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## **Patterns of Trust in Health Care Institutions**

Jürgen Kohl and Claus Wendt

**Prof. Dr Jürgen Kohl**  
Institute of Sociology  
University of Heidelberg  
Sandgasse 9  
D-69117 Heidelberg  
Tel.: +49/(0)6221-54-2980  
Fax.: +49/(0)6221-54-2996  
juergen.kohl@soziologie.uni-heidelberg.de  
<http://www.soz.uni-heidelberg.de>

**Dr Claus Wendt**  
MZES  
University of Mannheim  
A5, 6  
D-68159 Mannheim  
Tel.: +49/(0)621-181-2819  
Fax: +49/(0)621-181-2803  
claus.wendt@mzes.uni-mannheim.de  
<http://www.mzes.uni-mannheim.de>

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## Abstract

Current social policy reforms often go beyond simple cost containment measures, but may involve structural changes in the organizational set-up of programs. Since such changes are likely to affect the performance of programs, they may lead to growing popular dissatisfaction and potentially even undermine the legitimacy of the welfare state. Conversely, in a cross-national perspective, a certain level of, for instance, health expenditures may be compatible with very different institutional arrangements for providing health services and result in equally different levels of satisfaction with these services. The paper investigates the correspondence between particular institutional arrangements of providing social security and citizens' trust in the performance of these institutions, taking the health care system as a major part of the welfare state as an example. A comparative analysis of institutional patterns will be combined with a micro data analysis of attitudes towards these arrangements. The latter is based on Eurobarometer survey data for the "old" 15 EU health care systems (EB 44.3/1996; EB 57.2/2002).

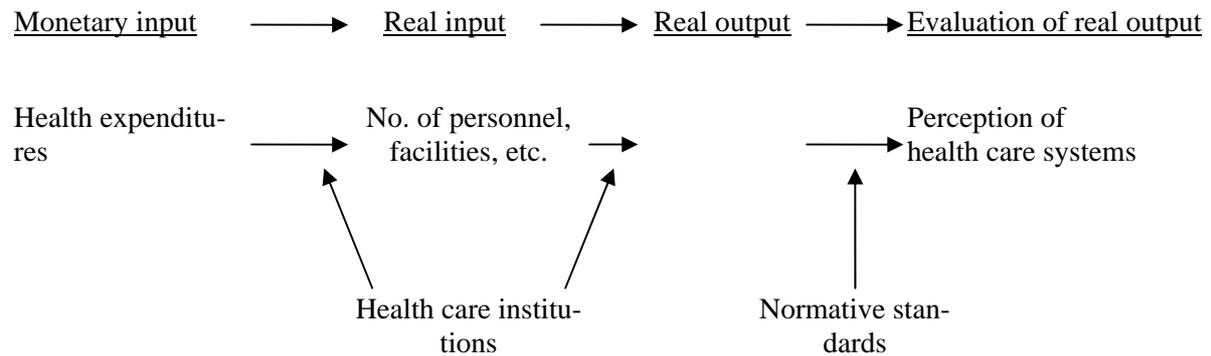
Our results only partly support the hypothesis of an incipient legitimacy crisis in the field of health care. Especially the level of satisfaction has declined in EU 15 countries during the 1990s indicating that (the results of) health care systems increasingly fail to meet the demands of the population. On the other hand in all EU 15 societies people are still overwhelmingly of the opinion that it is/should be the responsibility of the state to guarantee comprehensive health care for all citizens. Further, we see certain differences between social classes. This pattern, however, can especially be found in social health insurance schemes while national health service (NHS) systems in Great Britain and the Scandinavian countries show very low differences between social classes. The more inclusive NHS systems (but not the later developed NHS systems of Southern Europe) therefore seem to produce a more homogenous perception of the population compared to social health insurance (SHI) systems.

## 1 Introduction

Health care systems are undergoing quite significant changes. While the financial scope for health policy and further social policy measures has become more limited, the dependency on welfare state transfers has increased for certain population groups at the same time. These processes could potentially even undermine the legitimacy of the welfare state. Related to these changes, the political debate on the extent of state responsibility for citizens' welfare has been reopened. Both the preferences for an extensive governmental responsibility for citizens' well-being and satisfaction with the performance of health care systems may have changed due to a restructuring of institutions.

In this paper, we ask for the influence of different (types of) health care systems on patterns of public support. Following the "production process" of health care services, we focus on the influence of "monetary input" (health expenditure), "real input" (health employment), as well as "institutional arrangements" on the perception of health care systems (see *figure 1*).

**Figure 1: The “production process” of health care services**



Source: Kohl/Wendt 2004:326

Based on assumptions derived from institutional theory (DiMaggio and Powell 1991; Hall and Taylor 1996; Ingram and Clay 2000; Lepsius 1990, 1997; Scott 1994, 1995), we argue that public support of health care systems is framed by the institutional design of these systems (Arts and Gelissen 2002; Esping-Andersen 1990; Gelissen 2002; Wendt 2003a). Since medical-technical innovations enable health care providers to treat an increasing number of diseases, providers have to specialize and health care systems have become increasingly complex. In a situation where patients are less able to evaluate the process of service provision and to assess the quality of services, health care systems depend on a certain level of trust.

More generally, we have to take the importance of trust (Coleman 1990; Rothstein 2001) into account when analysing and comparing welfare state institutions. “Modern welfare states represent an important way of handling future uncertainties. They depend to a considerable extent on social trust. If people are not confident that welfare institutions will deliver, better than alternatives, what they may need they may be less willing to support them in elections and pay taxes to finance them“ (Taylor-Gooby 2005: 218). Rothstein argues that possible consequences are two interrelated social dilemmata: “The first is with the government: will the state actually, when the day comes, deliver what it has promised to deliver? For individuals, many things provided for by the welfare state have long-term horizons ... So the individual has to consider whether he can trust not only the current government, but also any future government. The second dilemma is with all other citizens: will they finally support the system or are they more likely to cheat and avoid paying taxes? And will they try to undermine the system by claiming benefits they are not entitled to, or will they play by the rules?“ (Rothstein 2001: 222). Building on the arguments by Taylor-Gooby and Rothstein, we hypothesize that it depends on the institutional design of the respective welfare state arrangements whether they

can be considered an investment in societal trust conveying an optimistic view to the future, or not.

