European Foundation for the Improvement of Living and Working Conditions

QUALITY OF LIFE IN EUROPE

Health and care in an enlarged Europe

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Foreword

The Lisbon Summit highlighted social policy as a core element in Europe's strategy for becoming 'the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with better jobs and greater social cohesion' by 2010. This objective defines a series of social policy challenges for the EU. A separate joint report of the Directorate General for Employment and Social Affairs and the European Foundation for the Improvement of Living and Working Conditions addresses several of these key issues, such as social exclusion and poverty, the relationship between quality of life and quality of work, fertility, migration and mobility, satisfaction with quality of life, care and intergenerational solidarity.

This particular report, which provided some of the material for the above study, focuses on the issue of personal health and access to health care.

Examining quality of life in 28 European countries, including the acceding and candidate countries as well as the current Member States of the EU, this report provides, for the first time, an analysis of views and experiences of the citizens of the new Europe on selected aspects of health, such as individual health and lifestyle, access to health care, the health care system, and responsibility for care in families. The analysis is based on data from the European Commission's Eurobarometer survey carried out in the acceding and candidate countries in Spring 2002 and standard EU 15 Eurobarometers.

This report represents one in a series of reports on quality of life in an enlarging Europe that will be published by the Foundation on the basis of its own survey's findings in the next few years.

Willy Buschak
Acting Director

Country codes in figures and tables

EU Member States (protocol order)	
Belgium	BE
Denmark	DK
Germany	DE
Greece	EL
Spain	ES
France	FR
Ireland	IE
Italy	IT
Luxembourg	LU
Netherlands	NL
Austria	AT
Portugal	PT
Finland	FI
Sweden	SE
United Kingdom	UK
Acceding countries (protocol order)	
Cyprus	CY
Czech Republic	CZ
Estonia	EE
Hungary	HU
Latvia	LV
Lithuania	LT
Malta	MT
Poland	PL
Slovakia	SK
Slovenia	SI
Candidate countries (protocol order)	
Bulgaria	BG
Romania	RO
Turkey	TR
EU 15	15 Member States of the European Union (pre-May 2004)
EU 25	25 Member States of the European Union (post-May 2004)
AC 10	10 countries to accede to the European Union in May 2004
ACC 13	10 acceding countries, plus the three candidate countries

Note: Unless otherwise stated, the aggregate figures for EU 15, EU 25, AC 10 and ACC 13 reported here are weighted to adjust for country population size.

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Additional data on this subject are available from the Foundation at ter@eurofound.eu.int

Introduction

Policy background

Living in good health is an important element of human well-being. A high standard of national health may also be considered a crucial element of a country's human capital and an asset to its international competitiveness. Providing sustainable health services with high quality therefore ranks among the European Union's four strategic policy goals in the area of social protection (together with the promotion of social inclusion, the provision of sustainable pensions and an employment policy which makes work pay). This was officially communicated first in 1999, in *The Concerted Strategy for Modernising Social Protection*, and formally confirmed by the Lisbon European Council of March 2000. In terms of expenditure, health outlays claim sizeable parts of public budgets, coming second only to pensions for retirement and survivors. Hence there can be no doubt that the sector of health and social services belongs to the most important realms of modern knowledge-based service societies.

For Europeans, access to health care is an essential element of human dignity and a basic human right, formally guaranteed in the European Union's Charter of Fundamental Rights in which Article 33 states that 'everyone has the right of access to preventive health care and the right to benefit from medical treatment'. The European Commission's communication on the future of health care and care for the elderly (COM (2001) 723 final) states that general accessibility, good quality and financial viability of the health care services are the major long-term policy objectives (European Commission, 2001a).

A crucial question then is to what extent the enlargement of the EU will facilitate or impede the realisation of these goals. Using the evidence from various Eurobarometer surveys and from the acceding and candidate countries' *Eurobarometer 2002.1*, we will explore how Europeans perceive their health, to what extent they display healthy and unhealthy lifestyles, how easily they can access their national health care system and how satisfied they are with its performance, and finally what public – private mix they envisage for the sector of care.

When Europe was still divided by the Iron Curtain, an east–west gap in deaths from avoidable causes began to open in the 1970s, when new drugs and techniques were made available in the West but not in the Communist part of Europe. Effective environmental policies were also only developed in Western democracies. In countries of Central and Eastern Europe (CEE), health conditions deteriorated immediately after the transition, but improved again in the second half of the 1990s, leading to modest progress also in a long-term perspective. Thus life expectancy at birth increased after 1995, while infant mortality declined (GVG, 2003; UNICEF, 2001). The recent improvement is not only related to better standards of living with changing patterns of nutrition, but also to better access to innovative forms of medical care (Davis, 2001; Velkova *et al*, 1997).

In the early years, the transition amounted to a rather mixed blessing for the health sector of CEE countries. On the one hand, the opening of markets and growing standards of living widened access to better forms of medical treatment, as well as to healthier diets including fruits and vegetables. On the other hand, free markets, open borders and the collapse of old command and control structures also implied wider access to new health hazards, such as aggressively advertised tobacco, junk food, new types of alcoholic beverages, motor vehicle accidents and sexually transmitted diseases. As these factors combined with adjustment problems caused by massive unemployment and by the collapse of the old order, including much of the traditional structures of

health care provision, morbidity and mortality increased especially among middle-aged men in many CEE countries in the immediate aftermath of the transition (Standing, 1996; UNICEF, 2001).

Wider access to a market of health-threatening products (such as cigarettes, alcoholic beverages or junk food) may well require counter-balancing efforts in health education as well as preventive programmes, which would help to promote healthy lifestyles especially among the younger generation. In western Europe, access to a wider variety of products, including those implying health hazards, had grown comparatively gradually, accompanied by the expansion of higher education which made for more critical consumers as well as for a growing post-materialist interest in healthy lifestyles. In CEE countries, in contrast, access to such products widened abruptly in a much less modernised context, where people also had to cope with stress and adaptation problems caused by the collapse of the accustomed order in the economic, political and health spheres.

Universal access to health care had always ranked among priority policy goals in CEE countries. Even though services were frequently rationed under the Communist system, comprehensive coverage had high prominence as a policy objective. This was also true outside the Communist bloc, where Cyprus and Malta had followed the British tradition of a national health service, while Turkey continues to have a mixed system with the establishment of a national health insurance scheme ranking among the policy objectives of several five-year plans (www.who.dk/document/E 79838.pdf). Hence, all acceding and candidate countries come close to fulfilling the first of the three central objectives of the European Commission for the health care sector, i.e. general access.[1]

Realising the additional goals of a high-quality service and financial viability may prove to be a more difficult task. Under the Communist system, universal access had been granted under national health care schemes that were financed from general taxation, integrated into the state budget, controlled by the government and dominated by institutional care in hospitals. While the objective of general access was maintained after the transition, significant shifts occurred with respect to the financing and administration of health care. In an attempt to relieve pressures on their state budgets, all former Communist countries changed to contribution-financed schemes of social insurance, following the Bismarck model, at least in theory. While seven countries had done so already in the first half of the 1990s, Bulgaria, Poland and Romania implemented this shift somewhat later, in 1999 (GVG, 2003, p. 99). All but two countries now have autonomous health insurance funds under varying degrees of state control. All of them also began to build up systems of primary care by physicians outside of hospitals, who are now frequently in private practice. This implied new needs of coordinating institutional care in hospitals and primary care in the community.

Despite the shift to contributory schemes in principle, various exemptions have kept coverage virtually universal and unrelated to contribution status. As high unemployment and a large informal economy kept the revenue base for employment-related contributions small, large deficits resulted, so that the governments had to step in with subsidies. The systems are now financed by various mixes of social contributions and general taxation. User charges are also frequently applied to mobilise revenue and informal payments made by the clients for providers are common practice

[1] Future research will have to aim at an integration of data from survey research with institutional data on the design of health care systems. For very useful information on institutional design and health care policies in ACC 13 countries, see Österreichisches Bundesinstitut für Gesundheitswesen (1999) and Gesellschaft für Versicherungswissenschaft und -gestaltung (GVG, 2003).

in most countries, albeit varying from a comparatively low share in the Czech Republic to sizeable shares in Bulgaria, Hungary, Poland, Romania and Slovakia (Davis, 2001; GVG, 2003, pp. 105-9). The CEE countries spend much lower shares of their gross domestic products on health care than EU countries. In the former Communist countries, expenditure shares rank from roughly 3% in Romania to 8.6% in Slovenia, whereas in the three Mediterranean countries they range between 5% in Turkey to 8.8% in Malta (GVG, 2003, p. 122).

In spite of the comparatively low levels of spending, the former Communist countries have severe difficulties in generating sufficient revenue. This is partly related to the fact that the employment-related contributions which they copied from continental European welfare states entail the same problems as in their model countries: since the revenue base remains small in a context of mass unemployment, contribution rates have to be high. This leads to a high cost of labour, which, in turn, impedes employment and provides incentives to escape to the 'shadow economy' where contributions and registered employment can be dodged. Hence there is a considerable risk of setting in motion vicious cycles of high contributions and low employment, as experienced by some of the continental European welfare states within the EU for some years (Esping-Andersen, 1996; Scharpf, 2000).

In summary, the populations of CEE countries experienced profound changes in health care after the transition. They had to cope with wide-ranging reforms of the established health care systems; they gained access to new medical technology and new pharmaceuticals; they found it easier to get better diets including fruits and vegetables; and they saw pollution problems in their environments finally tackled. But they were also confronted with new health hazards and had to adapt to new structures of service provision. The question then is how these experiences translated into their perceptions of their own health situation and of their systems of health and social services, and how this compares to the situation in the current 15 EU Member States (EU 15).

The focus of the following comparative analyses will be on descriptive and analytical issues. First, we want to show descriptively how much difference or overlap there is between EU Member States, acceding and candidate countries. Hence we will explore to what extent there are differences and similarities between these groups and to what extent the enlargement of the EU can be expected to entail growing heterogeneity in various aspects of health and social care. Comparisons will largely follow the sequence of accession, but since the citizens of Cyprus, Malta and Turkey did not share the experience of living under totalitarian control in a command economy, we will also point out to what extent these countries differ from those which had formed part of the Communist bloc for several decades and which now form the group that receives support under the Phare Programme financed by the European Communities.

Terms used in the report

Since the group that used to be referred to as 'candidate countries' at the time of the survey has, in the meantime, been divided into a group of 10 'acceding countries' (which will join the EU in May 2004) and three remaining future candidates (Bulgaria, Romania and Turkey), there is a risk of terminological confusion. The EU countries are sometimes compared to groups of countries whose construction does not follow the logic of enlargement but a different logic of constructing 'families of nations', which serve as reference groups in comparisons with the current EU 15.

In the interests of clarity, we will apply the following terminology conventions:

- We will refer to the 13 acceding and candidate countries which formed the subject of the survey by using lowercase letters (mostly but not always supplemented by the clarifying prefix 13). As a synonym, we shall also use the term ACC 13.
- We will refer to the 10 acceding countries as AC 10 or as 'acceding countries'.
- The three future candidates for accession will be referred to as 'the three candidate countries' or 'the three future candidates'.
- When we discuss the transition countries that were under extended Communist rule, we will refer to them as FC 10 or the 'former Communist countries', occasionally also as CEE (Central and Eastern European) countries.
- Finally, when we compare the three Mediterranean acceding and candidate countries to either the EU or the transition countries, we will use the term 'three Mediterranean candidates' or 'three Mediterranean countries' (thus occasionally neglecting the difference between the two acceding countries and the one candidate country in this group).

Structure of report

Moving beyond mere description, we also want to pursue analytical tasks in order to understand better which mechanisms produce similarities and differences. Three analytical aspects will be central, running as red threads through the analyses, namely:

- First, in light of the priority given to full employment policies by the European Communities, we want to find out what effect work has on health conditions, lifestyles and perceptions of the health care scheme. To what extent do the experience and opinions of working people differ from those of people outside employment?
- Second, we want to clarify how much the goal of social integration is impeded by the degree of polarisation or social heterogeneity within single countries or groups of countries, and we also want to analyse to what extent old inequalities related to social class or new inequalities (such as gender, generation or lifestyle) are the source of polarising inequality entailing the risk of exclusion.
- Third, special attention is given to the position of the middle classes, which command the majority of the votes as well as the median position in the electorate. To what extent are the middle classes, on whose support the stability of political systems critically hinges, currently privileged or underprivileged in the sectors of health care and social services? Also, to what extent are they satisfied or disaffected, and how do their perceptions of the desirable welfare mix differ from the rest of society?

These issues will be dealt with in four sections:

- *Chapter 1* examines health conditions and the distribution of stress as one aspect of unhealthy lifestyles.
- *Chapter 2* focuses on the proximity to services as one aspect of access to health care facilities.

- *Chapter 3* explores the distribution of satisfaction with health and the health care system in various countries and social groups.
- With current concern about the future sustainability of present provisions of care for the elderly in our ageing societies, *Chapter 4* looks at public–private solutions in the sector of care, examines the strength of mutual family support in various countries and explores to what extent the care preferences of various nations and social groups are similar or different.

Data and methodology

The presentations usually follow a standard pattern. We begin with macro-comparisons, in which we look at the country-specific distributions of our variables of interest and occasionally also on bivariate associations between variables on the macro level. Then we run micro-level analyses, in which we look at patterns of statistical association on the individual level; these usually begin in a simple tabular form where we present the evidence by country, but are then complemented by more complex statistical models.

A note of caution should be added when it comes to drawing policy conclusions from our analyses. When we give precise quantifications of group-specific differences between the EU 15 and various sub-groups of acceding and candidate countries, this is a politically sensitive issue because there is a debate about how much increase in heterogeneity each step of enlargement will entail and what policy conclusions are to be drawn from a specific degree of heterogeneity. Hence we should be aware of the risk of reifying the results of our statistical calculations. The extent to which we regard the EU 15 countries as similar to or different from other families of nations east of its current borders depends to a considerable extent on the composition of the reference group for comparison and on our exact statistical procedures when calculating averages, measures of dispersion or certain indices. Hence moving from our data to substantive conclusions about the degree of homogeneity or heterogeneity in Europe after various steps of enlargement will always involve a considerable leap of faith. This difficulty may well be illustrated with respect to the average level of stress experienced in different groups of countries (*see Table 1*) — an example which has the advantage of not immediately inviting conclusions about the heterogeneity of cultural values or material standards of living in an enlarged Europe.

Comparing the prevalence of stress in EU 15 and ACC 13 countries, we arrive at identical levels of stress in both groups (roughly 40%) when we calculate group-specific means, where each country is treated as a single case or unit with equal weight. However, if we calculate aggregate averages for each group, where the respondents' answers in each country are summed up and enter the calculation of averages with a weight reflecting the country's population size, then we obtain somewhat different results. Now the resulting averages are 39% for EU 15 and 43% for ACC 13 countries. In other words, we now find a higher level of stress in the ACC. (Even considering the variability of survey data in the light of confidence intervals, this difference is big enough to be statistically significant.) Such aggregate averages largely reflect the size and the degree of peculiarity of a few countries which are outliers, however. In this case, the difference is related to whether we count Turkey (with its high level of self-reported stress) as just one other country besides 12 others with equal status as a political unit or whether we weigh our result for Turkey by the country's size, thus making the impact of its stress level on the ACC 13 average proportional to the size of its population relative to the other countries.

Table 1: Sensitivity of results to methodological variations (% of self-reported stress by country group and weighting procedure)

Group	Weighted by population size	Unweighted by population size
EU 15	39.2	39.5
ACC 13	43.2	39.6
AC 10	36.6	36.8
FC 10	40.2	36.5

Source: Eurobarometer 52.1, Q21; Candidate Countries Eurobarometer 2002.1, Q23: *'Now, let's talk about your lifestyle. Do you or don't you … regularly feel stressed?'*

Secondly, the degree to which we judge the EU 15 countries as similar to or different from acceding and candidate countries very much depends on our composition of the reference group for the comparison: all ACC 13 nations, only the 10 acceding countries, or the 10 former Communist countries which form part of the Phare Programme. Based on weighted aggregate averages, we would judge the EU 15 citizens to have less stress than the 13 acceding and candidate countries, more stress than the 10 acceding countries (because of the absence of the three eastern countries with the highest stress levels, i.e. Bulgaria, Romania and Turkey) and about the same level of stress as the 10 former Communist countries. Based on unweighted country-means, we would, however, arrive at the conclusion that there is a higher prevalence of stress in the EU than in the group of countries which had been under Communist rule.[2] This sensitivity of substantive findings to differences in methodological procedure should be borne in mind when jumping to policy conclusions.

Readers should also be aware of one further limitation which has to do with the nature of our questionnaires. These are multiple-topic questionnaires, mostly designed to obtain basic information on a wide range of issues. This means that for many items we have neither follow-up questions (which attempt to differentiate or to cross-validate in detail what exactly the respondents may have had in mind when answering questions pertaining to a specific issue, such as the prevalence of long-term illness, access to health care facilities or a preference for a particular form of care) or batteries of questions systematically linked to each other with the purpose of testing rival hypotheses. Hence we frequently have to settle for rather crude information based on a single screening question and with analyses in terms of the standard-demography rather than analyses in terms of variables which would be interesting in the light of hypotheses on social mechanisms which produce the country- or group-specific patterns that we detect. This is especially true for our data for EU Member States which frequently come from different Eurobarometers so that micro-analyses testing for statistical associations on an individual level cannot be carried out and must be limited to the integrated dataset for the acceding and candidate countries. Hence, there are frequently considerable imponderables and uncertainties which should definitely be borne in mind when drawing politically relevant conclusions from our analyses.

[2] The discussion about the relative merits of weighted vs. unweighted comparisons of group-specific average will probably go on. In our discussions within the research consortium and with our colleagues from the Foundation, it was decided to use aggregate averages weighted by country size as the basis for our presentations — a procedure which this report follows respecting the results of the decision-making process. One should remember, however, that in a group of countries with 10 dictatorships with 10 million inhabitants each and one democracy with 110 million residents, we would conclude that the typical or average situation is to live in a democracy.

Health conditions and lifestyles 1

Measuring health

In order to judge the prevalence[3] of good or bad health in European countries, we will focus on two questions in the questionnaire. One question (Q24) gives the number of people who have a long-standing illness or disability; another one (Q23) yields the number of people who feel regularly stressed (as well as those considering themselves to have healthy or unhealthy lifestyles).[4]

In the 13 acceding and candidate countries, the percentage of people with a long-standing illness or disability averages 25% (*see Figure 1*).[5] National figures extend from 10% in Malta to highs above 30% in four countries. The prevalence of serious impairments is thus sizeably higher than in EU Member States, where 18% report to be suffering from a long-standing illness on average.[6] In the EU, only five countries report proportions above the ACC 13 mean of 25%. Even though the prevalence of long-term illness is on average distinctly lower in Member States than in acceding and candidate countries, it is equally remarkable that the different parts of Europe do not cluster together as clearly distinct families of nations, but that there is considerable overlap in the distributions of the 'old' and the 'new' Europe.

Prevalences of 25% in ACC 13 countries, and close to 20% in EU 15 countries, suffering from a chronic illness or disability indicate a remarkably high frequency of serious health impairments. However, it may be misleading to take these figures at face value and to regard them as straightforward indicators of health conditions. Without further information, we do not know what exactly respondents have in mind when they report to have a long-standing illness that has affected them for a period of time.[7] Hence the answers need not necessarily indicate the frequency of a significant impairment, but rather may signal cultural standards of coping with health challenges (such as different standards of assessing what constitutes a serious departure from a normal health situation) or country-specific institutional traditions of classifying various degrees of illness as a disability.

It must be remembered that identifying a given state of health as a 'long-term illness' is always the result of a social labelling process which should be understood as the interaction of two components: the presence of a certain health condition and its social definition or classification as 'chronic' or 'long-term'. In other words, the prevalence of long-term illness is not simply the function of objectively given health conditions, but also of their social perception and classification. Social policy institutions may be assumed to play a crucial role in such classification

[3] Even though sometimes used as synonyms, the terms 'prevalence' and 'incidence' denote different things in epidemiology. The 'prevalence' of a disease or risk gives the proportion of people subject to a given condition at a particular time *regardless of when that condition began* (so that the total number of cases with the given condition appears as the numerator). In contrast, the 'incidence' states the number of *new cases* with a specified condition during a defined period of time, e.g. in one year (so that the number of new cases appears as the numerator). Hence we will not use these terms as synonyms here.

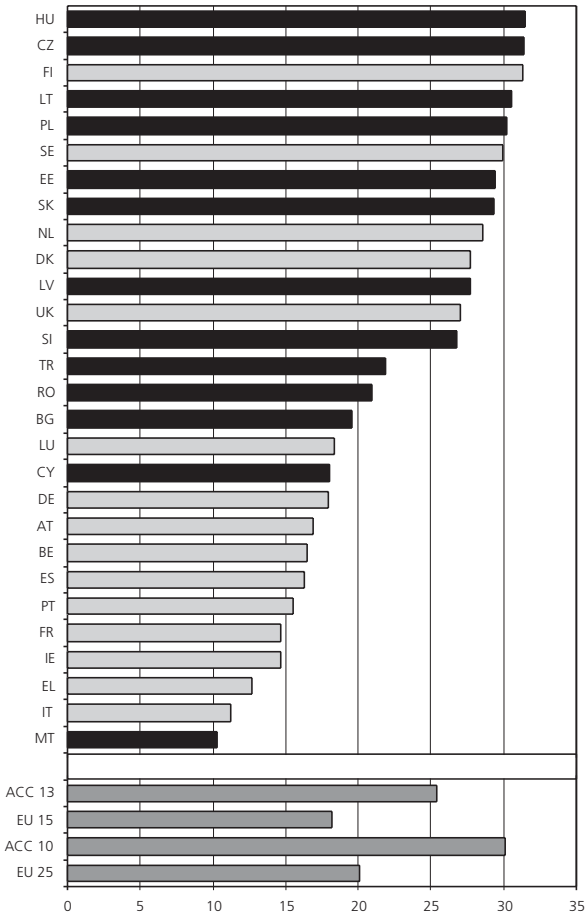
[4] There are two more questions pertaining to health conditions. There is information on the number of people who report a sickness or invalidity allowance as one or even the most important source of income (D30); and information on the number of people suffering from stressful or unhealthy work conditions (Q53, items 1-4). However, since the question on sick pay does not allow one to distinguish between sickness and invalidity benefits, we cannot clarify to what extent the self-reported illness is of a long-term character (resulting in disability benefits) or of a short-term nature (giving rise to sickness cash-benefits). The questions pertaining to unhealthy work conditions are analysed in the report on working conditions and quality of life by Kapitány and Kovács (2003).

[5] The question reads: 'Do you have a long-standing illness or disability that limits your activities in any way? By long-standing, I mean anything that has troubled you over a period of time or that is likely to affect you for a period of time.' Respondents could say 'yes' or 'no'. All percentages in this report are based on the total number of valid answers, eliminating those who failed to provide an answer.

[6] A special report on the prevalence of illness, disability and social inclusion similarly arrived at a prevalence rate of chronic illness or disability of 17% in the EU (Grammenos, 2003).

[7] The question on long-term disability may be considered as what is elsewhere referred to as an introductory 'screening question', which is unfortunately not succeeded by any clarifying follow-up questions in the survey (Grammenos, 2003).

Figure 1: Prevalence of long-term illness or disability (% reporting having a long-term illness or disability)



Source: Eurobarometer 52.1, Q23; Candidate Countries Eurobarometer 2002.1, Q24: '*Do you have any long-standing illness or disability that limits your activities in any way? By long-standing, I mean anything that has troubled you over a period of time or that is likely to affect you for a period of time*.'

or labelling processes. There are at least three institutional mechanisms that can be expected to boost the prevalence of long-term illness, especially in CEE countries. In sickness insurance schemes, physicians are presumably more willing to classify people as chronically ill in order to help them cope better with unemployment when jobs are scarce (especially if unemployment benefits are very low and if effective mechanisms of professional self-control still have to be developed). In pension insurance schemes, CEE countries have a tradition of early retirement (Standing, 1996) and in the context of massive labour market problems with high youth unemployment there is an incentive to resort to early retirement and to disability pensions as a means of reducing labour supply. Both these mechanisms are very familiar in EU Member States. But a third institutional mechanism may be unique to acceding and candidate countries. According to Barr (1999), who follows Milanovic (1998) in this respect, all CEE countries have adopted systems of social assistance which make the receipt of benefits contingent on having a low income and fulfilling an additional qualifying condition, such as 'the presence in the household of someone who is old or handicapped, or a determination that the family is dysfunctional'. Hence there is a strong incentive to declare somebody as handicapped or chronically ill because this opens access to means-tested transfers from public poor relief programmes.

Without further information from follow-up questions, it is impossible to know to what extent the self-reported impairment restricts the respondents' work capacity or their daily activities. We also do not know if an illness defined as long-standing 'over a period of time' refers to a permanent chronic disease or to a transitory problem of limited duration. Other research has shown that 'among people reporting disabilities a high proportion do not have a severe problem' (Grammenos, 2003).[8] Hence we should refrain from interpreting the data as indications of the prevalence of serious health problems in an objective sense, but see them as an indication of how many people subjectively perceive themselves as living with some sort of a long-standing deviation from health conditions which they would judge as normal or satisfactory.

An analysis examining the association between the prevalence of long-term illness and various measures of satisfaction and well-being validates this interpretation. On the one hand, we see that the question about long-standing illness does capture a genuine aspect of self-perceived health, since it is more strongly associated with health satisfaction than with other measures of satisfaction (such as satisfaction with life in general or with one's financial situation). In addition, the magnitude of the correlations with other health measures (such as the perception of good health as a factor that would improve current quality of life) is higher than the one with other indicators of well-being (general life satisfaction, satisfaction with financial situation, availability of friends). Secondly, we obtain a remarkably strong (and statistically significant) correlation coefficient of -.42 on the individual level between self-reported long-term illness and health satisfaction. This demonstrates that respondents who state to be long-term ill are significantly less satisfied with their own health (and vice versa). The negative association is not only confirmed for EU Member States and for acceding and candidate countries alike, but also for each individual country.[9]

Even though the prevalence of long-term illness is higher in the ACC than in the EU, its social structure shows remarkable similarities. In both groups of countries, women are more prone to report suffering from a long-standing illness than men. The gender gap is larger in Eastern Europe, where the prevalence is roughly six percentage points higher for women, whereas in EU countries the gap is limited to only three percentage points.[10] Within the EU, Ireland is the only country where men have a higher prevalence of long-term illness than women. Gendered differences to the disfavour of women in the other EU countries usually remain fairly small and margins that go beyond the magnitude of mere random effects in survey research are recorded in only 5 countries.

The prevalence of long-term illness clearly increases with age. It usually reaches its peak in the group above 70 years. In this age category, 59% of the ACC respondents and 40% in EU Member States report to be suffering from a long-term illness. The lowest prevalence is usually recorded in the age group 15-24 years. It is noteworthy that several EU countries report higher frequencies of

[8] This report estimates the proportion of the working-age population with a significant chronic illness or disability to range around 8-10% in EU countries (Grammenos, 2003). A report on 'Europeans and disability' based on Eurobarometer 54.2 (2001) arrived at the result that 'more than 5%' of EU 15 citizens consider themselves as disabled (*see* http://www.europa.eu.int/comm./employment_social/soc-prot/disable/news/eurobar_en.pdf). The data analysed here are from Eurobarometer 52.1 (1999).

[9] For EU 15, -.41; for ACC 13, -.43; for AC 10, -.51. For individual countries, the correlation coefficients range from -.56 in Hungary to -.28 in Turkey. An impact of institutional regulations on the prevalence of long-term illness is suggested by the fact that it is correlated positively and significantly with the frequency of receiving sickness cash or invalidity benefits. The Pearson correlation coefficient is r = .63 for all 28 countries on the macro level of analysis; r = .18 on the level of individual data.

