for cost reduction are, although to differing degrees, mayor issues in all EU health care systems (Abel-Smith and Mossialos, 1994; quoted by Taylor-Gooby, 1996).

Apart from rising costs and growing demand for services, health care systems struggle with a decline of caring capabilities of families in the context of falling birth rates and rising female labour participation. These changes transform social care services into increasingly important ingredients of welfare state production (Alber, 1995). The welfare state and its arrangements, were based on the dominant family relationships in the fifties: the male person being the main

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bread winner and the female partner being primarily engaged in domestic labour and caring duties. This model requires adjustment to meet new demands and preferences.

Given these developments and the continuous process of individualisation, the question arises as to whether the citizens of Western Europe, are willing to share the burden of rising health care costs. To what extent are solidarity and shared responsibility, according to the public, necessarily conflicting with the increasing emphasis on individual autonomy and self-realisation? To gain insight into this matter we examine the attitudinal patterns regarding popular support for public health care across 13 European countries, at the end of the 1990s. The Eurobarometer survey series contain information about the public opinion on government interventions in the area of health care. These data not only permit to describe national differences in attitudinal patterns, they also allow to get a deeper insight into the interpretation and explanation of cross-national differences. Unfortunately, the data focus on attitudinal patterns, which need not necessarily be consistent with actual behavioural patterns for the same reason as why stated preferences not always coincide with revealed preferences. In addition, data particularly addressing the public opinion on shared responsibility for social care services were not available; we therefore had to confine ourselves to popular support for public health care services. Hence, our first aim is to give an overview of the public opinion on health care in Western Europe. In addition, we also try to give insight into the ways in which supportiveness for welfare state provisions of health care is related to the type of welfare state regime<sup>2</sup>, the sort of health care programmes and individual characteristics, such as demographic ones, personal health, social position and ideological beliefs.

The organisation of the chapter is as follows. In Paragraph 2 we start with a brief introduction of the concept of solidarity; subsequently, we go deeper into the motivational bases of people to support solidary arrangements. In paragraph 3, we focus on the questions as to how different institutional settings may affect popular support for public health care, and how attitudes are constituted by individual characteristics. Based on these insights, in paragraph 4 hypotheses are formulated which will be empirically tested in subsequent sections of this chapter. In paragraph 5 we present the data, measurement and analytical strategy, followed by a description of the results of our analyses in paragraph 6. Finally, in paragraph 7, we discuss the conclusions and the wider implications of our results.

## **2. Solidarity and its motivational bases**

The western European welfare state might be regarded an organised system of solidarity. Historically it is based on solidarity among workers, later between workers and employers and subsequently evolving into solidarity between large social groups. In the latter sense we talk about solidarity between the healthy and the sick, between the young and the elderly and between the employed and the unemployed (Schuyt, 1998). Van Oorschot (1998: 1) defines solidarity as an actual state of interrelations between individuals, groups and the larger society, which enables the collective interests to take priority over the interest of individuals or subcollectivities. Such a state, as he elucidates, is based upon either a shared identity or a shared utility: individuals perceive themselves as members of the same collectivity and therefore feel a mutual sense of belonging and responsibility or they feel they need each other to realise their life opportunities. Subsequently he argues that the strength and the range of the system's solidarity are a function of the nearness and dependency among the social actors that it embraces. With respect to the motives people have to support solidarity arrangements,

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<sup>2</sup> Welfare state regime refers to the ways in which a country's welfare productions are allocated between state, market and family (Esping-Andersen, 1999).

theorists mostly refer, in line with van Oorschot's distinction, to self-interest and moral commitment (Taylor-Gooby, 1985; Peillon, 1996; Kangas, 1997). Such explanations are roughly based on two lines of thought about the motivational foundation of people's actions: the economical and the sociological (Kangas, 1997). Neo-classical economic theory portrays individuals acting like *Homo Economicus*: an all-informed, consumption-orientated maximizer acting in a rational manner in pursuit of individual gain and economic advantage. In contrast, sociological explanations of human action emphasise its social and normative bases: *Homo Sociologicus* is a value-oriented conformer directed by social norms and driven by a moral commitment to the common good. According to Lindenberg (1989, 1990), a man is neither homo economicus nor homo sociologicus alone, but instead *Homo Socio-economicus*, directed by both his/her own interest and collective norms. He assumes, following Adam Smith, that all individuals have at least three ultimate goals: social approval, physical wellbeing, and the minimalization of loss. These goals are strived for by everybody. People, then, differ less in their subjective wants than in their objective means to produce a particular amount of a high level good (1990: 745). These means vary with social position and every person defines his own instrumental goals for achieving the ultimate goals, given the constraints of the situation. Socialization enters the picture in that collective norms provide a framework for the interpretation of the situation, thereby playing an important role in conveying and coordinating preferences for certain instrumental goals. Someone's attitude towards solidary arrangements, according to this theory of human action, thus stems from both self-interest and moral considerations, and is dependent upon the constraints imposed on personal preferences by social structures.

Based on a profound review of the work of sociologists like Durkheim, Weber, Mayhew, Parsons and Hechter, van Oorschot (1998:8-9) argues that there may still be other motives for people, besides self-interest and moral sentiments, to support solidarity. He identifies four general motives to support solidarity. As a first motivational ground, van Oorschot points to writers like Mayhew, who emphasises the role of people's feelings and sentiments, that is, affectionate and emotional grounds for supporting solidarity. The degree to which people feel attracted to one another and be loyal to at the micro-level, and the degree to which they perceive a collective identity and we-feeling at the meso- and macro-level, are decisive for the extent of solidarity among them.

Cultural based convictions may be an important ground for supporting solidarity. The theoretical work by Durkheim and Parsons makes clear that people may also feel a moral obligation to serve the collective interest and to accept existing relations of solidarity. Like the affective and emotional motive for solidarity, the strength of this motive may vary. Institutional role obligations are culturally defined, so their number and strength may vary within cultural settings. For instance, in Southern European countries, where family and community ties are still strong and important in daily life, solidarity might have a different moral meaning than in Northern European countries, where individualistic values prevail.

Van Oorschot identifies long-term self-interest as a third motive to support solidarity. Both Hechter and Durkheim argue that individuals learn that they may benefit from contributing to the collective interest (if not immediately then in the long run). Solidary behaviour or contributing to the common good, can be motivated by an individual's perception that such a contribution is rewarded, here and now or maybe in the future. In this case, support for solidarity is based on a rational calculation. But is this self-interest indeed only based on long term or life cycle considerations? It is generally assumed that the *Homo Economicus* is guided by reflections of enlightened self-interest to allow for *strategic* behaviour. Strategic behaviour refers to long-term planning of action. In the light of the present research question, this would mean that people support the institutions of the welfare state because they expect to achieve future gains from it or to avoid future losses, thereby

showing a farsighted time horizon. However, it is also conceivable that people support or reject the welfare state for opportunistic motives, which involves self-interest seeking with guile (Williamson, 1975: 26). In that case it is assumed that the time horizon of individuals is rather limited. They look only a few months or only a few years ahead, and they respond mostly to current phenomena and ignore long term events. Myopia is the result, and only short-term gains or losses are considered important. The welfare state is then supported because benefits are expected from its institutions within a relatively short period of time or welfare arrangements are rejected because of the short-term costs they bring about. Hence, both enlightened self-interest and opportunism can be of relevance for people's motives for supporting solidarity. However, the usual assumption is that long-term considerations prevail when someone takes part in a solidary relationship. For example, de Swaan (1996) argues that rational considerations are part of a process of habit formation with respect to the acceptance of the welfare state. According to him, most workers in modern welfare states share in the 'composure of the welfare state'. That is, to them the welfare state has become a state of mind, because they became accustomed to the situation that considerable amounts of their income are withheld in exchange for a guaranteed income in times of need.

A final rationale for supporting solidarity might be 'accepted authority', because support for solidarity is not necessarily spontaneous or perfect voluntary. For instance, van Oorschot refers to Parsons, who argues that this condition should not be taken for granted, because contributing to the collective interest is an act of solidarity in so far it results from institutional role obligations. Purely voluntary contributions do not bind; they are merely manifestations of loyalty and lack of true commitment. Van Oorschot also addresses Hechter's theory on solidarity, in which enforcement even plays a more important role. Hechter argues that in order to avoid free riding of group members, coercion and control of contributions to the common good are necessary. Thus, when mutual affection and identification, moral convictions or perceived self-interest, are not strong enough to provide sufficient support for solidarity, enforcement by a higher authority may be necessary. However, this enforced solidarity can only be stable in the long run if it is sufficiently legitimised. Weber points to the possibility, that this authority can be legitimised by the motives mentioned above. However, he also points to the eventuality that obligations to behave solidary, imposed on citizens by the state, can be perceived as legitimate because the state itself is seen as a legitimate authority.