With regard to the perception of welfare state institutions, a number of hypotheses are discussed in the literature (Gelissen 2002; Mau 2001; Rothstein 2001; Svallfors 1997):

The hypothesis of declining legitimacy assumes a decrease of public support of welfare state institutions. Especially the processes of globalization and demographic ageing are expected to increase the pressure on dismantling or at least restructuring the welfare state (Pierson 2001; Taylor-Gooby 1999, 2005). Demographic ageing makes it more costly to maintain individual benefit levels. But to contain the aggregate bill of social expenditures requires cutting individual entitlements or benefits. High levels of social and health expenditure are increasingly discussed as major reasons for high labour costs and related disadvantages of national economies. The integrative function and further positive achievements of the welfare state, on the other hand, have become less prominent in recent debates.

The middle class hypothesis suggests a greater level of support for more inclusive schemes in contrast to selective ones. The central reason for this lies in the fact that universal schemes provide benefits for the majority of the population, including the middle class, thus leading to broad support (Korpi/Palme 1998; Pierson 2001; Taylor-Gooby 1999). Following this line of argumentation, universal national health care systems can be supposed to enjoy stronger public support than more selective social insurance schemes or means-tested schemes.

The self-interest hypothesis suggests that people likely to be or to become beneficiaries of welfare state institutions are more supportive of the welfare state (Korpi 2003; Svallfors 2004). These are people who are likely to be more dependent on welfare benefits in general, indicated by their position in the social and occupational structure. People who are not part of the active labour force but are unemployed, retired, a homemaker, or still in full-time education as well as people with low incomes are more likely to depend on some kind of welfare benefits and are therefore expected to support more extensive welfare policies in general.

In the case of health care it can be argued that people who evaluate their own state of health as bad or suffer from chronic diseases are more dependent on health services than do healthy people. Therefore, we expect them to be more supportive of extensive state responsibility in the area of health care. The same argument holds true with regard to age. As the risk of suffering from serious diseases rises with old age, older people will have a higher self-interest in the public provision of health care.

“Institutions matter” hypothesis: Some of the arguments related to the hypothesis that different institutions “produce / generate” different processes of orientation and therefore different perceptions have already been discussed as part of the middle class and the self-interest hypothesis. Beside the idea that universal programmes should lead to a higher popular support than selective ones, it is of interest, why health care systems enjoy different levels of support in different countries. Not only the universality or selectivity of a programme will lead to different levels of public support, but also other institutional characteristics. „[I]t can be argued that major welfare-state institutions are likely to be of relevance for the formation of values, attitudes, and interests among citizens“ (Korpi 2003: 598). Health care systems can first be characterized by their level of generosity. More importantly, however, institutional arrangements in different countries might transfer the monetary input (total health care expenditure) into higher or lower levels of benefits and services. Due to the lack of studies that focus on the effects of different institutional regulations on public attitudes, we are not able to test our hypothesis with findings from previous research. In this paper, we will use instead selected indicators for different aspects of the institutional structure, and in the concluding part, we will discuss preliminary ideas in what respect institutions matter for the development of public attitudes.

## **2 Data and Methods**

The empirical analysis is based on data from the Eurobarometer survey series (“standard Eurobarometer surveys”)<sup>1</sup>. In each Member State, representative samples of the population aged fifteen years and over are asked an identical set of questions.<sup>2</sup> The basic sampling design in all Member States is a multi-stage, random probability one, and selected respondents are interviewed face-to-face in their homes. In this study, we use data from Eurobarometer (EB) 57.2 (conducted from March till May 2002) which includes attitudes towards health care systems. In addition, previous data from Eurobarometer 44.3 (1996) have been included for analysing developments over time.

In the first place, we analyse two items concerning attitudes towards health care systems: preferences for extensive state / public responsibility (for a differentiation between extensity and intensity of state responsibility see Gelissen 2002; Roller 1992; Wendt 2003b) for provid-

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<sup>1</sup> Information about the Eurobarometer survey series is available at [http://www.gesis.org/en/data\\_service/eurobarometer/](http://www.gesis.org/en/data_service/eurobarometer/) or at [http://ec.europa.eu/public\\_opinion/index\\_en.htm](http://ec.europa.eu/public_opinion/index_en.htm).

<sup>2</sup> The regular sample in standard Eurobarometer surveys is 1,000 people per country (except Germany: 2,000 with 1,000 in East and West Germany, Luxembourg: 600, United Kingdom 1,300 including 1,000 in Great Britain and 300 in Northern Ireland). Due to still existing differences in living conditions and attitudes (Roller 2002) we chose to analyze East and West Germany separately.

ing health care, and satisfaction with the existing health care system. It is, in our view, essential to distinguish between these two aspects of public support:

- The extensity of public or state responsibility for health care refers to the *normative expectations* of citizens regarding the *desirable* organisation and provision of health services;
- Satisfaction refers to the citizens' evaluation of an *existing* health care system with regard to its effects.

The first aspect is measured with the item "The government or social insurance should only provide everyone with essential services, such as care for serious diseases, and encourage people to provide for themselves in other respects", with answer categories on a five point scale ranging from 1 "strongly agree" to 5 "strongly disagree". We interpret disagreement with this statement as indicating support for *public* health care services. Satisfaction with the health care systems is operationalized by the item "Please tell me whether you are satisfied, fairly satisfied, neither satisfied nor dissatisfied, not very satisfied or not at all satisfied with the health care system in our country." Thus, the answer categories for this item also range from 1 to 5. We recoded this item so that 1 means "not at all satisfied" and 5 means "very satisfied". For both items, the "Don't know" category was coded as missing.

The explanatory variables at the individual level were all coded as dummies and operationalized as follows:

To operationalize the *class position*, five social classes have been distinguished on the basis of the European Socio-economic Classification (ESeC). ESeC 1 includes "higher and lower salariat", ESeC 2 "higher grade white and blue collar workers", ESeC 3 "petty bourgeoisie or independents", ESeC 4 "lower grade white collar workers" and ESeC 5 "skilled, semi- and non-skilled workers". Pensioners or housewives are coded according to their former occupation. Additionally two classes are coded that include the unemployed and people in education (see Harrison and Rose 2006).

Because of too many missing values on the income variable, a subjective measure is used as substitute indicator for the *household's income position*. Respondents were asked how well they get by with their household income. We recoded a dummy with the value 1 for those who replied "easily" or "very easily" while all other groups received the value 0.

People's *health status* is used as an indicator for dependency on health services. It is measured by two dummies. The first measures the subjective perception of one's state of health during the last 12 months, where 1 indicates a subjectively bad state of health. The second is an indicator for chronic diseases where a score of 1 means that people suffer from a long-standing illness, health problem, or handicap that limits their work or daily activities.