[10] Assuming that women are more likely than men to be counted as dependent household members, this difference might be related to the fact that an entitlement to the receipt of a social assistance benefit usually requires not only low income, but also the presence of a person with some sort of handicap in the households of CEE countries. In line with this idea, the Czech Republic, which is frequently praised as being exceptional for its formal recognition of a general right to minimum subsistence (Ferge, 2001), stands out as the only former Communist country where men report long-term illnesses more frequently than women.

long-term illness in this youngest group than in the ACC, so that the EU 15 average of more than 9% is slightly higher than the one for ACC 13 countries. Four Western European countries even report a prevalence of more than 15% in the youngest age group (Denmark, Sweden, the Netherlands and UK). In the absence of any follow-up questions, it is difficult to say if this really indicates a higher prevalence of bad health among younger respondents or merely a greater readiness of younger groups to perceive or classify themselves as long-term ill.

The prevalence of long-term illness varies with income in both parts of Europe (*see Table 2*). Income is here (as in all following analyses) measured by the quartile distribution of the household-equivalence income. Social inequalities are somewhat more marked in the group of acceding and candidate countries, however, where the self-reported frequency of long-term illness in the lowest income quartile is 11 percentage points higher than in the highest one. In the EU, the respective difference is 10 percentage points. On aggregate, the prevalence of long-term illness grows monotonously as income declines in both parts of Europe, but this pattern does not usually repeat itself without any deviation in single countries. A substantive interpretation of these findings is difficult because the available data tell us little about the mechanisms which link income to long-term illness. The causal order of the two variables remains unclear. Hence we do not know if people with lower incomes are more prone to have long-standing illnesses or if people with long-standing illnesses are more likely to have only modest earnings and low incomes.

A crucial question with respect to quality of life and social inclusion is to what extent long-term illness is concentrated among the poorer strata if we control for age, gender and employment status.[11] The multivariate analysis confirms our previous findings. Even if we control for age, gender and employment status, people with low income have a higher risk of suffering from a long-term illness. In this sense, health deprivation tends to coincide with economic deprivation. This income effect is very similar in all groups of countries. The general pattern is found in EU Member States and in acceding and candidate countries alike, but the effect is strongest in the 10 acceding countries.[12] Hence people in lower income groups are more frequently confronted with multiple deprivation, including health risks, in countries that do not yet belong to the current EU.

Prevalence of healthy and unhealthy lifestyles

Europeans do not perceive healthy or unhealthy lifestyles as alternatives. As the surveys show, most European citizens usually combine elements of both. The questionnaire asked for two indications of a healthy lifestyle (eat a good balanced diet and exercise at least twice a week) and for three indications of an unhealthy lifestyle (regularly drink alcohol, smoke and feel stressed). It also asked for a self-assessment of the respondent's own lifestyle as being healthy. A key result is that people do not regard it as mutually exclusive to display elements of a healthy and an unhealthy lifestyle at the same time. An aggregate analysis for Europe as a whole demonstrates that the prevalence of healthy and unhealthy lifestyles is in fact statistically independent of each other. Countries with high proportions of respondents reporting two healthy habits do not necessarily have low proportions of respondents displaying several unhealthy lifestyles, and vice versa.

[11] Employment status is controlled for because retired people are also more likely to report a long-term illness if we hold age constant. This reflects the fact that disability favours early retirement.

[12] Data show that the proportion of long-term ill people decreases as we move from lower to higher income deciles. We also examined the distribution of long-term illness by the absolute level of (household-equivalence) income. In this analysis, we used a random effects logistic regression model in order to control for the heterogeneity of income between the different countries. The results further confirm both the negative effect of income on illness and the stronger influence of income in the acceding countries than in Western Europe.

Table 2: Long-term illness by income (% reporting having a long-term illness or disability by quartiles of household-equivalence income)

Countries	Lowest	Second	Third	Highest	Total	Difference Highest-Lowest*
AT	21.4	17.2	20.0	11.5	17.4	-10.0
BE	22.6	21.6	9.6	14.7	17.2	-8.2
FR	16.0	17.1	15.4	14.2	15.7	-2.1
DE	20.9	19.8	14.7	14.4	17.5	-6.6
LU	15.7	21.7	24.0	14.4	19.1	-1.6
IT	10.6	11.5	13.3	12.4	11.9	1.9
EL	24.3	14.7	12.8	6.3	14.6	-18.3
PT	29.9	14.7	15.0	11.8	17.9	-18.4
ES	32.8	17.1	11.9	9.0	17.6	-23.6
IT	27.8	16.0	14.3	12.8	17.8	-14.5
NL	33.6	28.9	30.4	28.4	30.3	-5.4
UK	43.1	30.1	25.7	18.5	29.6	-24.5
DK	36.9	35.0	21.8	23.0	29.2	-13.7
FI	38.1	33.2	31.5	25.6	32.1	-12.4
SE	36.8	29.9	22.9	27.0	29.3	-9.9
CZ	40.9	51.7	28.3	22.0	35.8	-18.9
SK	44.9	28.9	31.7	18.2	31.6	-26.6
SI	37.8	19.6	30.0	19.7	27.2	-18.2
HU	48.8	29.7	38.1	17.5	33.4	-31.3
PL	28.0	41.1	35.0	24.3	32.1	-3.7
EE	36.8	42.8	28.1	18.9	31.2	-17.9
LT	44.8	36.1	26.9	25.4	33.4	-19.0
LV	31.9	42.6	23.6	17.7	28.7	-14.1
MT	11.7	9.9	10.9	5.7	9.6	-5.4
CY	39.4	18.8	6.4	11.2	18.8	-27.9
BG	27.6	24.3	20.2	11.8	21.0	-15.8
RO	26.9	24.7	19.7	13.9	21.4	-13.1
TR	25.4	19.3	23.8	19.3	22.0	-6.2
ACC 13	30.1	28.5	26.8	19.2	26.2	-10.9
EU 15	24.8	20.0	17.4	15.1	19.3	-9.7
AC 10	35.7	38.5	33.2	21.8	32.3	-13.9
EU 25	26.9	23.4	20.4	16.3	21.7	-10.6

*The given percentage point differences result from a linear regression of long-term illness on dummy variables for the independent variable (here, the four relative income categories). The stated number is the b-coefficient for the fourth income quartile compared to the first one (as the reference category). Differences from the percentage point difference calculated from the rounded numbers in the table for the specific quartiles result from rounding errors (which typically occur when using the SPSS Crosstabs command with weighted variables).

Source: Eurobarometer 52.1, Q23/D29; Candidate Countries Eurobarometer 2002.1, Q24/D29: '*Do you have any long-standing illness or disability that limits your activities in any way? By long-standing, I mean anything that has troubled you over a period of time or that is likely to affect you for a period of time.*'

A micro-analysis of individual data sustains this idea. Among respondents who report to display all three 'vices' together in Europe (i.e. those who drink, smoke and feel stressed), one-half consider their lifestyles to be healthy. If we assume that drinking, smoking and being under stress actually do constitute elements of an unhealthy lifestyle, there is a remarkable difference in the degree of self-conscious realism among Eastern and Western Europeans. In the ACC, only 38% of those having all three 'vices' in combination consider themselves as living healthily, but in EU Member States, 63% of those who display all three elements of an unhealthy lifestyle declare their own lifestyle to be healthy.[13] This would suggest that health education campaigns are at least as necessary in EU Member States as in the ACC.

The greater reservation of citizens in the ACC to describe themselves as living healthily when actually displaying unhealthy habits partly reflects different base levels. Citizens in these countries are not only more self-consciously aware of their lifestyles when they display unhealthy habits, but they are also more hesitant to describe their lifestyle as healthy in general. On average only 63% do so, as compared to 83% in EU Member States. To the extent that such figures can be taken at face value, several healthy lifestyles in combination are also much more prevalent in EU Member States. On average, 24% of the respondents in the acceding and candidate countries (compared to 34% in the EU) report to observe two rules of a healthy lifestyle. Inside and outside current EU boundaries, we find considerable country-specific variation, however, so that the various parts of Europe do not cluster together in a clear-cut fashion.

By themselves, crude comparisons of this kind do not tell us if the greater reservation of eastern Europeans represents a more self-critical assessment of their own individual habits (such as insufficient determination to exercise or consumption of unhealthy products) or else an awareness of their limited opportunity to afford costly elements of a healthy lifestyle (such as eating a good and balanced diet). If the reported frequency of healthy lifestyles reflects a self-critical assessment of one's individual choices rather than a complaint about limited opportunities in the societal context, we would expect it to be statistically independent of the income situation.

A micro-analysis of individual data shows that living healthily, in the sense of simultaneously reporting two healthy lifestyles, is in fact easier when economic resources allow easier access to better food and to more healthy recreational activities. Practically everywhere in Europe, people with higher incomes tend to live more healthily than those with lower incomes. Hence access to economic resources is an important prerequisite of a healthy lifestyle. In the ACC, 30% of those in the highest income quartile (as compared to 16% in the lowest quartile) report two healthy lifestyles simultaneously. This stratified pattern is confirmed in most single countries. Within the EU, the differences between the highest and the lowest income quartile are usually less marked, suggesting that the dissemination of healthy lifestyles is less constrained by unequal economic opportunities. Helping the ACC citizens to display more healthy lifestyles would therefore not only require health education campaigns (passing on relevant information on habits which are favourable or detrimental to good health), but also require improvements in the standard of living so that wider access was available to the needed resources and opportunities.

[13] It must be noted that these comparisons are based on very small numbers. In all ACC 13 except Turkey, the number of respondents who report all three elements of an unhealthy lifestyle is less than 50. Within the EU Member States, there are four countries where this is also true, six countries with numbers between 50 and 100, and 5 countries with numbers above 100.

Higher education favours healthy lifestyles similarly in all parts of Europe. In Eastern and Western countries alike, those still studying have the highest prevalence of several healthy lifestyles and those with more years of schooling live more healthily than those with less schooling.[14]

In summary, the distribution of healthy lifestyles across social groups follows rather similar patterns in both parts of Europe despite some country-specific variations. By and large, the pattern of distribution of healthy lifestyles shows similarities to the distribution of post-materialist values in Western and Eastern Europe alike (Inglehart, 1997). This means that healthy lifestyles generally tend to be most prevalent among the more affluent, the higher educated and, especially in CEE countries, the younger generation.

An analysis of the distribution of specific healthy and unhealthy lifestyles provides a further understanding of similarities and differences within various parts of Europe. Given the frequently shown importance of stress for cardiovascular mortality and other types of mortality (Gavrilova *et al*, 2001; Kivimäki *et al*, 2002), the prevalence of stress in various countries and contexts is not only a crucial component of quality of life, but also an issue of prime importance to health policymakers. Hence we will first focus on the prevalence and social distribution of self-reported stress.[15]

As pointed out in the Introduction, a comparison of the prevalence of stress in various groups of European countries is sensitive to variations in the methods of calculating averages and measures of dispersion. Hence the basic message with respect to the prevalence of stress in Europe is that various groups of countries inside and outside the EU do not stand apart as distinct families of nations, but display considerable overlap when we look at the country-specific distributions (*see Figure 2*). There tends to be a little more heterogeneity in ACC 13 countries, where four countries stand apart with particularly high levels of self-reported stress, whereas four others are conspicuous for their low prevalence of stress. Within the EU, only Greece stands out with a particularly high level of stress; the other countries are fairly similar, with the Scandinavian nations reporting the lowest levels. Overall, there is thus a little more homogeneity in the group of EU countries.[16]

Given the discrepant levels of affluence and economic development in ACC and EU countries, it is remarkable that the mean levels of self-reported stress are fairly similar in both groups. This seems to equally contradict two similarly popular, yet rival ideas about the effects of economic growth and modernisation. According to one view, poverty and limited opportunity — and in this sense a lack of modernity — breed stress, so that we should expect distinctly higher levels of stress in the poorer countries outside current EU borders. Another view holds that modernity makes life more stressful, as high performance pressure and constant time shortage coincide with a growing output of goods and services which forces harried consumers to allocate their limited time among

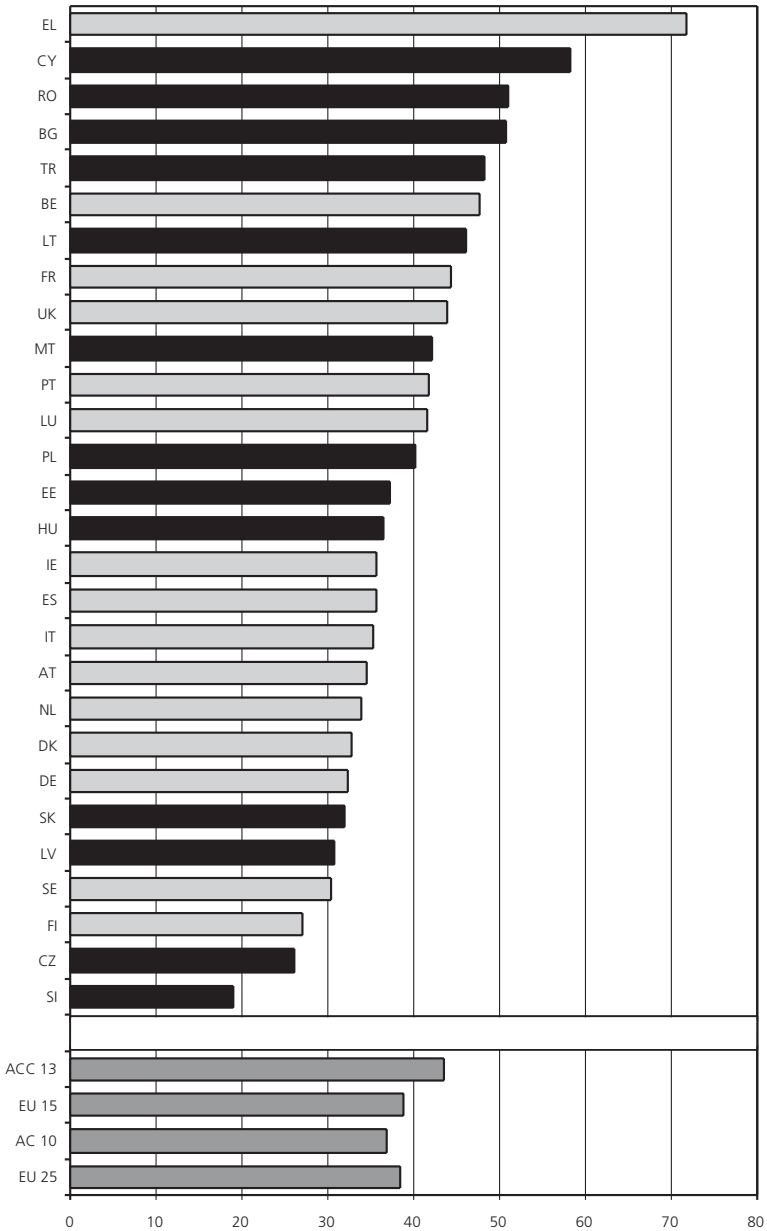
[14] There are, however, some country-specific variations. Thus, among the ACC 13, Slovenia does not fit the general pattern and within the EU, Finland and Sweden stand out as countries where healthy lifestyles have proliferated independently of educational status. The distribution by age shows a higher prevalence of healthy lifestyles among younger generations on average, with some considerable country-specific variation.

[15] Smoking and drinking are, of course, also important drivers of morbidity and mortality. However, our dataset only gives crude information on the self-reported prevalence of both habits, but yields no information on the quantity or intensity of consumption. In the absence of such more refined information, the finding that only 8% of ACC citizens (compared to about 25% of EU citizens) describe themselves as 'regularly drinking alcohol' cannot give us any clues for answering the question if the enlargement of the EU will increase or decrease the prevalence of habits which are detrimental to health and likely to become burdens for the European health care systems. Hence we will abstain here from any further analysis of this data.

[16] The standard deviation among the EU 15 of 10.2 compares to a standard deviation of 10.7 among the ACC 13.

a growing number of rival opportunities with high opportunity costs for each choice (Linder, 1970; Linsky and Straus, 1986). From this perspective, we should expect Western Europeans to perceive life as distinctly more stressful.

Figure 2: Self-reported stress (% reporting feeling stressed regularly)



Source: Eurobarometer 52.1, Q21; Candidate Countries Eurobarometer 2002.1, Q23: '*Now, let's talk about your lifestyle. Do you or don't you … regularly feel stressed?*'

A third possibility would be to combine both perspectives and to conceive of stress as a multi-dimensional concept. This would provide two possible explanations for the similarity of the perceived stress load in ACC and EU countries. The first possibility is that our respondents think of different notions of stress when they are confronted with an undifferentiated question about their stress perception, while the second possibility is that they consider various types of stress in a

similar way, but weigh their total stress load in light of their circumstances. From the latter perspective, identical levels of self-reported stress in our groups of countries could result from different compositions of the total stress load, which would primarily consist of stress related to economic worries in poorer countries, but of stress related to a heavy work load and constant time pressure in a more affluent setting.[17]

In the absence of clarifying follow-up questions, we can get some clues regarding the nature of stress perceptions from context-specific correlations where we enter potential stressors as independent variables. On the level of macro comparisons, we find a statistical association near zero between the level of affluence and the prevalence of stress in Europe as a whole (r = -.13). Within the groups of countries inside and outside the EU, the level of affluence and the frequency of stress also vary largely independently of each other (r = .06 in ACC 13 and r = -.34 in EU 15).[18] There is, however, one noteworthy peculiarity. If we abstract from the three Mediterranean countries (which did not experience the strain of a transition from collectivism to a market economy) and focus exclusively on the group of 10 former Communist countries, a strong negative correlation between the level of affluence and the frequency of self-reported stress shows up (r = -.82). This macro-correlation seems to suggest that in the former Communist countries stress may be primarily related to economic worries and basic insecurity, whereas in EU countries it may result, above all, from the work load and from time pressure.

Our micro data allow us to analyse how socio-economic success or deprivation translate into subjective experiences of stress by examining how perceived stress co-varies with income and work on an individual level. If it is true that respondents in the EU think of stress primarily as being overworked and time-pressured, whereas respondents in former Communist countries think of it as a synonym of economic worries, self-reported stress in CEE countries should be much more prevalent among the poor and non-working people than among the working and more affluent, whereas the Western European pattern should be the other way around.[19] Our analysis will proceed in three steps:

- the extent to which income and perceived economic difficulties vary with stress in different contexts;
- the extent to which inclusion or exclusion from the labour market is at the root of context-specific stress perceptions; and
- interaction effects between work and income.

A crude analysis by relative income position[20] suggests that the distribution of stress does follow context-specific patterns. Within the group of EU countries, stress is not related to income. Differences across income quartiles remain small and, if anything, there is a slight tendency for

[17] I am thankful to my colleague Martin Potucek for drawing my attention to different types of stress and to the difficulty of comparing crude self-reported levels of unspecified stress without the further possibility of discerning what kind of stress respondents have in mind.

[18] The modest low negative correlation for the group of EU Member States largely reflects the peculiar position of Greece and becomes virtually zero without this case (r = .01).

[19] Unfortunately, many of the desirable analyses are only possible for the 13 candidate countries because Eurobarometer 52.1, which contained the question on perceived stress in EU Member States, did not cover some of the other variables which would be suited for our analysis. Thus neither questions on the perception of the income situation nor questions on working hours per week or perceived stress at work were asked in Eurobarometer 52.1. Hence some of the issues can only be pursued on the basis of the integrated dataset for CC countries.

[20] Income quartiles were calculated on the basis of household-equivalence income.

those at the top to find life a little more stressful than those at the bottom quartile of the income distribution. In Eastern Europe, those in the poorer quartiles report more stress than those higher up in the income distribution. However, even in the acceding and candidate countries there is no monotonous association between income and stress, as those in the two middle quartiles report a similar or slightly lower prevalence of stress than either those at the bottom or the top of the distribution. Within each quartile, ACC citizens tend to experience life as more stressful than EU citizens.[21] However, there are no consistent patterns across all nations and again there is considerable overlap in Eastern and Western distributions.

A multivariate analysis shows that the distribution of stress across income becomes much more similar in EU 15 and ACC 13 countries once we control for employment status, as well as for age and gender.[22] In both parts of Europe, we then find low income to contribute to stress. Hence the seemingly different influence of income on stress in Western Europe as compared to ACC countries presumably reflects different employment structures.[23] If work breeds stress and the fraction of working citizens with high income is higher in the EU, then some of the positive income effect merely reflects the stress involved in economic activity.

A more immediate comparison of the working and non-working population shows that economic activity contributes to making life more stressful throughout all parts of Europe. On average in the enlarged EU, being economically active raises the level of stress by roughly 15 percentage points compared to those who are out of work. The effect is a little smaller for ACC countries than for EU Member States, but contrary to the notion that CEE citizens perceive stress predominantly as an element of economic insecurity, those who have a job report to be more stressed than people who are not working (*see Table 3*). Only Cyprus and Malta deviate from this general pattern in the 13 acceding and candidate countries. In line with the idea that stress is primarily related to the workload in EU countries, the difference in disfavour of working people is larger in Western Europe (16 vs. 10 percentage points).[24]

A cross-tabulation of employment and income confirms that the distribution of stress follows rather similar patterns inside and outside current EU borders once we look at individual data. Practically everywhere, life is experienced as least stressful when leisure (in the sense of not being economically active) coincides with a high income, whereas stress is highest when employment coincides with a low income (*see Table 4*). Comparing the two polar groups — i.e. those who have neither work nor a high income with those who are in employment with high earnings — stress tends to be higher in the latter group. In other words, being economically active and relatively affluent leads to more stress than being out of work with relatively low income. This pattern holds

[21] The aggregate difference is highest in the lowest income quartile. Again, this is largely an effect of our weighting procedure, which gives high importance to Turkey with its large population and comparatively high levels of stress.

[22] Based on a logistic regression model of stress on income for the Western Europe and CEE countries, data give the regression coefficients of dummy-variables for quartiles of the household-equivalence income, with the lowest income quartile serving as the reference category. A negative number means that the prevalence of stress is lower in the specified quartile than in the lowest income quartile. Hence the more negative the number, the lower the prevalence of stress.

[23] The regression coefficient linking stress to being employed is .74 in the EU and .61 in the CEE.

[24] The Netherlands is the only country where the difference between working and non-working groups is rather small. The outstanding difference in Germany is not due to a particularly high perception of stress among working people, but due to the exceptionally low stress perception among non-working groups. In the former dimension the German value corresponds almost exactly to the EU average, but in the latter it is at the bottom of the rank-order with a value that is only at 58% of the EU mean.

for both Western and Eastern Europe. There is only one aspect that distinguishes the group of acceding and candidate countries from EU countries: the double exclusion from employment and higher incomes is accompanied by a higher prevalence of stress than in the EU. However, if we look at single countries rather than at group averages, there is no consistent or dominant pattern in either group of countries.

Table 3: Self-reported stress by economic activity (% reporting feeing stressed regularly by employment status)

Countries	Total	Working	Not working	Difference working-not working*
AT	34.8	45.4	21.8	23.7
BE	47.5	55.3	40.6	14.9
FR	44.8	52.2	36.2	15.9
DE	33.6	46.2	18.3	27.8
LU	42.2	51.6	33.6	18.2
IT	36.5	41.3	32.0	9.3
EL	72.0	77.2	66.4	10.8
PT	41.1	43.8	38.1	5.7
ES	35.2	44.0	25.6	18.5
IE	36.5	39.2	34.5	4.7
NL	34.4	34.9	33.9	1.1
UK	43.7	49.5	37.8	11.6
DK	32.2	41.3	22.5	18.8
FI	27.7	33.3	22.6	10.9
SE	30.5	39.5	19.8	19.7
CZ	25.8	32.3	18.5	13.8
SK	30.4	40.9	21.8	19.2
SI	19.5	24.0	15.9	8.0
HU	36.1	48.0	28.6	19.3
PL	40.5	47.8	36.5	11.4
EE	37.0	38.8	35.3	3.5
LT	46.2	49.7	42.6	7.2
LV	30.1	31.8	28.5	3.2
MT	43.3	38.9	46.0	-6.9
CY	58.7	58.5	58.9	-0.5
BG	49.9	53.9	47.9	6.0
RO	49.8	59.1	45.5	13.6
TR	48.2	56.4	44.6	11.9
ACC 13	43.2	49.7	39.5	10.2
EU 15	39.2	46.9	30.8	16.0
AC 10	36.6	43.3	31.9	11.4
EU 25	38.7	46.4	31.1	15.3

* Calculated as b-coefficient in a linear regression

Source: Eurobarometer 52.1, Q21/D15a; Candidate Countries Eurobarometer 2002.1, Q23/D15a:
'Now, let's talk about your lifestyle. Do you or don't you … regularly feel stressed?'

Table 4: Self-reported stress by income and employment (% reporting feeling stressed regularly in combinations of employment status and household-equivalence income)

Countries	Not employed low income	Employed high income	Employed low income	Not employed high income
AT	21.0	45.4	62.0	20.7
BE	53.2	58.7	43.8	34.1
FR	44.1	52.1	57.9	23.0
DE	25.9	46.1	45.6	6.0
LU	44.4	48.3	48.8	37.1
IT	34.4	46.1	16.1	21.1
EL	70.1	74.0	83.3	59.6
PT	34.7	45.5	48.5	51.2
ES	24.5	44.3	48.6	30.3
IE	38.9	36.7	33.3	21.1
NL	42.0	36.6	33.9	17.2
UK	42.1	44.3	67.4	21.2
DK	23.1	42.5	33.3	22.6
FI	31.1	29.7	20.0	5.6
SE	28.3	42.1	31.0	14.8
CZ	13.7	28.9	35.8	42.5
SK	23.3	44.4	42.3	32.3
SI	16.4	31.8	25.0	16.0
HU	39.8	44.7	62.5	18.7
PL	48.3	49.8	50.5	33.8
EE	54.1	38.0	48.3	18.0
LT	51.9	48.4	53.1	26.1
LV	35.2	29.2	41.0	20.0
BG	62.0	45.9	78.9	27.3
RO	51.3	56.8	60.0	41.6
TR	51.7	56.3	49.6	45.3
CY	60.6	60.0	40.0	51.9
MT	44.7	31.3	33.3	22.7
ACC 13	47.6	49.6	49.8	39.2
EU 15	35.3	46.6	47.8	20.8
AC 10	40.4	43.7	47.4	30.7
EU 25	36.3	46.1	49.8	32.7

Source: Eurobarometer 52.1, Q21/D29/D15a; Candidate Countries Eurobarometer 2002.1, Q23/D29/D15a: *'Now, let's talk about your lifestyle. Do you or don't you … regularly feel stressed?'*

An analysis by occupation provides further evidence that stress coincides with demands related to economic activity and the work load in all parts of Europe. In Europe as a whole, as in several groups of countries, it is not the unemployed or manual workers but rather the self-employed categories who report feeling stressed most frequently (*see Table 5*). In this sense, our analyses

Table 5: Self-reported stress by occupational status
(% reporting feeling stressed regularly by employment category)

Stress - occupation	Total	Responsible for ordinary shopping, not working	Student	Unemployed or temporarily not working	Retired or unable to work through illness	Farmers (5+6)	Upper service class (7, 10-12)	Self-employed (8+9)	Lower service class (13-15)	Skilled manual workers (16+17)	Unskilled manual workers (18)
AT	34.8	23.3	39.5	48.3	10.3	45.8	51.1	53.6	43.5	36.3	45.6
BE	47.5	42.4	47.9	60.0	29.8	50.0	58.8	59.5	58.0	41.7	60.0
FR	44.8	38.4	39.0	51.9	30.3	35.3	58.2	54.0	55.4	47.1	46.9
DE	33.6	13.3	49.2	30.1	6.9	33.3	49.8	62.7	44.0	40.4	46.6
LU	42.2	36.0	48.3	50.0	20.6	60.0	45.9	65.0	56.8	55.6	41.9
IT	36.5	33.9	34.4	46.9	25.1	33.3	39.4	50.5	33.6	48.0	45.5
EL	72.0	73.3	61.3	84.2	59.5	75.3	82.9	75.7	75.6	84.6	78.6
PT	41.0	48.8	30.4	54.2	29.5	26.9	37.5	52.4	46.5	46.7	40.0
ES	35.2	29.1	31.3	16.9	21.3	33.3	57.5	38.2	52.0	37.7	31.7
IE	36.5	32.0	29.6	53.0	35.5	32.9	42.9	50.0	37.8	40.0	37.0
NL	34.3	33.3	41.1	43.8	29.2	33.3	36.5	44.4	34.9	30.7	30.0
UK	43.7	47.6	39.1	56.6	26.3		40.4	50.0	51.3	53.2	52.2
DK	32.2	23.8	37.1	30.4	11.2	41.7	46.4	53.6	44.1	29.3	34.8
FI	27.7	25.5	33.3	32.0	12.6	48.1	38.2	34.2	31.7	28.7	15.4
SE	30.6	73.3	37.5	12.1	9.8	50.0	51.2	56.3	31.0	40.9	27.0
CZ	25.9	36.4	30.3	31.6	8.9	12.5	35.0	29.5	35.7	29.6	17.4
SK	30.3	25.0	31.4	25.3	16.3	25.0	45.5	51.2	43.1	33.7	13.6
SI	19.5	16.7	20.8	22.1	12.3	14.3	36.3	18.6	25.9	16.2	17.6
HU	36.1	34.1	21.5	38.0	27.9	62.5	56.7	55.9	45.7	32.6	60.3
PL	40.5	39.7	32.7	45.3	33.5	34.1	54.8	47.4	55.7	42.6	28.6
EE	37.0	43.2	17.2	56.1	38.0	37.5	35.9	43.5	41.7	34.6	41.7
LT	46.1	48.7	18.6	60.4	44.4	42.9	47.0	54.8	49.7	49.4	53.3
LV	30.1	27.9	15.5	41.0	27.4	28.6	38.8	27.8	27.7	30.0	34.0
MT	34.7	54.0	27.0	36.8	42.0		38.0	26.9	42.9	31.7	70.6
CY	58.9	64.5	62.5	64.0	46.5	33.3	54.8	66.7	64.1	52.9	63.2
BG	49.8	55.2	30.1	62.2	43.0	100.0	51.5	71.0	57.3	45.8	48.3
RO	49.7	54.6	36.1	60.7	40.4	60.0	67.3	62.5	59.7	52.4	73.7
TR	48.1	43.4	42.2	50.3	40.1	41.8	55.8	61.7	59.4	61.9	62.0
ACC 13	43.2	44.1	34.2	49.4	33.2	39.9	51.8	55.8	51.0	46.0	54.2
EU 15	39.2	34.7	39.6	41.5	22.0	43.0	47.9	53.1	46.2	44.4	46.0
AC 10	36.6	39.2	29.4	42.5	28.0	34.6	48.2	43.5	46.3	37.4	42.5
EU 25	38.7	35.0	37.3	41.8	23.3	40.1	47.9	52.1	46.2	43.4	45.7

Most frequent stress
Least frequent stress

Source: Eurobarometer 52.1, Q21/D15a; Candidate Countries Eurobarometer 2002.1, Q23/D15a: *'Now, let's talk about your lifestyle. Do you or don't you … regularly feel stressed?'*

confirm a phrase coined by the Swedish sociologist Göran Therborn (2000) according to whom the 'leisure class has changed its place of residence' in Europe. By this he meant that it is no longer industrial workers who have the least amount of free time and who work hardest, but rather it is self-employed people and managers who are most likely to live as 'workaholics' in post-industrial societies. Even though the basic pattern repeats itself also in ACC 13 countries, they still lag behind in the sense that unskilled manual workers frequently report a higher level of stress than their peers in EU countries.

