

## POPULAR SUPPORT FOR HEALTH CARE IN EUROPE REVIEW OF THE EVIDENCE OF CROSS-NATIONAL SURVEYS<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-1970s onwards; the results of the survey showed no traces of this crisis. Neither did the results of an in-depth trend-study on welfare attitudes by Coughlin (1980). Despite a considerable ambivalence among the public towards some programmes, 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, pp. 74-75) concluded, 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% 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), despite the many differences in their set-up, these health care systems face 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 or cost reduction are, although to differing degrees, major 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 1950s: the male person being the main 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.

These rather recent economic, demographic, and technological developments are attached to an encompassing secular trend of on-going modernisation in Western societies. One of the most important elements of the overall process of modernisation is a long-term and continuous process of individualisation. The latter process has three main aspects (Wilterdink, 1995). First, the relational aspect refers to increasing instability and changeability of social relations. Second, the situational aspect suggests that the range of behavioural options for individuals has increased in nearly all situations. Third, the normative aspect refers to an increasing stress on the moral significance of individual autonomy. Although individualisation has proceeded for a long term in all Western societies, this process has been more advanced in some countries than in others. This raises the question of whether all the citizens of Western European countries are to the same degree willing to support public health care services and prepared to share the burden of rising health care costs. The provisional theoretical answer to this question has to be in the negative. If the above-mentioned processes differentially influence not only countries, but also social categories, groups and individuals, then their readiness to support and contribute will also differ. However, this is not the only reason why the provisional answer is in the negative. Comparative research shows that individualised people do not always and everywhere opt for individualistic choices. Individualism appears to be domain specific and above all there appear to be marked cross-national variations in individualism (Ester et al., 1994; Halman, 1996). This raises a new question. To what extent are organised solidarity and shared responsibility, according to people themselves, necessarily conflicting with the increasing emphasis on individual autonomy and self-realisations?

The organisation of the chapter is as follows. In the second part we start with a brief introduction of the concept of solidarity; subsequently, we go deeper into people's motivational bases for supporting solidary arrangements. In the third part, we focus on the questions of 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 the fourth part hypotheses are formulated which will be empirically tested in subsequent sections of this chapter. In the fifth part we present the data, measurement and analytical strategy, followed by a description of the results of our analyses in the sixth part. Finally, in the seventh part, 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, p. 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 people's motives for supporting solidarity arrangements, theorists mostly refer, in line with Van Oorschot's distinction, to self-interest and moral commitment (Kangas, 1997; Peillon, 1996; Taylor-Gooby, 1985). 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 well-being, and the minimalisation of loss. Everybody strives for these goals. People, then, differ less in their subjective wants than in their objective means to produce a particular amount of a high level good (1990, p. 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. Socialisation 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.

In the introductory chapter, we already discussed Van Oorschot's classification of these motivational bases for supporting solidary arrangements, of which health care and care for the elderly are obviously important examples. This framework also enables us to specify more precisely why people may give support to health care and care for the elderly. People may feel affectionately and emotionally close to the ill and the elderly, either because they are in the same position or because they are carers in the identity of spouses, daughters, and daughters-in-law, sons, parents, relatives, or close friends, which often have a very personal relationship with the person in need of care (Pijl, 1994, pp. 3-4). In both cases, feelings of affection and loyalty at the micro level may translate into a more general supportiveness for health and social care services that are directed at the care for these vulnerable groups. Furthermore, feelings of moral obligation and culturally based convictions may dictate a greater supportiveness for health care and social care services, because people may feel a strong commitment to the collective interest as far as medical and social care for the ill and the elderly are concerned. For instance, in the Mediterranean countries, where family and community ties are still strong and important in daily life, solidarity as exemplified by social care for the elderly might have a different moral meaning than in Northern European countries. In the Northern countries, the role of the family in the informal care for the elderly is more limited (Pacolet et al., 1999, p. 27). Another motive for solidarity more directly oriented to health care and care for the elderly may be based on perceived, long-term self-interest. Among the many risks of life, virtually everybody will sooner or later be confronted with the risk of sickness or with the risk of frailty in old age. People may thus give support to health care and to social protection for dependency in old age because they expect to benefit from health and social care services in the short or the long run. Finally, when these three motives do not provide enough support to bear a system of health care and social care for the elderly, a higher authority (i.e. the state) that is sufficiently legitimised among its citizens, may step in to enforce and to back up such a collective health and social care system.

### 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. Recently, this approach has been followed by many other researchers (e.g. Gelissen, 1999; Papadakis and Bean, 1993; Svallfors, 1997). Here we will mainly follow the arguments put forward by Gelissen (2000) in his discussion of explanations for intra- and inter-country variations in levels of public support for the welfare state. In our effort to explain differences in support for the welfare state provision of health care, we will thus 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 (Esping-Andersen, 1990; Gallie, 1983; Korpi, 1980). Esping-Andersen (1990, p. 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, p. 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, p. 12):

The liberal welfare state regime is characterised by heavy reliance on means tested programmes, 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 organisational 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 and 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

<http://www.springer.com/978-1-4020-0164-2>

Solidarity in Health and Social Care in Europe

Editor-in-chief: ter Meulen, R. - Arts, W.; Muffels, R.  
(Eds.)

2001, XXII, 506 p., Hardcover

ISBN: 978-1-4020-0164-2