Thus, according to van Oorschot (1998: 9), four different motives for supporting solidary relations can be distinguished: 1) Mutual affection and identification, 2) moral convictions, 3) perceived self-interest and 4) accepted authority. While the four motives are not mutually exclusive, their respective roles in different situations may vary, depending, for example, on the type of personality, social relation and collectivity. Support for solidary relations will generally be stronger to the extent that: 1) such relations are connected with existing patterns of mutual affections and identification, 2) they correspond to relevant moral convictions and perceived duties, 3) they correspond to the (long-term) self-interest of individuals and groups involved, and 4) they are backed by a more legitimate authoritative body. Solidary relations and arrangements that are legitimate on the grounds of all four motives, however, are likely to be the strongest. Van Oorschot also asserts that if we regard solidaristic welfare arrangements and institutions as serving the collective interest of a society, then the previous analysis offers the opportunity to measure and to analyse the legitimacy of welfare state solidarity. Such legitimacy is stronger to the extent that 1) more people are motivated to contribute to the arrangements, e.g. by paying taxes and paying premiums, and 2) people have more different motives to contribute.

### **3. Reasons for welfare state support**

Few studies have attempted to determine which factors are important in the formation of public attitudes towards solidaristic welfare arrangements. The ones that did, have mostly been focused either upon the impact of institutional characteristics of the welfare state or upon the impact of social position and ideological beliefs among the population. From the foregoing, however, it is clear that attitudes towards solidarity arrangements are likely to depend upon both, social structures and one's position therein. Lately, this approach has been followed by many other researchers (e.g. Papadakis and Bean, 1993; Svallfors, 1997; Gelissen, 1999). Here we will follow their lead. In our effort to explain differences in support for the welfare state provision of health care, we will go into the influences of macro-level indicators as well as micro-level factors.

#### **3.1 Welfare state regimes**

First of all the level of support for the welfare state is considered to be affected by the institutional characteristics of welfare states (Korpi, 1980; Gallie, 1983; Esping-Andersen, 1990). Esping-Andersen (1990: 23, 55) in his socio-political account points out, that the welfare state is not just a mechanism that intervenes in the structure of inequality, but a system of social stratification in itself. Based on variations in social rights and welfare state stratification, welfare states cluster in regime-types with qualitatively different arrangements between state, market and the family (1990:26). He classifies Western welfare states into three regimes: the liberal regime, the conservative (corporatist) regime and the social-democratic regime. The brief description of the three regimes that follows, is gratefully derived from Diane Sainsbury (1996:12): “The liberal welfare state regime is characterized by heavy reliance on means tested programs, modest social insurance benefits, market solutions in the form of occupational welfare (employer sponsored benefits), and private insurance. In the conservative corporatist welfare state regime, social insurance schemes are central but they are differentiated according to class and status. Benefits are designed to maintain the status quo with respect to income distribution, class structure, and societal institutions - the state, the church and the family. The social democratic regime is typified by universal benefits and services covering the entire population, a weakening of the influence of the market on distribution, and a strong commitment to full employment.”

The organizational features of the welfare state actively determine social relations while public benefits tend to segment or integrate the population and, therewith, provide support for the articulation of social solidarity, class and status differentiation. Based on the work of Esping-Andersen and Korpi's model of 'welfare backlash', Papadakis & Bean (1993) argued that universal schemes will lead to stronger support for the welfare regime as they provide wide coverage. Selective schemes will more easily result in a 'welfare backlash' and hence less support, since benefits are targeted onto specific groups through means testing, thereby dividing the population into payers and receivers. Another argument is that services devoted to minorities only might fail to attract the support of the majority. Hence, the institutional set up of the welfare state constitutes the context in which citizens' attitudes toward solidarity are shaped and which imposes constraints on the citizens of the welfare state. These constraints might affect the individual preferences for particular welfare state arrangements. Moreover, we may also consider the institutional characteristics of a country to be the crystallization, at least to some extent, of the preferences of its population about welfare state responsibilities. Hence, the ways in which welfare state arrangements are shaped

is both a product of people's preferences as well as of the context through which preferences for certain arrangements are constrained.

Empirical studies have addressed the question as to the relationship between the level of support for a welfare state and its institutional structure. Papadakis and Bean (1993) found little support for the hypothesis that the level of popularity of welfare services is likely to vary with the institutional context of a welfare regime. They conclude that classifications of regimes like that of Esping-Andersen (1990) offer little help to explain the popularity of welfare state services. Research by Peillon (1996) and Svallfors (1997), on the other hand, indicates that characteristics of the type of welfare regime really matter for the support a welfare state gets, and for the overall support for state intervention. Then again, Peillon also underlines that other factors such as the scope of a service and whether it renders benefits in kind or cash transfers, carry more weight in producing support for a particular welfare programme. We should realise that the classification of the liberal, conservative and social-democratic welfare regimes is based on ideal types which in real practice may not exist, at least in ideal-typical sense. In practice, different national systems combine elements of all three (Taylor-Gooby, 1991). The point of using typologies, as Esping-Andersen (1999) points out, is economy of explanation. First of all, they allow for greater analytical parsimony so that we can see the forest rather than the myriad of unique trees. Two, if various species can be clustered according to similar crucial attributes, the analyst can more easily identify some underlying connecting logic of movement and maybe even causality. Three, typologies are useful tools for generating and testing hypotheses. However, as parsimony is bought at the expense of nuance, the resulting forest might bear little resemblance to reality, which will impair its value for the explanation of concrete social phenomena. It might thus be important to study the real differences in the characteristics of welfare state programmes to serve as indicators for the support of welfare state services.

### **3.2. *Structural characteristics of the national care system***

Because the present study is devoted to popular support for welfare state provisions of health care, institutional characteristics pertaining to the national care systems may have considerable explanatory value. Peillon (1996: 179) points to the size of welfare state programmes being a relevant factor for welfare state support. He argues that the populations in nations with a large social policy sector are more supportive to the welfare state. For the same reason will 'heavy' social programmes enjoy a stronger support. Esping-Andersen (1990: 32-33) acknowledges that this seems paradoxically as 'it is generally believed that welfare state backlash movements .... are initiated when social expenditure burdens become too heavy'. Contradictorily, he finds that anti-welfare-state sentiments have generally been weakest where welfare spending has been heaviest. Moreover, Peillon warns us to differentiate the size of a welfare programme from its scope, for a large programme (as measured by proportion of the GDP it absorbs) does not necessarily spread widely. It has already been argued, that services granted to a minority are not very likely to attract the support of the majority. Peillon stresses this, in asserting that a widespread social programme upholds support, while the narrow scope of a programme hampers high support (1996: 190). Taylor-Gooby (1985) for example, attributes the popularity of pension, education- and health service programmes in Britain to the fact that these services are directed, potentially at least, to the whole of the population: they 'command mass support because they meet mass demands'. Thus higher levels of support are enjoyed when a service benefits the whole population.

Furthermore, Ardigó (1995) shows that the way health care services are financed affects the degree of responsibility attributed to the government for providing good medical



care. His findings reveal that the level of consensus on the idea that the government is responsible for good medical care is higher in countries with a strong public health system than in countries with a largely private health system. Elola (1996) studied the differences in the structures and processes of the NHS and social security systems of western European countries and the influences on their outcomes. NHS (national health) systems perform better than social security systems in controlling costs, guaranteeing equity, and, most likely, establishing efficiency in improving a populations' health. However, public satisfaction with the health care system is lower in countries with NHS systems than in countries with social security based health systems. Moreover, within the NHS group of countries, Southern European countries have less public support for their health care systems than have countries with older, more consolidated NHS systems, such as Denmark and Great-Britain. According to Elola, insufficient political commitment to the transformation of former social security systems into NHS systems, such as happened in Greece, Italy, Spain and Portugal, might account for the much lower levels of popular support for the health care system in these countries than in other Western European countries with NHS systems.