The burden of stress

Summarising our stress-related findings, we may conclude that respondents in EU and ACC countries apparently think of similar notions of stress when answering undifferentiated questions about their stress load. Europeans east and west of current EU borders perceive work as stress. The mirror image of this finding is that throughout Europe groups who are not economically active report their lives to be least stressful: in CEE countries this tends to be students, while in the EU it is retired people. In seven of the 13 ACC countries, students stand out as reporting the least stress, whereas they perceive life as more stressful than the average respondent in several of the EU Member States.[25]

It is particularly noteworthy that we do not find unemployed people suffering from a particularly high burden of stress. They report the highest prevalence of stress only in two of the 13 acceding and candidate countries (Latvia and Lithuania) and in four of the 15 EU Member States (Belgium, Ireland, Portugal and UK). Since survey research usually finds unemployed persons to be most unhappy or depressed (Winkelmann and Winkelmann, 1998), this is further evidence that respondents throughout Europe conceive of stress as a synonym for work overload and time pressure rather than as a concomitant of economic worries.

Concerning the distribution of stress, acceding and candidate countries and EU Member States have one further aspect in common. In both contexts, women are more likely to feel under stress than men. In the ACC 13 group, there are only three countries where men report stress more frequently — in Slovenia, Turkey and Malta.[26] In all other ACC countries, the prevalence of stress is at least four percentage points higher among women. Similar or even larger gender gaps prevail in most of the EU Member States. In the light of our findings — that work functions as a major stressor — this is remarkable because women are less frequently economically active than men. Nevertheless, one of the explanations why they are more frequently stressed is that they often have to render informal care work in addition to their usual activities in private households or at the workplace (*see Chapter 4 for further details*).

One basic result of these analyses is that the similarities between EU Member States and the ACC are in many respects more striking than the differences. Even though the prevalence of health

[25] It should be of relevance to educational policies to find out if the conspicuous levels of stress reported by students in some European countries reflect the country-specific situations of the universities (such as varying student-teacher ratios, different requirements in curricula or varying degrees of guidance and control). Germany stands out as the Western European country where students report the highest prevalence of stress. In our comparisons by employment status, we left farmers and fishermen out of the consideration when they numbered less than 30 in national samples.

[26] The extraordinary difference of 24 percentage points in favour of women in Malta should be seen in the light of the small sample size (135 men and 77 women), which leads to large standard errors of all estimates.

problems is higher in acceding and candidate countries than in the EU, the range of a given characteristic within each family of nations is usually greater than the distance between the respective group averages. In addition, we frequently found a bewildering variety of country-specific results rather than clear group-specific patterns. Examining the distribution of health-related variables across social groups, we also found similar patterns with a tendency for health impairments to co-vary with the structure of socio-economic privilege. The following discussion explores whether similar results are obtained when examining the similarities and differences in access to health care facilities.

Access to health care facilities 2

Universal access to health care facilities is an important element of quality of life, as well as a crucial policy goal within the European Union. Hence we should analyse to what extent, if any, the enlargement of the EU creates impediments for the fulfilment of this goal of universal access. The most important dimension of access is to what extent citizens are legally entitled to use available services and to what extent there are institutional barriers, such as users' charges.

Our questionnaire does not provide any information on these dimensions of access, but it does contain questions that tell us what geographical distance citizens have to bridge in order to find access to health care services. This tells us something about the distribution of opportunities to access health care services provided that all citizens are similarly entitled to use the services without any group-specific legal barriers. The following analyses will centre on four questions:

- a comparative description of how far removed health care facilities are from the citizens of various European countries;
- analyses of the extent to which there are similarities and differences between single nations and to what extent these cluster to form families of nations which correspond to their different EU membership status;
- clarification of how the different steps of enlargement move Europe closer or further away from the common goal of universal access (as measured by geographical proximity in our analyses); and
- identification of countries that present particular problems in the sense of having a conspicuous degree of unequal access to health care facilities.

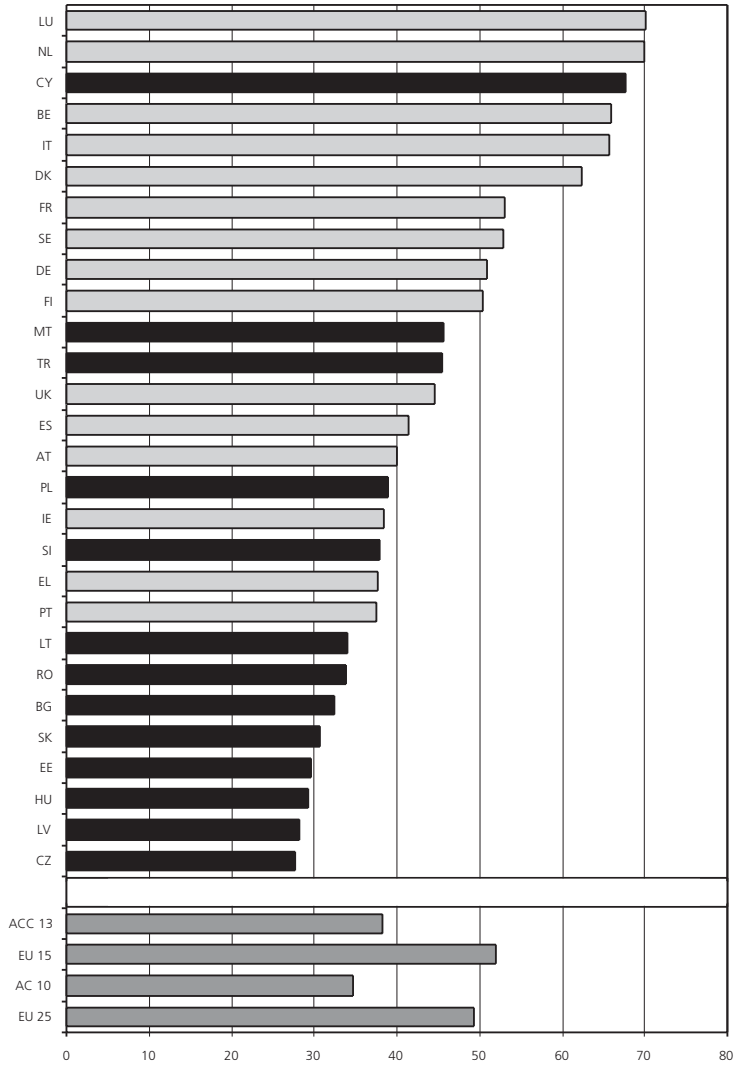
Proximity to hospitals

Two questions in the questionnaire concerned the proximity in which respondents live to their nearest hospital: (a) How long does it take to get there — less than 20 minutes, 20-50 minutes, one hour or more? and (b) Is the nearest hospital within walking distance? If we measure the ease of access by the harsh standard of a distance which takes less than 20 minutes to bridge, quick access to hospital care is far from being universal in Europe. Within the EU, only slightly more than one-half of the citizens live this close to hospitals, whereas in the 13 acceding and candidate countries 38% have this easy access. Comparing the European averages after various steps of enlargement, we do not detect very great changes. After the entry of the acceding countries, the percentage of EU citizens who have quick access to hospital care would only drop from 52% to 49%; after the completed entry of all acceding and candidate countries, it would decline just one percentage point further.

As noted in the Introduction, such comparisons of aggregate averages may give a rather distorted picture. In this case, the small enlargement effect is due to the fact that the acceding and candidate countries which provide less easy access are rather small in population size so that they have little impact on the calculation of our aggregate average. A look at the country-specific distribution of the proximity to hospital care in Europe shows that countries do cluster together in families of nations which largely reflect their current EU membership status (*see Figure 3*). Among the 13 acceding and candidate countries, only the three Mediterranean countries and two of the post-Communist transition countries intermingle with the group of EU Member States, whereas eight

transition countries are united at the bottom of the distribution with levels clearly below the ones of the countries which currently form the rear within the EU (Greece and Portugal). In the current EU, there are only six countries where less than half of the respondents live in immediate proximity to hospitals, but in the ACC only Cyprus surpasses the 50% level. Hence, by this measure of proximity, EU enlargement will involve greater challenges to the realisation of the goal of easy access to hospital care than the mere comparison of our aggregate averages before and after enlargement would suggest.

Figure 3: Proximity to hospitals — less than 20 minutes (% having access to a hospital in specified time)

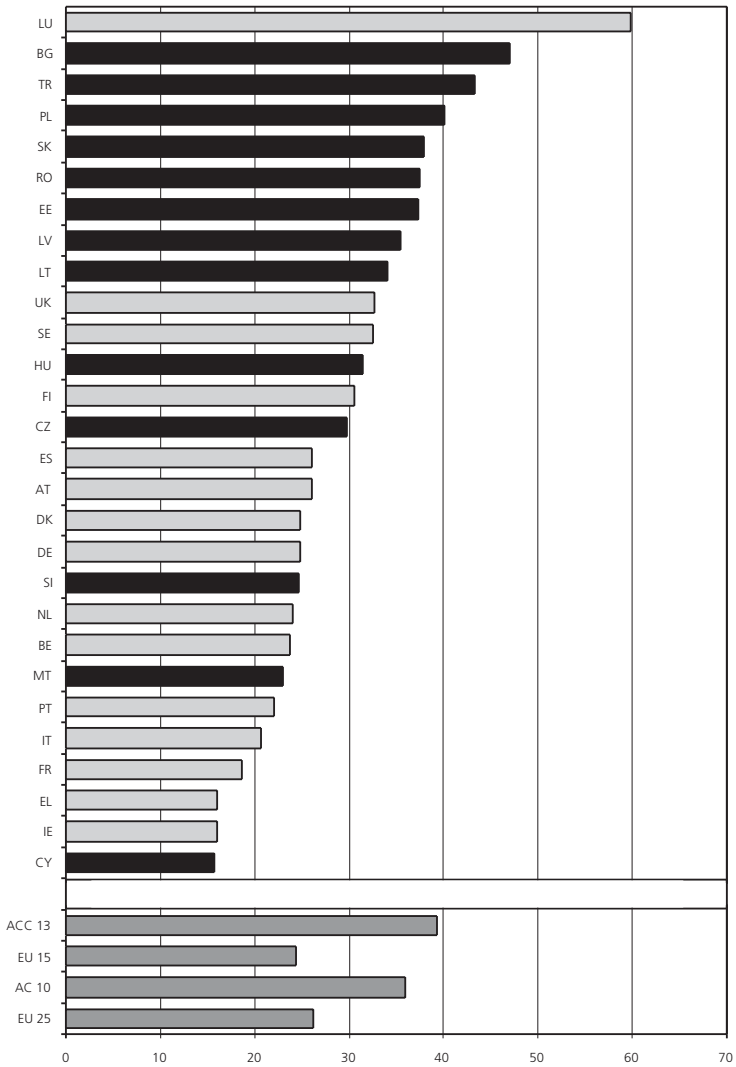


Source: Eurobarometer 52.1, Q17; Candidate Countries Eurobarometer 2002.1, Q25: *'If you had to go to each of the following places from home, how long would it take you? — The nearest hospital.'*

Common sense would lead us to believe that respondents give very similar answers to both questions — if it takes less than 20 minutes to get to a hospital and if hospitals are within walking distance of their home. However, this is not the case. As seen in Figure 3, EU citizens report distinctly easier access than ACC citizens when we ask for the time it takes to reach a hospital. When we ask for walking distance, however, it is the ACC countries that usually lead the rank-

order with high proportions of respondents who report quick access. If we abstract from the unusual case of Luxembourg, eight acceding and candidate countries are ahead of EU Member States (*see Figure 4*). A correlation analysis shows that both supposedly related indicators of hospital access vary rather independently of each other on the macro level (r = -.17).

Figure 4: Proximity to hospitals — walking distance (% finding a hospital within walking distance)

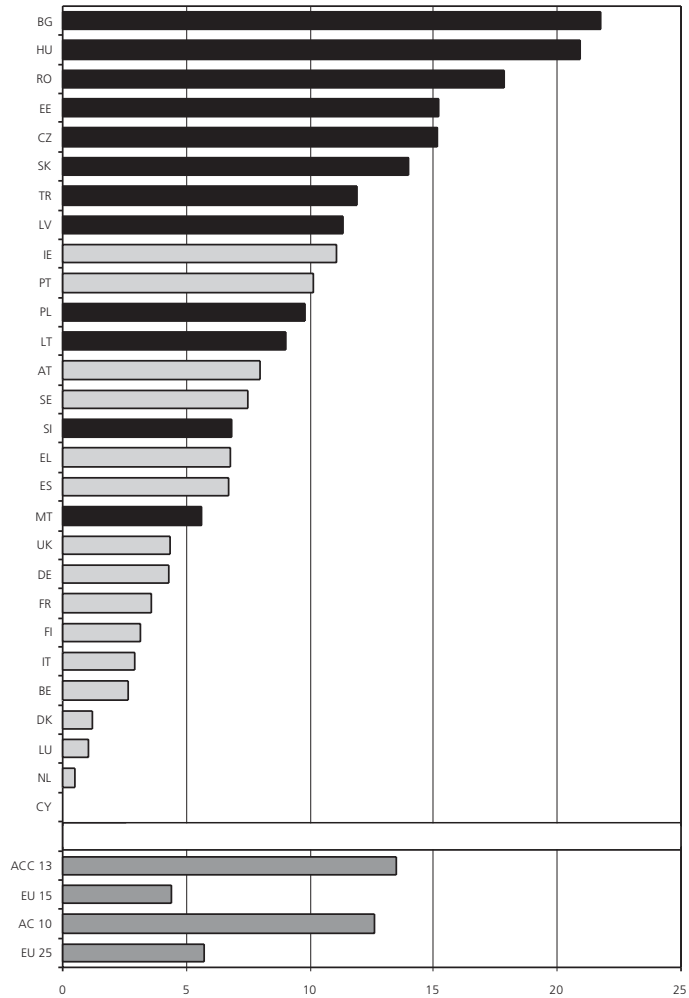


Source: Eurobarometer 52.1, Q17; Candidate Countries Eurobarometer 2002.1, Q25: '*If you had to go to each of the following places from home, how long would it take you? — And which of them are in walking distance from your home? — The nearest hospital.*'

This unexpected result suggests interpreting the answers not as straightforward indicators of the supply of health care facilities, but as indications that eastern and western Europeans have very different concepts of what the term 'within walking distance' means. ACC citizens presumably have cognitive maps which encompass much wider distances as being within walking range. Compared to EU citizens, who are more used to using their cars or public transportation to bridge distances, ACC citizens probably are much more used to span even medium-range distances by foot. This interpretation receives some support if we examine to what extent the two indicators are associated

with the level of national wealth (GDP per capita at purchasing power parities). Countries with higher national wealth have higher proportions of respondents who claim to get to a hospital in less than 20 minutes (r = .74), but there is no similar correlation between GDP per capita and hospitals within walking distance (r = -.10). This suggests that the distance in minutes could be regarded as the more valid indicator of access to the health care system.[27]

Figure 5: Proximity to hospitals — one hour or more (% having access to a hospital in specified time)



Source: Eurobarometer 52.1, Q17; Candidate Countries Eurobarometer 2002.1, Q25: '*If you had to go to each of the following places from home, how long would it take you? — The nearest hospital.*'

Given these difficulties with our indicators, it may be more telling for policymakers to know where access is very much impeded, in the sense of requiring more than one hour's travel. By this measure, countries within the EU come very close to realising the goal of universal easy access to hospital care. On average, 96% of the population need less time than one hour to get to a hospital (*see Figure 5*).[28] Only two EU countries (Ireland and Portugal) have minorities above 10% of the

[27] There is, however, a possibility that even this indicator might actually tell us more about the system of public transportation or the frequency of car ownership than about the supply of health care facilities.

[28] It should be noted that in most country samples the absolute number of cases with severe access problems is small.

respondents who need more than one hour. In the ACC, however, eight countries are above the 10% threshold, among them five of the acceding countries. Again, a crude comparison of European averages before and after enlargement would not reveal these discrepancies: it would show the European average to change modestly from 4% to 6% after the first wave of accession and to 7% after the completion of enlargement.

The high proportions of respondents who report to have easy access to hospitals in the EU suggest that social inequalities of access remain within narrow limits in EU countries. We will examine the degrees of inequality and exclusion from hospital care by comparing how selected groups who run particular risks of marginalisation compare to more privileged groups. We do this in various dimensions of inequality. First, we examine how access for the bottom quartile of the income distribution compares to access for those in the highest quartile. Secondly, we compare the situation of people living in rural and urban areas. Thirdly, we analyse if retired and unemployed people have greater problems of access than economically active people. Finally, we check how long it takes for those reporting a long-term illness to find access to hospitals compared to those who are not chronically ill. Since in many countries the number of those who need one hour or more to get to a hospital remains very small, we will focus the analysis on the more sizeable numbers of those who need more than 20 minutes to reach a hospital.

Within the current EU, 45% of those in the lowest income quartile and 60% of those in the highest quartile have easy access to hospitals within 20 minutes. Thus people with lower income have worse access to hospitals and a difference of 15 percentage points separates those with higher incomes from those with lower incomes. In the acceding and candidate countries, the income gap is much larger — with a difference of 26 percentage points on average. Hence EU enlargement will bring about some widening of inequality in hospital access. On average, the income gap will grow from its current 15 percentage points to 17 percentage points once the 10 acceding countries have joined, and to 19 percentage points after enlargement is completed. Again, these aggregate averages downplay the margin of change somewhat since they do not sufficiently reflect the situation in single countries (*see Table 6*). Within the current EU, the income gap is larger than 20 percentage points in only five countries, but eight of the 13 acceding and candidate countries — including five of the 10 acceding countries — report income gaps of this size or larger. At least by this measure, ensuring the goal of social inclusion in the health care sectors of EU countries will require some fresh efforts in the years to come.

Rural – urban differences are another important dimension of inequality in health care access. For the acceding and candidate countries, we can analyse to what extent people living in the countryside are blocked from easy access to hospitals compared to those living in towns and cities (*see Table 7*). A similar analysis for EU countries is not possible, however, because the survey which asked for the proximity to medical services did not contain a question concerning the place of residence. In the acceding and candidate countries, the rural–urban gap is just as important as the income gap with which it is statistically associated. Whereas only about 5% of the citizens living in cities need more than one hour to get to a hospital, about one-fifth of the population in the countryside needs this amount of time. Hungary reports the most severe problems of hospital supply in rural areas among the acceding countries, but the rural populations in the candidate countries of Bulgaria and Romania have even more difficulties. Securing general access to hospital services for all citizens is thus an uncompleted task that will require special health policy efforts in several countries currently aspiring to EU membership.

Table 6: Proximity to hospitals by income (% having access to a hospital in less than 20 minutes by quartiles of household-equivalence income)

Countries	Total	Lowest quartile	Highest quartile	Difference in percentage points
AT	40.8	38.7	42.9	4.2
BE	66.0	53.6	78.9	25.3
FR	54.4	43.4	65.3	21.9
DE	52.7	48.0	56.8	8.9
LU	69.7	69.9	69.6	-0.3
IT	60.9	47.0	75.2	28.2
EL	39.9	35.7	44.3	8.5
PT	37.8	27.2	49.0	21.9
ES	41.4	38.4	44.2	5.8
IE	44.6	40.5	48.7	8.2
NL	72.5	66.8	77.8	11.0
UK	45.5	34.2	57.8	23.6
DK	64.0	58.7	69.2	10.5
FI	50.9	48.0	53.8	5.8
SE	58.0	56.0	60.0	4.0
CZ	28.7	27.1	30.3	3.2
SK	31.8	16.6	49.7	33.1
SI	37.9	30.5	46.2	15.7
HU	31.4	16.0	46.8	30.8
PL	42.8	30.2	55.1	24.9
EE	28.1	21.1	35.1	13.9
LT	37.5	36.3	38.8	2.5
LV	31.8	23.9	40.1	16.2
MT	46.6	32.0	61.0	28.9
CY	69.1	55.1	81.9	26.8
BG	30.4	20.5	40.7	20.2
RO	33.3	19.4	46.7	27.3
TR	47.5	32.6	61.8	29.1
ACC 13	40.4	27.6	53.1	25.6
EU 15	52.8	44.9	60.4	15.5
AC 10	37.5	26.5	48.6	22.2
EU 25	50.0	41.5	58.3	16.8

Source: Eurobarometer 52.1, Q17/D29; Candidate Countries Eurobarometer 2002.1, Q25/D29: *if you had to go to each of the following places from home, how long would it take you? — The nearest hospital.'*

Table 7: Proximity to hospitals by residence in rural or urban settings (% living in specified proximity to a hospital by location of residence)

	Less than 20 minutes				One hour or more			
Countries	Rural	Town	City	Difference Rural–City	Rural	Town	City	Difference Rural–City
CZ	7.1	32.8	42.1	-35.0	22.9	12.7	11.3	11.5
SK	11.5	40.8	43.8	-32.3	23.4	10.6	4.9	18.4
SI	25.0	48.4	60.4	-35.4	11.1	3.0	1.0	10.0
HU	4.4	40.1	51.6	-47.2	34.9	14.4	8.7	26.2
PL	14.5	55.7	54.5	-40.0	17.5	5.6	3.5	14.0
EE	8.9	49.2	30.5	-21.6	26.7	10.0	9.8	16.9
LT	16.4	60.6	33.3	-16.9	19.6	1.9	4.8	14.8
LV	13.2	48.4	33.8	-20.6	26.0	6.6	3.2	22.8
MT	57.7	47.1	39.3	18.4	1.9	9.6		
CY	37.7	76.2	88.1	-50.4				
BG	10.8	36.7	43.7	-32.9	43.1	16.5	11.1	31.9
RO	15.9	44.1	55.9	-40.0	33.9	5.4	2.2	31.7
TR	28.3	61.1	57.9	-29.6	19.6	3.7	6.9	12.7
ACC 13	19.0	50.6	52.4	-33.4	23.4	7.1	6.2	17.2
AC 10	12.3	47.9	48.4	-36.1	21.6	8.5	5.6	15.9

Note: Empty cells indicate zero respondents in that category.

Source: Candidate Countries Eurobarometer 2001, Q25/D25: '*If you had to go to each of the following places from home, how long would it take you? — The nearest hospital.*'

Economic activity not only provides income and social contacts, but also better access to hospitals. In EU Member States, as in the ACC, people who are working usually live in greater proximity to hospital care than the population average. Non-working groups usually have less easy access, but within the EU the respective differences are not very large. Even among retired people and the unemployed, roughly one-half find easy access to hospitals in the EU. Differences related to employment status are usually higher in acceding and candidate countries, where less than one-third of retired people find easy access to hospitals. The average gap separating retired people from the economically active is almost twice as large in the ACC as in the EU (nine rather than five percentage points), whereas the gap for the unemployed is identical in both groups of countries. This suggests that securing easy hospital access for retired people will remain a challenge for health policymakers in several acceding and candidate countries.

To what extent are people with a long-term illness at a disadvantage compared to healthy people when it comes to easy hospital access? In the EU, the gap separating the long-term ill from the healthy is usually not very large. With one-half of the chronically ill having easy access to hospitals on average, the proportion is just three percentage points lower than among healthy people. In the ACC, the average gap is not much larger, but the percentage of long-term ill people who find easy access to hospitals is sizeably lower than in the EU. While there is no single country in the current EU where less than one-third of the long-term ill report easy access to hospitals, the majority of acceding and candidate countries remain below this mark. Comparing the ease of access for the chronically ill with that for healthy people, we find the latter report easier access than the long-term

ill in most EU 15 and most ACC 13 countries alike. In this sense, the structure of access tends to run counter to the structure of need. As the average gaps remain small, however, there are no alarming signs of a disproportionate exclusion of the long-term ill from hospital care in either group of countries and there is no pattern of disadvantage that would clearly distinguish one group of nations from another.

Proximity to general practitioner's surgery

Using our yardstick of quick access to a hospital within 20 minutes, the goal of securing easy access to primary care is realised for 85% of the citizens in the EU 15 countries, but for only 62% in the ACC 13 countries. Once again, judging from the aggregate averages, we would not see large effects of the various steps of enlargement. The first wave of accession will lower the European average by only three percentage points, while the second wave would lower it by a further four points. Yet a look at individual countries reveals marked differences, with a tendency for EU 15 countries and ACC 13 countries to cluster together as rather distinct families of nations at opposite ends of the distribution (*see Figure 6*). In the EU, there are only two countries where less than 70% of the respondents report reaching a general practitioner's surgery in less than 20 minutes. On the other hand, only five of the 13 acceding and candidate countries attain this level of widespread easy access. Severe problems in reaching a doctor's surgery are rare, however. The proportion of people with very difficult access (in the sense of more than one hour's travel to the nearest doctor's office) is small and extends only in Bulgaria and Turkey to above 5%. In other words, throughout all acceding and candidate countries more than 90% of citizens get to a general practitioner within less than one hour and in this sense there is almost universal access to primary care.