*Age* is controlled for by 6 dummy variables (15-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, and 65+). We chose to include dummies instead of a continuous variable because descriptive analysis has shown that a linear relationship cannot be assumed.

Furthermore, we look at the *evaluation of health care services* at the point of contact between doctor and patient. This was operationalized as agreement/disagreement with the statement "Doctors do not spend enough time with you when you go to them".

In this paper it has not been possible to include indicators of the institutional structure in the multivariate analysis. In a second descriptive part of the analysis, we focus therefore on certain characteristics of health care systems which have a possible influence on public attitudes. Data on the level of *total health expenditure* (per capita and in % of GDP) are included since expenditure increases are often justified as necessary for safeguarding the functioning of health care systems. As an indicator for the level of health care providers we include the number of *general practitioners* (per 1,000 population) who are in general the first point of contact for patients, decide upon a major part of total health care resources, and are responsible for transferring patients to specialist health care and further care givers (OECD 1994). Further, the share of *private co-payments* (in % of total health expenditure) is included to capture the degree of "risk privatization" (Hacker 2004) in health care systems. Finally, the level of *public health expenditure* (per capita and in % of total health expenditure) is taken as an indicator for the interventionist power of the state (Alber 1988) in the field of health care provision.

### **3 Patterns of popular support in the field of health care**

Today, a number of international comparative studies with a focus on public attitudes towards the welfare state are available (e.g. Borre and Scarbrough 1995; e.g. Coughlin 1979; Gelissen 2002; Mau 2001; Svallfors 1997, 2002, 2004). The findings by these authors do not lend support to the hypothesis of declining legitimacy of the welfare state. As already shown by Coughlin (1979) on the basis of data from the early 1970s and corroborated in more recent comparative work (Gelissen 2002; Taylor-Gooby 1999), attitudes and especially social values towards the welfare state turn out to be surprisingly stable. In particular, it has to be empha-

sised that the question whether the state should play a major role with regard to social security received strong public support (Gelissen 2002). The middle class hypothesis receives only weak support in empirical studies on public attitudes. According to Esping-Andersen (1990), the level of class conflicts should be highest in “liberal” welfare states and lowest in “social democratic” welfare states. These conflict constellations should be mirrored by respective patterns of public support in different types of welfare regimes. Svallfors (2004), however, finds evidence for the largest differences of public support for the welfare state between social classes in Sweden (social democratic type) and the smallest differences in the United States (liberal type). Neither the level nor certain patterns of public support of the welfare state can be grouped according to the welfare regime types introduced by Esping-Andersen (Gelissen 2002). This holds also true when taking into account the more reliable replicated decommodification index developed by Scruggs and Allen (2006), an extended version of Esping-Andersen’s typology (Arts and Gelissen 2002) or – with regard to health care – a “decommodification of health care services” index introduced by Bambra (2005).

When concentrating on the field of health care, studies show high levels of public support for health care systems in EU 15 countries (Gelissen 2002; Marmor, Okma and Latham 2006; Mossialos 1997). In 1996 there has been no correlation between the level of satisfaction with the health care system and the relative share of total health expenditure (as a percentage of GDP). Southern European health care systems (Spain, Portugal, Italy, and Greece), however, received a quite low level of satisfaction already in the mid-1990s (Kohl and Wendt 2004). At that time, a majority of citizens in EU 15 countries supported an increase of health care expenditure (especially in Southern Europe) if otherwise the level of health care services would be reduced (Kohl und Wendt 2004). Furthermore, the “health care arena” (Tuohy 2003) is according to Gelissen (2002) characterised by a high level of solidarity. Public support of the health care system is largely independent from social class or income level. „[A] moral commitment to the public good outweighs self-interest as a motive for the overwhelming support for public health care services in the European Community“ (Gelissen 2002: 162).

The comparative studies discussed above, however, are based on data from the mid-1990s. In the following decade, EU 15 countries implemented a number of health policy reforms that often combined increasing private co-payments and a reduction of the benefit package. These changes presumably have a negative effect on the perception of health care systems (Mossialos 1997). Furthermore, studies on public support towards health care systems often do not clearly distinguish between the demand for comprehensive health care for all citizens and the level of satisfaction with the existing health care systems (see above). According to Roller

(1992), the first aspect focuses on the extensity of state responsibility and the second one on the effects of health care systems.

When analysing changes over time, we find a high level of support with regard to state intervention as well as concerning the results/effects of health care system in 1996. Until 2002, however, the support of a strong role of the state has even increased (from 57% to 60% on average for EU 15 countries), while the results are perceived in a much more negative way (the level of satisfaction has actually declined from 56% to 36%). At the beginning of the 21<sup>st</sup> century, more people in EU 15 countries are dissatisfied than satisfied with their health care system (see EB 44.3/1996 and EB 57.2/2002).

Next we will analyse differences between socio-economic groups with regard to the perception of health care systems and control whether patterns of public support differ across (types of) health care systems (section 3.1). Furthermore, in a descriptive analysis we will analyse the effects certain institutional characteristics have for the preferred level of extensity (public responsibility) as well as on overall satisfaction with health care systems (section 3.2).

### **3.1. Results of the Multivariate Analysis**

When analysing the attitudes of different socio-economic groups (see regression results in *table 1*) we find the following patterns: While Gelissen (2002), Svallfors (2004), or Taylor-Gooby, Hastie and Bromley (2003) see no differences between social classes concerning public attitudes towards the welfare state in general, we find at least slight differences between social classes, with regard to the preferred role of the state in health care systems (extensity). Using the European Socio-economic Classification (ESeC) (see Harrison and Rose 2006), “the higher and lower salariat” (ESeC 1) as well as “the petty bourgeoisie or independents” (ESeC 3) show less support for extensive state provision of health care compared to lower social classes (“lower grade white collar workers”/ESeC 4; “skilled, semi- and nonskilled workers”/ESeC 5). This can be interpreted as a lower degree of solidarity of ESeC classes 1 and 3, while ESeC class 2 (“higher grade white and blue collar workers”) are more in favour of a comprehensive role of the state. The greatest differences between social classes, however, can be found in countries with social health insurance (SHI). Especially in Germany the self-employed (ESeC 3), which are not included in the social health insurance scheme, support an extensive role of the state at a much lower rate than the other social classes. In the Austrian social health insurance that covers the total population as well as in the “mature” national health service (NHS) schemes of Denmark, Great Britain and Sweden, on the other hand, hardly any differences between social classes are apparent. How people are integrated in

health care systems – on the basis of citizenship or on the basis of contributions with exit options for part of the population – might therefore produce rather homogenous attitudes in NHS systems and more heterogeneous patterns in SHI schemes.