In response to the classification of welfare regimes by authors like Esping-Andersen, several researchers (Orloff; 1993; O'Connor, 1993; Alber, 1995; Anttonen and Sipilä, 1996) have argued that additional institutional characteristics of social care services should be included in these comparative social policy studies. Anttonen and Sipilä (1996) state, that while the de-commodification concept is primarily directed at the (male) liberation from the market through the abolition of dependency between market affiliation and income (Rostgaard and Fridberg, 1998:13), Esping-Andersen does not provide the tools necessary for the analysis of other types of dependency relations. As far as women are concerned, they argue, basic social rights include those that make them less dependent on family and marriage: rights to separate from the family. In a recent re-examination of the family, Esping-Andersen (1999) acknowledges the importance of 'de-familialization' in the different welfare regimes. Whereas a familialistic welfare regime assigns a maximum of welfare obligations to the household, de-familializing policies lessen individuals' reliance on the family; they maximize individuals' command of economic resources independently of familial or conjugal reciprocities (1999: 45). The demand for social care services is fuelled by problem pressures related to children who increasingly need attendance in a context marked by the double labour force participation of both parents. It is this, together with the growing proportion of people of very advanced years who need care on one side, and a decline of caring capacities of families in the context of falling birth rates and rising female employment on the other side which pose the problem (Alber, 1995). Hence, socio-demographic and socio-economic changes make social care services increasingly important ingredients of welfare state production. It might not even be that far-fetched to hypothesize that the demands for social care services may also influence support for health care provisions. The distinction between the two is often not very clear-cut, what is more, health care and social care act as communicating vessels. As health care is increasingly dedicated to specialized care, many services traditionally provided by health care institutions are nowadays acted out by social care institutions. In familialistic welfare states such responsibilities are still or once again entrusted to the family; informal care, then, meets many of the needs of children and particularly the elderly, sick people, the disabled and mentally handicapped. Thus, in countries with scant social services, extended public health care services would relieve families for their caring duties, more so than in highly de-familialized countries. Hence, it important to study how the structural characteristics of the social care system, such as the extent of government-sponsored social care services and the number of people dependant on care, relative to the capacity of families to supply care, are related to public support for health care.

### **3.2 Individual, social and ideological position**

A third line of research is aimed at explaining adherence to welfare state efforts by studying demographic variables, social position and ideological position. As was put forward in paragraph 2, economically oriented explanations of support for welfare arrangements generally emphasize the *self-interest thesis* (D'Anjou et.al., 1995: 357) which states that there is a direct relationship between one's position in the social structure and one's attitude. Svallfors (1993: 268), for example, argues that different groups tend to perceive, interpret and value inequality in different ways: those who are better off in the stratification structure hold more favourable views on inequality. The better off will be less concerned about redistribution, and more prone to argue for the necessity of inequality to induce incentives of various kinds. However, in line with Lindenberg, Svallfors argues that perceptions and attitudes are not formed as calculated responses to economic realities and self-interest. The process of attitude formation is a much more complex one, where frameworks of interpretation and ideological commitments, tend to blur the impact of raw self-interest. An *ideology thesis* (d'Anjou ea., 1995: 359) has been proposed, which refines the self-interest thesis. This thesis states that there is no direct relationship between people's position in the stratification structure and their attitudes, but that this effect is mediated by people's ideological position or their socio-political beliefs. These ideological features give guidance to people in their decisions and shape their attitudes and preferences, which are related to more mundane and concrete phenomena. As such they affect the probability that someone holds certain attitudes or preferences, but do not determine them, since a certain ideological position does not imply full agreement with specific goals, means or outcomes. This also means that people's ideological position is in turn affected by their position in the stratification system. In this way, support for welfare state arrangements is indirectly related to people's location in the stratification structure as well, through their ideological position. It can, hence, be argued that not only a structural position in the stratification system goes hand in hand with a motivation to support the welfare state based on self-interest, but also that a particular ideological position may induce a motivational pattern causing people to support the welfare state. In the following, we will go deeper into the impact of both factors on the support for health care arrangements.

First of all, direct effects on the level of support can be expected from age differences and gender differences. Being dependent on care heavily increases with age (Alber, 1995) so that elderly people are more likely to benefit from publicly funded care services. Based on the self-interest thesis, we would thus expect higher levels of support for health provisions among the elderly population. Furthermore, voluntary or informal care that meets many of the needs of children and elderly, sick people, the disabled and mentally handicapped, has traditionally been distributed very unequally, and continues to be almost exclusively supplied by women. Extended supply of public health care services would allow women to downsize their caring duties and to reduce their dependency from the male breadwinner. Also, other sources for women's disadvantaged position in the labour market (including occupational segregation and pay discrimination) make them more likely to be dependent on welfare state arrangements. Self-interest and a moral commitment to helping others are thus expected to crystallize into stronger levels of support among women than among men.

Income and educational attainment are generally conceived as being negatively related to support for the welfare state. This is illustrated by Kluegel and Miyano (1995, 82-83), who argue that welfare state policies differentiate among those who bear the costs and those who benefit in the short or long run. One of the prime determinants is income, since this variable clearly defines who pays for or who benefits from the welfare state. Because educational attainment is strongly related to income, the higher educated, independently of having a

higher income, may expect to benefit less from welfare state policies than lower educated persons. However, Hasenfeld and Rafferty (1989: 1031) point to a counter-argument to this, self-interest related, explanation. They argue that socialisation to democratic values, as measured by years of formal education, is said to evoke greater respect and commitment to social equality and social rights, which in turn leads to stronger support for the welfare state, independently of income. Moral commitment to the common good thus may play a significant role as well.

Papadakis and Bean (1993) and Svallfors (1997) show that belonging to a so-called transfer class (Alber, 1984) encourages greater support for welfare state arrangements. Alber (1984) postulates a potential conflict between the recipients of social benefits, such as the unemployed with low income, the pensioners, the disabled, and taxpayers, i.e. the current generation of employees. Members of transfer classes, as they are more directly dependent than others on the welfare state, are thought to have a collective interest in ensuring that the welfare state, including health care, will not be eroded. Along the same line of reasoning we would expect that dependency on health care services will increase public support for health care. People long-suffering from illness, health impairments or a handicap will benefit from health care services for which their healthy fellow citizens, at least partially, share the costs.

As far as ideology is concerned, political party identification is seen as an important predictor for people's preference about the level of government protection. It is assumed that a more rightists or conservative political orientation leads to weaker support for welfare state efforts. Typical 'new right' views of the welfare state perceive it as uneconomic, unproductive, inefficient, ineffective, despotic and a denial of freedom (Pierson, 1997: 48). A leftist stance implies more or less rational value considerations. Here, support for the welfare state is determined by a conscious belief that reducing social inequality and fostering social integration constitutes part of the objectives of the welfare state, alongside the achievement of economic efficiency.

## 4. Hypotheses

Earlier, we claimed the institutional set up of the welfare state, through the political process, to be a product of public opinion preferences, but at the same time it forms the context in which citizen's attitudes toward solidarity are shaped, therewith affecting individual preferences for particular welfare state services. Moreover, we argued that the support for particular welfare state services is also associated with the individual's demographic characteristics, someone's health, social position and ideological beliefs. *Figure 1* of the Appendix depicts the hypothetical relationships between support for health care and these characteristics.

Furthermore, in Paragraph 2 we discussed the different motives people may have to support solidaristic welfare state arrangements. We also slightly touched upon the notion that the strength of a certain motive is dependent upon framing (Tversky & Kahneman, 1981, 1984; Lindenberg, 1989). Framing is the process through which the situation is defined in a person's mind, that is the information is coded and evaluated in a certain way. As a consequence of this particular way of looking at the situation, one particular motive may become more salient and might exert a stronger influence on a person's preference or choice, whereas other motives submerge to the background. Lindenberg argues that this is the way in which culture and collective norms exert their influence on personal preferences and we infer that this may also be the way in which the explanatory factors specified in the model above exert their influence on public support for solidaristic health care arrangements. Unfortunately, we lack the empirical evidence being the indicators to actually relate the

various motives to the revealed preferences. We will, however, use them – in conjunction with the theoretical considerations and the empirical findings discussed earlier - to formulate hypotheses on the relationships between support for welfare state provisions of health care and some other variables. These variables are, first, different welfare state regimes, secondly, the specific institutional characteristics of the national health care system and, finally, the social and ideological position of the individual.