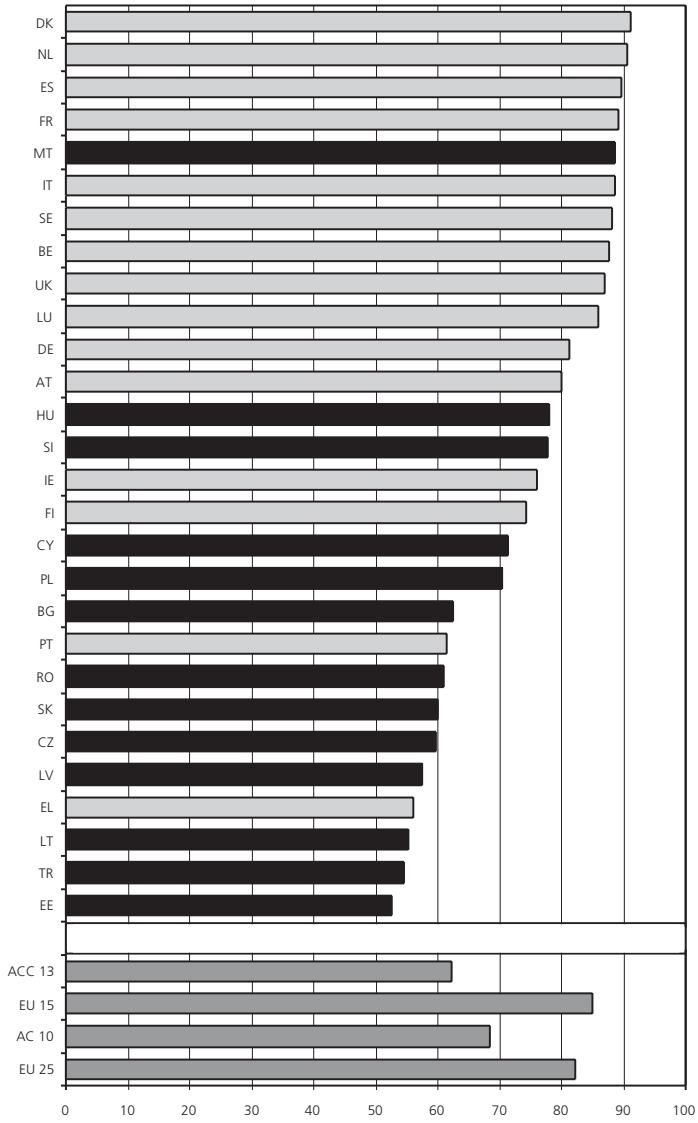
Policymakers need to know if a problematic access to medical facilities is rooted in a general shortage of supply, in the unequal regional distribution of supply or in the system of (public) transportation. To the extent that it is rooted in the scarcity of supply, we would expect a positive correlation between supply indicators (such as the number of physicians or hospital beds per population) and the ease with which respondents find access. If, however, we find access to be independent of aggregate indicators of supply, this would be an indication of a distorted distribution rather than an inadequate level of supply (or else perhaps also of difficulties in access to means of transportation). Correlating the number of physicians per 100,000 population with the time it takes to find access to a doctor's surgery, we find no association between supply and access in either the acceding and candidate countries ($r = -.06$) or EU 15 countries ($r = -.00$). In both groups, a higher supply of physicians does not visibly translate into easier access (for all 28 countries together, $r = .15$). This might suggest that the regional distribution of doctors is skewed since at least some groups of doctors such as specialists tend to be heavily concentrated in cities.[29]

Our data on physician density do not distinguish between general doctors, specialists and hospital doctors, but for the acceding and candidate countries, our survey allows an analysis of the extent to which the rural population has difficulties in getting access to a general doctor's surgery within

[29] In order to eliminate possible effects of the (public) transportation system, we can further analyse if access in terms of living within *walking distance* from a doctor's surgery varies independently of physician supply. This analysis substantiates that a higher physician density does not immediately translate into easier access. Neither within the EU 15 ($r = .03$) nor within the ACC 13 ($r = .25$) do we find a correlation that is significantly higher than zero ($r = .04$ for all countries together). This is further evidence that physicians tend to be concentrated in cities and that their regional distribution probably does not follow the regional distribution of demand for medical care.

reasonable time limits. As Table 8 shows, the rural–urban gap is less marked than we might have expected on the basis of the hypothesis that physicians tend to flock to cities. On average, the majority of people living in the countryside need less than 20 minutes to get to a doctor's surgery in the ACC. However, in half of the 10 acceding countries and in one of the candidate countries, a majority of the rural population does not live in such proximity to a doctor's surgery. Nonetheless, severe problems of access are not very widespread, as even among people living in the countryside only small minorities report to need more than one hour to find a doctor. Whereas there is a visible rural – urban gap with respect to quick and easy access, very difficult access is almost as rare in the countryside as in the city.

Figure 6: Proximity to general practitioner's surgery (% having access in less than 20 minutes)



Source: Eurobarometer 52.1, Q17; Candidate Countries Eurobarometer 2002.1, Q25: '*If you had to go to each of the following places from home, how long would it take you? — Your general doctor/health centre.*'

Table 8: Proximity to general practitioner's surgery by residence in rural or urban settings (% having access in less than 20 minutes by location of residence)

	Less than 20 minutes				One hour or more			
Countries	Rural	Town	City	Difference Rural–City	Rural	Town	City	Difference Rural–City
CZ	47.1	66.8	62.2	-15.1	8.2	2.8	0.8	7.4
SK	61.7	57.4	63.2	-1.5	3.3	3.5	2.5	0.8
SI	74.8	82.5	74.2	0.6	1.8	0.7	1.0	0.8
HU	75.8	76.7	82.4	-6.6	5.4	1.2	4.0	1.5
PL	56.8	78.4	80.9	-24.1	4.1	1.4	2.0	2.1
EE	48.4	64.5	46.7	1.7	9.2	1.6	2.5	6.7
LT	44.4	71.2	55.0	-10.6	10.5	1.4	0.2	10.3
LV	46.7	57.1	64.2	-17.5	8.7	3.3	2.0	6.7
MT	88.2	87.7	90.2	-2.0	2.0	0.4		
CY	48.6	78.9	84.2	-35.6	0.7			
BG	67.4	58.6	61.3	6.1	10.0	6.8	2.9	7.1
RO	62.0	62.1	57.8	4.2	5.0	1.1	3.6	1.4
TR	47.9	66.0	55.4	-7.6	11.7	4.5	7.1	4.6
ACC 13	55.5	69.5	64.1	-8.5	7.8	2.6	4.3	3.6
AC 10	59.2	73.9	73.9	-14.7	5.1	1.8	2.1	3.0

Note: Empty cells indicate zero respondents in that category.

Source: Candidate Countries Eurobarometer 2002.1, Q25/D25: *'If you had to go to each of the following places from home, how long would it take you? — Your general doctor/health centre.'*

Within the current EU, proximity to a doctor's surgery is not related to income. The proportion of respondents who report quick access in the highest income quartile is only three percentage points higher than in the lowest income quartile; indeed, there are some EU countries where those in low-income groups report even quicker access. In the ACC group, no such reverse order case exists and the income gap is usually higher, reaching 10 percentage points on average. In the EU, there are only three exceptions to the rule that at least 70% of those in the lowest income quartile get to a doctor's surgery quickly, whereas in the ACC 13 group only two countries attain this target (*see Table 9*). Once again the development of the European average size of the income gap before and after enlargement conceals the dynamic of change rather than reveals it. The individual country data show that effectively securing access to primary health care for low-income groups in all member countries will actually become a more challenging task for health policymakers in the enlarged Europe since there are considerable gaps in several countries.

Exclusion from work is not closely linked with exclusion from quick access to health care, but working people, in comparison to retired people, do report more frequently being able to find easy access to a doctor. On average, the differences to retired people or unemployed people are not very large. However, there are seven countries within the current EU, and eight within the group of acceding and candidate countries, where a gap beyond five percentage points separates retired people from those who have a job. On average, the work-related gap tends to be larger in the ACC. Unemployment is nowhere consistently related to difficulties in finding a doctor, but it has more impact on access in the ACC than in the EU, where unemployed persons frequently even report easier access than those who are economically active.

Table 9: Proximity to general practitioner's surgery by income (% having access in less than 20 minutes by quartiles of the household-equivalence income)

Countries	Total	Lowest quartile	Highest quartile	Difference in percentage points
AT	75.8	85.0	67.1	-17.9
BE	89.0	82.5	95.9	13.4
FR	87.8	86.9	88.6	1.7
DE	81.9	82.9	81.0	-1.9
LU	84.4	85.7	83.1	-2.6
IT	91.1	90.1	92.1	2.0
EL	58.1	50.8	65.7	14.9
PT	64.6	64.4	64.7	0.3
ES	90.7	92.2	89.4	-2.8
IE	83.2	80.8	85.7	4.9
NL	91.9	89.0	94.6	5.5
UK	83.4	77.4	89.7	12.3
DK	91.4	88.5	94.2	5.7
FI	76.1	68.9	83.3	14.4
SE	91.1	86.6	95.6	9.0
CZ	63.5	62.1	64.9	2.9
SK	58.2	51.5	66.1	14.6
SI	80.0	76.2	84.2	8.0
HU	74.3	66.5	81.9	15.4
PL	71.2	64.6	77.5	12.9
EE	53.0	49.5	56.3	6.9
LT	61.5	56.6	66.9	10.2
LV	59.9	55.0	64.9	9.8
MT	89.4	87.4	91.3	4.0
CY	71.7	60.6	81.7	21.2
BG	58.5	58.1	58.8	0.7
RO	59.6	54.7	64.3	9.6
TR	54.4	49.2	59.2	10.0
ACC 13	61.7	56.6	66.7	10.1
EU 15	84.7	83.3	86.0	2.7
AC 10	69.1	63.1	75.1	11.9
EU 25	81.8	79.4	84.0	4.6

Source: Eurobarometer 52.1, Q17/D29; Candidate Countries Eurobarometer 2002.1, Q25/D29: *'If you had to go to each of the following places from home, how long would it take you? — Your general doctor/health centre.'*

The majority of long-term ill people find easy access to a general practitioner in EU Member States and acceding and candidate countries alike. Beyond this similarity, however, there are some noteworthy differences, which the aggregate averages once more tend to conceal. Within the EU, Greece and Portugal are currently the only countries where less than 60% of the long-term ill find

quick access to a doctor. Within the ACC group, nine remain below this margin, among them six of the acceding countries. In EU Member States and acceding and candidate countries alike, those who are chronically ill report to have less easy access to primary care than those who are healthy and hence would actually need the services less. Currently, there are only three EU Member States where the illness-related gap in access extends to above five percentage points, but it is beyond this magnitude in 10 of the ACC 13 countries. Realising the goal of universal access to health care services throughout the EU will thus require intensified policy efforts after enlargement.[30]

[30] Once again, a crude comparison of aggregate averages in EU 15 and ACC 13 countries tends to conceal rather than reveal this pattern. The average gap to the disfavour of the long-term ill will grow in Europe only marginally from its current size of 2 percentage points to roughly 5 percentage points after the first wave of accession. After the second wave of enlargement it would even shrink on average, but this largely reflects the peculiar situation in Turkey which is the only ACC country where the long-term ill report even better access, but which influences the aggregate average decisively due to its population size.

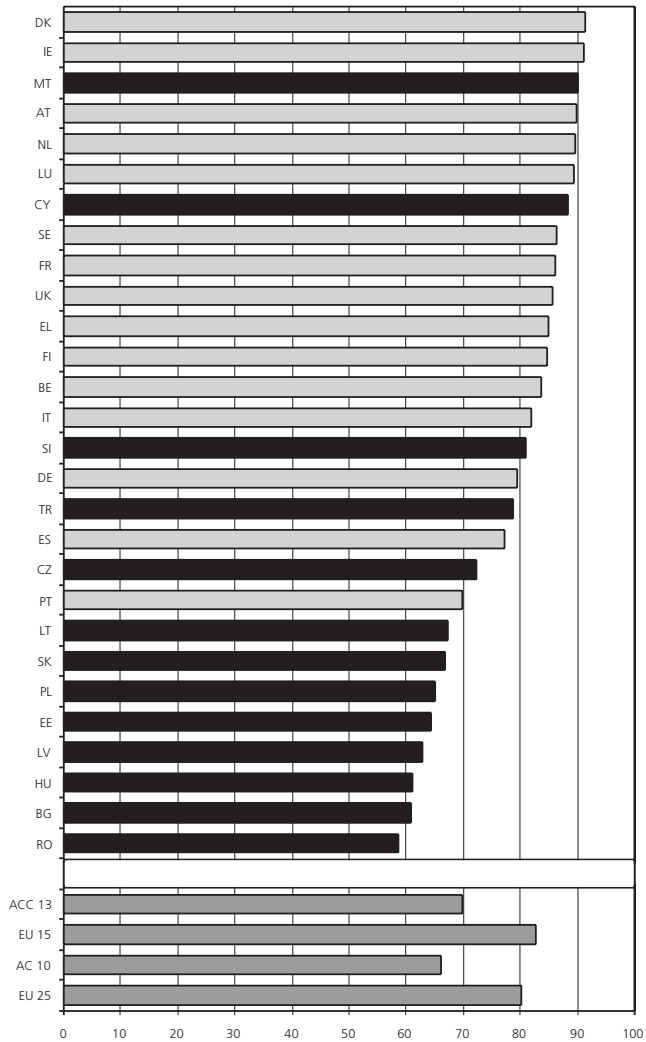
3 Satisfaction with health and the health care system

Satisfaction with personal health

The satisfaction of people with their own health is interesting for two reasons. Firstly, it is an important contributor to subjective well-being and in this sense also an important element of perceived quality of life in its own right. Secondly, it may be regarded as an indicator of the actual health status of the population.

In our surveys, respondents were asked if they were 'very satisfied', 'fairly satisfied', 'not very satisfied' or 'not at all satisfied' with their own health condition. The results are shown in Figure 7, which plots the sum of the fractions of 'fairly satisfied' and 'very satisfied' respondents for each country.

Figure 7: Health satisfaction
(% being fairly or very satisfied with their own health)



Source: Eurobarometer 52.1, Q13; Candidate Countries Eurobarometer 2002.1, Q4.2: *'Please tell me whether you are very satisfied, fairly satisfied, not very satisfied or not at all satisfied with each of the following? — Your own health.'*

On average, about 80% of Europeans are at least fairly satisfied with their health. However, there are striking differences between EU 15 and ACC 13 countries. In the acceding and candidate countries, only about 70% are at least fairly satisfied and in the 10 acceding countries this fraction is even lower. If we look at the country level, at least two groups of countries can be identified. The first group has relatively low satisfaction rates and is formed by the post-Communist states (with the exception of Slovenia) and by Portugal. The second group, with higher satisfaction rates, is formed by the EU Member States and by Slovenia, Turkey, Cyprus and Malta. To a large extent, then, the differences in health satisfaction between the EU and ACC are the result of low satisfaction rates in the post-Communist states of Eastern Europe.

It may appear doubtful to what extent the differences in health satisfaction between the post-Communist countries and other European nations are specific to health, because it can be argued that various countries have different cultures of expressing satisfaction with any object. This argument would imply that satisfaction with health may vary in a randomised fashion, which is independent of actual health status. However, we have two possibilities to gain further information on the validity of health satisfaction as an indicator of the actual health condition.

The first possibility is to analyse the connection between health satisfaction and indicators of the actual health status. Our questionnaire provides us with three such indicators: the question whether a respondent has a long-standing illness or disability; the question whether sickness or invalidity allowance is among the sources of income; and the question whether good health would improve the respondent's quality of life. Correlating health satisfaction with each of these indicators, we find health satisfaction to decrease when indicators of bad health status are present. This is true on the aggregate level as well as on the individual level: countries with high levels of bad health tend to have lower rates of health satisfaction and within each country respondents with a bad health status have lower health satisfaction than those with a better health status. This suggests that health satisfaction does indeed express the satisfaction with the respondent's health condition rather than just a general inclination to describe oneself as satisfied.

The second possibility to validate health satisfaction as an indicator of the actual health condition is to inspect the health satisfaction of groups that are known for their health problems. Since the prevalence of health problems is known to increase with age, for example, older people should be more dissatisfied with their health status than younger people, if our indicator is valid. As Table 10 shows, this is indeed the case. The fraction of respondents who are at least fairly satisfied with their own health is lowest in the oldest age group and highest in the youngest age group in almost all countries. The effect of age on health satisfaction is on average much stronger in acceding and candidate countries than in EU Member States. It is strongest in the acceding countries, where those in the youngest age quartile are about as satisfied with their health as their peers in the EU, whereas the older groups display a much lower level of satisfaction. In other words, the 'newcomers' to the EU have a much higher age-related inequality of health satisfaction than the old-established members. However, the basic pattern of an age impact on health satisfaction is found in countries both inside and outside current EU borders. Even in cases where the pattern of monotonous increase is not reproduced exactly, we still find a general tendency for health satisfaction to decrease with age. This provides further evidence that health satisfaction can be regarded as a valid indicator of actual health status.[31]

[31] When we analyse how health satisfaction varies with occupational status, no consistent tendencies show up since there is a lot of country-specific variation. Most countries, however, have it in common that students tend to report high satisfaction levels with their health, whereas retired people tend to have low health satisfaction scores. Once more, this underlines the effect of age.

Table 10: Health satisfaction by age
(% being fairly or very satisfied with their own health by quartiles of age)

		Age Quartiles			
Countries	Total	Lowest	Second	Third	Highest
AT	89.0	97.0	97.6	93.5	73.6
BE	83.2	86.8	86.5	82.6	79.0
FR	85.8	90.7	91.1	88.7	75.9
DE	79.3	93.7	89.0	81.5	64.1
LU	89.1	93.0	89.7	88.6	87.3
IT	81.3	93.3	92.7	82.9	65.9
EL	84.8	94.1	92.6	89.5	70.6
PT	69.1	94.1	86.4	69.0	38.2
ES	77.3	90.0	88.7	78.7	57.5
IE	90.5	93.6	95.5	93.7	81.7
NL	88.6	92.2	92.0	85.3	85.7
UK	85.7	92.5	90.0	83.3	79.8
DK	91.4	94.6	95.0	91.8	86.1
FI	84.3	94.0	91.2	83.3	74.5
SE	86.2	89.2	93.5	87.1	78.5
CZ	71.2	90.9	84.1	73.8	45.2
SK	65.7	91.2	86.9	61.6	35.9
SI	79.8	94.6	92.1	75.3	64.5
HU	60.5	89.4	83.7	52.1	40.0
PL	64.7	91.8	79.4	62.8	34.5
EE	63.4	88.7	78.1	58.1	37.3
LT	67.3	86.5	79.3	60.3	48.4
LV	62.7	89.5	75.9	57.1	37.7
MT	89.6	98.5	97.6	87.9	80.6
CY	87.8	97.0	96.7	88.0	75.3
BG	60.3	93.3	83.4	61.0	32.0
RO	58.5	84.5	76.8	56.5	34.5
TR	79.3	88.4	78.1	72.8	71.8
ACC 13	69.3	89.2	79.6	65.0	43.7
EU 15	82.5	92.3	90.5	83.7	69.6
AC 10	65.7	91.1	81.7	62.8	39.4
EU 25	79.8	92.0	89.3	80.0	65.1

Source: Eurobarometer 52.1, Q13/age; Candidate Countries Eurobarometer 2002.1, Q4.2/age: *'Please tell me whether you are very satisfied, fairly satisfied, not very satisfied or not at all satisfied with each of the following? — Your own health.'*

A vast body of research has shown health conditions to co-vary with socio-economic status (Marmot and Bobak, 2000; Marmot and Wilkinson, 1999; Maucher, 1996). Thus, lower social groups tend to be less well-nourished, to live more frequently in unhealthy environments and to have more dangerous jobs than the more affluent. Hence, to the extent that it is a valid indicator, we would also expect health satisfaction to co-vary with income. Table 11 shows that this is indeed

the case. In 16 of the 28 countries, health satisfaction increases continuously with income; in 11 of the remaining 12, we find at least the overall tendency of growing health satisfaction in higher income categories.[32] Once again, we find the current EU Member States to be more egalitarian with respect to health satisfaction than the acceding and candidate countries, as the income-related differences in satisfaction are much lower in the EU 15 countries.

Table 11: Health satisfaction by income (% being fairly or very satisfied with their own health by quartiles of household-equivalence income)

Countries	Total	Lowest	Second	Third	Highest	Difference Highest - Lowest
AT	88.9	85.3	86.9	86.9	96.0	10.7
BE	82.4	74.3	80.9	88.9	86.4	12.1
FR	84.6	80.2	86.2	83.9	87.7	7.5
DE	79.3	71.2	77.2	83.2	85.7	14.5
LU	87.3	91.9	88.0	84.0	85.9	-6.0
IT	78.6	78.2	77.4	79.1	79.7	1.5
EL	84.5	73.7	83.4	86.2	95.0	21.3
PT	63.6	42.3	58.4	70.8	84.3	42.0
ES	76.9	59.9	77.2	82.3	87.4	27.5
IE	89.7	83.5	86.8	92.5	96.5	13.0
NL	88.2	83.1	87.4	91.0	91.2	8.1
UK	85.7	75.2	88.9	90.1	89.4	14.2
DK	91.3	88.3	88.5	96.0	92.5	4.2
FI	84.4	82.1	85.4	80.7	89.3	7.2
SE	86.4	81.3	88.5	87.8	88.1	6.8
CZ	69.3	57.7	62.6	76.5	81.4	23.7
SK	61.6	44.9	59.1	64.8	80.3	35.4
SI	79.4	68.8	83.7	80.4	86.5	17.7
HU	59.3	45.6	57.3	60.1	73.9	28.3
PL	63.0	61.5	54.6	60.6	75.0	13.5
EE	61.4	54.6	43.3	67.1	78.5	23.9
LT	66.0	57.6	66.6	66.2	74.3	16.7
LV	60.9	55.1	42.3	66.8	78.7	23.6
MT	90.7	87.7	84.4	92.0	98.3	10.6
CY	88.2	73.2	85.6	94.9	98.5	25.3
BG	59.5	47.1	51.8	56.1	82.7	35.6
RO	57.4	45.3	48.0	61.5	75.5	30.2
TR	79.3	73.6	78.9	80.2	84.1	10.5
ACC 13	68.7	61.1	63.9	70.1	79.7	18.6
EU 15	81.7	74.3	81.2	84.4	87.0	12.7
AC 10	63.9	57.1	57.5	64.3	76.7	19.6
EU 25	78.4	71.0	76.9	80.5	85.1	14.1

Source: Eurobarometer 52.1, Q13/D29; Candidate Countries Eurobarometer 2002.1, Q4.2/D29: *'Please tell me whether you are very satisfied, fairly satisfied, not very satisfied or not at all satisfied with each of the following? — Your own health.'*

[32] Luxembourg shows an income effect in the opposite direction, but the difference between the most satisfied and the least satisfied income group is not statistically significant.

Finally, we can look at the gendered distribution of health satisfaction (*see Table 12*). Even though women are known to have a higher life expectancy than men, they usually report more days of poor physical and mental health, have a higher prevalence of a number of chronic illnesses and are more likely to be hospitalised for mental health conditions (*see* http://www.hlunix.hl.state.ut.us/action2000/section2.pdf).[33] In line with this body of research, we found women to be more

Table 12: Health satisfaction by gender (% being fairly or very satisfied with own health by gender)

Countries	Total	Female	Male	Difference Male-Female
AT	89.0	87.5	90.7	3.2
BE	83.2	82.6	83.9	1.3
FR	85.8	84.0	87.8	3.8
DE	79.3	77.4	81.5	4.1
LU	89.1	89.4	88.7	-0.7
IT	81.3	78.6	84.2	5.6
EL	84.8	82.5	87.2	4.7
PT	69.1	63.9	74.8	10.9
ES	77.3	73.6	81.3	7.7
IE	90.5	91.6	89.4	-2.2
NL	88.6	86.1	91.2	5.1
UK	85.7	85.4	86.0	0.6
DK	91.4	89.4	93.4	4.0
FI	84.3	84.4	84.1	-0.3
SE	86.2	84.8	87.7	2.9
CZ	71.3	71.7	70.8	-0.9
SK	65.7	61.5	70.9	9.4
SI	79.5	74.3	85.8	11.5
HU	60.5	54.9	67.5	12.6
PL	64.7	59.7	70.3	10.6
EE	63.4	58.1	69.4	11.3
LT	67.3	64.9	70.0	5.1
LV	62.8	56.5	70.0	13.5
MT	89.6	90.3	89.0	-1.3
CY	87.8	88.7	86.9	-1.8
BG	60.4	57.3	64.0	6.7
RO	58.8	51.8	67.1	15.3
TR	79.3	75.5	82.9	7.4
ACC 13	69.3	64.6	74.4	9.8
EU 15	82.5	80.5	84.6	4.1
AC 10	65.8	61.6	70.6	9.0
EU 25	79.8	77.3	82.5	5.2

Source: Eurobarometer 52.1, Q13/D10; Candidate Countries Eurobarometer 2002.1, Q4.2/D10: *'Please tell me whether you are very satisfied, fairly satisfied, not very satisfied or not at all satisfied with each of the following? — Your own health.'*

[33] For a recent empirical discussion of the old wisdom that 'women are sicker, but men die quicker', see Annandale and Hunt (2000) and Hurrelmann and Kolip (2002).

frequently subject to long-term illness than men. The subjective satisfaction with health reflects this gendered distribution of morbidity. In 23 of the 28 countries, women are more dissatisfied with their health than men.[34] Gendered differences in health satisfaction tend to be higher in the acceding and candidate countries than in the current EU Member States, but in both groups gendered inequalities are smaller than the income-related differences.

Satisfaction with the health care system and social services

From a quality of life perspective, it is certainly relevant to know to what extent citizens are satisfied with their health condition and to what extent social inequalities in satisfaction are more or less divisive in one context than another. From a policy perspective, however, it may be even more important to know how citizens perceive the health care system and how united or divided they are in the assessment of the prevailing public provisions.

Since the health care system and social services are major domains of modern welfare states, their acceptability can be regarded as an important basis for the legitimation of the political system. Three questions in the questionnaire provide information on the degree of acceptance of the health care system and of social services. In one question, respondents were asked if they were 'very satisfied', 'fairly satisfied', 'not very satisfied' or 'not at all satisfied' with their country's health care system in general. In two other questions, people could express their satisfaction with the health services and social services on an anchored scale between 1 ('not at all satisfied') and 10 ('extremely satisfied'). The data show a remarkable similarity across all three questions[35], which suggests that they may be considered to be different measurements of the same attitude.

Given the affinity of all three indicators, we can sum up respondents' answers and obtain a summary measure, which helps cancel out some of the random measurement errors. However, since only the two questions about satisfaction with the health care system and the social services were asked in the same Eurobarometer survey, we can only aggregate the values for these two questions.[36] The resulting index is calculated as the mean value for both questions and ranges from one to 10 (where one is 'not at all satisfied' and 10 is 'extremely satisfied'). This combined index serves as the basis for all following analyses. Hence, when we speak of the 'satisfaction with the health care system' or 'health care satisfaction' in the following discussion, we always mean the combined satisfaction with health care and the social services.