The analysis of different income groups shows a significantly lower support level of an extensive state involvement and therefore lower solidarity in higher income groups. In countries with early developed NHS systems (Denmark, Great Britain, and Sweden), however, we find – as with regard to social class – very low differences between income groups. In SHI systems (with the exception of Luxembourg and the Netherlands) and also in later developed NHS systems, we find a much lower support of state extensity in high income groups. NHS systems in Southern Europe (and also in Ireland) are characterized by high levels of private co-payments that are especially a burden for people with low income positions (see also section 3.2). This indicates that the higher the “privatization of risk” (Hacker 2004) in the “health care arena” (Tuohy 2003), the lower is the level of solidarity in higher income groups.

Regarding the preference for state responsibility in health care, there is no clear pattern confirming the self-interest hypothesis. Contrary to our expectations, people evaluating their own state of health as bad or suffering from chronic diseases do not support extensive public responsibility more than healthy people, although they can be said to be more “dependent” on health services than others.

We also hypothesized that the elderly would be rather in favour of extensive state provision as they may perceive a higher risk to suffer from serious diseases and potentially contribute less to the system in absolute terms than during their economically active phase. However, effects are far from uniform across all countries. There are virtually no age effects in most countries. And contrary to our expectations, in Denmark, Finland, Great Britain, Italy and Sweden, the oldest group supports public health care even to a lesser extent than other age groups.<sup>3</sup>

Satisfaction with the current health care system is also related to support of extensity (see *table 1*, 3<sup>rd</sup> row from the bottom). The overall direction of the coefficients indicates that people who are not satisfied with the health care system in their country are to a greater extent in favour of extensive public health care than those who are satisfied. This can be interpreted as criticism of retrenchment processes in the health sector. Strikingly, we find highly significant correlations in the health insurance systems of Austria, (West) Germany, and the Netherlands, i.e. in countries where private health insurance is of high importance.

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<sup>3</sup> However, the coefficients are only significant in comparison to some of the younger groups, i.e. in Denmark to groups 3-5, in Finland to group 2, in Great Britain to group 3, in Italy to groups 2 and 3, and in Sweden to group 2-5.

Our analysis of subjective satisfaction with health care systems shows different patterns compared to the preferences for an extensive role of the state (see *table 2*). With regard to social classes, only ESeC 3 (“petty bourgeoisie or independents”) indicates a lower level of satisfaction while there are hardly any differences between other social classes. The lower level of satisfaction of the self-employed might be related to their opposition towards a strong role of the state (see *table 1*). With regard to the single countries, we only observe very low variations across social classes (Ireland is an exception).

With regard to income, the results show quite universal patterns across all countries. Higher income groups are more satisfied with the health care system than the rest of the population. The finding of rather homogenous patterns with respect to social classes on the one hand and a great variance between income groups on the other might be related to high and still increasing private co-payments which are a lower burden for those with superior household income.

People in bad health (but not those with chronic sickness) are less satisfied with the health care system which gives some support to the self-interest hypothesis. Again our results with regard to age groups are not consistent with our expectations. While there are nearly no differences between the highest age group and the two youngest ones, the age groups in-between show a lower level of satisfaction. Groups that are well integrated in the labour market (and often have children) support an extensive role of the state and are at the same time less satisfied with the functioning of the health care system.

Finally a positive evaluation of health care services at the point of contact between doctor and patient has a positive effect on satisfaction. People who disagree with the statement “doctors do not spend enough time with you when you go to them” are more satisfied with the system as a whole. Doctors and especially general practitioners are often the first point of contact with the health care system and, therefore, have a strong influence on how the health care system is perceived on the whole. People who are satisfied with the doctor-patient-relationship are therefore also to a higher degree satisfied with the overall health care system. Strengthening the doctor-patient-relationship might thus be a possibility to increase levels of satisfaction which is crucial for public support and thus important for long-term legitimacy of the systems.

**Table 1: Extensivity of public responsibility for health care**

	Total	AUT	BEL	DNK	D west	D east	ESP	FIN	FRA	GBR	GRC	ITA	IRL	LUX	NLD	POR	SWE
Subj. bad health	0.013	-0.027	0.006	0.039	0.024	0.017	0.029	-0.02	0.014	0.037	0.08	0.001	-0.019	-0.029	-0.002	-0.015	0.018
Chronic disease	0.024*	0.002	0.024	0.102**	0.090*	0.013	-0.032	-0.011	0.035	-0.01	-0.037	0.079*	0.077*	0.039	0.023	-0.012	0.016
Age (Ref. 65+)																	
15-24	-0.007	0.02	-0.027	0.081	0.017	-0.148**	0.004	0.064	-0.044	0.027	0.017	0.072	-0.044	0.032	-0.033	-0.02	0.084
25-34	0.034**	0.032	-0.058	0.077	0.034	-0.088*	0.061	0.087*	0.036	0.067	0.044	0.102*	-0.012	0.025	0.061	-0.016	0.188***
35-44	0.037***	-0.02	-0.018	0.162***	0.021	-0.066	0.051	0.069	-0.012	0.092*	0.065	0.143***	-0.016	0.115	0.071	-0.024	0.137***
45-54	0.029**	0.04	-0.033	0.092*	0.03	0.032	0.024	0.04	0.009	0.079	0.014	0.046	-0.031	0.081	0.071	0.042	0.083*
55-64	0.014	-0.011	-0.04	0.172**	-0.004	0.025	0.012	0.07	-0.069	0.059	0.011	0.043	-0.019	0.002	-0.013	-0.016	0.092*
Class position/ESEC (Ref. ESeC 4 and 5)																	
ESeC 1	-0.027**	-0.012	-0.062	0.037	-0.098**	-0.041	0.016	-0.036	-0.045	0	0.009	0.009	-0.089*	-0.025	-0.067	0.04	-0.032
ESeC 2	0.009	-0.01	0.014	0.015	0.025	-0.015	0.042	-0.066	0.052	-0.004	0.001	-0.001	-0.039	-0.062	0.054	0.084*	0.016
ESeC 3	-0.024**	-0.002	-0.103**	-0.029	-0.126***	0.007	-0.016	-0.001	-0.084*	-0.045	0.037	-0.024	-0.044	-0.073	0.007	0.079*	-0.011
Unemployed (6)	-0.008	0.024	0.006	-0.006	-0.038	0.045	-0.027	-0.023	-0.056	-0.057	0.025	-0.02	-0.044	-0.077	0.036	0.003	-0.005
In education (7)	-0.005	-0.016	0.007	0.062	-0.019	0.026	-0.002	-0.042	0.052	-0.031	-0.008	-0.023	-0.116**	-0.005	-0.001	0.041	-0.028
Subj. high income	-0.052***	-0.092**	-0.163***	0.011	-0.056	-0.015	-0.122***	0.006	-0.074*	-0.04	-0.071*	-0.043	-0.116**	0.007	-0.018	-0.085*	-0.023
Doctors spend enough time	0.066***	0.116***	0.120***	0.062	0.05	0.091**	0.093**	-0.025	0.013	0.06	0.087**	0.141***	0.070*	-0.06	0.085**	-0.029	0.042
Satisfaction with health system	-0.073***	-0.146***	-0.018	-0.008	-0.141***	-0.058	-0.025	-0.079*	-0.025	-0.071*	-0.086**	-0.099**	-0.04	-0.099*	-0.136***	-0.059	-0.039
N	14506	941	901	967	922	929	909	964	930	971	974	905	859	507	931	936	960
adj. R <sup>2</sup>	0.016	0.032	0.044	0.033	0.044	0.033	0.016	0.003	0.021	0.011	0.016	0.033	0.036	0.01	0.033	0.01	0.017