We take Esping-Andersen's rich account of welfare state regimes (1990) just as a point of departure for making empirically testable inferences on the association between public support and the type of welfare state regime. Preliminary studies for this chapter<sup>3</sup> suggested that it is more fruitful to use a combined index of conservative, liberal and social-democratic characteristics of a national system (Esping-Andersen, 1990: 74, table 3.3), in stead of a classification based on the most dominant attribute. A hierarchical cluster analysis on these three types of attributes yielded four clusters. Sweden is identified as the most purely social-democratic welfare state. Denmark, the Netherlands and Great-Britain have many social-democratic attributes but also some liberalistic. West-Germany, France, Italy and Austria are welfare states having predominantly conservative attributes and Ireland and Finland appear not having a clear profile and are identified as hybrid welfare states. We assume that the more the institutional arrangements of a welfare state regime emphasize universality and collective responsibility, the more salient moral considerations become as a motive for solidarity, and the higher the levels of support for solidaristic welfare arrangements will be among the citizens of that particular welfare state. More selective social programmes will accentuate social cleavages, so that the self-interest motive becomes more salient in attitude formation, resulting in dissent among citizens.

Since the present study focuses on European welfare states, we need to take a closer look at the position of the southern welfare states (Italy, Portugal, Spain and Greece). In Esping-Andersen's classification as well as in our cluster analysis, Italy - being the sole southern welfare state in Esping-Andersen's typology - is identified as a subcategory of the corporatist welfare state regime. However, it is often argued that the Mediterranean welfare states, including Italy, constitute a separate type of welfare state regime (*e.g.* Leibfried, 1992; Ferrera, 1996; Bonoli, 1997; Arts & Gelissen, 1999). These welfare states are identified by the non-existence of a guaranteed minimum benefit, little government intervention in the field of social care, a strong reliance on the family, and particularism and clientelism as discriminating features, among others. Esping-Andersen lended credit to these arguments (1996: 66). Hence, it seems reasonable to presume that Italy, Portugal, Spain and Greece do indeed constitute a separate type of welfare state regime, and that levels of support for welfare state programmes will systematically differ from the levels of support in the other regime types. More specifically, we expect that the populations of these countries will strongly favour government interventions to develop a welfare state that is comparable to other European welfare states. The southern welfare states are often labelled as 'welfare laggards' within Europe, because their social security systems are fairly young and not fully developed compared to the other European welfare states. The citizens of these countries will thus have much more to gain from increased welfare state efforts than the citizens of the other European welfare states. We expect the level of support for state interventions to be higher in the southern type of welfare state than in the social-democratic welfare state, whose citizens got accustomed to widespread government interventions and who therefore evaluate these as less important than citizens in the juvenile southern welfare states.

Thus, we assume: a) that the more moral commitment to the welfare state is reflected in the institutional attributes of a welfare state regime through the dominant existence of

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<sup>3</sup> Further information concerning these studies can be requested from Josette Gevers, Work and Organization Research Centre, Tilburg University, P.O.Box 90153, 5000 LE Tilburg, The Netherlands.

universal programs, the higher the levels of support for solidaristic welfare arrangements will be among the citizens, b) that when the institutional arrangements of a welfare state contain dominantly selective social programmes, social cleavages and self-interest will be emphasized, which will lead to diminished support for solidaristic welfare state arrangements, and c) if people live in a young welfare state and their expectations about the progress of the welfare state have risen due to positive past experiences, their support to welfare state services will be higher than in welfare states whose members got accustomed to a matured welfare state. Based on these assumptions, we can formulate hypotheses about the support for the European welfare states, except for those identified as hybrid:

*With the position of the hybrid welfare states remaining unpredicted, the level of support for welfare state provisions of health care will be highest in southern welfare states, followed by social-democratic welfare states. Corporatist welfare states will show the lowest levels of support.* (1)

Looking at more concrete characteristics of social policy, we argued in paragraph 3.2 that popular support for health care services is related to the institutional characteristics of the national health and social care system. We have seen from earlier studies that generous universal and publicly financed welfare state programmes enjoy more support and lead to stronger consensus about a public responsibility for such provisions. Besides a stronger commitment to the public good, the widespread positive past experience with the fruits of such programmes are likely to result in stronger affirmative expectations with respect to the future performance of welfare state programmes. We may thus expect higher levels of support for widespread public health care services in countries where health care is currently provided by means of a NHS system, than in countries with a social security based health care system. Moreover, as we mentioned earlier, past experiences of deficiency in less consolidated NHS systems due to insufficient political commitment - as in the case of the southern European countries -, may even lead to stronger support for public health care programmes because citizens in these countries have more to gain from it. Widespread public care services will particularly receive high levels of support in countries where socio-demographic changes lead to an increasing number of people needing care due to a decreasing capacity of the family to supply for care caused by the rise in female employment. Because social care services relieve women from their caring duties, particularly strong support for public care may be expected in countries with a high dependency ratio and high female labour force participation. Thus, at the concrete social policy level we might notice that positive attitudes towards solidarity arrangements are not just based on moral commitment, but also on self-interest. This leads us to posit the following hypotheses:

*When a country's health care programme is basically funded through generous public expenditures to provide for universal types of health care services, and when a positive and widespread past experience and a strong moral commitment to the public good prevail, it will result in higher levels of public support for health care services.* (2)

*Support for public health care will be higher in countries with a NHS system than in countries with a social security type of health care system, especially in countries with less consolidated NHS systems, such as the southern European countries.* (3)

*Self-interest motives for the support of public interventions will lead to higher levels of support for public health care services in countries with scant social care services for the*

*children and the elderly, with a high dependency ratio, and a large share of female (part-time) employment.* (4)

In Paragraph 3.3 it was argued that attitudes towards welfare state arrangements are related to people's ideological position or socio-political beliefs and, indirectly, to their position in the stratification structure; that is, their demographic characteristics and social position. First, we have shown that dependency on welfare state provisions will likely result in self-interest related motives to support health care. Second, it was shown that a higher education level and a leftist stance on the political spectrum are probably associated with a stronger moral commitment to the provision of public care services. We may thus hypothesize that:

*Self-interest and a moral commitment to helping others will lead to stronger levels of support for the provision of public health care services among women than among men.* (5)

*Dependency on welfare state services - because of old age, health problems, a low income, or belonging to a transfer class - will emphasize the importance of self-interest motives to support public health care services and will likely result in a more positive attitude towards public (health) care.* (6)

*The stronger one's commitment to the public good as reflected in a leftist stance on the political spectrum, and a higher educational attainment, the stronger someone's support for government sponsored health care will be.* (7)

One final factor that might affect the individual support for health care is a person's satisfaction with the current health care system. This relates to the characteristics of the national health care system and someone's individual position. Dissatisfaction with a nation's current care system is likely the result of negative experiences with the supply of care by people currently dependent on care. These two factors, as we already noticed before, feed self-interest related motives to support public health care programmes. Then again, the person who perceives its health care system as inadequate, may also welcome a widespread and generous supply of public care services from a moral point of view. Our final hypothesis thus reads as follows:

*If a person perceives its country's current health care system as inadequate, motives of self-interest and moral sentiment will result in higher levels of support for the provision of public health care.* (8)

## **5. Data, operationalization and methodology**

### **5.1. Data**

Data for this study are taken from the Eurobarometer survey 44.3, conducted between 27 February and April 3 in 1996, in 15 of the European Union Member States. This survey interviewed respondents, amongst other things, about their views on the health care system in their country, the need for reforming the system, the level of health expenditures and the government's responsibility in providing health care. On the basis of the availability of comparable data on the main dependent variables, the following 13 countries were selected

for the present study: Denmark, Greece, West-Germany, Italy, Spain, France, Ireland, the Netherlands, Portugal, Great Britain, Finland, Sweden and Austria. Each sample is weighted according to a national weighting procedure for sex, age and region. Furthermore, an international weighting procedure is applied to adjust samples to a standard size of 1000 respondents. Conclusively, the data cover the population of the respective nationalities of the thirteen European Union member states, aged 15 years and over, being resident in each of the member states.

## 5.2. Measures

The dependent variable in this study, the level of support for the welfare state with respect to the provision of (health) care services, was measured using the following three items from the *Eurobarometer 44.3*:

- Q121c: The government should only provide everyone with the essential services such as care for serious diseases and encourage people to provide for themselves in other respects (1 = agree strongly - 5 = disagree strongly);
- Q121d: It is impossible for any government or public or private health insurance scheme to pay for all new medical treatments and technologies (1 = agree strongly - 5 = disagree strongly);
- Q122: Here are three opinions. Please tell me with one comes closest to your own?
- 1) The government has to ensure that health care is provided to all people residing legally here, irrespective of their income;
  - 2) The government has to ensure that health care is provided only to those people residing legally here, with low income;
  - 3) The government does not have to ensure that health care is provided to people residing legally here, not even those with low income.