Figure 8 gives the mean satisfaction scores by country. On average, the satisfaction with the health care system is sizeably lower in acceding and candidate countries than in the EU. Two distinct groups of countries are visible: the first, with low satisfaction scores, is dominated by the ACC, while the second, with high satisfaction scores, unites the EU Member States. The exceptions to

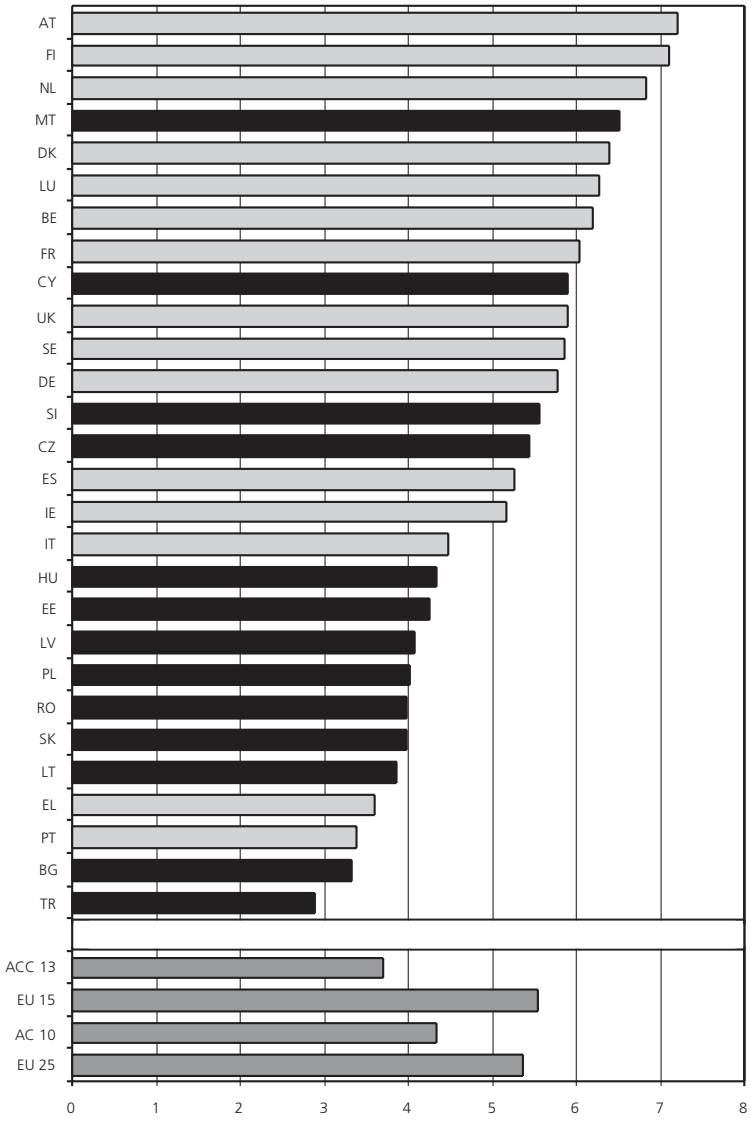
[34] The exceptions to this pattern are Luxembourg, Ireland, the Czech Republic, Cyprus and Malta, but none of the differences between men and women in these countries is statistically significant.

[35] Our results for satisfaction with the health care system in EU Member States are very much in line with the findings of the Eurobarometer survey in 1996, which contained a special section on citizens' perceptions of their country's health system (Mossialos, 1998). Data show that there is a correlation of .89 between the average national satisfaction scores reported in the 1996 survey and in our 1998 survey. The rank-order correlation is .69. The discrepancy is largely due to Austria, which has the highest health satisfaction score in our 1998 Eurobarometer survey, but occupied only rank 9 in the 1996 survey.

[36] Biplots and factor analysis indicate that Q26a and Q26b measure the same dimension, whereas the answers to the question with the 4-point scale (Q4.3) measure something else. Cronbach's alpha for a simple additive scale from Q26a and Q26b is about .81, which may be regarded as sufficient.

this are Greece, Portugal and Italy, which have similarly low satisfaction scores as the acceding and candidate countries, whereas Slovenia, the Czech Republic, Cyprus and Malta have similarly high scores as the EU Member States.

Figure 8: Satisfaction with health care system (combined index of satisfaction with health care and with social services)



Source: Eurobarometer 50.1, Q35; Candidate Countries Eurobarometer 2002.1, Q26: *'On a scale from 1 to 10, how satisfied are you with the social services in (OUR COUNTRY)? And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?'*

The EU policy goal of social cohesion implies that social inequalities should remain within reasonable margins so that the population is not polarised into distinctly different segments whose members have little in common. In addition, political systems may only be considered stable to the extent that they enjoy widespread support of the citizens. In modern welfare states, support critically hinges on the perception of the effectiveness of public services. Hence we would like to know how much inequality there is in the perception of state services, what type of inequality is

most marked and to what extent the middle mass of people, who pay most of the taxes and control the bulk of the votes, are satisfied with the prevailing services. We will proceed in two steps:

- first, we analyse the degree of polarisation in various dimensions of social inequality;
- then we take a closer look at the satisfaction of the middle mass.

We define 'polarisation' as the difference of the mean satisfaction scores in different groups: the higher this difference, the higher the polarisation between the groups. Satisfaction with the health care system is measured by our additive index of satisfaction with health services and of satisfaction with social services. Our groups are formed by employment, age, gender, income and occupational class.

Theoretically, we may expect the most crucial group differences to run between employment and retirement. Retired people are generally older and therefore at a higher risk of encountering health problems. As a consequence, they benefit from high-quality services provided by the health care system. On the other hand, the financial burden of a health care system is mainly on employed persons, who benefit to a lesser degree from its services. Sociologists refer to inequalities that are created by the distorted distribution of state-provided burdens or benefits as 'transfer classes' or 'risk categories' (Alber, 1984; Baldwin, 1990; Lepsius, 1979). Hence we may see retired and employed people as distinct transfer classes with different interests. The potential tensions between them are moderated, however, because employed people can expect to eventually become net beneficiaries of the health care system also. We use the degree of dissatisfaction among employed people relative to the retired as an indicator for the strength of the potential cleavage. Table 13 shows the empirical data, displaying the mean satisfaction scores by employment status. To emphasise the contrast between employed and retired people, we have added a column where the health care satisfaction of employed people is subtracted from the satisfaction score of retired people. Negative numbers indicate that employed people are less satisfied with the health care system and vice versa.[37]

The main result emerging from Table 13 is that employed people tend to be more dissatisfied with the health care system than the retired. The data sustain the idea of a tension between risk categories created by the unequal impact of public policies. It is noteworthy, however, that the country-specific size of the gap is not related to the expansion of the public health care system in our countries. Among those with a relative high degree of polarisation are Slovenia, Greece, Malta, the UK and France. These countries have different kinds of health care systems, with vastly discrepant levels of public health expenditure.[38] Since these differences do not translate into

[37] One methodological qualification must be noted. The averages for the country groups may give a distorted impression because the proportion of retired and employed people may vary systematically between countries with high and low satisfaction scores. Thus, retired people may be found more frequently in countries with low satisfaction scores, whereas employed people may be more sizeable in high satisfaction countries. Hence, the aggregate means which we calculate for our families of nations do not only result from group-specific levels of satisfaction, but also from the different *general* levels of satisfaction in countries where our social groups are represented in different proportions. Similar composition effects can influence all other comparisons based on average group-specific differences in our various families of nations (such as EU 15, ACC 13 or AC 10). Hence we must always be cautious with interpretations of averages of group-differences in various aggregates of countries.

[38] Previous research has shown a tendency for satisfaction with the health care system to co-vary with per capita expenditure on health (Mossialos, 1998). We have collected data on public health expenditures in order to test the relationship between expenditure levels and health care satisfaction. However, standard sources for health expenditure ratios (http://www.oecd.org/dataoecd/12/39/2957398.xls; WHO Health Report, 2002) turned out to give such widely discrepant information that we could not reliably determine, for example, if expenditure grew or shrank over selected years. Hence we abstained from a formal analysis.

corresponding gaps of satisfaction among transfer classes, we conclude that the own position in the structure of privilege created by health care policies remains probably too vague and invisible for citizens to have a clear impact on their perceptions of policy performance. As already suggested, one possible explanation for this is that people's positions in the transfer class structure are not stable over the life-cycle, so that present payment of high taxes or contributions coincides with expectations of over-proportionate benefits in the future.

Table 13: Satisfaction with health care system by economic activity (combined index of satisfaction with health care and social services by employment status)

Countries	Total	Housewives	Retired	Unemployed	Employed	Difference retired – employed
AT	7.2	7.4	7.5	6.4	7.1	0.4
BE	6.2	6.0	6.6	5.8	6.1	0.5
FR	6.0	5.7	6.6	5.5	5.9	0.7
DE	5.8	5.8	6.0	5.1	5.8	0.2
LU	6.3	6.6	6.3	5.6	6.3	0.0
IT	4.4	4.4	4.6	4.4	4.4	0.2
EL	3.5	3.7	4.1	3.1	3.3	0.8
PT	3.3	3.3	3.5	3.0	3.3	0.2
ES	5.3	5.4	5.5	4.8	5.2	0.3
IE	5.1	4.9	5.4	4.5	5.3	0.1
NL	6.8	6.8	6.7	6.7	6.9	-0.2
UK	5.9	5.9	6.4	5.3	5.7	0.7
DK	6.4	6.6	6.4	6.2	6.4	0.0
FI	7.1	6.9	7.1	6.7	7.1	0.0
SE	5.9	7.2	5.9	6.2	5.8	0.1
CZ	5.4	5.5	5.8	5.5	5.3	0.5
SK	3.9	4.1	4.3	4.0	3.7	0.6
SI	5.5	5.8	6.2	5.2	5.1	1.1
HU	4.3	4.8	4.6	4.2	4.0	0.6
PL	4.0	4.2	4.3	3.9	3.8	0.5
EE	4.1	4.3	4.2	3.8	4.1	0.1
LT	3.8	2.9	4.2	3.4	3.8	0.4
LV	4.0	4.3	4.0	3.4	4.2	-0.2
MT	6.6	6.5	7.2	5.6	6.5	0.7
CY	5.9	6.1	6.4	5.0	5.8	0.6
BG	3.3	3.6	3.4	2.8	3.4	0.0
RO	3.9	3.8	4.0	3.9	3.9	0.1
TR	2.9	3.0	3.1	2.7	2.9	0.2
ACC 13	3.7	3.3	4.2	3.3	3.7	0.5
EU 15	5.5	5.4	5.9	5.1	5.5	0.4
AC 10	4.3	4.4	4.6	4.0	4.2	0.4
EU 25	5.4	5.3	5.6	4.9	5.3	0.3

Source: Eurobarometer 50.1, Q35/D15a; Candidate Countries Eurobarometer 2002.1, Q26/D15a: *'On a scale from 1 to 10, how satisfied are you with the social services in (OUR COUNTRY)? And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?'*

Age is another variable that can be expected to structure satisfaction with the health care system. Not only is age related to retirement, but it is also related to other stages in the life-cycle which have an impact on health, such as family formation or labour force entry. Again, age is expressed in terms of quartiles in the age distribution. The empirical results displayed in Table 14 show that satisfaction with the health care system tends to increase with age. On average, the age effect is stronger in the ACC than in the EU, but in most cases it is not very strong. Yet even the slight age-related effect is remarkable because it shows that elderly people, who tend to be less satisfied with their own health, who are more frequently ill and hence are more dependent on the health care system, tend to be more satisfied with it than younger people, who need it less. This may be interpreted as an indication that the European model of securing universal access to health care for all citizens serves important integrative functions since it works to the even slightly over-proportionate satisfaction of the elderly who tend to need health care most. On the other hand, it is equally remarkable that the age-related differences do not reach a magnitude which would signal a generational cleavage. Even in Cyprus, where we observe the highest degree of age-related polarisation, the average health care satisfaction increases by only about one point on our 10-point satisfaction scale as we move from the lowest to the highest age quartile. Hence the basic message is that in all European countries people throughout the life-cycle are united in displaying rather similar degrees of satisfaction with the health care system.

There are also no gender-related differences in satisfaction with health care systems in Europe. Judging from the small differences in their reported satisfaction scores, European men and women share very similar perceptions of their country's health care system. This applies to EU Member States and ACC alike. Both inside and outside the current EU, the pattern of differences between men and women corresponds almost exactly to what one would expect if the differences were a purely random process. Hence we conclude that Europe's health care systems work to a similar degree of satisfaction for both men and women.

Differences of health care satisfaction in various income groups are also fairly small in most countries. In this respect, too, there is no relevant difference between EU Member States and the acceding and candidate countries. Respondents with higher incomes tend to be slightly more satisfied than those with less income (*see Table 15*). The highest impact of income inequality is observed in Latvia, but even in this extreme case the average health care satisfaction increases by just half a point on our 10-point satisfaction scale as we move from the lowest income quartile to the highest. Hence we infer that there are no relevant income-related differences in the perception of health care systems in Europe: in most countries, poorer and richer strata display similar degrees of satisfaction with the health care services. This may be seen as further evidence of the integrative success of the typically European approach to provide more or less universal access to health care.

Table 14: Satisfaction with health care system by age (combined index of satisfaction with health care and social services by age)

		Age quartiles			
Countries	Total	Lowest	Second	Third	Highest
AT	7.2	7.2	7.1	7.0	7.5
BE	6.2	6.1	6.1	6.0	6.5
FR	6.0	5.8	5.9	5.9	6.3
DE	5.8	5.6	5.7	5.7	5.9
LU	6.3	5.9	6.3	6.3	6.4
IT	4.5	4.5	4.5	4.4	4.5
EL	3.6	4.0	3.2	3.4	3.9
PT	3.4	3.8	3.2	3.2	3.4
ES	5.3	5.3	5.3	5.1	5.4
IE	5.2	5.5	5.0	5.1	5.2
NL	6.8	7.0	6.8	6.7	6.8
UK	5.9	5.8	5.5	5.7	6.4
DK	6.4	6.3	6.5	6.2	6.5
FI	7.1	7.2	7.1	7.1	7.1
SE	5.9	5.6	5.8	5.9	6.0
CZ	5.5	5.5	5.2	5.3	5.8
SK	4.0	4.1	3.9	3.8	4.2
SI	5.6	5.9	5.0	5.3	6.0
HU	4.3	4.4	4.1	4.2	4.6
PL	4.0	4.3	3.8	3.9	4.2
EE	4.3	4.8	4.1	4.1	4.2
LT	3.9	4.6	3.5	3.6	4.1
LV	4.1	4.6	4.1	3.9	4.0
MT	6.5	5.9	6.4	6.3	7.1
CY	5.9	5.7	5.4	5.8	6.4
BG	3.3	4.0	3.2	3.1	3.3
RO	4.0	4.7	3.9	3.7	4.0
TR	2.9	2.9	2.6	2.9	3.6
ACC 13	3.7	3.7	3.4	3.6	4.2
EU 15	5.6	5.5	5.5	5.5	5.7
AC 10	4.3	4.5	4.1	4.2	4.6
EU 25	5.4	5.3	5.3	5.3	5.6

Source: Eurobarometer 50.1, Q35/age; Candidate Countries Eurobarometer 2002.1, Q26/age: *'On a scale from 1 to 10, how satisfied are you with the social services in (OUR COUNTRY)? And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?'*

Table 15: Satisfaction with health care system by income (combined index of satisfaction with health care and social services by quartiles of household-equivalence income)

Countries	Total	Lowest	Second	Third	Highest	Difference Highest - Lowest
AT	7.2	7.3	7.2	7.1	7.2	0.0
BE	6.3	6.0	6.2	6.4	6.4	0.1
FR	6.1	5.9	6.1	6.0	6.4	0.3
DE	5.8	5.6	5.7	5.9	5.9	0.1
LU	6.4	6.2	6.2	6.4	6.8	0.4
IT	4.5	4.5	4.4	4.5	4.5	0.0
EL	3.6	3.8	3.7	3.7	3.4	-0.2
PT	3.4	3.3	3.1	3.5	3.6	0.2
ES	5.3	5.3	5.1	5.1	5.6	0.3
IE	5.2	4.8	4.9	5.3	5.6	0.4
NL	6.9	6.7	6.7	7.0	7.1	0.2
UK	5.8	5.8	6.1	5.9	5.5	-0.3
DK	6.4	6.0	6.5	6.5	6.5	0.1
FI	7.1	7.0	6.7	7.2	7.6	0.5
SE	5.9	5.8	5.9	6.2	5.9	0.0
CZ	5.5	5.3	5.8	5.4	5.4	-0.1
SK	3.9	4.1	3.9	3.4	4.2	0.3
SI	5.5	5.5	5.3	5.8	5.6	0.1
HU	4.4	4.4	4.6	4.5	4.1	-0.3
PL	4.0	4.1	4.1	4.0	3.8	-0.2
EE	4.2	4.0	4.3	4.2	4.5	0.3
LT	3.8	3.7	3.7	3.6	4.1	0.3
LV	4.1	3.6	3.8	4.3	4.6	0.5
MT	6.5	6.2	6.8	6.5	6.6	0.1
CY	5.9	6.3	6.0	5.5	5.9	0.0
BG	3.3	3.0	3.1	3.5	3.7	0.4
RO	4.0	3.8	3.9	4.1	4.1	0.1
TR	2.9	2.7	3.1	2.9	3.0	0.1
ACC 13	3.6	3.5	3.7	3.6	3.7	0.1
EU 15	5.6	5.5	5.6	5.6	5.7	0.1
AC 10	4.3	4.3	4.4	4.3	4.2	-0.1
EU 25	5.4	5.3	5.4	5.4	5.5	0.1

Source: Eurobarometer 50.1, Q35/D29; Candidate Countries Eurobarometer 2002.1, Q26/D29: '*On a scale from 1 to 10, how satisfied are you with the social services in (OUR COUNTRY)? And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?*'

Another question is to what extent different occupational categories differ in their perceptions of health care systems. This differentiation is of some interest because some health care schemes vary the structure of financing, as well as the definition of entitlements, according to positions in the occupational structure. Hence we might expect these institutional differences to translate into

occupation-specific degrees of satisfaction with system performance. The data, however, show bewildering country-specific variations rather than general patterns. Only one difference between the ACC and EU Member States is worth mentioning. In the EU, it is the higher occupational echelons that tend to be more satisfied than the unskilled manual workers. In some of the acceding and candidate countries, it is the other way around. This raises the question to what extent these countries may face problems with the integration of the middle classes, who represent the backbone of society and control the bulk of the votes. In the judgement of sociologists such as Wilensky (2002), modern welfare states always run the risk of a tax-welfare backlash on the part of the 'middle mass' whose members have to foot the bill for the welfare state, but believe more in individual mobility than in collective solidarity. Probing this question first requires an operational definition of the term 'middle mass'. We here define the 'middle mass' on the basis of income data as those who have .75 to 1.75 times the mean household-equivalence income within each country. As we define it, the middle mass extends from the middle of the second income quartile up to the middle of the fourth income quartile, leaving out roughly the lower third as well as those at the very top of the income distribution (the latter can easily purchase private services and are hence less dependent on welfare state arrangements).

If we compare the middle mass with those below it, we usually find the middle mass to be more satisfied with the health care system (*see Table 16*).[39] If we take the Western European countries as a yardstick, the degree of relative middle mass satisfaction is lower in the ACC 13 group, but nothing in the Eastern European pattern suggests an outright disaffection of the middle mass. There are only five countries where the middle mass is less satisfied than those below it — Hungary, Poland, the Czech Republic, Slovakia and Cyprus. Among these, only Hungary, Poland and Cyprus combine over-proportionate middle mass dissatisfaction with over-proportionate dissatisfaction of the self-employed or of the service class. In these countries, it may perhaps require special policy efforts to prevent a disaffection of the middle mass from the European goal of high-quality health care services with universal access for all citizens. It is not possible here to probe deeper into the conditions that make for more or less dissatisfaction of the middle mass. This would require a special study by national experts which would also take the institutional design of the national health care systems into consideration.

As long as we lack more specific knowledge of the exact features of the health care systems with which respondents are satisfied, crude measures of citizen satisfaction with the health care system will have a certain vagueness, which implies a high degree of ambivalence for policymakers. On the one hand, citizens who are dissatisfied with public services may signal legitimation problems, but dissatisfied citizens may also become a political resource for policymakers who seek to reform the present health system. Satisfied citizens, on the other hand, may defend the prevailing system to an extent that they veto reforms which policymakers perceive as necessary in order to ensure the sustainability of high-quality health services in ageing societies. As the second half of the 1990s saw widespread attempts to impose budget controls, to increase efficiency and to rationalise the provision of health care, information on recent changes in health care satisfaction may be more telling than a comparison of mere levels of satisfaction. Assuming that reforms aiming at cost containment were similarly made throughout Europe, we may interpret changing satisfaction scores as an indicator of the public approval or disapproval of these reforms.

[39] A difference in the opposite direction can be found in five countries, but only the value for Cyprus is significant. Even this statistical significance vanishes once we control for age and gender in a regression model.

Table 16: Middle mass satisfaction with health care system (combined index of satisfaction with health care and social services among people between 75% and 175% of mean household-equivalence income)

Countries	Total	Below middle mass	Middle mass	Over middle mass
AT	7.2	7.2	7.2	7.2
BE	6.3	6.1	6.4	6.3
FR	6.1	5.8	6.1	6.9
DE	5.8	5.6	5.8	6.1
LU	6.4	6.2	6.4	7.4
IT	4.5	4.5	4.5	4.5
EL	3.6	3.8	3.7	3.3
PT	3.4	3.2	3.5	3.8
ES	5.3	5.2	5.3	5.4
IE	5.2	4.9	5.5	5.5
NL	6.9	6.7	7.0	7.1
UK	5.8	5.9	5.8	5.5
DK	6.4	6.2	6.5	6.2
FI	7.1	6.9	7.3	7.4
SE	5.9	5.9	6.1	5.6
CZ	5.5	5.6	5.4	5.6
SK	3.9	4.0	3.8	4.3
SI	5.5	5.5	5.6	5.8
HU	4.4	4.5	4.4	4.3
PL	4.0	4.1	4.0	3.7
EE	4.2	4.2	4.3	4.5
LT	3.8	3.7	3.8	4.1
LV	4.1	3.7	4.5	4.5
MT	6.5	6.2	6.6	6.4
CY	5.9	6.3	5.7	5.6
BG	3.3	3.1	3.5	3.5
RO	4.0	3.8	4.1	4.2
TR	2.9	2.9	2.9	3.0
ACC 13	3.6	3.5	3.8	3.6
EU 15	5.6	5.5	5.6	5.8
AC 10	4.3	4.4	4.3	4.2
EU 25	5.4	5.3	5.4	5.6

Source: Eurobarometer 50.1, Q35/D29; Candidate Countries Eurobarometer 2002.1, Q26/D29: '*On a scale from 1 to 10, how satisfied are you with the social services in (OUR COUNTRY)? And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?*'

Changes in satisfaction levels

Respondents were asked whether they were 'more satisfied', 'less satisfied' or 'as satisfied' with their national health care system as they were two years ago. Conceptually, such a question is an attempt to obtain a change-score in the absence of longitudinal measurements. Change-scores are differences between identical measurements at different time points. Instead of asking the same respondents about their satisfaction with the health care system at two points in time and calculating change-scores from these two answers, our question requests respondents to remember their satisfaction of two years ago and to subtract this value from their actual satisfaction. This is not at all an easy task for the respondents. Hence the answers might reflect the ability to solve this task rather than the true change in health care satisfaction.

Besides reflecting measurement error, a changing satisfaction with the health care system may be perceived for two different reasons. First, the health care system may have changed; in this case (and in the absence of other changes), the reported changes in satisfaction show policymakers whether their policy is supported by public opinion or not. Secondly, the living conditions of the individual respondent may have changed in a way that either changes their dependence on the health care system or their chances for access. If, for example, a country's public health insurance limits private health insurance contracts to those above an income limit, changing satisfaction with the prevailing system may be a function of one's earnings career rather than of the performance of the health care system.[40]

The health care systems of European countries are subject to constant change. Throughout Europe, governments have been trying to adapt their national schemes to shrinking resources, growing demands and technological change. The greatest turbulence was experienced by the post-Communist transition countries. They all changed from the centralised Soviet Semashko model to contribution-financed social insurance schemes. In Bulgaria, Poland and Romania, this change was made only recently — in 1999 (GVG, 2003, p. 99). Hence we might expect stronger changes of satisfaction with the health care systems in the more turbulent environments of the transition countries, especially in Bulgaria, Poland and Romania. It is an empirical question, however, whether the institutional reforms increased or decreased citizens' satisfaction with their health care systems.

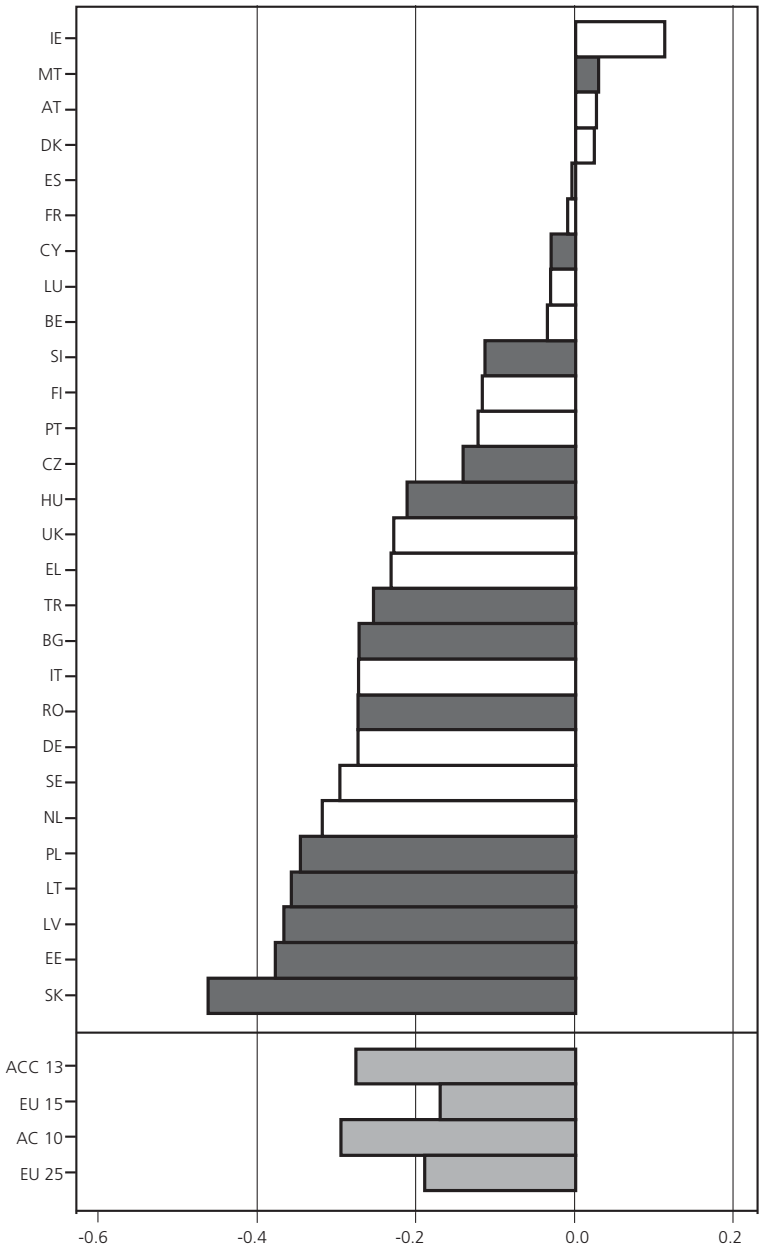
Figure 9 displays the net balance of reported satisfaction changes. Negative values indicate that the fraction of respondents with decreasing satisfaction is higher than the fraction of respondents with increasing satisfaction. Values near zero may either indicate a population that is polarised into groups with growing or shrinking satisfaction, or a population with a high fraction of people whose satisfaction remained constant.

The overwhelming result seen in Figure 9 is that satisfaction with health care systems is decreasing in most European countries. There are only very few countries without a clear direction of change; Ireland stands out as the only country to report a slight increase in satisfaction on balance. As we

[40] We must furthermore consider that changes in satisfaction cannot be caused by factors which are invariate in time. Being male, for example, can only be a cause for being more or less satisfied than two years ago if changes in the health care system apply to men and women differently — or if there are gendered differences in the ability to do the change-score calculation which the questionnaire requests.

expected, the change is more marked in the former Communist countries, where the Czech Republic and Slovenia are the only countries to report net decreases in satisfaction which remain below the European average. Obviously, Europeans have become more discontent with their national health care policies. The decline in average satisfaction is not attributable to the discontent of a small critical minority, which might theoretically shape our aggregate scores if change in the population majority is absent. Dissatisfaction is, in fact, very widespread. The growth in discontent is practically as great in the middle mass as in the population at large.

Figure 9: Change of satisfaction with health service (% with increasing satisfaction minus % with decreasing satisfaction)



Source: Eurobarometer 50.1, Q35; Candidate Countries Eurobarometer 2002.1, Q26: *'And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?'*

The decreasing satisfaction of the middle mass, on whose support the legitimation of democratic systems critically hinges, should be of concern to health policymakers. Where dissatisfaction is related to policy cutbacks and where cutbacks cannot be avoided, the reasons for setting limits to health expenditure must be communicated to the public in ways that allow citizens to accept reforms as reasonable and comprehensible. So far, European citizens apparently perceive the reforms more as cutbacks and budget controls and less as initiatives to make health care systems more responsive to citizens' needs. In case those who are higher up on the ladder of social stratification become disaffected, withdraw their support for welfare state schemes and desert to private solutions, the policy goal of universal access to health care systems with high-quality service for all will be much more difficult to maintain or attain.