Standardized beta coefficients

\* p &lt; 0.05, \*\* p &lt; 0.01, \*\*\* p &lt; 0.001

Abbreviations: AUT: Austria; BEL: Belgium; DNK: Denmark; D west: West Germany; D east: East Germany; ESP: Spain; FIN: Finland; FRA: France; GBR: Great Britain; GRC: Greece; ITA: Italy; IRL: Ireland; LUX: Luxembourg; NLD: Netherlands; POR: Portugal; SWE: Sweden

**Tabelle 2: Satisfaction with existing health care systems**

	Total	AUT	BEL	DNK	D west	D east	ESP	FIN	FRA	GBR	GRC	IRL	ITA	LUX	NLD	POR	SWE
Subj. bad health	-0.068***	-0.087**	-0.112**	-0.044	0.011	-0.06	-0.102**	-0.107**	-0.058	0.012	-0.063	-0.014	-0.058	-0.215***	0.049	-0.052	0.013
Chronic disease	0.007	-0.090*	-0.096*	-0.012	-0.062	-0.026	-0.002	-0.07	-0.044	-0.082*	0.013	-0.023	-0.034	-0.018	-0.068	-0.008	0.045
Age (Ref. 65+)																	
15-24	0.008	0.062	0.038	-0.123**	0.023	0.182***	-0.029	0.089	0.092*	-0.186***	-0.025	0.127*	-0.023	0.049	0.031	-0.004	0.061
25-34	-0.007	-0.019	0.025	-0.158***	0.043	0.058	-0.006	-0.028	-0.061	-0.179***	-0.068	0.007	0.009	0.065	-0.011	-0.026	0.027
35-44	-0.039***	-0.016	-0.058	-0.133***	0.043	0.05	-0.075	-0.025	-0.059	-0.266***	-0.116**	-0.028	-0.069	0.046	-0.025	-0.069	0.006
45-54	-0.048***	0.052	-0.079	-0.082*	-0.025	0.012	-0.014	-0.033	0.005	-0.198***	-0.127**	-0.048	-0.100*	-0.036	-0.041	-0.059	-0.087*
55-64	-0.047***	0.016	-0.001	-0.02	-0.055	-0.029	-0.026	-0.016	-0.027	-0.161***	-0.067	-0.04	-0.052	-0.05	-0.107*	-0.082	-0.075*
Class position/ESEC (Ref. ESeC 4 and 5)																	
ESeC 1	0.011	-0.022	-0.002	-0.005	-0.069	0.016	0.027	0.032	0.017	0.014	-0.039	0.089*	0.017	0.02	0.071	-0.089*	0.069
ESeC 2	-0.012	0.016	-0.003	-0.088*	-0.044	0.016	-0.001	0.018	-0.023	-0.006	-0.022	0.102**	-0.04	0.041	0.064	-0.06	0
ESeC 3	-0.037***	0.04	-0.065	0.055	-0.002	0.036	-0.043	-0.04	-0.044	-0.064*	0.069	0.119**	0.003	-0.066	0.023	-0.012	0.009
Unemployed (6)	-0.020*	0.028	-0.048	0.027	-0.032	-0.012	-0.037	0.024	-0.002	0.012	0.055	0.152***	-0.059	0.062	0.056	-0.003	0.008
In education (7)	0.001	-0.071	0.007	0.026	0.073	0.074	-0.018	0.01	-0.014	0.017	-0.005	0.006	0.072	0.013	0.056	0.042	-0.001
Subj. high income	0.148***	0.143***	0.156***	-0.013	0.110***	0.069*	0.170***	0.003	0.056	0.075*	0.159***	0.113**	0.143***	-0.01	0.048	0.031	0.105**
Doctors spend enough time	0.111***	0.168***	0.098**	0.048	0.089**	0.067*	0.093**	0.160***	0.04	0.102**	0.061	0.036	0.133***	0.101*	0.085*	0.048	0.223***
Pro extensity	-0.081***	-0.106***	-0.004	-0.026	-0.160***	-0.067*	-0.049	-0.081**	-0.011	-0.054	-0.139***	-0.066	-0.164***	-0.142**	-0.116***	-0.135***	-0.049
N	14506	941	901	967	922	929	909	964	930	971	974	859	905	507	931	936	960
adj. R <sup>2</sup>	0.059	0.078	0.091	0.031	0.06	0.067	0.046	0.067	0.019	0.071	0.062	0.048	0.082	0.078	0.034	0.036	0.069