The original encoding of the last item was recoded so that on all three items a high score indicates a positive attitude towards the welfare state. Principal Component analysis on the three variables yielded a single factor in all countries that can be interpreted as *the level of support for public health care*. The factor scores, calculated with the Bartlett method, will be the dependent variable in this study. The factor loadings of the three items for each country are presented in Table 1 of the Appendix. The welfare regime typology, macro-level indicators and micro-level factors that will be used in our study are described in more detail in the sequence.

The welfare state regimes were operationalized as follows. Sweden represents a typical social-democratic welfare state regime on its own. Denmark, the Netherlands and Great-Britain comprise a welfare state regime with many social-democratic attributes but also some liberalistic and conservative ones. The conservative, corporatist welfare regime was presumed to exist in West-Germany, France and Austria. Ireland and Finland represent a cluster of hybrid welfare states. Finally, a fifth, southern welfare state regime type, was added which was presumed to exist in Italy, Greece, Spain and Portugal. Dummies were constructed to bring this typology into the analyses, using Sweden as the reference category.

The structural characteristics of the health care and social care systems of the countries are presented in Table 2 of the Appendix. The data on health care expenditure, health care coverage and the dependency ratio are taken from the Human Development Report of 1994. The dependency ratio represents the ratio of the population defined as dependent, under 15 and over 64 years, to the working-age population, aged 15 to 64 (HDR, 1994). The distributions of the coverage rate and the dependency ratio have been improved by means of a

log-linear transformation on the first and a square root transformation on the latter. To measure the effect of the way health care is organized a distinction was made between countries with a national health service system and those with a social security system alike type of health care system (0 = social security type of health care system; 1 = nhs). The classifications on this variable are derived from Elola (1996: p241, table 2). The indicators for the social care system are derived from the work of Anttonen and Sipilä (1996) on European social care systems. They made an inventory of the supply of care services for the frail elderly and of children's daycare services in the western European countries. The supply of care for the frail elderly is measured by the proportion of elderly people over 65 years of age in residential care services and the number of elder recipients of the same age in home help services, as a proportion of the corresponding age group. The main data source is a summary report by the OECD on the supply of old age welfare state services. Unfortunately, the category of residential services comprises both social welfare and health care, and the category of care services comprises both, private, commercial services and public services. The latter, however, is inevitably so, because as in many countries social services are publicly funded but provided by private companies. In our analysis, we use the sum of the standardised scores of the two variables to represent *the supply of services for the elderly* in a particular country. The supply of children's day care services is measured by the proportion of children under three years old in day care and the proportion of children aged 3 to 5 years in nursery school (kindergarten). These data include only information on public day care centres, where public authorities are responsible for funding and the execution of the service. Again, the sum of the standardized scores of the two variables is used to represent *the supply of children's day care services*. Finally, the capacity of the family to supply for care, and the division of care and domestic labour by sex, is operationalized using two variables on women's position in paid employment: *the proportion of women in the active labour force* (as a proportion of all women of working-age) and *the share of women working part-time*. The data, originally collected by the OECD, are also derived from the work of Anttonen and Sipilä (1996).

The explanatory variables at the individual level are, apart from the usual demographic variables like *gender* (0 = male; 1 = female) and *age*, measures of social location, political location and perceived adequacy of the health care system. Social location is operationalized by means of the *duration of a person's schooling period*. Following Schmidberger (1997: 119), the age of stopping full-time education is classified in 9 ordered categories ranging from 0 '1 through 14 years' to 1 '22 years or older'. Those younger than 22 years of age and still in education are categorised on the basis of current age. A variant of social location is the notion of *transfer classes*. Persons belonging to transfer classes, who profit more directly from the welfare state, are thought to have a common interest in ensuring that the welfare state will not be eroded. To examine the influence of belonging to a transfer class three dummies are constructed: people who are not in the labour force, the unemployed and pensioners or the disabled. Because low-income groups are also perceived as belonging to the transfer classes, another set of dummies (3 in total) was constructed for the quartiles of *household income*. Here, the lowest quartile is taken as the reference group. Dependency on the care system could, according to the same reasoning as with respect to transfer classes, influence people's attitude towards the welfare state, especially when health care provisions are concerned. Two measures of personal health are used as indicators for (possible) dependency on care provisions. A fairly objective measure of personal health is based on the question whether one has any *long-suffering illness, health problems or handicaps* that limits, to some extent or severely, one's capability to work or perform the daily activities (0 = no; 1 = yes). This includes all types of health problems as well as those of old age. *Subjective personal health* is measured by means of a question that asked respondents if they would rate their health status in the last twelve months as very good, good, fair, bad or very bad. Two dummies are



constructed: people who feel they are in 'very good health' and people who rate themselves in 'good health'. Those who feel their health is fair/neutral, bad or very bad are taken as the reference category. Political orientation is assessed by means of a question that asked respondents to place their personal political views on a *left-right* continuum, ranging from 1 'left' to 10 'right'. Finally, for the operationalization of *perceived adequacy of the countries health care system* factor scores were calculated applying a Principal Component Analysis technique, using the following three questions as indicators:

Q121c: Health services available to the average citizen are inefficient (1 'agree strongly' to 5 'disagree strongly').

Q123: In general would you say you are (1) very satisfied, (2) fairly satisfied, (3) neither satisfied/nor dissatisfied, (4) fairly dissatisfied or (5) very dissatisfied with the way health care runs in our country?

Q124: Which of these four statements on the way health care runs in our country comes closest to your own point of view?

1) On the whole health care in our country runs quite well;

2) There are some good things ..., and minor changes might make it work better;

3) There are some good things ..., but only fundamental changes would make it work better;

4) Health care in our country runs so badly that we need to rebuild it completely.

The original encoding of the items q123 and q124 were recoded so that on all three items a high score indicates a positive stance towards the running health care system.

### **5.3 Method of analysis**

Our model for the supportiveness for welfare state provisions of health care involves micro-level factors; i.e. demographic variables, social position and ideological position, as well as macro-level factors; i.e. welfare state regimes and health care indicators. A common strategy to test hypotheses about micro-and macro-level factors in cross-national research is to calculate estimates using Ordinary Least Squares regression on a pooled data set, in which these factors are included as explanatory variables. However, this approach raises two methodological problems. First of all, Schmidberger (1997: 111) argues - referring to Snijders (1995) - that the traditional OLS regression approach leads to incorrect estimates in the case of a large number of context units (following a 'rule of thumb': 10 context units or more). Secondly, it is difficult to separately assess the modelled variance both at the individual level and at the context level. These drawbacks can be avoided by using multilevel modeling. Using multilevel techniques, values of  $R^2$  can be calculated for both the individual level model and the context level model, thus providing more information (Schmidberger, 1997: 111). Therefore, we performed two analyses within the framework of hierarchical linear models. The first analysis involved the data on the individual level (level 1) analysed together with the welfare state typology (level-2). The second analysis involved the same individual level variables, now analysed together with the health care indicators (level-2). The two macro-level factors cannot be analysed together in one model because the health care arrangements are in many ways specifications of the welfare regime types causing multicollinearity, which leads to misspecifications of the model. Moreover, because some of the health care arrangements indicators were not available for Greece and Austria, these countries had to be omitted from the second analysis. However, as these countries are included in the first analysis, we should note that this hinders comparability between the two models.

To test our hypotheses, two 2-level hierarchical regression models were estimated. The general form of the level-1 equation, which represents the outcome Y (supportiveness for

public health care) for case  $i$  (respondent) within unit  $j$  (country), is as follows (Bryk, Raudenbusch & Congdon, 1996):

$$Y_{ij} = \mathbf{b}_{0j} + \sum_{q=1}^Q \mathbf{b}_{qj} X_{qij} + r_{ij}$$

where  $\mathbf{b}_{qj}$  ( $q=0,1,\dots,Q$ ) are the level-1 coefficients,  $X_{qij}$  is the level-1 predictor  $q$  for case  $i$  in unit (=country)  $j$ , and  $r_{ij}$  is the level-1 random effect. In the level-2 model, each of the level-1 coefficients  $\mathbf{b}_{qj}$ , defined in the level-1 model becomes an outcome variable in the level-2 model:

$$\mathbf{b}_{qj} = \mathbf{g}_{q0} + \sum_{s=1}^{S_q} \mathbf{g}_{qs} W_{sj} + u_{qj}$$

where  $\mathbf{g}_{qs}$  ( $q=0,1,\dots,S_q$ ) are level-2 coefficients,  $W_{sj}$  is a level-2 predictor and  $u_{qj}$  is a level-2 random effect. The parameters of this two-level random intercept model are estimated with the multi-level HLM program (Bryk, e.a, 1996).