In the following discussion, we examine the social profile of satisfaction changes. Who is most dissatisfied and do differences in satisfaction change vary systematically with the respondents' position in the social structure, thus reflecting prevailing social inequalities? We pursue this issue with respect to various dimensions of inequality.[41] Table 17 shows the changes in health care satisfaction in different income quartiles. Again, negative values indicate decreasing satisfaction and positive values increasing satisfaction. By and large, there is only a very small income effect if we compare the net satisfaction change in various income quartiles. There are also no systematic patterns among different families of nations. Thus, the post-Communist countries, which all went through radical transformations of their health care systems, do not stand out as having particular problems of disaffection among citizens with low income who might have been expected to perceive cost-sharing and other elements of recent reforms as particularly burdensome.

A slightly different picture arises when we compare the unemployed with the average respondent (*see Table 18*). Here, there is a moderate tendency for unemployed people to become over-proportionately dissatisfied with the health care system. However, as before, no specific families of nations stand out in either direction. Another question is how unskilled workers reacted to recent health policy reforms. As they tend to have low incomes and unhealthy jobs, they may feel more dependent on a health care system with universal access and little private cost-sharing. Since most of the recent reforms in health care systems amounted to increasing cost-efficiency and user-charges, they may have perceived these measures as particularly inflicting upon them. Following our survey, this has apparently not been the case. Throughout Europe, unskilled workers even tended to become a little less dissatisfied with the health care system than the average population. Once again, we find the pattern of satisfaction change in CEE countries not to be conspicuously different from the pattern in EU countries despite the rapid and radical transformation of health care systems in Central and Eastern Europe.

Finally, retirement is of special interest for an analysis of satisfaction change. Firstly, retired people represent a growing proportion of populations so that they have an increasing impact in national elections. Secondly, they are either older than the average population or, if on early retirement, more disabled. Hence we might expect them to give more importance to the health care system than the average respondent and to react more sensitively to recent reforms. Table 18 shows that retired people do indeed tend to get more dissatisfied with the health care system than the average respondent. This tendency is particularly marked in CEE transition countries. The question to what

[41] It should be noted that individuals do not often change their social structural positions over a short period of time. Group-specific differences of our change-scores will hardly reflect individual patterns of mobility, but rather differences between social groups which have more or less privileged access to the services of the health care system.

extent this reflects their changing relationships to national health care systems can only be pursued by more in-depth studies.[42] As a note of caution, we can simply add that retirement is not a constant feature over time. In most cases, entrance into retirement is simply the consequence of attaining the pensionable age. If this happened during the past two years for which respondents were asked to report on changing satisfaction, the difference between retired people and the population average might reflect the consequences of recent retirement rather than changes in the health care entitlements of pensioners in the national health care systems.

Table 17: Change of satisfaction with health service by income (% with increasing satisfaction minus % with decreasing satisfaction by quartiles of the household-equivalence income)

Countries	Total	Lowest	Second	Third	Highest
AT	0.0	0.0	0.0	0.0	0.1
BE	-0.1	-0.1	-0.1	0.0	-0.1
FR	0.0	0.0	0.1	0.0	0.0
DE	-0.3	-0.3	-0.2	-0.4	-0.3
LU	-0.1	0.0	-0.1	-0.1	-0.1
IT	-0.3	-0.3	-0.3	-0.3	-0.2
EL	-0.2	-0.3	-0.2	-0.1	-0.2
PT	-0.1	-0.2	-0.2	-0.1	0.0
ES	0.0	-0.1	0.0	0.0	0.0
IE	0.1	-0.1	0.0	0.2	0.1
NL	-0.3	-0.3	-0.3	-0.3	-0.4
UK	-0.2	-0.2	-0.2	-0.2	-0.3
DK	0.0	0.0	0.0	0.0	0.1
FI	-0.1	-0.1	-0.1	-0.1	-0.1
SE	-0.3	-0.2	-0.3	-0.3	-0.3
CZ	-0.1	-0.2	-0.2	-0.1	-0.1
SK	-0.5	-0.6	-0.5	-0.4	-0.5
SI	-0.1	-0.1	-0.2	-0.2	-0.1
HU	-0.2	-0.2	-0.3	-0.2	-0.2
PL	-0.4	-0.4	-0.3	-0.3	-0.4
EE	-0.4	-0.3	-0.5	-0.4	-0.4
LT	-0.4	-0.3	-0.4	-0.4	-0.4
LV	-0.4	-0.4	-0.4	-0.3	-0.4
MT	0.0	0.0	0.0	0.0	0.0
CY	0.0	0.0	0.0	-0.1	0.0
BG	-0.3	-0.1	-0.4	-0.3	-0.2
RO	-0.3	-0.2	-0.3	-0.3	-0.3
TR	-0.3	-0.2	-0.2	-0.3	-0.3
ACC 13	-0.3	-0.3	-0.3	-0.3	-0.3
EU 15	-0.2	-0.2	-0.2	-0.2	-0.2
AC 10	-0.3	-0.3	-0.3	-0.3	-0.3
EU 25	-0.2	-0.2	-0.2	-0.2	-0.2

Source: Eurobarometer 50.1, Q35/D29; Candidate Countries Eurobarometer 2002.1, Q26/D29: *'And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?'*

[42] The 1996 Eurobarometer survey contained a battery of more specific assessments of health policy measures which would allow further analysis (Mossialos, 1998), but we are not aware of similar comparative surveys for the candidate countries.

Table 18: Change of satisfaction with health service by occupational status (% with increasing satisfaction minus % with decreasing satisfaction by employment category)

Countries	Total	Responsible for ordinary shopping, not working	Student	Unemployed or temporarily not working	Retired or unable to work through illness	Farmers (5+6)	Upper service class (7, 10-12)	Self-employed (8+9)	Lower service class (13-15)	Skilled manual workers (16+17)	Unskilled manual workers (18)
AT	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	-0.1	0.1
BE	0.0	-0.1	0.1	0.0	-0.1	-0.4	0.0	0.0	0.0	0.0	-0.1
FR	0.0	0.1	0.1	-0.1	0.0	-0.1	0.0	0.0	0.0	0.0	-0.1
DE	-0.3	-0.2	-0.2	-0.3	-0.3	0.2	-0.3	-0.3	-0.3	-0.3	-0.2
LU	0.0	0.0	0.0	0.1	-0.1	0.0	-0.1	0.1	-0.1	-0.1	0.1
IT	-0.3	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.2	-0.3	-0.3
EL	-0.2	-0.2	-0.2	-0.2	-0.2	-0.4	-0.2	-0.2	-0.2	-0.3	-0.4
PT	-0.1	-0.1	0.0	-0.3	-0.3	-0.1	0.0	-0.1	-0.1	-0.1	-0.2
ES	0.0	0.0	0.0	0.0	0.0	-0.4	-0.1	0.1	0.0	0.0	0.1
IE	0.1	0.1	0.2	-0.1	-0.1	0.0	0.2	0.1	0.2	0.2	0.2
NL	-0.3	-0.4	-0.1	-0.4	-0.3	-0.1	-0.4	-0.4	-0.4	-0.4	0.0
UK	-0.2	-0.3	-0.1	-0.1	-0.3	0.0	-0.2	-0.4	-0.2	-0.2	-0.3
DK	0.0	-0.3	0.0	0.2	-0.1	0.1	0.1	0.2	0.0	0.1	0.0
FI	-0.1	0.0	-0.1	-0.1	-0.1	-0.3	-0.1	-0.1	-0.1	-0.1	-0.1
SE	-0.3	-0.7	-0.3	-0.4	-0.2	-0.3	-0.3	-0.5	-0.4	-0.1	-0.2
CZ	-0.1	0.0	0.0	0.0	-0.1	-0.4	-0.2	-0.2	-0.1	-0.2	-0.1
SK	-0.5	-0.6	-0.3	-0.4	-0.6	-0.1	-0.4	-0.6	-0.5	-0.5	-0.3
SI	-0.1	0.0	0.0	-0.1	-0.1	-0.3	-0.2	-0.1	-0.1	0.0	-0.3
HU	-0.2	-0.1	-0.1	-0.2	-0.2	0.0	-0.2	-0.3	-0.2	-0.4	-0.4
PL	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.5	-0.4	-0.4	-0.4	-0.4
EE	-0.4	-0.4	-0.1	-0.3	-0.5	-0.3	-0.4	-0.5	-0.5	-0.4	-0.4
LT	-0.4	-0.3	-0.3	-0.3	-0.4	-0.5	-0.4	-0.3	-0.5	-0.3	-0.3
LV	-0.4	-0.4	-0.2	-0.5	-0.4	-0.3	-0.5	-0.4	-0.3	-0.3	-0.4
MT	0.0	0.0	-0.1	0.0	0.1	0.0	0.2	-0.2	-0.1	0.1	0.1
CY	0.0	0.1	0.0	-0.1	0.1	0.4	-0.1	-0.2	0.0	-0.2	-0.2
BG	-0.3	-0.2	-0.3	0.0	-0.4	-0.3	-0.3	-0.5	-0.3	-0.3	-0.2
RO	-0.3	-0.3	0.0	-0.4	-0.3	0.0	-0.2	-0.1	-0.3	-0.3	-0.3
TR	-0.3	-0.2	-0.2	-0.4	-0.4	0.0	-0.3	-0.2	-0.4	-0.3	-0.2
ACC 13	-0.3	-0.2	-0.2	-0.3	-0.3	-0.1	-0.3	-0.3	-0.3	-0.3	-0.2
EU 15	-0.2	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
AC 10	-0.3	-0.3	-0.2	-0.3	-0.3	-0.4	-0.4	-0.3	-0.3	-0.4	-0.3
EU 25	-0.2	-0.2	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2

Source: Eurobarometer 50.1, Q35/D15a; Candidate Countries Eurobarometer 2002.1, Q26/D15a: '*And, on a scale from 1 to 10, how satisfied are you with health services in (OUR COUNTRY)?*'

Differences and similarities between country groups

In summary, our analyses have produced somewhat mixed results. On the one hand, we found rather high levels of satisfaction with the health care systems in most European countries and a remarkable homogeneity of satisfaction across social groups. Clearly, widespread access to health care of high quality is an important aspect of the European social model and making good health care available to all citizens effectively contributes to social integration. Our analyses show that Europeans are similarly satisfied with their health care systems regardless of their social position. Underprivileged groups and those who need health care most tend to be similarly satisfied with the health care system as more privileged groups. In this sense, universal health care serves as a socially inclusive mechanism which unites people in Europe.

On the other hand, we have found satisfaction with health care to be declining almost everywhere in Europe over the past two years preceding the survey. Again, there are no signs that the growing dissatisfaction is socially polarised or concentrated among underprivileged groups. With respect to health care, Europeans tend to be fairly equal and united even in their growing dissatisfaction. This is equally true on a macro-level and on a micro-level of analysis.

On the macro-level, we find no patterns that would clearly distinguish acceding and candidate countries or post-Communist transition countries from countries that are currently members of the EU. On the micro-level, the remarkable homogeneity in satisfaction levels and in satisfaction change stands out. In democracies, which need the support of the majority of their citizens, the general tendency for growing dissatisfaction and the discontent among the middle mass and among retired people should be of particular concern. Policymakers must make extended efforts to demonstrate that the objective of reforms to health care systems is to meet citizens' needs and to make the systems more responsive to the needs of consumers. This also implies the necessity of finding out what *are* the needs and concerns of the citizens. In the following discussion, we will explore what preferences citizens inside and outside the EU profess in the sector of care for the elderly.

Responsibility for care 4

Prevalence of family care situations

For a long time, demands on European welfare states could be kept within manageable limits because work and family functioned as prime sources of welfare production (Esping-Andersen, 1997). Full employment labour markets fuelled consumers' purchasing power and ensured a continuous level of high demand. In families women rendered a host of services, from child care to care for the elderly, thus effectively unburdening the state from care responsibilities.

This 'old order' no longer prevails. Many people now remain without a job, mass unemployment entails mounting fiscal problems and declining birth rates, as well as the increasing participation of women in the labour force, are leading to a shrinkage of the care potential in private households as the growing number of elderly people is faced with a shrinking number of younger family relatives who would be available as private carers. In this situation, crucial questions to examine are what services citizens expect public authorities to supply, what they perceive to be the proper way of financing the growing burden of care in ageing societies and to what extent families and civil society networks can still be expected to unburden the state from care responsibilities.

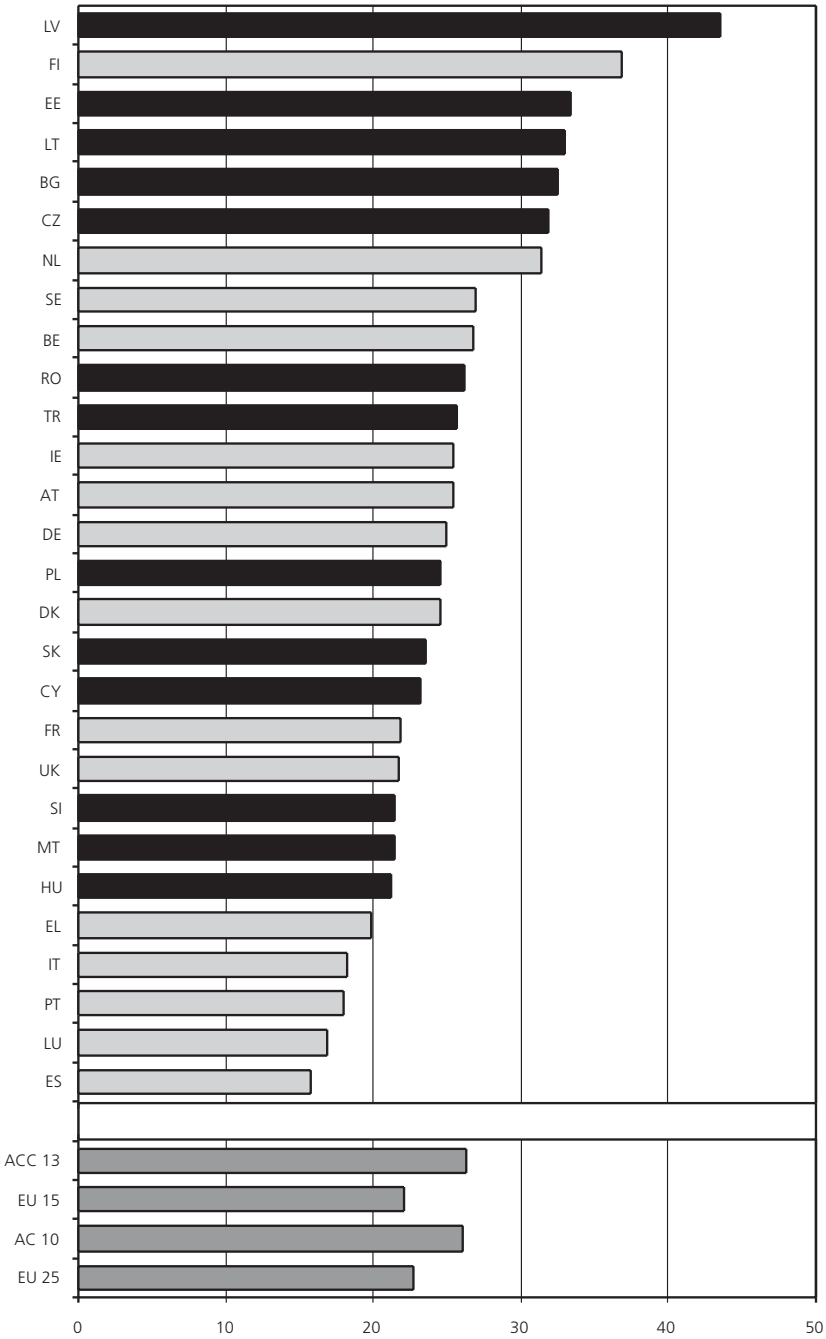
The survey contained a number of questions which help to shed some light on these issues. Attempting to measure the strength of support within civil society and the burden of care still shouldered by families, the questionnaire asked if respondents had 'extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly'. This question was then split up into help for 'anyone living with you' who has such impairments, on the one hand, and into 'regular service or help to such a person not living with you', on the other. Within both possibilities, 10 different potential recipients of help were distinguished, such as a child under or over five years, a spouse (husband, wife, partner), another relative, a friend, another person, with each of the adult categories subdivided into people under or over 60 years.

These subdivisions result in an extraordinarily complex question, which demands quite a lot of cognitive capacity from the respondents. They have to focus on informal help for chronically ill, handicapped or elderly people, thus neglecting any regular routine services they might render (such as ordinary child care). Asking for 'family responsibilities', they should leave out of consideration any professional care work that they might be engaged in and presumably also discard any volunteer work of a similar nature. Asking for 'regular service or help', they should presumably discard activities such as mere visits to friends or relatives in hospitals or residential care facilities, and think of more intensive support work instead. And even though the question explicitly asked them to think of 'extra family responsibilities', it requested them just as explicitly to include their help to 'friends' or 'other persons' in their considerations. To the extent that all respondents in our 28 countries mastered this complex intellectual challenge similarly, we will be dealing with substantive results rather than with mere measurement errors in our following analyses of their answers.

Adding up all those who reported to perform some sort of care-giving role, either inside or outside their own household, we obtain a remarkably high prevalence of informal care-giving throughout Europe. One out of four respondents in acceding and candidate countries, and over one out of five citizens in the EU, report to be active as a care-giver. Looking at individual countries, there is no clear pattern that would sharply distinguish the group of ACC 13 countries from those of the EU 15 (*see Figure 10*). Even though the average level of reported care activities is somewhat higher

in acceding and candidate countries, there are no signs that the expansion of the welfare state in EU countries amounted to an erosion of informal family support, as the level of reported care activities is still impressively high.

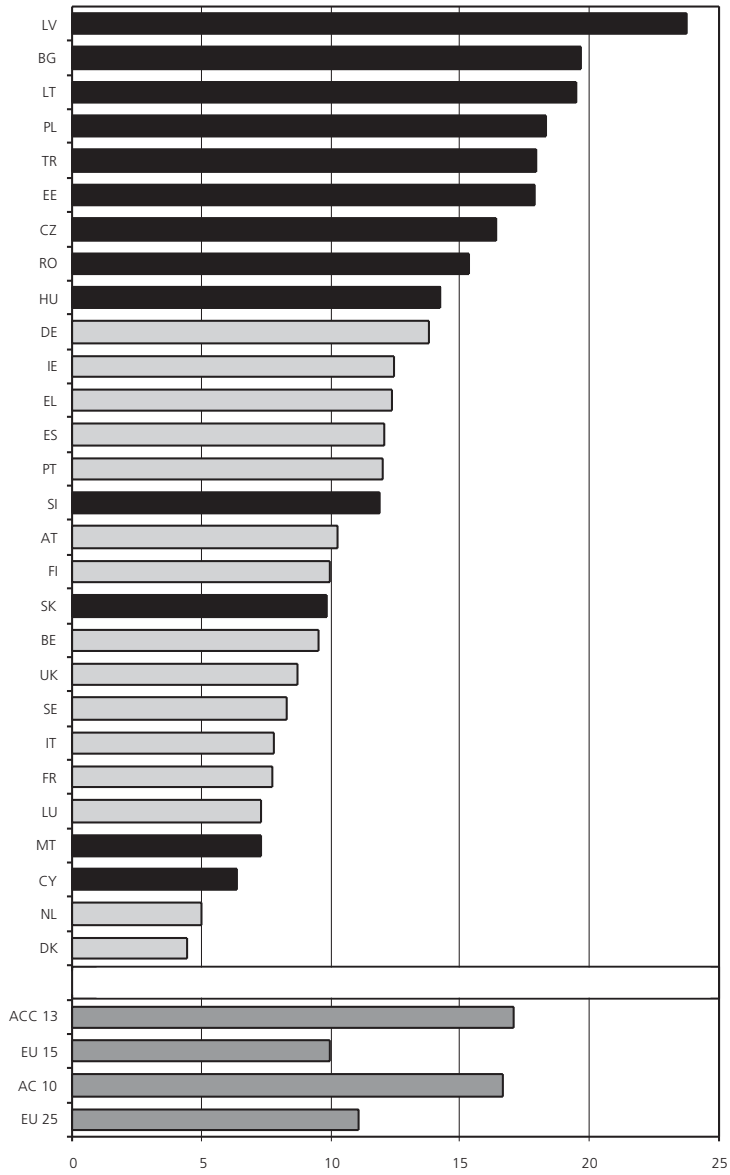
Figure 10: Prevalence of informal care activities (% giving care to any person)



Source: Eurobarometer 51.0, Q37; Candidate Countries Eurobarometer 2002.1, Q22: *'Some people have extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly. Is there anyone living with you who has a long-term illness, who is handicapped or elderly, whom you look after or give special help to? And do you provide some regular service or help to such a person* NOT *living with you?'*

If we look more specifically at single countries, the range of informal care activities in Europe is large, extending from a prevalence of 16% in Spain to 44% in Latvia. In the top group of informal care-giving we find five post-Communist transition countries, whereas the four southern European countries cluster at the rear end, together with Luxembourg. This crude overview suggests two preliminary conclusions: as countries currently inside and outside the EU overlap, we do not see a clear distinction between 'two Europes' in informal care; on the other hand, there is a wide range of country-specific variety, so that there is no European social model of family support, but a remarkable degree of diversity that cuts across groups with different EU membership status.

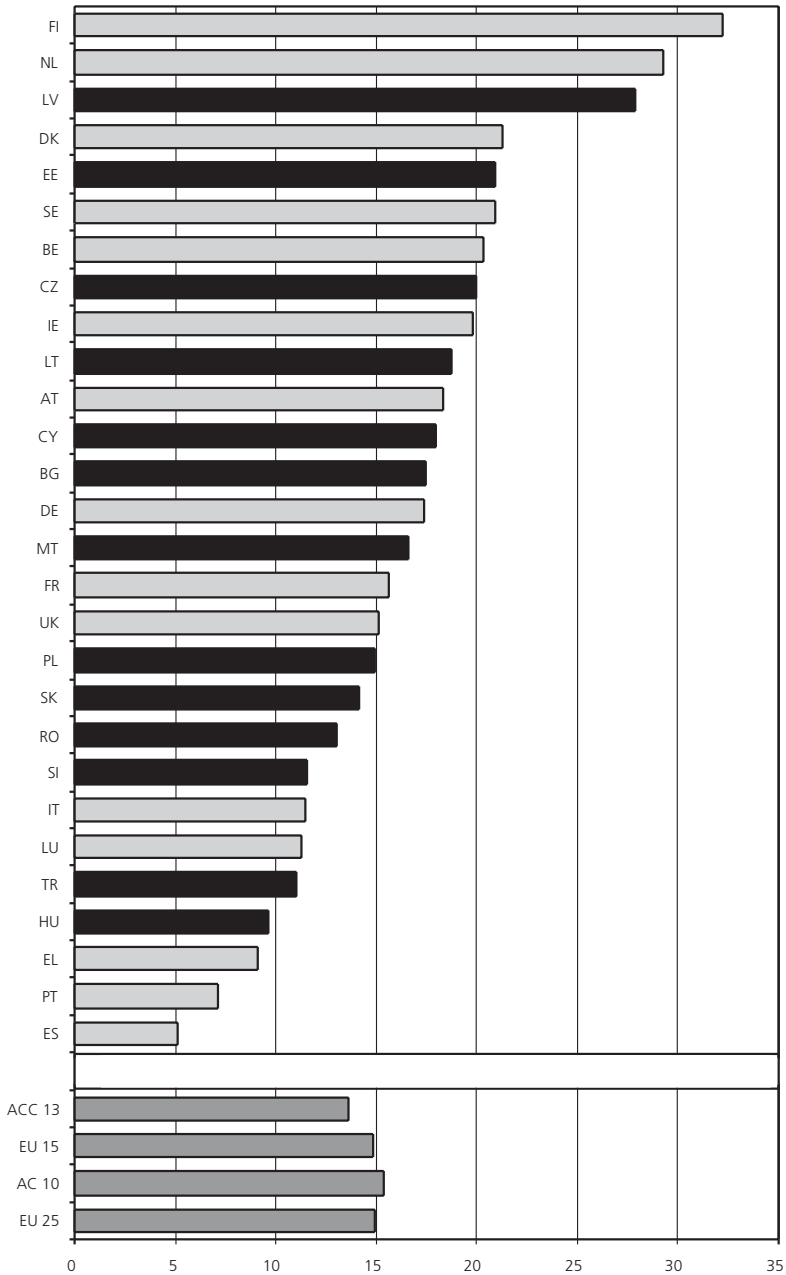
Figure 11: Prevalence of care-giving within private households (% giving care to a co-resident)



Source: Eurobarometer 51.0, Q37; Candidate Countries Eurobarometer 2002.1, Q22: '*Some people have extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly. Is there anyone living with you who has a long-term illness, who is handicapped or elderly, whom you look after or give special help to?*'

A closer inspection reveals that the overlap between the ACC and EU countries conceals strong differences in the composition of informal care. Once we distinguish between care rendered inside and outside one's own household, some differences between families of nations do become visible. Now, we clearly see two separate worlds of care in Europe — care at home is given much more frequently in acceding and candidate countries, whereas external care tends to be more frequent in EU countries (*see Figures 11 and 12*).

Figure 12: Prevalence of care-giving outside private households (% giving care to a person not living in the same household)



Source: Eurobarometer 51.0, Q37; Candidate Countries Eurobarometer 2002.1, Q22: '*Some people have extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly. Do you provide some regular service or help to such a person* NOT *living with you?*'

Informal care within one's own household is reported by 17% of ACC 13 citizens, as compared to 10% in the EU, and only three AC countries are below the average level of the EU (*see Figure 11*). Nine of the ACC 13 countries unite at the top of the distribution, preceding Germany as the current EU country that reports the highest prevalence of care work in private households. The Netherlands and Denmark, two countries known for their extended community care services (Jamieson, 1991; Jani-Le Bris, 1993; Kröger, 2001; Salvage, 1995), stand out for their particularly low prevalence of extra family responsibilities at home. At the other end, the traditionally Catholic countries of Ireland and southern Europe join Germany in coming at least close to the levels of home care rendered in the ACC 13 countries.

Within the EU, there has always been a north–south divide regarding the strength of family care. The enlargement of the EU will now contribute to strengthening the model of family care. It is an open question how to explain the high prevalence of family care in the ACC 13 countries, however. There are at least two plausible explanations, which need not be mutually exclusive. The first one is that family care is strong where publicly provided or supported community care is weak. In this sense, the strength of family support would merely mirror the paucity of public services in the acceding and candidate countries (and this would also explain why Germany leads the league of informal care-giving within the EU). The second possibility is that family care is an expression of cultural values rather than a policy response. In this sense, the prevalence of informal care in families would above all reflect people's more lasting normative preferences, as well as the degree to which collective actors, such as the Catholic church, help to effectively channel these preferences into the political system. Two considerations suggest that cultural traditions do indeed play a crucial role in shaping the care mix: (1) within the EU, Catholic countries stand out for their extended family care[43]; and (2) for the ACC 13 countries, a body of research has shown that traditional views of the family (with an emphasis on the importance of women's role in the household and a negative attitude towards mothers' employment) have prevailed, especially in countries with a Catholic past despite the decades of Communist rule (Gerhards and Hölscher, 2003; Knudsen and Waerness, 1999; Watson, 2000).

The citizens of ACC 13 countries do not limit their caring activities to their own private households, but also play very active care roles in networks outside their homes (*see Figure 12*). This might be interpreted as an indication that a lack of public services forces people to actively knit support networks beyond their private households. Indeed, there are several acceding and candidate countries where even more people report active care-giving outside than inside their homes. Nevertheless, informal care work outside one's own household is, on average, more prevalent among EU Member States. Within EU nations, informal care work outside one's own household is even typically more frequent than help within the private sphere at home. In this sense, caring support within the EU has transcended the confines of private co-residence and has spilled over into larger civil society networks of support.