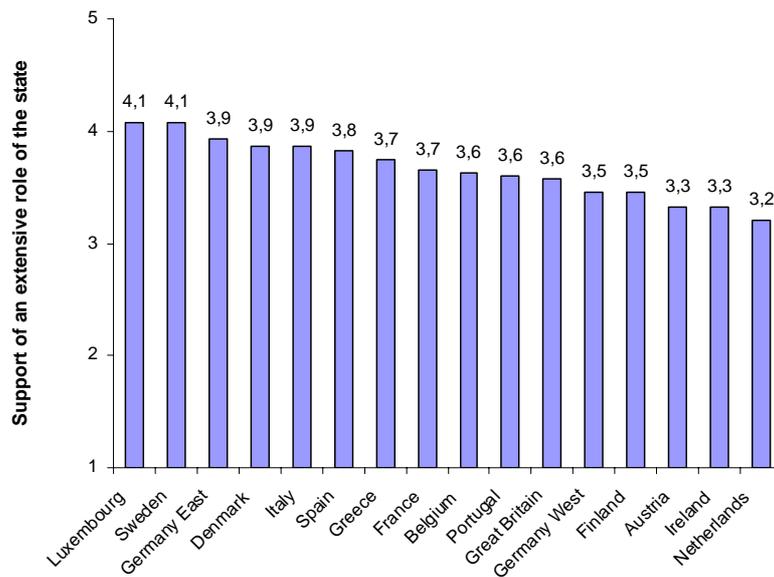
Standardized beta coefficients

\* p < 0.05, \*\* p < 0.01, \*\*\* p < 0.001

### 3.2 Differences between health care systems

Differences between countries cannot be explained solely by patterns at the individual level. The regression results presented in *tables 1* and *2*, however, point at first differences between (groups of) countries that might be related to institutional characteristics. This second part our analysis therefore concentrates on certain characteristics of health care systems that help to explain differences across countries.

**Figure 2: Support of an extensive role of the state in health care systems, 2002**



Source: Eurobarometer 57.2/2002

*Figure 2* shows that in Luxembourg, Sweden, Denmark, Italy, and Spain people are highly in favour of a strong role of the state with regard to the provision of comprehensive health care, while The Netherlands, Ireland, Austria, and West Germany are ranked at the lower end of the country scale. With the exception of Luxembourg (and East Germany) support of a strong role of the state is therefore highest in NHS systems and, with the exception of Ireland, lowest in SHI systems.

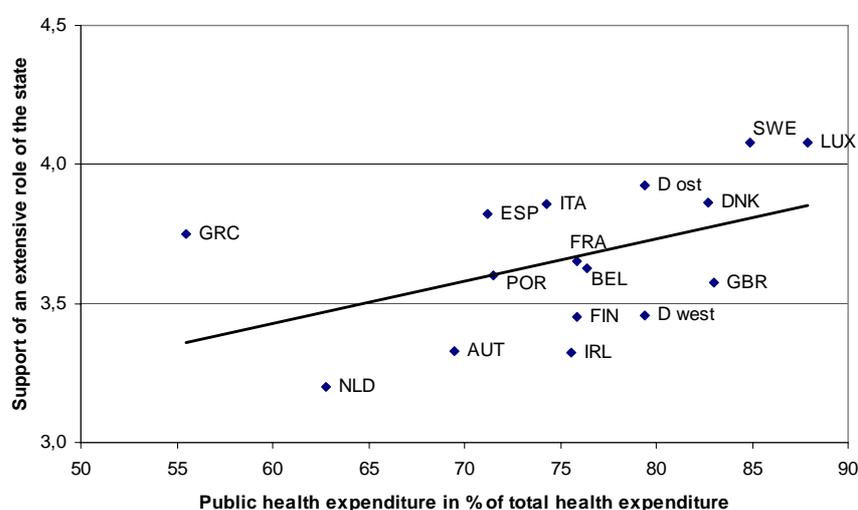
Additionally to the „type of health care system“ we take the level of total health expenditure, the number of general practitioners, the level of private co-payments, and the share of public financing into account as possible explanations for cross-country differences. We find no correlation between the level of total health expenditure (in US\$ per head in % of GDP) and the support of high state responsibility. There is also no effect of the number of general practitioners or the level of private co-payments (see *table 3*).

**Table 3: Correlations Extensity, 2002**

	Pearson's R	N
Total health expenditure in US\$ per head (PPP)	0.1683	16
Total health expenditure in % of GDP	-0.0151	16
General practitioners per 1,000 population	-0.0409	16
Private co-payments in % of total health expenditure	0.1467	13
Public health expenditure in US\$ per head (PPP)	0.3616	16
Public health expenditure in % of total health expenditure	0.4678*	16

\*\* p < 0.05, \* p < 0.1

Source: OECD Health Data 2006; Eurobarometer 57.2/2002; own calculation

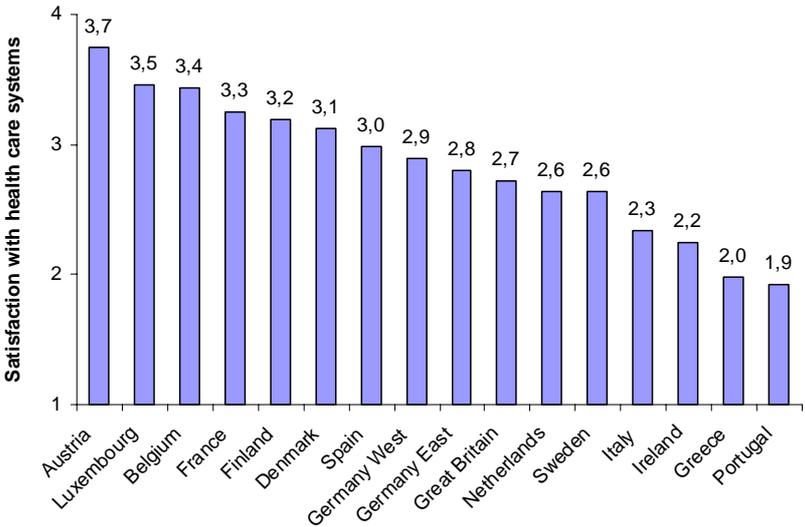
**Figure 3: Level of public health expenditure and extensity, 2002**

Source: OECD Health Data 2006; Eurobarometer 57.2/2002; own calculation

The only indicator of those included in the analysis with an effect on the perception of state extensity is the level of public financing as a percentage of total health expenditure (*figure 3*). The comparatively low engagement of the state in the financing of health care services finds some support in The Netherlands and Austria but not in Greece. At the other end of the spectrum, the high state involvement in Sweden, Denmark, and East Germany is consistent with the expectations of the population, while in Great Britain and West Germany there seems to be some potential for reducing the high share of public funding. With regard to institutional differences we find in general a lower level of support in social health insurance systems, even if they are overwhelmingly financed out of public sources. In countries with national health service support of state involvement is in general higher, even if private funding is at a relatively high level as, for instance in later developed NHS systems in Southern Europe (especially in Greece, but also in Spain and Italy).