In the level-1 model, a positive coefficient indicates that when the value of the explanatory variable increases, supportiveness for welfare state provisions of health care also increases. A negative coefficient indicates that as the value of the explanatory variable increases, public support decreases. In the level-2 model we seek to explain the variability in the intercepts of the different regression equations for each country. The model does not explain the variation across countries of the regression slopes. It is assumed that they are a function of the average regression slopes for these variables and the level-2 random effects  $U$ .

## 6. Results

### 6.1. Attitudes towards public health care

In the following, we will first take a look at the distributions of the three items, which were used to measure the public opinion on public health care. Table 3 presents the percentage of people in each country that agree completely with the statements of q121c and q121d. For item q122, the table shows the percentage of people in each country that is sharing the opinion that the government has to ensure that health care is provided to all people residing legally in the country, irrespective of their income. Additionally, measures of central tendency, dispersion and shape are displayed.

From the table it is clear that overall a positive attitude exists towards public health care in the European Union. The high proportion of citizens demonstrating a pro-welfare attitude and the measures of central tendency, dispersion and shape show a rather unanimous support. In all countries, except for Portugal, Finland and Austria, at least one quarter of the population disagrees completely with the statement that the government should provide only essential services such as care services for serious diseases and that the government should encourage people to provide for themselves in other respects. This indicates a strong preference for broad public health care provisions. Support is especially high in Great Britain, Denmark and Italy. Similar high levels are found in Sweden, Spain and the Netherlands. The

lowest levels of support are found in Portugal and Austria; countries with typically high levels of private health expenditures.

The statement that it is impossible for any government or public or private insurance scheme to pay for all new medical treatments and technologies, taps respondents' views on the feasibility of such a wide ranging health care system. In comparison to the previous statement, disagreement with this statement is less widespread. The results show that people from the southern European countries are particularly optimistic in this regard, whereas the Scandinavians seem cautious. All other countries score somewhere in between. Apparently, even though people in most countries prefer an extensive health care system, the perceived feasibility of such a system is related to the range of facilities already covered in the health care system and the financial burden associated with it. Because their health care system is highly developed and contributions are correspondingly high, the Scandinavian citizens might not see a need for broader provisions. In the southern European countries, with less consolidated health care systems more room is left for extended provisions and contributions.

Very high levels of agreement with the third statement provide evidence of a widespread preference for universal health care policies in all countries. Within as well as across countries, responses are unanimous in this regard. Support for an all-encompassing health care system is especially high in countries with highly developed National Health Services, such as Denmark, Great Britain and Sweden. Equally high proportions are found in countries with less consolidated National Health Services, like Greece and Spain. Austria and Ireland show the lowest percentages of people opting for broad health care provisions, but still more than half of their population favours universal over selective provisions.

## **6.2. Explaining differences in attitudes towards public health care**

Combining the three variables in a factor score provides us with one measure for the level of support for public health care. The mean factor scores are reported for each country in table 4, together with the standard deviations and the number of valid responses. Cross-national comparison, using ANOVA, indicates that there are significant differences in the level of support across the European Union member states ( $F(12; 11101) = 53.272; p < .000$ ). To specify these cross-national differences and to assess our hypotheses about the affect of welfare regime types, institutional arrangements and individual characteristics on the support for public health care, we will now turn to the multi-level analyses. Starting with the country level variables, we will first discuss the effect of the welfare state regimes; then we examine the results of the structural characteristics; and finally, we turn to the individual level variables which are included in both models.

The results of modeling the relationship between welfare state regime types and individual characteristics on the one side and support for public health care on the other, are reported in table 5. Our first hypothesis, addressing differences in public support between five welfare state regime types, is partly confirmed by the results. In comparison to Sweden, the cluster of social-democratic welfare states shows a lower level of support for public care, followed as predicted by the corporatist welfare states. In contrast to our expectations no differences in support occur between Sweden and the southern welfare states. The lowest levels of support are found in the hybrid welfare states, a finding for which there is no obvious explanation. With 11% macro-level modelled variance<sup>4</sup>, the explanatory power of this classification of welfare state regime types is low. Still, the typology successfully distinguishes clusters of countries with different levels of support for public health care.

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<sup>4</sup> The values of  $R^2$  are measured in accordance with the guidelines provided by Snijders and Bosker (1994: 351).

Moreover, the differences in public support between the southern welfare states and the other types of welfare state regimes, apart from Sweden, strengthens the argument to classify them as a separate distinguished welfare state regime type.

Hypotheses 2 through 4 address the influence of the structural characteristics of a country's health care system on the support levels for public health care. These hypotheses were tested in a second hierarchical regression model for the association between these structural characteristics and the individual characteristics on the one side and support for public health care on the other. The results are reported in table 6. Hypothesis 2 predicted that the levels of support would be higher if a country has a universal public health care system. As predicted, higher levels of support are found in countries with a larger number of people eligible for public health care, whereas support drops when health care services are largely privately funded. Unlike our expectations, support for public health care is lower in countries with higher total health care spending. Moreover, contrary to the predictions of hypothesis 3, the level of support for public health care appears higher in countries with a social security type of health care system than in countries with a National Health Service. However, looking at the mean scores, support proves to be particularly high in the southern European countries with less consolidated NHS system ( $M = 0.08$ ), whereas the countries with a social security type of health care system and the remaining NHS-countries both show fairly low mean scores (respectively  $M = -0.05$  and  $M = -0.09$ ). Hypothesis 4 is fully confirmed by the results. As predicted, higher levels of support are found in countries with scarce social services for children and the elderly, and larger proportions of female (part-time) employment. Dependency ratio shows no effect on the dependent variable. To conclude, almost all the macro level factors contribute significantly to the model for explaining differences in attitudes towards public health care. Moreover, with 14 % of the variance in supportiveness explained, the model proves to be more powerful than the welfare state typology. Nevertheless, considering the extensive and detailed description of the health care system provided by the structural characteristics, the explanatory power of the model remains rather disappointing in comparison to the simple typology model.

Finally, we turn to the relationship between the individual characteristics, the micro-level factors in the models, and support for public health care. For some of the factors there is a slight divergence in results between the two models. Because more countries are included in the first model, our discussion of hypotheses 5 through 8 will be based on the results of table 5. In accordance with hypothesis 5, women show a stronger tendency to support public care services than men do. Old age does not affect support in the way we expected. We argued that old age would increase dependency on welfare state provisions leading to stronger support, whereas the results show that it has no impact whatsoever. Also other sources of dependency on public health care contribute only marginally to explaining support. The unemployed show a stronger tendency to support public health care than the working. The level of support among those who are out of the labour force, the pensioners and the disabled people do not differ from the support of the working. Moreover, support actually increases as household income rises, though only the highest income group is significantly more supportive than the lowest income group. Having a long-suffering illness, health problem or handicap has no significant effect on support; only those who rate their health as very good show lower levels of support. All in all, we find little support for hypothesis 6 that dependency on the welfare state increases support for public health care. With respect to the impact of people's ideological position the results confirm that a leftist stance on the political spectrum goes hand in hand with a higher level of support for public health care. The second part of hypothesis 7, that people with a higher educational attainment would be more in favour of public health care receives little support. Finally, hypothesis 8 cannot be confirmed because the public opinion on health care support appears unaffected by personal opinions on the adequacy or inadequacy

of the health care system. To conclude, with reference to the modelled variance of 5 %, the individual level variables provide a significant, though limited contribution to the explanatory power of our model for explaining differences in attitudes towards the provision of public health care services.

## **7. Conclusions and discussion**

The objectives of this chapter were to explore attitudes towards public health care in the European Union member states and to identify the factors that might explain the public opinion scores, and to examine the effects of welfare state regimes, typical features of the national care system and individual characteristics.

The results leave no doubt with respect to the overwhelming support for public care services within Europe. In all countries positive attitudes towards public health care prevail, demonstrating a general preference for a universal health care system with a broad range of health care services. Cross-national variation appears limited, although our analyses reveal some important factors that perform relatively well in explaining the divergence in people's preferences for public health care.