It is worthwhile taking a closer look at the pattern of distribution within the EU because it contradicts the idea that informal private care and publicly provided community care are inimical twins which do not co-exist, but substitute for each other. Private care outside one's household is

[43] We are aware of the difference between the Roman Catholic church and the Orthodox church of Greece, but we use the term 'Catholic' here for countries which are neither Protestant nor religiously mixed.

actually most frequent in countries where formal community services are most developed (as in Scandinavia, the Netherlands and Belgium) and it is least prevalent in southern European countries where public services are known to be scarce. This suggests that public and private services may complement each other, rather than act as substitutes. One explanation for this is that informal care has significant costs for the carers and that it is facilitated where these costs are relieved by formal support. In several EU Member States, public policies are currently shifting from the direct provision of formal care to the promotion of informal care and to supporting its better coordination with other available services in the welfare mix (Kröger, 2001).

Table 19: Types of informal care activities (% giving informal care of the indicated type)

Countries	Within the family	Outside the family	For elderly people (60+)	For children
AT	21.4	8.6	20.8	5.7
BE	19.6	10.8	18.2	4.2
FR	16.4	7.4	15.5	2.1
DE	20.3	11.2	20.9	7.3
LU	12.5	5.1	12.9	2.3
IT	12.8	5.8	13.5	1.0
EL	15.8	4.6	17.5	1.0
PT	15.1	3.3	13.8	0.8
ES	13.6	2.9	11.2	1.8
IE	21.5	11.0	20.7	8.5
NL	18.9	17.5	25.9	1.6
UK	17.5	6.8	15.2	4.8
DK	20.7	6.2	17.4	3.9
FI	31.7	12.4	30.3	10.8
SE	22.0	8.3	18.7	6.8
CZ	26.4	8.3	23.9	4.8
SK	21.1	2.6	16.4	3.1
SI	18.8	3.9	15.2	3.8
HU	19.7	2.3	12.8	6.8
PL	21.2	4.3	16.0	6.6
EE	27.3	9.0	22.8	9.7
LT	26.6	9.6	24.5	6.4
LV	38.9	9.2	28.2	11.7
MT	20.4	3.4	14.4	2.6
CY	18.5	4.6	17.6	2.2
BG	29.9	4.6	25.7	6.1
RO	22.1	5.0	19.3	3.3
TR	23.7	2.5	17.3	4.4
ACC 13	23.2	4.0	18.1	5.2
EU 15	17.2	7.8	16.8	3.8
AC 10	22.5	4.9	17.5	6.2
EU 25	18.1	7.3	17.2	4.2

Source: Eurobarometer 51.0, Q37; Candidate Countries Eurobarometer 2002.1, Q22: *'Some people have extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly. Is there anyone living with you who has a long-term illness, who is handicapped or elderly, whom you look after or give special help to? And do you provide some regular service or help to such a person* NOT *living with you?'*

In order to understand better what extra care responsibilities Europeans are taking up, we distinguish between four kinds of services, which we re-grouped into two dichotomies: services inside or outside the family, on the one hand, and services for elderly people (people over 60) or for children, on the other (*see Table 19*).[44] Looking at the second dichotomy first, we see what might be expected: care work predominantly goes to elderly people in both parts of Europe. It is noteworthy, however, that both types of informal care (for elderly people and for children) are more prevalent in ACC 13 countries, so that the probability of encountering typical 'sandwich-generation' problems with dual care responsibilities (upwards to parents and downwards to children) is higher there.

The comparison between care inside and outside of the family helps to shed further light on the likely determinants of the higher prevalence of informal care in ACC 13 countries. A line of sociological thinking suggests that trust and mutual support are originally confined to the realm of the family and are only gradually extended beyond family boundaries when political and socio-economic conditions allow for the growth of civil society. From this perspective, an archaic tendency to 'amoral familism' (Banfield, 1965) is revived under totalitarian rule, when citizens learn to distrust each other and tend to withdraw into the security of their private spheres (Allen, 1973; Schelsky, 1957). To the extent that this perspective is valid, we would expect ACC citizens, and in particular those of the post-Communist transition countries, to stand out with the following characteristics: they should focus their informal care work on family members; they should do this to a higher degree than EU citizens and they should render less informal care outside the family than their European cousins living within current EU borders. All these tendencies do show up in our statistics.

Throughout Europe, informal care predominantly goes to family members. In the ACC, informal care is much more heavily concentrated on the family than in the EU, however. In the former, family care is six times more prevalent than extra-family care, whereas in the EU it is roughly twice as prevalent.[45] On average, 23% of ACC 13 respondents, as compared to 17% of EU 15 respondents, deliver care to family members. In contrast, informal care outside the family is more frequently rendered within the EU. On average, roughly 8% of EU citizens, as compared to 4% in ACC 13 countries, render help outside their families. Once more, this suggests that the Central and Eastern European pattern of care is not merely a response to a lack of supply of public services, but an indication of a stronger adhesion to family values, which previous survey research has found (Malnar, 1999).

Who does the informal care work, which is of such remarkable importance in both parts of Europe? In order to find this out, we will examine three questions: (a) To what extent is care work predominantly a female activity? (b) How frequently is care work a double burden on those who are economically active and to what extent do retired and unemployed people use their leisure to help out with informal care work? (c) How is care work distributed over the life-cycle? Is it predominantly rendered by younger age groups, by those who are at prime working age or by those who are already at pensionable age themselves?

[44] The first distinction explicitly delimits help within the kinship system from the one outside the family and is not identical with the distinction between help within one's private household or outside of it. Within the second distinction between old and young, services rendered inside or outside the family are grouped together again.

[45] However, the general tendency in candidate countries is not particularly strong in the countries that were under Communist rule, but even more pronounced in Cyprus, Malta and Turkey.

Many authors have highlighted the gendered nature of care and there is a considerable body of research that demonstrates that women do, in fact, deliver the bulk of care work (Alber, 1990; Baltes *et al*, 1999; Kröger, 2001; Lewis, 1997; Turner, 1994). Our surveys also confirm that women deliver care more frequently than men throughout Europe. However, the gendered differences found are surprisingly small in the light of previous research results. On average, 28% of women and 25% of men in the ACC, as compared to 23% and 21% within the EU, report rendering informal care. Neglecting rounding errors, the percentage point differences indicating the size of the gender gap are identically small in both groups. In both groups, we even find three countries where men report to give care more frequently than women. Distinguishing between care given to co-residents and to people living outside one's own household, we find gender gaps to be larger in the case of care outside one's household, because men are more frequently giving care to co-residents than outside their home.

Analysing the two special Eurobarometer surveys focused on attitudes to ageing in 1992 and 1999, Walker (1999) arrived at the surprising result that 'taking the EU as a whole, the proportions of men and women providing both in-house and out-of-house care are roughly equal'. One possible explanation for these discrepant results from specialised research on care activities is that our surveys simply report on the frequency, but not on the intensity of care-giving. Hence women and men might similarly often provide some sort of care, but the bulk of the work could still be done by women.[46]

Informal care activities are distributed fairly equally among economically active and non-active people (*see Table 20*). This means that working people are not effectively relieved from the double burden of formal and informal work responsibilities. In the acceding and candidate countries, care work coincides with formal work more frequently than in the EU. In most of the ACC 13 countries, economically active people report even over-proportionate shares of informal care compared to the average respondent, whereas in most EU countries they remain slightly under average. In the EU, retired people are the group that report care work most frequently, while in the ACC it is the unemployed. But in both cases, the non-working groups differ only marginally from economically active people. In this sense, people outside the labour force do not stand out as effectively lowering the dual burden for working people. With respect to care outside one's household, working people even appear as the most active suppliers of care in acceding and candidate countries, whereas their care activity in the EU is practically identical to that of the non-working groups. Home care for co-residents is the only case where non-working groups stand out as giving care more actively than people who are working. In the EU, retired persons are the most active care-givers at home, whereas in the ACC, the unemployed stand out with the highest activity rate.

An analysis by age shows that the probability of playing informal care roles peaks at prime working age in the middle of the life-cycle. On average and on aggregate, this pattern shows up for ACC and for EU Member States alike. However, the age distribution varies considerably by the type of care. Home care for co-residents is frequently given by people aged over 60. This reflects the fact that dependence on care increases sharply only beyond age 85, so that children doing the care work

[46] Another possibility is that the complex wording of the question in the Eurobarometer questionnaire may have overburdened the respondents and may have incited men, especially those who perceive themselves as heads of households, to report care activities of *any* member in the household rather than only those which they delivered themselves individually.

tend to be already at an advanced age themselves.[47] In EU countries, people in their third age are even more likely to give domestic care than people at working age. In acceding and candidate countries, those in the middle of the life-cycle are still most active as care-givers. Yet people over 60 in ACC 13 countries give care to co-residents more frequently than their counterparts in the EU. In several acceding and candidate countries, about one in five people over 60 is engaged in giving care to a co-resident. Among EU countries, only older people in Germany report a similarly high frequency of care responsibilities.

Table 20: Informal care-giving by economic activity (% giving care of the indicated type by employment status)

Countries	Total care-giving				Care inside household (for co-residents)				Care outside household			
	Total	Working	Retired	Un-employed	Total	Working	Retired	Un-employed	Total	Working	Retired	Un-employed
AT	25.5	26.6	24.6	25.0	10.3	9.7	15.0	3.6	18.2	20.4	11.6	20.0
BE	26.8	28.6	22.5	34.5	9.6	9.5	8.5	13.4	20.4	22.3	16.3	25.6
FR	21.8	19.8	27.4	29.8	7.8	6.2	14.3	10.6	15.6	15.0	15.0	24.4
DE	25.0	23.6	26.0	23.4	13.8	12.1	17.0	11.9	17.4	17.0	17.2	16.7
LU	16.8	15.5	18.8	23.1	7.2	5.5	9.2	7.7	11.4	11.9	10.6	23.1
IT	18.2	17.5	18.6	24.2	7.9	7.4	5.5	12.7	11.4	11.0	14.5	11.3
EL	19.8	19.7	19.4	19.0	12.4	11.9	15.2	14.3	9.0	10.0	5.2	7.9
PT	17.9	16.3	21.2	20.0	12.0	10.4	17.3	16.0	7.1	6.9	4.4	8.0
ES	15.8	15.4	16.3	20.8	12.0	10.5	15.6	14.3	5.1	6.3	2.5	7.9
IE	25.5	23.5	22.0	28.9	12.5	9.5	15.6	12.3	19.8	20.1	12.5	24.4
NL	31.4	30.3	32.6	33.3	5.0	4.5	7.3		29.2	28.6	29.6	33.3
UK	21.7	22.7	23.3	17.2	8.8	7.4	12.0	7.7	15.0	17.3	13.3	11.1
DK	24.6	26.4	24.6	32.0	4.5	4.7	6.9		21.3	23.0	18.9	32.0
FI	36.4	43.4	30.4	30.3	10.0	10.9	9.6	7.1	31.8	39.4	23.5	25.7
SE	27.0	25.6	34.3	19.3	8.3	7.6	10.9	5.3	20.9	20.2	25.6	17.5
CZ	31.9	34.2	26.3	39.1	16.3	15.2	20.5	15.6	20.1	23.1	10.7	31.1
SK	23.5	25.1	23.3	25.5	9.8	7.5	13.0	13.7	14.1	18.3	10.3	12.7
SI	21.4	21.2	22.3	18.8	11.9	9.4	15.0	7.4	11.7	14.7	8.3	11.6
HU	21.2	24.5	18.1	29.9	14.2	17.1	11.7	19.2	9.7	11.4	8.3	14.1
PL	24.6	27.1	26.6	24.1	18.3	19.2	20.5	17.7	15.0	17.3	16.4	13.3
EE	33.5	34.4	31.6	44.6	18.0	17.2	16.7	27.6	21.0	23.1	19.5	29.7
LT	33.1	35.8	31.7	31.1	19.4	18.9	22.3	19.3	18.7	21.9	13.3	19.3
LV	43.6	43.8	37.6	52.4	23.7	24.1	15.9	36.0	27.9	28.8	26.4	27.5
MT	21.7	18.6	19.3	22.2	7.3	5.7	9.6	16.7	16.8	15.5	12.0	5.6
CY	23.2	24.6	12.7	25.0	6.6	8.5	4.3		17.8	18.5	8.6	25.0
BG	32.5	39.1	26.8	34.3	19.7	18.9	19.8	23.0	17.4	26.4	10.8	14.9
RO	26.3	26.8	27.4	23.8	15.3	13.9	17.1	14.3	13.0	15.3	12.1	13.1
TR	25.7	23.7	21.2	29.3	18.0	17.3	10.7	23.9	11.1	9.4	13.4	8.1
ACC 13	26.3	27.6	25.0	28.5	17.1	16.8	16.8	20.8	13.6	15.6	13.0	11.8
EU 15	22.1	21.5	23.8	23.6	10.0	8.8	12.5	10.9	14.9	15.3	14.6	15.4
AC 10	26.1	28.9	24.9	27.4	16.7	16.9	17.8	18.2	15.4	18.3	13.6	15.5
EU 25	22.7	22.5	24.0	24.6	11.0	9.9	13.7	12.9	15.0	15.7	14.3	15.4

Source: Eurobarometer 51.0, Q37/D15a; Candidate Countries Eurobarometer 2002.1, Q22/D15a: '*Some people have extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly. Is there anyone living with you who has a long-term illness, who is handicapped or elderly, whom you look after or give special help to? And do you provide some regular service or help to such a person* NOT *living with you?*'

[47] In Germany, the percentage of people depending on care is below 10% until age 80, but then it rises sharply to about 25% in the age-group 85-89. For summary accounts of respective research findings, see Alber and Schölkopf (1999).

Care for people outside one's own household is less likely to be given by people over the age of 60. In the ACC and EU countries alike, it is mostly rendered by people in the middle of the life-cycle, who thus combine formal and informal work. There is a remarkable heterogeneity in Europe with respect to the external care activities of senior citizens. In the ACC, the range extends from 5% in Hungary and Turkey, to 27% in Latvia. In the EU, less than 5% of the elderly in three southern European nations (but around 25% in Finland and Sweden) report caring for someone outside their home. Obviously, there are different worlds of care in Europe. Given the already wide dispersion within the current EU, the accession of new countries will not, however, add much to European diversity in this dimension. Having studied the prevalence of care-giving activities in Europe, the following discussion will analyse policy preferences and attitudes about care among European citizens.

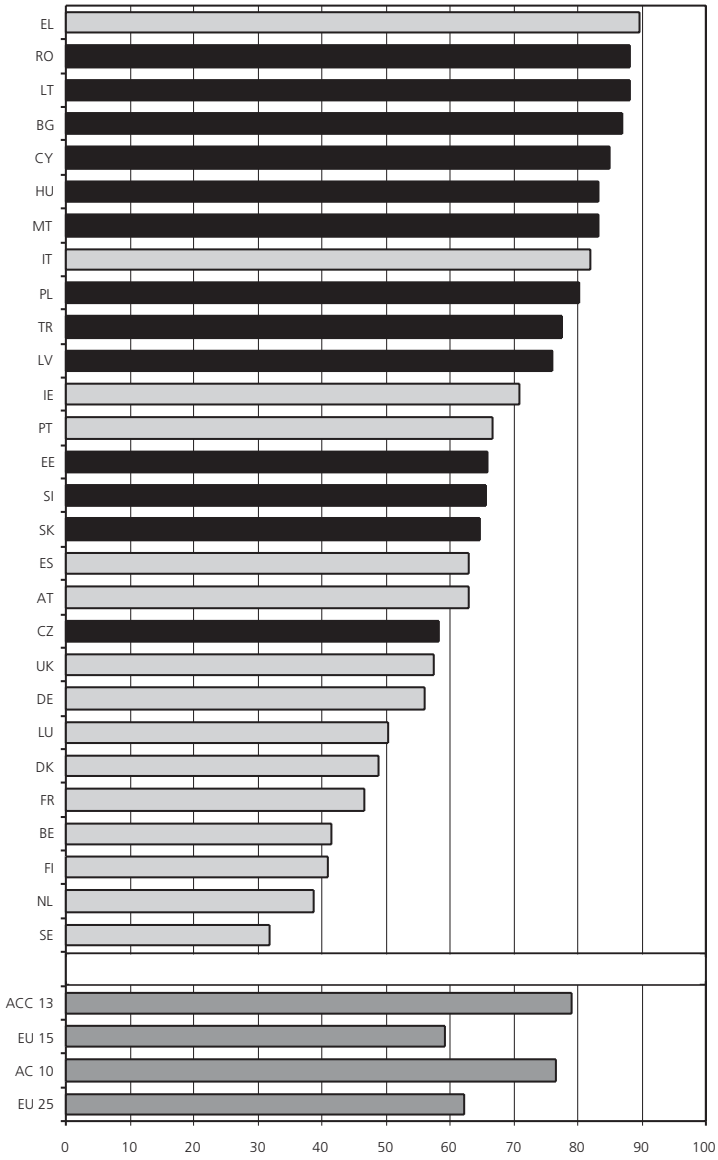
Strength of family support

European citizens were asked whether they would consider it a good or a bad thing if in future years working adults would have to look after their elderly parents more than nowadays. In the ACC, about four out of five respondents would consider it 'a good thing' to strengthen the family responsibility in looking after elderly parents; only four countries report less than 70% who share this view. In stark contrast, citizens in EU Member States usually express much more scepticism about extended family responsibilities. On average, only 59% of EU citizens advocate more family support in the future. Hence there is a clear tendency for Western and Eastern European countries to stand apart, with rather opposite views concerning the desirability of future family care for the elderly (*see Figure 13*). Within the EU, Greece and Italy are the only countries to share the ACC 13 pattern of widespread support for extended family responsibilities, whereas among the ACC only the Czech Republic resembles the Western European pattern of greater scepticism.

Once again, we see that a cleavage separating different views about adequate care policies is nothing new in the EU. Within the current EU, family support is favoured by more than 60% of the respondents only in the Catholic countries of Ireland and southern Europe. In six other countries of western and northern Europe (Belgium, France, the Netherlands, Denmark, Finland and Sweden), less than one-half of the population advocates strengthening the responsibility of adults to look after their parents. This is further evidence that already the current EU has a care-policy divide that separates a secular and Protestant north-western culture of care from a Catholic culture in southern Europe and in Ireland. An enlarged Europe will merely supplement this cleavage, with a related divide between Western and Eastern views on family responsibilities for care of the elderly.

The questionnaire did not only ask if respondents considered extended family care a good thing, but also gave them the possibility of rejecting it explicitly as a bad thing. Hence we can calculate the balance between the percentage of those who advocate more family care and those who reject it. This basically reiterates the findings above. Again, we find a remarkable degree of heterogeneity which, however, will not grow much after enlargement because the major differences are found within the current EU. The range extends from countries with vast majorities for the proponents of extended family care to countries where the proponents are even in a minority compared to those who explicitly reject extended family responsibilities.

Figure 13: Perception of future family responsibilities for elderly care (% of respondents advocating that working adults should look after their elderly parents)



Source: Eurobarometer 50.1, Q33; Candidate Countries Eurobarometer 2002.1, Q18: '*If in the future, working adults would have to look after their elderly parents more than they do nowadays, would you say that this would be rather a good thing or rather a bad thing?*'

Why do citizens of different nations have different ideas about the appropriate way of caring for the elderly? As already noted, there are basically two different explanations. On the one hand, we might assume that the respondents' attitudes reflect their experiences with the available forms of care in their countries. If the answers were really predominantly a response to prevailing policies, we should also know in what role the respondents see themselves when answering the question about future care. Do they give their answers from the perspective of the potential care-recipient or from the perspective of the potential care-giver? In either case, two alternative reactions to the prevailing situation are possible. Where there is no access to any formalised forms of help, or

where existing services are known to be of poor quality, it may simply be beyond the respondents' imagination that family responsibilities could be satisfactorily substituted by professional care-givers. Hence they might advocate more family care out of a realistic resignation concerning the potential for effective public support in their country. In case they give their answers from the perspective of the potential care-recipients, this would simply reflect their self-interest in getting the best available form of care. If they voice a preference for family care from the perspective of the potential care-giver, however, this would reflect an altruistic perspective which takes the best interests of the recipients of care into account. A narrow rational choice perspective would lead us to expect a different option on the part of self-interested care-givers. To the extent that families are burdened with extra responsibilities and lack effective public support, we would expect respondents who see themselves as care-givers to be aware of the likely costs of care to themselves, to express a preference for more services that would make their lives easier and hence to reject stronger family responsibilities in the future.

The other, and fundamentally different, possible explanation is that different cultures of care reflect above all religious and ideologically rooted normative ideas about the appropriate role of family support, such as the principle of subsidiarity advocated by the Roman Catholic church, for example. In this case, we would expect the respondents to answer the question similarly, regardless of which side of the care relationship they imagine themselves when giving their answers.

A clarification of these issues would require a battery of follow-up questions in a questionnaire specifically designed to pursue such matters. Our multiple-topic survey cannot serve this function. However, we can analyse the extent to which support for more family support in the future varies in social groups that have a different likelihood to function as givers or recipients of care.

As previously mentioned, we have found women to render care more frequently than men. The gender-specific differences were not very great, but they were in line with previous research which has shown that women do most of the care work, especially if the intensity of care is taken into account. Hence we might expect women to be more hesitant to advocate family care since they know that the task would predominantly fall to them. This, however, is not what our data show. In the ACC and in EU Member States alike, female respondents are even more likely to express a preference for more family care in the future and in this sense women show a remarkable degree of altruism in their attitudes on care (*see Table 21*). Sweden and the Netherlands, two of the countries with very extended formal care services, stand out as the only cases where a majority of women reject the idea of extended family responsibilities. Swedish, Dutch and Finnish men join them in this sceptical attitude about family care. This might reflect the respondents' positive assessment of the prevailing formal care arrangements in these countries. In all other EU countries, as well as in the acceding and candidate countries, men and women agree that extending family responsibilities would be a good thing rather than a bad thing. Again, the gendered differences are not very large, but they are almost everywhere in the same direction. For both women and men, we usually find the proponents of extended family care to outrun the opponents by large majorities. The margins are greater among women in most countries, however, and this tendency towards female altruism shows itself in similar fashion in both parts of Europe.

Table 21: Perception of future family responsibilities for elderly care by gender (percentage point difference between those advocating and those rejecting extended family responsibilities by gender)

Countries	Total	Women	Men	Balance Women – Men
AT	51.3	54.7	47.6	7.1
BE	16.4	20.3	12.1	8.2
FR	15.6	20.3	10.3	10.1
DE	39.5	42.5	36.2	6.2
LU	19.3	25.9	12.3	13.6
IT	75.5	76.2	74.7	1.5
EL	85.2	85.9	84.4	1.5
PT	58.9	61.6	55.9	5.7
ES	51.9	52.5	51.2	1.3
IE	62.3	61.0	63.7	-2.6
NL	-6.6	-7.6	-5.6	-2.0
UK	34.2	30.5	38.2	-7.7
DK	11.7	7.7	15.8	-8.1
FI	-2.2	6.1	-11.3	17.4
SE	-17.2	-23.3	-11.0	-12.4
CZ	42.7	46.7	37.6	9.1
SK	47.1	49.1	44.7	4.4
SI	44.0	46.6	41.1	5.4
HU	74.4	75.7	72.7	3.1
PL	68.8	71.6	65.5	6.1
EE	43.8	42.0	45.8	-3.8
LT	85.2	87.4	82.7	4.7
LV	58.7	57.5	60.1	-2.6
MT	75.8	78.6	73.1	5.5
CY	74.3	73.7	75.0	-1.3
BG	80.4	85.5	74.4	11.1
RO	82.6	84.1	80.8	3.4
TR	58.7	57.3	59.9	-2.6
ACC 13	64.0	66.8	64.0	2.8
EU 15	38.3	40.8	38.3	2.5
AC 10	61.7	66.6	61.7	4.9
EU 25	42.0	45.1	42.0	3.1

Source: Eurobarometer 50.1, Q33/D10; Candidate Countries Eurobarometer 2002.1, Q18/D10: '*If in the future, working adults would have to look after their elderly parents more than they do nowadays, would you say that this would be rather a good thing or rather a bad thing?*'

In order to assess the prospects for future developments of care policies, it is important to know to what extent there is consensus or cleavage among different generations. Furthermore, a comparison by age is interesting because it allows us to at least approximate a solution to the problem of whether respondents see themselves in the role of care-giver or care-taker when giving their answers. In a question about future scenarios, it is likely that those who are already above

the age of 60 perceive themselves as recipients, whereas those below 35 see themselves as potential providers of care. This makes it interesting to find out to what extent the answers of these age-cohorts differ.

The results are in line with the idea that respondents at different ages see themselves in different roles when answering the question. Throughout Europe, those in the highest age group are more in favour of extended family support than those in the youngest age group and those in the middle of the life-cycle (*see Table 22*). This average tendency is repeated in the great majority of countries inside and outside the EU, with only a few notable exceptions. Differences between the generations tend to be greater in the EU. The basic similarity between generations is more noteworthy than the differences, however. Thus, the proponents of extended family support usually outnumber its opponents by large margins, even in the youngest generation. This is remarkable because the younger generation is likely to be the future supplier of informal care. In this sense, younger respondents seem to profess a normative preference against their immediate self-interests. In the ACC, there is not a single exception to this rule; indeed, in two countries the youngest respondents report even slightly higher margins for the proponents of family responsibilities than the older generation. Generation gaps in care preferences thus remain small in countries aspiring to become EU members. Slovenia is the only case where the margin of victory for the proponents of family care is sizeably smaller in the younger generation.

In the EU, four countries (all of which have a record of extended public care provisions) deviate from the general pattern of majority support for family care across generations. In Denmark, Sweden and the Netherlands, the elderly seem to champion the idea of 'intimacy at a distance' (Rosenmayr, 1978), as opponents of extended family support have an edge over its proponents even in the older generation. The Danish case is peculiar not only for its huge generational cleavage in care preferences, but also because of the direction of the age-related differences. A majority of younger Danes seem to be turning away from the prevailing system in their country, advocating a return to extended family responsibilities. Finland and Sweden, on the other hand, stand out as the only EU countries where a relative majority of the younger generation consider extended family responsibilities a bad thing. Low margins of majority for the proponents of family care are furthermore noteworthy in Belgium, France, Luxembourg and the Netherlands. In contrast, the southern European nations stand out with a strong advocacy of family support also among the younger generations. Abstracting from the peculiar patterns in Scandinavia and the Netherlands, we may conclude that Europeans across the generations usually tend to be united in favour of extended family support. In most countries, there is no indication of a coming cleavage between the likely recipients and providers of care, and in this sense Europe once again proves to be remarkably integrative, fostering unity rather than division among the generations.

As noted on page 42, contributors and beneficiaries of pension schemes may be considered to form different transfer classes with different interests. In a similar vein, we might consider the givers and recipients of care to form different risk categories. The issue of a tension or cleavage between such risk categories can now be pursued one step further — by asking to what extent the support model championed by retired people differs from the one economically active people recommend (*see Table 23*). In the ACC and EU countries alike, retired people advocate extended family care distinctly more strongly than people who are economically active. Working people presumably see themselves as likely providers of care and have the dual burden in mind, whereas the older

generation thinks of the situation as the recipients of care. This interpretation helps in understanding why support for extended family responsibilities is much more widespread among retired people. It is equally noteworthy, however, that even among the economically active those who see extended family responsibilities as a good thing rather than a bad thing hold sizeable majorities.