With regard to the level of satisfaction the variance across countries is much higher than concerning support of state extensity. We find the highest satisfaction scores in SHI systems (Austria, Luxembourg, Belgium, and France) and late developed NHS systems (Greece, Portugal) at the other end of the scale (figure 4).

**Figure 4: Satisfaction with health care systems, 2002**



Source: Eurobarometer 57.2/2002

**Table 4: Correlations Satisfaction, 2002**

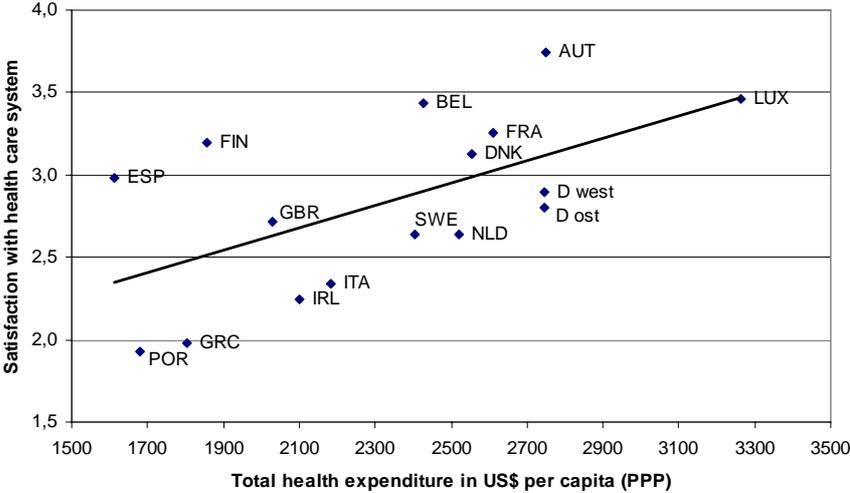
	Pearson's R	N
Total health expenditure in US\$ per head (PPP)	0.5915**	16
Total health expenditure in % of GDP	-0.1627	16
General practitioners per 1,000 population	0.6984*	16
Private co-payments in % of total health expenditure	-0.5302*	13
Public health expenditure in US\$ per head (PPP)	0.5812**	16
Public health expenditure in % of total health expenditure	0.3898	16

\*\* p < 0.05, \* p < 0.1

Source: OECD Health Data 2006; Eurobarometer 57.2/2002; own calculation

The level of total health expenditure per capita strongly influences the level of satisfaction (figure 4). However, since very similar levels of total health expenditure (per capita) produces different patterns of satisfaction, further institutional characteristics have to be taken into account. At similar levels of health expenditure satisfaction is, for instance, much higher in Spain than in Portugal or Greece, and in Austria higher than in Germany (figure 5).

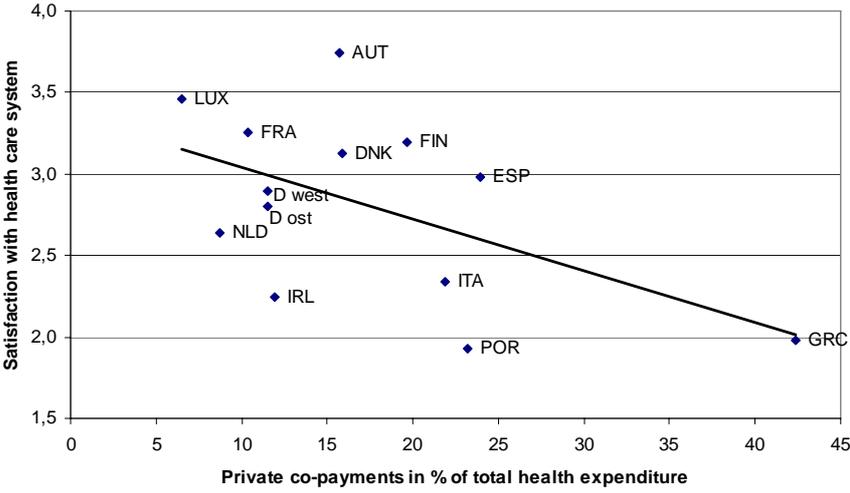
**Figure 5: Total health expenditure (in US\$ per capita) and satisfaction, 2002**



Source: OECD Health Data 2006; Eurobarometer 57.2/2002; own calculation

The amount of private co-payments has a negative effect on the level of satisfaction (figure 6). The growing share of private co-payments (as a percentage of total health expenditure) in EU 15 countries has increasingly transferred the risk of sickness towards the individual patient. This is presumably one of the reasons for a decline of satisfaction in EU 15 countries since the mid-1990s.

**Figure 6: Private co-payments in % of total health expenditure and satisfaction, 2002**



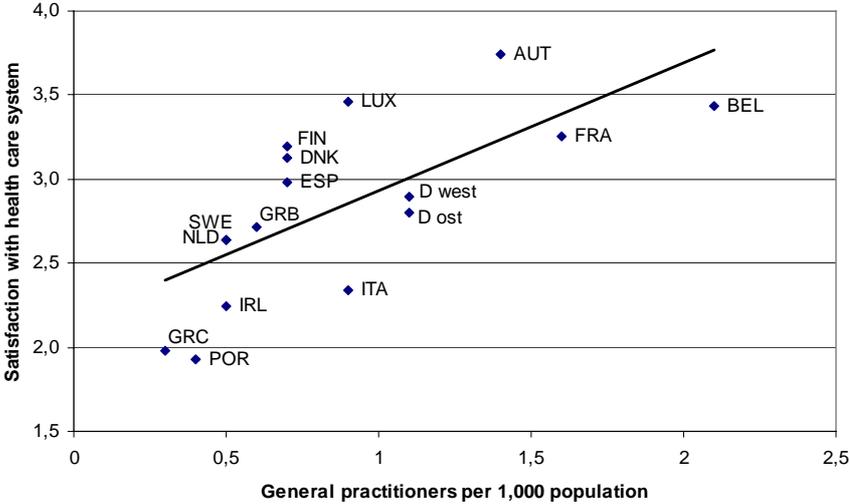
Source: OECD Health Data 2006; Eurobarometer 57.2/2002; own calculation

Especially health care systems in Southern Europe are to a great extent funded by private co-payments and patients, therefore, face much higher direct costs than in most other NHS systems. Also, the NHS systems of these countries have until now not obtained the characteris-

tics of a universal system, and especially in Greece and Portugal part of the former social insurance scheme continued to operate in parallel to the NHS (Davaki and Mossialos 2005; Oliveira and Pinto 2005).