First of all, evidence was found for the presumed relationship between the various types of welfare states, as identified by their degree of conservatism, liberalism and social-democratism, and support for public health care. Support appears particularly linked to social-democratic attributes of the welfare states; support drops with increasing degrees of liberalism and conservatism. Apparently, the moral considerations embedded in these welfare state attributes put their stamps on the public opinion. In addition, the highly positive attitudes towards public health services in the young southern European welfare states suggest that a lagged development of the welfare state operates as a strong motive for supporting solidary care arrangements.

Second, similar commitments to the public nature of care are revealed in the relationship between national health care arrangements and people's preferences. Support for public health care proves not to be associated with higher health care expenditures, but with wider coverage and public funding. Once again, the level of development of the welfare state turns out to be important; only in countries with less consolidated national health care services the preference for public health care is higher as opposed to countries where health care is financed by means of social security payments. Looking at the supply of social care services and the caring capacity of the family, self-interest proves to be just as strong a motive for supporting solidary care arrangements. High shares of women entering paid employment, therewith trading in their traditional role of caregiver for a position on the active labour market, lead to strong support for the widespread supply of health care services. Especially in countries with a lack of social care services for the elderly we find high levels of public support, but this effect also holds for countries with few services for young children.

Third, examining individual characteristics, we found remarkably little evidence for self-interest oriented motives which affect the preference for solidary health care arrangements. With respect to the transfer classes, solely the unemployed appear more in favour of public health care provisions than the working. Notably, the preference for public health care was stronger for people in the highest income group than for those with the lowest incomes. Being dependent on health care didn't show up to have particular strong effects either; only those rating themselves very healthy were less supportive. As expected, a leftist political orientation was associated with higher levels of support, and also women were more supportive than men. The latter might be motivated by either morality or self-interest.

To conclude, these results indicate that a moral commitment to the public good outweighs self-interest as a motive for an overwhelming support for public health care services with the European Community. This is not surprising, considering remarks made by Kangas (1997) that respondents tend to show a strong commitment to solidaristic values on general level questions, whereas this strong commitment begins to crumble quite swiftly with more specific questions that specify particular groups of beneficiaries of redistributive policies. With the use of responses to general level questions in this study, our findings seem to corroborate his results. On the other hand, the overall preference for solidary health care arrangements, even among the working and those with higher incomes, may also stem from self-interest considering the general character of health risks: every person runs the risk of contracting an illness, handicap or health problem and becoming dependent upon health care services as a result of that. Furthermore, because support is so high across all countries there is also little room left for cross-national variation. Nevertheless, a fairly simple typology of welfare state regimes proves to be almost as powerful in explaining variance as a rather extensive and detailed model of structural characteristics of health care systems. Following the principle of model building that a model should be as simple as possible and as extensive as necessary, we have to disagree with Papadakis and Bean (1993) that welfare state classifications do not help to explain the popularity of welfare state services. Of course, the amount of variance explained by the country-level indicators is rather limited, but large proportions of explained variance should not be expected from survey research, especially not when dealing with value orientations (Kalmijn and Kraaykamp, 1999). The attitudes we try to explain are influenced by many other factors, biological and psychological ones, for instance. These, however, go beyond the scope of our research. Moreover, with large-scale opinion surveys like the Eurobarometer, all kinds of irrelevant factors also affect the responses. Nonetheless, we agree with Kangas that future research should make more use of particular questions about concrete actions with respect to social policy. In this way it will be possible to shed more light on the social foundations of public support for solidary care arrangements in modern welfare states.

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## Appendix: Figure and Tables

Figure 1. Figurational model for supportiveness for public health care.

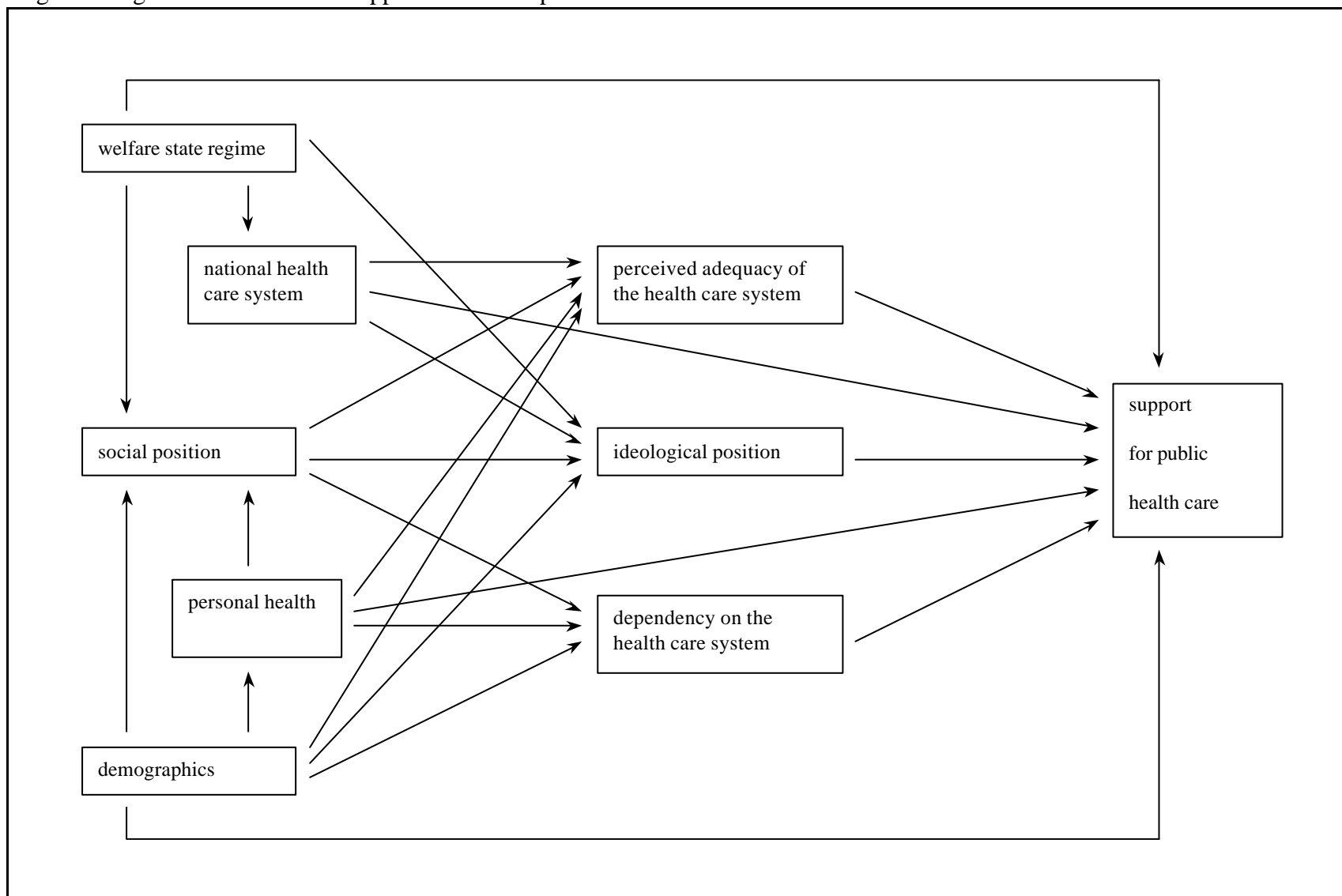


Table 1: Factor loadings for items q121c, q121d and q122 for measurements of the level of support for public health care.

	COUNTRY												
	DM	WG	G	I	S	F	IRL	NL	P	GB	FIN	SW	A
q121c The government should provide everyone with only essential services such as care for serious diseases and encourage people to provide for themselves in other respects	.79	.82	.86	.84	.84	.83	.81	.76	.83	.81	.77	.74	.87
q121d It is impossible for any government or public or private insurance scheme to pay for all new medical treatments and technologies	.70	.80	.86	.82	.81	.82	.75	.72	.80	.76	.69	.64	.84
q122 The government has to ensure that health care is provided to all people residing legally here, irrespective of their income	.46	.58	.17	.29	.37	.33	.51	.38	.37	.44	.58	.53	.34

Note: DM=Denmark; WG=West Germany; G=Greece; I=Italy; F=France; IRL=Ireland; NL=Netherlands; P=Portugal; GB=Great-Britain; FIN=Finland; SW=Sweden; A=Austria

Table 2: Structural characteristics of the health and social care systems of the European countries.

