

# Do Welfare State Institutions Provide Orientation?

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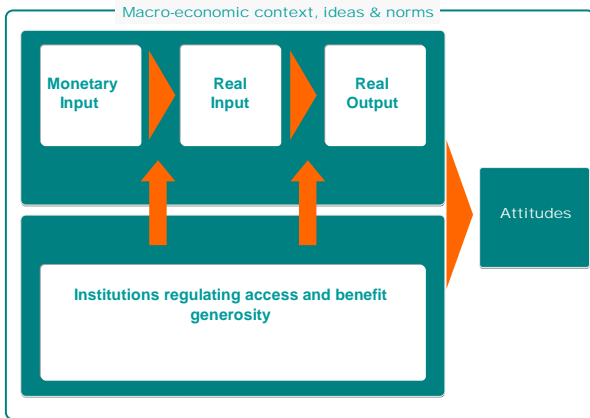
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## Introduction

The project investigates attitudes towards European welfare states in comparative perspective. Based on assumptions derived from institutional theory (Lepsius 1990; Powell and DiMaggio 1991; Rothstein 1998), it is argued that public support is framed by the institutional design of the welfare state. More specifically, we hypothesize that citizens are aware of their own socio-economic position when forming their attitudes, but that they also are aware of what this position means in the institutional structures of the welfare state. We argue that it is the design of specific social policy programmes that matters here. In order to substantiate this point, we combine institutional analysis with the study of attitudes towards three policy areas, namely healthcare, family policy and minimum income protection.

## Framework of Analysis



## Institutional Indicators

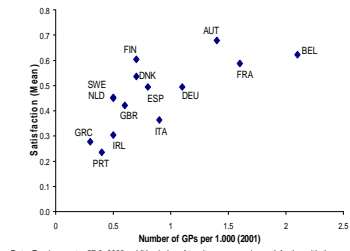
Field	Healthcare	Family Policy	Minimum Income Schemes
Dimensions			
Monetary Input	Policy Specific Expenditure		
Access	Eligibility criteria Gatekeeping	Eligibility criteria	Eligibility criteria
Generosity	Private Co-payments	Replacement rate Duration	Replacement rate
Real Input	Facilities Personnel	Facilities Personnel	
Outcome	Utilization of healthcare	Female employment rate	Poverty rates
Norms & Ideas	Equal access	Gender equality	Deservingness perceptions

## Healthcare

Satisfaction with the healthcare system varies strongly across countries. We find the highest satisfaction scores in SHI systems (Austria, Belgium). Late developed NHS systems (Greece, Portugal) are at the other end of the scale with very low levels of satisfaction.

Satisfaction levels are associated with the number of general practitioners (GPs). The higher the number of GPs, the more satisfied people are with their overall healthcare system. The number of GPs indicates the level of healthcare services provided in a country, because they are often the first point of contact for patients and transfer patients to specialists and other caregivers.

The variance of GP density is high in the observed countries and can be related to important institutional differences. For GPs (and specialists) restrictions for establishing their own practice are usually lower in SHI than in NHS systems. This leads in general to a higher density of doctors in SHI type countries and these have also a higher capacity to react to the varying demand of GPs across regions.

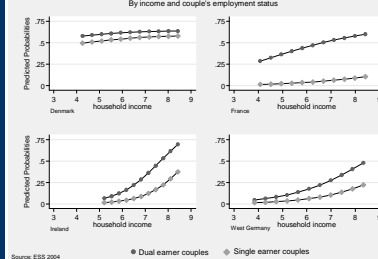


Data: Eurobarometer 57.2, 2002, additive index of two items measuring satisfaction with the national healthcare system and perceived need for reform; standardized between 0 = low satisfaction and 1 = high satisfaction; OECD Health Data 2007

The fact that countries with a lower concentration of GPs like Finland or Denmark receive at average higher satisfaction scores than e.g. Germany shows that further factors matter for the relation between personnel and satisfaction.

## Family Policy

Predicted probabilities of using childcare services for selected countries



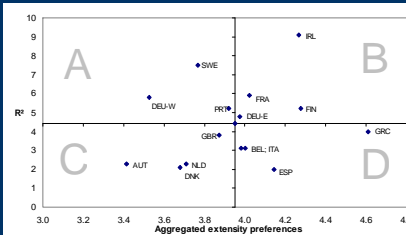
Source: ESS 2004

Based on data from the European Social Survey (ESS) module "family, work and well-being" (2004), we analyze how families cope with the challenge to combine work and care in Europe. In the presented graphs we exemplarily investigate families' use of different types of childcare in Denmark, France, Ireland, and Germany. What is shown are the predicted probabilities of using care services derived from multinomial logistic regression.

In general, the use of care services is highest in Denmark and other Scandinavian countries and much lower in Continental as well as Southern Europe. Patterns vary not only across countries but also within countries across families with different employment participation (dual versus single earner couples) and income levels.

Dual earner couples as well as families with a higher income use care services more often. Polarization is, however, much more pronounced in some countries like Germany (West) and Ireland where state support for the dual earner family model is low. In Denmark support is high and the use of care services much more homogeneous across social groups. In France, overall usage of care services ranges in-between Denmark and the two other countries and a higher family income raises the probabilities only for dual earner couples.

## Minimum Income Protection



Data: Eurobarometer 56.1, 2001, additive index of agreement to government responsibility for MIP  
X-axis: aggregated national mean preference  
Y-axis: degree of societal polarization measured with variance explained (R<sup>2</sup>) by an OLS regression with socio-economic characteristics (gender, age, education, income, social class) as determinants  
Intersection of axes: average on both measures

Countries in quadrant A show low aggregate preference levels, but an above-average degree of polarization. The tension between an expensive welfare state and economic performance might highlight who pays and who receives benefits, thus increasing social polarization. Countries in quadrant B exhibit strong preferences for state responsibility with similarly high levels of polarization, especially Ireland and Finland. Both countries have undergone major economic changes quite recently, which make up divides between socio-economic groups.

First results on minimum income protection (MIP) regard the question whether the government should at all be responsible for providing elements of MIP (extensity dimension). This includes a guaranteed basic income, decent housing and a decent standard of living for the unemployed.

In countries with well-functioning labor markets, both aggregate preference levels and societal polarization are low (quadrant C). In Southern Europe (quadrant D) the demand for state extensity is higher, whereas there are few differences between socio-economic groups, i.e. the population might perceive the labor market as flawed and demand the state to step in.

## References

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