The strongest effect on the level of satisfaction, however, has the number of general practitioners. The higher the number of general practitioner per 1,000 inhabitants the more satisfied are people with their overall health care system (figure 7). The number of general practitioner is seen as an important indicator for the level of health care services in a country (OECD 1994) since they are in general the first point of contact for patients in a health care system and transfer patients, if necessary, to specialists and other care givers. The importance of the relationship between doctors and patients for the perception of health care systems has also been emphasised by the fact that health systems are evaluated in a more positive way under the condition that doctors spend enough time with their patients (see table 2). This requirement is easier to fulfil under the condition that a sufficient number of general practitioners is available.

**Figure 7: General practitioners per 1,000 population and satisfaction, 2002**



Notes: Number of general practitioners in Spain is for 2004; Values for Sweden and The Netherlands are identical.

Source: OECD Health Data 2006; Eurobarometer 57.2/2002; own calculation

The high variance with regard to the density of general practitioners can be related to important institutional differences between the countries. Restrictions for establishing their own practice are for general practitioners (and specialists) usually lower in SHI systems than in NHS systems. This leads in general to a higher density of doctors in countries with social health insurance and these countries have also a higher capacity to react to the – across regions often different – demand of general practitioners. Especially Greece and Portugal might

improve the level of satisfaction with the overall health care system by increasing the number of general practitioners. Spain, on the other hand, has already reached the level of earlier developed NHS systems. The fact that countries with lower concentrations of general practitioners like Finland or Denmark receive higher satisfaction scores than Germany show that further factors have an influence on the relation between health care personnel and satisfaction.

#### **4 Summary and discussion**

The paper has sought to examine public attitudes towards health care systems by looking at different societal groups as well as at different health care systems in EU 15 countries. Taking up a concept introduced by Roller (1992) the focus was on the level of preferred state extensivity in the “health care arena” as well as on the evaluation of the results of health care systems by the citizens.

Our results only partly support the hypothesis of an incipient legitimacy crisis in the field of health care. Especially the level of satisfaction has declined in EU 15 countries during the 1990s indicating that (the results of) health care systems increasingly fail to meet the demands of the population. On the other hand in all EU 15 societies people are still overwhelmingly of the opinion that it is/should be the responsibility of the state to guarantee comprehensive health care for all citizens. Growing dissatisfaction, therefore, has not the effect that people increasingly prefer private forms of security for the case of sickness. This can be interpreted as still existing trust in the state to provide better protection than private alternatives. The preference of security, however, seems to be higher with regard to health care than in other fields of social policy. For Germany, for instance, it has been shown that the willingness of the population to invest in private pension schemes is increasing (Bulmahn 2003).

Our analysis of social classes has shown a comparatively low level of solidarity of ESeC 1 (“higher and lower salariat” and ESeC 3 (“petit bourgeoisie or independents”). In contrast to the findings of Gelissen (2002) and the basis of data from the mid-1990s we therefore see certain differences between social classes. This pattern, however, can especially be found in social health insurance schemes while national health service systems in Great Britain and the Scandinavian countries show very low differences between social classes. The more inclusive NHS systems (but not the later developed NHS systems of Southern Europe) therefore seem to produce a more homogenous perception of the population compared to SHI systems.

When focussing on groups of the population that depend to a larger degree on health care benefits we find no general trend of a higher support of state dependency or lower levels of satisfaction. In contrast to our expectation that older people due to their more frequent use of

health care services demand greater state extensity we see a tendency that especially those age groups which are predominantly on the labour market favour to a higher extent comprehensive public health care than older (and younger) people (at country level we find this pattern only in early developed NHS systems). There is also no correlation between the favour of extensity and poor health. These results indicate that the perception of health care systems is highly influenced by demand for *security* against major life risks and less by the actual state of health.

The comparative analysis of certain characteristics of health care systems shows a strong relation between the density of general practitioners and the level of satisfaction. This finding is consistent with the regression results indicating that the more people are satisfied with the time doctors spend with them the more they are satisfied with the system as a whole. The number of general practitioners is to be seen as an important indicator for the level of health care services since they are in general the first point of contacts for patients and often decide on medical treatments provided by further health care providers. Structural reforms in the field of health care therefore have to ensure that the doctor-patient relationship is not negatively affected (Calnan and Sanford 2004; Stevenson 2006).

According to Gelissen (2002) and Svallfors (2004) there is only little correspondence between the typology of welfare states introduced by (Esping-Andersen 1990) and attitudes towards the welfare state. This holds also true regarding replications (Scruggs and Allen 2006) or extensions (Arts and Gelissen 2002) of this typology. In contrast to findings by Gelissen (2002) or Kohl and Wendt (2004) on the basis of 1996 data, Eurobarometer data from 2002 show also no correspondence between types of welfare states and the perception of health care systems (see *figures 2 and 4*). Also the comparison of national health service (NHS) type countries and social health insurance (SHI) type countries shows no clear patterns. A more detailed differentiation between health care systems, however, give evidence for the highest level of satisfaction in SHI systems, followed by early developed NHS systems while the late developed NHS systems of Southern Europe can be found at the lower end of the country scale.

Our results in general seem to confirm the hypothesis derived from institutional theory that individuals orientate at specific institutional arrangements and that their attitudes (and also their behaviour) are guided by these processes of orientation (Hall and Taylor 1996; Lepsius 1990). This is also supported by the finding that the evaluation of the health care system by social classes seems to be more homogenous in early developed NHS systems compared to SHI systems.

However, institutional characteristics of health care systems have been included in our comparative analysis only in a very limited way. Obviously further information with regard to institutional arrangements is needed for distinguishing between certain types of health care systems and for analysing attitudes towards these – more distinct – types. The importance of the density of general practitioners for the level of satisfaction indicates that especially further information with regard to patients' access to health care services is of importance. This is, for instance, related to the questions whether patients have a free choice of doctors or whether they have to sign on the list of a general practitioner for a longer period of time, if only general practitioners or specialists as well have the right to establish their own practice, or how self-employed doctors are remunerated in different countries. These and further information will presumably help us to provide a more clear-cut picture of the effects of institutional regulations in the "health care arena" on patterns of trust and satisfaction.

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