Country	GDP per capita (PPP\$), 1991 <sup>a</sup>	Total health expenditure (as % of GDP), 1991 <sup>a</sup>	Private health expenditure (as % of total health expenditure), 1989-1991 <sup>a</sup>	Type of health care system <sup>b</sup>	% of population eligible for public health insurance, 1987 <sup>a</sup>	Dependency ratio, 1991 <sup>a</sup>	Elderly people, 65 and over, in institutional care as prop. of age group, 1985-1991 <sup>c</sup>	Recipients of home-help services aged 65 and over as prop. of age group, 1985-1992 <sup>c</sup>	Children under 3 in daycare as prop. of age group, 1985-1986 <sup>c</sup>	Children aged 3-5 in preparatory school as prop. of age group, 1985-1986 <sup>c</sup>	women in active labour force (as prop. of all working-aged women), 1991 <sup>c</sup>	women in part-time jobs (as prop. of all women in active labour force), 1991 <sup>c</sup>
DM	17880	7,0	18,5	nhs	100	49	6	20	44,0	87	79	38
WG	19770	9,1	28,2	socsec	92	46	6	3	3,0	60	58	34
G	7680	4,8	23,0	nhs	--	49	0,5	--	2,5	60	40	7
I	17040	8,3	22,5	nhs	100	46	2	1	5,0	88	46	10
S	12670	6,5	17,8	nhs	97	49	2	1	1,0	66	41	11
F	18430	9,1	26,1	socsec	98	52	3	7	22,5	95	57	23
IRL	11430	8,0	24,2	nhs	37	62	5	3	0,5	52	40	18
NL	16820	8,7	26,9	socsec	72	45	10	8	1,5	50	54	62
P	9450	6,2	38,3	nhs	100	51	2	1	4,0	25	63	10
GB	16340	6,6	16,7	nhs	100	53	5	9	2,0	44	53	27
FIN	16130	8,9	19,1	nhs	100	49	7	10	22,0	62	72	10
SW	17490	8,8	22,0	nhs	100	56	5	12	29,0	79	80	41
A	17690	8,5	32,9	socsec	99	48	--	--	--	--	--	--

Note: DM=Denmark; WG=West Germany; G=Greece; I=Italy; F=France; IRL=Ireland; NL=Netherlands; P=Portugal; GB=Great-Britain; FIN=Finland; SW=Sweden; A=Austria.

Source: <sup>a</sup>Human Development Report (1994); <sup>b</sup>Javier Elola (1996); <sup>c</sup>Anttonen & Sipilä (1996).

Table 3: Distribution measures for q121c, q121d and q122

		COUNTRY												
		DM	WG	G	I	S	F	IRL	NL	P	GB	FIN	SW	A
q121c The government should provide everyone with only essential services such as care for serious diseases and encourage people to provide for themselves in other respects	% disagree completely	41.9	25.6	29.2	41.9	35.2	26.6	25.0	39.0	21.3	44.9	23.3	36.8	18.6
	mode	5	4	4	5	4	4	4	5	4	5	4	4	4
	Standard deviation	1.41	1.26	1.30	1.54	1.20	1.35	1.30	1.46	1.20	1.21	1.38	1.08	1.27
	skewness	-0.70	-0.47	-0.67	-0.29	-0.84	-0.45	-0.32	-0.44	-0.44	-1.03	-0.22	-1.06	-0.10
q121d It is impossible for any government or public or private insurance scheme to pay for all new medical treatments and technologies	% disagree completely	9.7	13.2	28.8	26.9	21.5	23.3	10.4	16.1	12.9	16.8	5.1	8.4	10.5
	mode	2	2	4	5	4	4	2	2	4	2	2	2	2
	standard deviation	1.31	1.26	1.19	1.48	1.23	1.24	1.21	1.38	1.22	1.36	1.11	1.23	1.22
	skewness	0.79	0.07	-0.68	0.07	-0.32	-0.33	0.53	0.45	-0.01	0.25	-0.33	0.27	0.16
q122 The government has to ensure that health care is provided to all people residing legally here, irrespective of their income (%)	% choosing alternative 1	86.5	71.8	87.2	71.7	90.1	76.2	58.9	77.7	72.0	85.9	79.6	94.8	65.0
	mode	1	1	1	1	1	1	1	1	1	1	1	1	1
	standard deviation	0.38	0.57	0.47	0.53	0.4	0.58	0.58	0.5	0.59	0.41	0.43	0.27	0.61
	skewness	2.52	1.52	2.85	1.44	3.39	1.79	0.84	1.84	1.53	2.60	1.70	4.87	1.18

Note: DM=Denmark; WG=West Germany; G=Greece; I=Italy; F=France; IRL=Ireland; NL=Netherlands; P=Portugal; GB=Great Britain; FIN=Finland; SW=Sweden; A=Austria.

Table 4: Means, standard deviation and Valid N on 'Support for public health care' by country

	COUNTRY												
	DM	WG	G	I	S	F	IRL	NL	P	GB	FIN	SW	A
Mean	-.15	-.11	.34	-.07	.35	.10	-.38	-.14	-.03	.20	-.31	.17	-.34
Standard deviation	.95	1.05	.96	1.14	.91	1.02	1.01	1.00	.94	.95	.93	.77	1.03
Valid N	934	839	906	822	742	878	878	817	748	919	916	865	839

Note: DM=Denmark; WG=West Germany; G=Greece; I=Italy; F=France; IRL=Ireland; NL=Netherlands; P=Portugal; GB=Great-Britain; FIN=Finland; SW=Sweden; A=Austria



Table 5: Two level statistical model of factors affecting support for welfare state provisions of health care with welfare state regime typology as macro-level indicator.

Model with Welfare state regime typology as macro-level indicator (N=8889)	
Intercept	-0.02
<b>Welfare state regime typology:</b>	
Reference: Sweden	
Southern cluster: Italy, Spain, Portugal, Greece	-0.04
Social-Democratic cluster: Denmark, Netherlands, Great-Britain	-0.29***
Conservative cluster: West-Germany, France, Austria	-0.33***
Hybrid cluster: Ireland, Finland	-0.37***
<b>Macro level modelled variance: <math>R^2 = 0.11</math></b>	
<b>Individual level variables</b>	
<u>Demographics</u>	
Gender	0.09**
Age	-0.00
<u>Social location</u>	
Duration of educational attainment	-0.02
Transfer classes	
Reference: Working	
Not in the labour force	-0.01
Unemployed	0.18**
Old-age pensioners/disabled	0.01
Household income	
Reference: lowest income quartile	
Second income quartile	0.02
Third income quartile	0.04
Highest income quartile	0.11**
<u>Personal health</u>	
Having a longstanding illness, health problem or handicap	0.08
Subjective personal health	
Reference: bad health	
Good health	-0.04
Very good health	-0.11**
<u>Political orientation</u>	
Subjective left-right placement	-0.05***
<u>Perceived adequacy</u> of the running health care system	0.01
<b>Micro level modelled variance: <math>R^2 = 0.05</math></b>	

\*\*\* p < .001; \*\* p < .01; \* p < .05

Table 6: Two level statistical model of factors affecting support for welfare state provisions of health care with structural characteristics of the care system as macro-level indicators.

Model with Structural characteristics of the care system as macro-level indicators (N=7642)	
Intercept	-0.03
<b>Structural characteristics of the care system:</b>	
Total health care expenditures	-0.06***
Private health care expenditures	-0.03***
Type of health care system (0=social security system, 1=NHS)	-0.22***
Health care coverage	0.09***
Dependency ratio	0.00
Volume of children' day care services	-0.04***
Volume of services for the elderly	-0.16***
Women in active labour force	0.01***
Women in part-time jobs	0.01***
<b>Macro level modelled variance: <math>R^2 = 0.14</math></b>	
<b>Individual level variables</b>	
<u>Demographics</u>	
Gender	0.09**
Age	-0.00
<u>Social location</u>	
Duration of educational attainment	excluded
Transfer classes	
Reference: working	0.02
Not in the labour force	0.19**
Unemployed	0.00
Old-age pensioners	
Household income	
Reference: lowest income quartile	
Second income quartile	0.04
Third income quartile	0.04
Highest income quartile	0.09*
<u>Personal health</u>	
Having a longstanding illness, health problem or handicap	0.05
Subjective personal health	
Reference: bad health	
Good health	-0.04
Very good health	-0.12**
<u>Political orientation</u>	
Subjective left-right placement	-0.06***
<u>Perceived adequacy</u> of the running health care system	-0.01
<b>Micro level modelled variance: <math>R^2 = 0.05</math></b>	

\*\*\* p < .001; \*\* p < .01; \* p < .05