Table 22: Perception of future family responsibilities for elderly care by age (percentage point difference between those advocating and those rejecting extended family responsibilities by age)

Countries	Total	15-34	35-59	60+	Balance Oldest–Youngest
AT	51.3	42.0	49.7	66.7	24.6
BE	16.4	4.2	16.8	32.2	28.0
FR	15.7	9.2	6.6	41.6	32.4
DE	39.4	28.0	40.2	52.1	24.2
LU	19.4	5.2	8.1	51.3	46.1
IT	75.5	74.5	69.8	85.5	11.0
EL	85.1	76.3	87.6	93.2	17.0
PT	59.0	56.6	55.6	68.4	11.8
ES	51.6	42.0	53.0	64.5	22.5
IE	62.3	52.8	62.7	75.3	22.5
NL	-6.6	2.5	-14.3	-6.9	-9.5
UK	34.1	29.9	36.1	36.8	6.9
DK	11.5	39.0	7.5	-20.9	-59.8
FI	-2.2	-8.7	-2.7	7.3	16.0
SE	-17.3	-23.5	-18.2	-8.1	15.4
CZ	42.7	34.8	39.8	59.2	24.4
SK	46.9	47.6	47.6	44.9	-2.7
SI	44.3	23.5	45.6	72.4	48.9
HU	74.4	65.8	77.8	78.6	12.8
PL	68.8	60.8	71.8	75.9	15.1
EE	43.8	46.3	35.3	52.1	5.8
LT	85.1	84.9	85.3	85.3	0.4
LV	58.7	52.5	57.0	72.2	19.8
MT	75.4	70.5	76.3	80.2	9.7
CY	73.9	76.4	70.9	76.1	-0.3
BG	80.6	77.7	78.6	86.3	8.6
RO	82.4	83.4	81.0	83.4	0.0
TR	58.7	57.8	59.3	62.7	4.9
ACC 13	65.4	60.8	66.2	73.7	12.9
EU 15	39.6	34.1	37.0	51.4	17.3
AC 10	64.3	57.1	65.9	72.0	14.8
EU 25	43.6	37.8	41.9	54.6	16.7

Source: Eurobarometer 50.1, Q33/age; Candidate Countries Eurobarometer 2002.1, Q18/age: '*If in the future, working adults would have to look after their elderly parents more than they do nowadays, would you say that this would be rather a good thing or rather a bad thing?*'

Table 23: Perception of future family responsibilities for elderly care by economic activity (percentage point difference between those advocating and those rejecting extended family responsibilities by employment status)

Countries	Total	Retired	Working	Unemployed	Balance Retired-Working
AT	51.3	64.2	50.2	37.0	14.0
BE	16.3	29.1	14.9	1.2	14.2
FR	15.5	36.0	4.3	22.6	31.7
DE	39.4	50.1	34.4	42.6	15.7
LU	19.4	43.5	3.4	-8.3	40.1
IT	75.6	80.8	73.9	80.8	6.9
EL	85.1	92.4	81.0	73.7	11.4
PT	58.8	68.8	56.8	41.7	11.9
ES	51.8	62.3	48.7	31.3	13.5
IE	62.4	71.4	64.9	57.5	6.5
NL	-6.5	-10.8	-7.6	-25.5	-3.2
UK	34.2	35.4	25.8	53.6	9.6
DK	11.8	-19.2	16.8	20.6	-36.0
FI	-2.2	-0.5	-7.4	13.3	7.0
SE	-17.1	-6.7	-26.0	9.8	19.2
CZ	42.7	59.3	36.7	23.7	22.6
SK	47.0	51.7	42.1	49.4	9.6
SI	44.1	69.1	31.2	65.7	37.9
HU	74.4	78.6	68.2	78.9	10.4
PL	68.8	70.5	63.5	73.9	6.9
EE	43.8	49.6	38.7	49.3	10.9
LT	85.3	87.5	82.9	86.0	4.6
LV	58.6	72.2	56.6	49.1	15.7
MT	75.5	78.8	76.8	78.9	1.9
CY	74.1	73.9	74.5	80.0	-0.6
BG	80.3	84.7	71.1	84.8	13.6
RO	82.7	86.2	77.1	83.9	9.1
TR	58.7	48.3	59.3	64.8	-11.0
ACC 13	65.5	71.3	61.0	70.2	10.4
EU 15	39.6	46.9	34.1	40.9	12.8
AC 10	64.3	69.9	57.5	70.1	12.4
EU 25	43.7	51.9	37.3	48.2	14.6

Source: Eurobarometer 50.1, Q33/D15a; Candidate Countries Eurobarometer 2002.1, Q18/D15a: '*If in the future, working adults would have to look after their elderly parents more than they do nowadays, would you say that this would be rather a good thing or rather a bad thing?*'

The majorities for the proponents of family care are much higher in acceding and candidate countries, but they are also impressive in most EU countries. Obviously, there is a strong and rather unbroken tradition of family support in Europe. Again, there are only very few exceptions. We find the usual peculiarities in Denmark, Finland, Sweden and the Netherlands, the four EU countries that have gone furthest in developing formal care arrangements and where the model of extended family responsibilities does not even have a majority among retired people (the majority of pensioners express a preference for the model of independent living with intimacy at a distance). The economically active also opt against the model of family support in this family of nations.

There is, however, one noteworthy exception. In Denmark, the same unexpected cleavage shows up which we already observed in the analysis by age-cohorts: those who work declare a preference for extended family responsibilities, whereas retired people want less family obligations. From a risk-category perspective, this is remarkable because it would lead us to expect just the opposite result. Throughout Europe, we usually find very little indication of a potential cleavage between the providers and recipients of care. Instead the dominant finding once again is one of impressive social integration across different risk categories. There are only six countries where the differences between working and retired people reach a magnitude that might indicate a potential for tensions — the Czech Republic and Slovenia among the ACC 13 group, and France, Luxembourg, Denmark and Sweden in the EU 15.

For the acceding and candidate countries, we can directly examine how and to what extent rendering care to elderly people shapes attitudes about the desirable degree of family support in the future. Unfortunately, the possibility of cross-tabulating the answers to the questions about having extra family responsibilities and about the preferred future of family care does not exist for the EU countries because the two questions were asked in different Eurobarometer surveys. Our analysis for the ACC confirms, however, that giving care to elderly people tends to foster positive rather than negative thoughts about extended family responsibilities in the future. The differences between those who already have care responsibilities and those who do not are not great, but are positive in 11 countries out of the ACC 13. Hence those who perform care work in acceding and candidate countries do not want to liberate families from this task and to externalise the cost of care to others, as a rational choice perspective might suggest; rather, they want to strengthen the caring relationship within families. This may reflect either a pessimistic assessment of the future possibilities of building up formal care in their countries or else a status-enhancing normative underpinning of what one is actually doing as morally good or normatively superior. Our analysis does not allow clarification of this here, but at any rate it further confirms the impressive vitality of family support in acceding and candidate countries. The downside of this active family life is that many people have a dual burden since they render formal and informal work simultaneously.

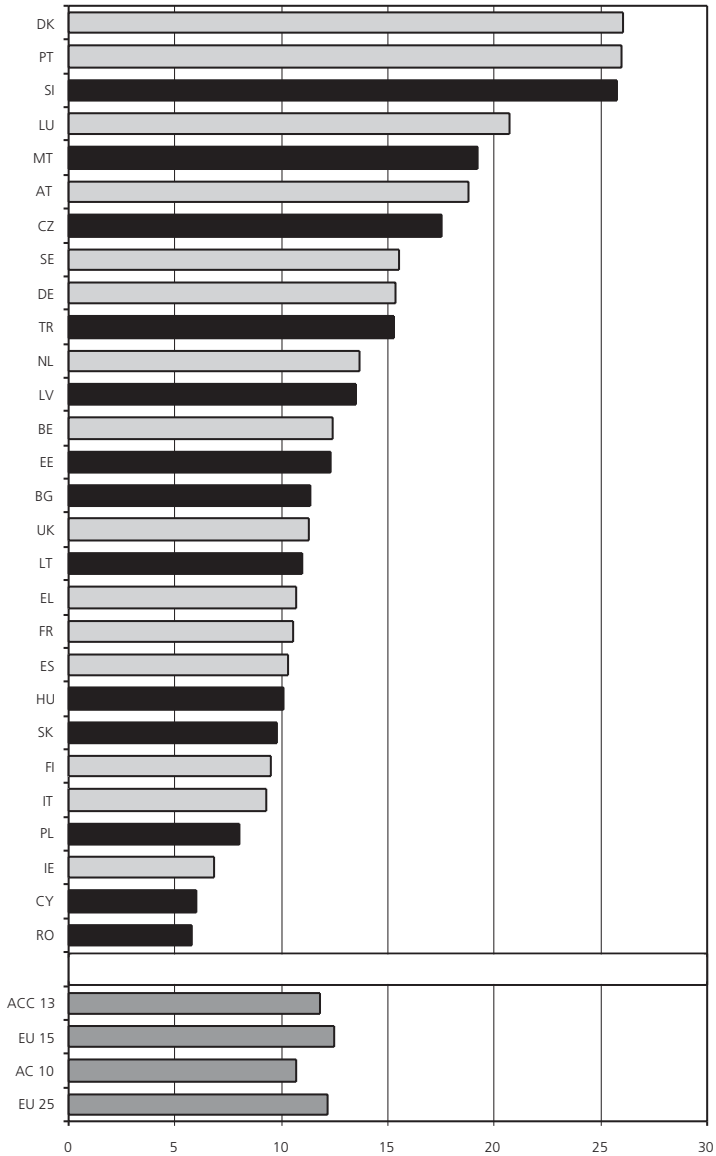
Care of the elderly

Eastern and western European citizens are fairly united when it comes to considering the adequate form of formal help for elderly people who need care. Sending elderly people to residential care facilities is a highly unpopular solution. In 12 of the 13 candidate countries, more than 80% of the respondents prefer social services that allow elderly people to remain in their own homes. Only Slovenia has a somewhat more sizeable minority of proponents of residential care. On average, the advocates of domestic care outnumber those who favour residential care by a margin of 88:12 (*see Figure 14*). The citizens of EU Member States prefer domestic care over residential care to an almost identical degree. Denmark and Portugal are the only countries where more than one in 5 respondents declares a preference for residential care. It is remarkable that the Danes and Portuguese share such similar views about residential care considering that the two countries are usually found to represent different cultures of care.

The preference for domestic care over residential care and for family support models rather than formalised help becomes even stronger when respondents are asked to think about the best way of caring for their own parents should they become dependent. The majority of respondents in the

acceding and candidate countries clearly opt for family support when they are given a choice between 5 alternatives — moving together either in the parents' or in the children's household[48], moving closer to each other, having the parents move into residential care facilities, or having the parents stay in their own home and be attached to domestic care services. In order to simplify the analysis, we can first dichotomise the answers into a preference for family support (moving together or closer to each other) and for formal support (residential care or domestic care services), as shown in Figure 15.[49]

Figure 14: Percentage advocating residential care for elderly persons

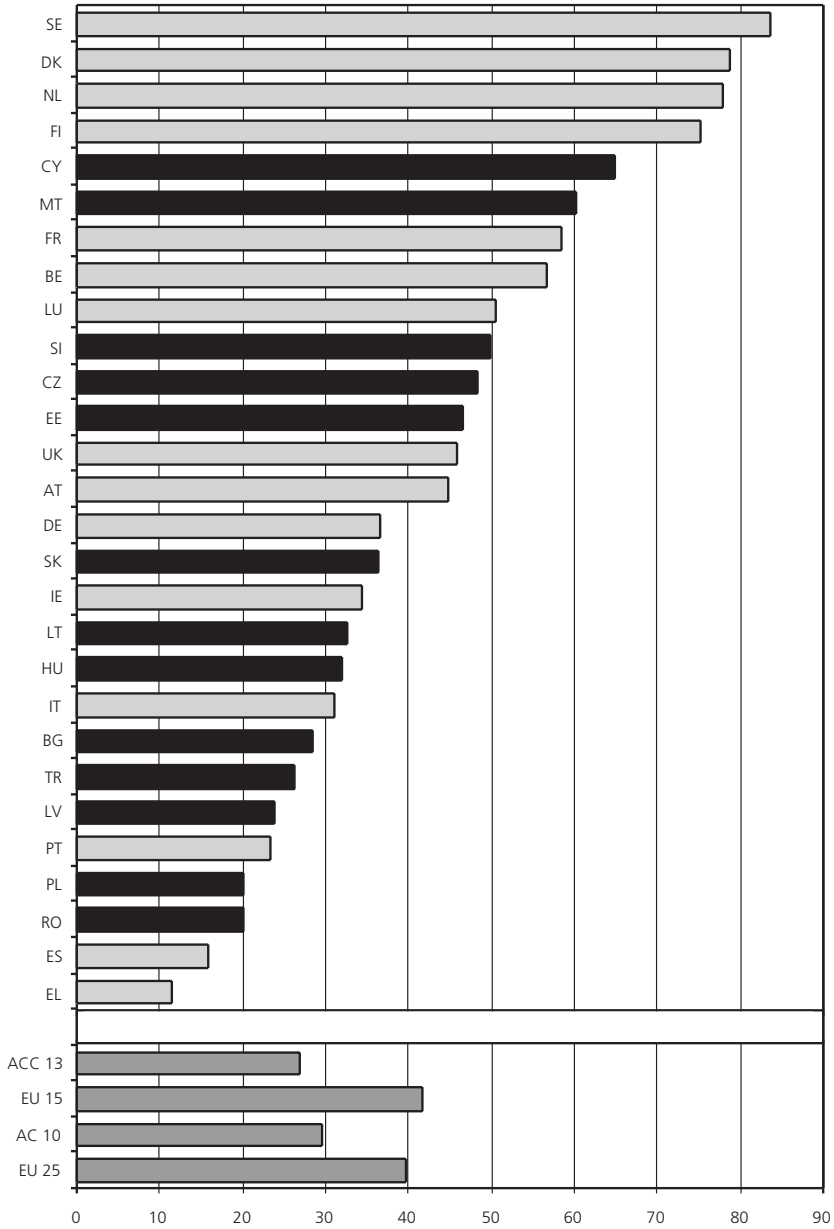


Source: Eurobarometer 51.0, Q36; Candidate Countries Eurobarometer 2002.1, Q19: *'Which comes closest to your own opinion? — Elderly people needing personal care should go into residential/nursing homes — OR — The social services should help the elderly to remain in their homes for as long as possible.'*

[48] These two items were kept separate in the questionnaire, but were fused and analysed jointly here.

[49] Figure 15 shows the percentage of respondents in favour of formal solutions. The preference for family solutions results as the difference to 100.

Figure 15: Percentage advocating formal care solutions for own parents (% in favour of domestic or residential care)



Source: Eurobarometer 50.1, Q36; Candidate Countries Eurobarometer 2002.1, Q20: '*Let's suppose you had an elderly father or mother who lived alone. What do you think would be best if this parent could no longer manage to live on his/her own?*

- *Myself or one of my brothers or sisters should invite my father or mother to live with one of us.*
- *I or one of my brothers or sisters should move in with my father or mother.*
- *One should move closer to the other.*
- *My father or mother should move into an old people's home or a nursing home.*
- *My father or mother should stay at home and receive visits there, as well as appropriate health care and services.*'

Eight of the 13 ACC countries report at least two-thirds majorities for family solutions. In three countries, the respondents waver more or less equally between family and formal care. Cyprus and Malta are the only acceding and candidate countries where large majorities opt for formal care. The EU Member States are much more divided in their views on desirable forms of care. We find three patterns:

- the family model once again enjoys the highest support in Catholic nations;
- in contrast, formal or institutional care is preferred by a vast majority in Scandinavian countries; and
- the continental European countries are somewhere in between these two views, with France, Belgium and Luxembourg being closer to the Scandinavian model, while Austria and Germany, as well as the UK and Ireland, are closer to the southern pattern, with majorities in favour of informal family support.

How much Europeans are divided in their opinions on the appropriate ways to care for the elderly becomes further visible if we go into more detail (*see Table 24*). In 11 of the 13 ACC, at least a relative majority advocate moving together with their parents into a joint household; in eight of these countries, an absolute majority made this choice. Ranking behind the idea of moving together, the idea of preserving the parents' autonomy and leaving them in their own homes with the help of domestic services is usually perceived as the second-best solution. Moving closer to elderly parents is only supported by minorities of up to 13% of the respondents. This is enough, however, to attain rank three in the rank-order of Eastern European care preferences, because moving parents to residential care facilities is extremely unpopular. Only in three countries do proponents of this solution number more than 10%. Again, it is unclear the extent to which these choices reflect culturally rooted preferences for a particular form of care or more pragmatic choices related to country-specific availability and quality of various forms of services.

As seen in Table 24, current EU Member States are more strongly divided into blocks of nations with widely discrepant care preferences. Five countries stand out as cases where the absolute majority of respondents prefer moving in together with parents. In five further countries, moving together with the parents is supported by relative majorities. However, in the remaining five countries (Denmark, Finland, Sweden, the Netherlands and France), the overwhelming majority of respondents have reservations or do not want to move together with their elderly parents if they need care; in four out of these five countries, a relative majority prefers the parents to live autonomously with the help of domestic services. Sweden is the only country where a relative majority favours residential care even for their own parents. The citizens of most other European nations are very hesitant to propose residential care for their own kin.[50] In 10 EU countries, proponents of this solution number less than 20%. In Portugal, a preference for residential care is no longer discernible when the question applies to the respondents' own parents. In most countries, however, it is even more unpopular to leave parents on their own and to settle with merely moving closer together. Support for this most rudimentary solution of the care problem comes nowhere near 20%.

[50] Again, in the absence of more specific follow-up questions, we do not really know how to interpret such findings. On the one hand, the Swedish peculiarity may indicate that Sweden has gone furthest in defining people as individuals and in dissolving family bonds (as in official Swedish household statistics where everyone over age 18 is counted as living in an independent household regardless of the actual living arrangements). On the other hand, family solidarity may be just as strong in Sweden as elsewhere in Europe, but the quality of residential care may be so much higher that people have comparatively high trust in state-provided solutions and hence little reservation about leaving their parents with the support of high-quality public services including residential care facilities.

Table 24: Preferred type of care for own parents (order of care preferences if own parents could no longer manage to live on their own)

Countries	Rank 1	Rank 2	Rank 3	Rank 4
AT	39.5	33.4	15.7	11.4
BE	39.6	33.0	23.7	3.8
FR	43.3	37.5	15.1	4.1
DE	48.9	25.2	14.5	11.4
LU	46.1	28.6	21.8	3.5
IT	59.0	29.3	9.8	1.9
EL	71.8	16.9	11.0	0.4
PT	73.9	13.4	10.0	2.6
ES	80.7	10.5	5.4	3.4
IE	55.6	30.4	10.0	4.0
NL	42.4	35.5	15.5	6.5
UK	39.6	29.3	16.5	14.6
DK	46.0	32.8	10.9	10.2
FI	58.1	17.4	17.1	7.4
SE	43.0	40.6	11.6	4.8
CZ	41.7	34.2	14.1	10.0
SK	50.7	31.9	12.9	4.6
SI	42.2	28.2	21.6	7.9
HU	58.6	27.6	9.3	4.5
PL	75.0	18.9	5.0	1.1
EE	44.2	42.3	9.3	4.2
LT	54.4	28.7	13.1	3.8
LV	63.4	20.4	12.8	3.4
MT	46.5	33.8	13.6	6.1
CY	61.1	29.8	5.5	3.7
BG	62.3	23.7	9.3	4.8
RO	67.7	19.1	12.3	0.9
TR	72.0	23.5	2.7	1.8
ACC 13	66.9	23.6	6.2	3.4
EU 15	48.6	29.0	12.7	9.7
AC 10	62.8	25.0	7.7	4.5
EU 25	50.8	28.4	11.4	9.4

Legend for rank orders	Move together	Move closer	Domestic help	Nursing home

Source: Eurobarometer 50.1, Q36; Candidate Countries Eurobarometer 2002.1, Q20: *'Let's suppose you had an elderly father or mother who lived alone. What do you think would be best if this parent could no longer manage to live on his/her own?*

- *Myself or one of my brothers or sisters should invite my father or mother to live with one of us.*
- *I or one of my brothers or sisters should move in with my father or mother.*
- *One should move closer to the other.*
- *My father or mother should move into an old people's home or a nursing home.*
- *My father or mother should stay at home and receive visits there, as well as appropriate health care and services.'*

Hence we once more find the now-familiar pattern. Attitudes about appropriate care arrangements are most diverse within the EU. Even though the exact composition of the groups may occasionally vary, there are basically three preference patterns. The major dividing line distinguishes a southern and central European culture of care from a northern and western European culture. The Catholic countries of Ireland and southern Europe favour family support, while the Protestant nations of the Netherlands and northern Europe advocate state-provided formal care. The other continental European countries tend to be somewhere in between these two poles. The marked heterogeneity of care preferences in the EU will make attempts to arrive at a coordination or convergence of care policies in Europe extremely difficult and, on the basis of our data, there is little doubt that the family support model will become strengthened after enlargement.

Of course, the concrete choices that people make in their daily lives need not necessarily be in line with their expressed normative policy preferences. Hence it would be interesting to know to what extent the general care-policy preferences of respondents are consistent with their personal choices when it comes to considering the best solution for their own parents. Unfortunately, a micro-level cross-tabulation of both responses is only possible for the ACC because in Western Europe the respective questions were asked in two different Eurobarometer surveys.

In the acceding and candidate countries, there is a striking divergence between general preferences and personal choices. On average, not even half of the respondents who advocate residential care for elderly people in general regard this also as the best solution for their own parents (*see Table 25*). The discrepancy between general policy options and personal choices is most marked in Poland, Latvia, Romania and Turkey, where more than 85% of the proponents of residential care

Table 25: Consistency of general care preferences and care preferences for own parents (%)

Countries	% of those advocating residential care in general who prefer it also for their own parents	% of those advocating domestic care in general who prefer residential care for their own parents
SI	54.4	9.0
CZ	53.3	4.3
MT	47.4	4.8
CY	41.4	1.1
HU	36.5	0.8
LT	35.6	0.1
BG	35.0	1.0
SK	32.2	0.6
EE	20.4	1.3
LV	13.7	1.2
RO	13.2	0.1
TR	12.6	0.9
PL	8.3	0.4

Source: Candidate Countries Eurobarometer 2002.1, Q19/Q22: *'Which comes closest to your own opinion? — Elderly people needing personal care should go into residential/nursing homes — OR — The social services should help the elderly to remain in their homes for as long as possible. — AND — Some people have extra family responsibilities because they look after someone who has a long-term illness, who is handicapped or elderly. Is there anyone living with you who has a long-term illness, who is handicapped or elderly, whom you look after or give special help to? And do you provide some regular service or help to such a person NOT living with you?'*

in general do not want this for their own parents. It is noteworthy that the discrepant responses with respect to general policy preferences and personal preferences cannot be attributed to an erratic response behaviour because we find high consistency in the answers concerning domestic care. Here, only tiny minorities below 5% of those who advocate home help services generally switch to proposing residential care for their own parents.

The results in Table 25 reiterate how very unpopular residential care is in the acceding and candidate countries and how widespread support there is for the idea of family support. The rejection of residential care does not necessarily mean that ACC citizens will never adopt the idea of 'intimacy at a distance'. This concept can only become attractive, however, when a sufficient supply of adequate housing will allow multi-generational households to split up at a reasonable cost. Once again, we do not really know if the ACC citizens make their professed choices because they want to or because they have to, given the limited range of available opportunities. Beyond this uncertainty, our findings suggest two conclusions: (1) the strength of family support will help to span inter-generational cleavages in Europe's ageing societies; and (2) the strength of family support may help to unburden the welfare state, but it will also put a heavy dual burden on working people in acceding and candidate countries who already have to struggle to make ends meet, but are facing a growing challenge to combine formal and informal work.

Views on who should pay for care

When asked who should pay for the care of elderly parents, ACC citizens' opinions are mixed — between favouring state financing and preferring children to pay the cost. Proponents of family support, in the sense of child obligations, are particularly strong in the three candidate countries of Bulgaria, Romania and Turkey. Sizeable minorities of ACC 13 citizens also favour splitting the cost evenly between the state, children and the elderly. By far the least popular idea is to have the elderly themselves bear the cost. This pattern again underlines how very strong the idea of family support is enshrined in acceding and candidate countries. It also indicates that the professed care preferences are not merely a response to the prevailing opportunity structures of care, but are also an expression of cultural values which cherish respect for the elderly and underline children's obligations. The idea of sustainable social policies that take the interests of future generations into account still seems to have very little prominence in acceding and candidate countries.

EU 15 citizens are more frequently in favour of state financing. They are also much more hesitant to have the children pay and they have less reservations on making the elderly bear the cost themselves. In eight of the 15 EU countries, the idea that the elderly should pay the bill themselves is more popular than the idea that children should pay. Within the EU, we once again find the usual divide between the Mediterranean countries, which have considerable margins of support for the family support model, and Scandinavia and the Netherlands, where the idea of letting children pay is very unpopular. Inside and outside the current EU, we find much heterogeneity without a clearly predominant mode of financing preferences (*see Table 26*).[51]

[51] If there were less heterogeneity, Table 26 would not look like a patchwork, but would appear as consisting of four solid blocks.

Table 26: Care-financing preferences (order of perceived responsibility to pay for care of own parents)

Countries	Rank 1	Rank 2	Rank 3	Rank 4
AT	44.0	22.8	20.7	11.3
BE	50.7	21.5	15.2	11.2
FR	50.7	17.1	16.3	14.1
DE	48.7	20.0	19.0	11.6
LU	39.5	24.7	19.2	14.6
IT	43.3	24.5	17.1	12.4
EL	40.7	27.5	22.1	9.1
PT	48.0	30.1	11.7	8.2
ES	38.1	31.9	14.8	13.1
IE	47.3	23.9	18.4	6.4
NL	66.2	14.1	10.0	6.9
UK	59.6	13.0	12.4	12.1
DK	88.7	5.5	2.0	1.8
FI	67.6	14.8	11.8	3.5
SE	81.0	8.9	6.8	2.5
CZ	38.0	34.4	18.1	8.9
SK	58.1	21.3	10.5	8.9
SI	42.7	20.7	18.8	17.7
HU	34.8	29.8	29.6	4.6
PL	41.2	21.5	19.8	17.2
EE	52.9	21.0	20.9	4.0
LT	42.6	22.5	19.6	14.8
LV	57.5	17.6	16.5	7.3
MT	64.5	13.6	11.6	9.4
CY	54.2	29.9	13.1	2.0
BG	33.8	33.6	24.1	8.5
RO	45.6	24.3	22.5	7.1
TR	58.4	31.3	5.9	4.1
ACC 13	37.8	34.4	17.6	9.7
EU 15	50.3	17.8	15.4	14.7
AC 10	40.6	25.8	19.3	13.7
EU 25	48.7	18.0	17.0	14.5

Legend for rank orders	Elderly parents themselves	Their children	State or other public authorities	Everyone equally

Source: Eurobarometer 50.1, Q37; Candidate Countries Eurobarometer 2002.1, Q21: '*Irrespective of your answer, who do you think should mainly pay for taking care of elderly parents? — The elderly parents themselves, their children, or the State or other public authorities (e.g. local government, Social Security, etc).*'

Political economists typically worry that democratic societies with ageing electorates will have difficulties in developing sustainable policies in the interest of future generations. As the median voter grows older, so the argument goes, politicians will find it increasingly difficult to legislate reforms that would impinge burdens on current voters in order to unburden future generations who do not yet appear at the polls (Sinn and Übelmesser, 2002). To the extent that this mechanism is

effective, we would expect older generations to opt more frequently for externalising the cost of care to the younger generation or to the state (which in practice would also amount to shifting the burden to the young). We would expect younger people instead to favour shifting the burden to the elderly and hence to opt less frequently for financial obligations of children or the state. Table 27 shows to what extent members of different generations differ in their financing preferences in a way that would be in line with these expectations.

Table 27: Care-financing preferences by age (percentage point difference between people over 60 and of age 15-34)

	Preferred financing agent			
Countries	The elderly parents themselves	Their children	The State or other public authorities	Everyone equally
AT	-0.1	19.7	-7.2	-13.0
BE	8.9	-1.8	-19.2	10.2
FR	5.9	7.4	-14.7	2.0
DE	16.0	1.5	-14.5	-2.7
LU	7.8	1.2	-13.6	3.6
IT	3.3	-4.3	2.0	-0.9
EL	2.3	-6.0	2.3	0.8
PT	2.0	1.1	-1.8	-3.6
ES	1.7	6.4	-5.4	-1.9
IE	4.9	0.2	4.0	-9.0
NL	5.5	-9.6	-0.5	2.8
UK	13.9	-3.3	-10.4	-1.6
DK	3.0	-1.9	-4.9	-0.3
FI	5.1	1.4	-7.2	0.3
SE	10.2	0.5	-9.2	-0.9
CZ	1.0	5.1	-13.0	8.1
SK	1.0	-5.0	-3.2	8.0
SI	13.5	5.1	-20.2	1.8
HU	2.9	0.7	-5.1	0.3
PL	7.3	2.4	-8.5	-0.9
EE	4.5	3.7	-8.7	0.5
LT	1.9	5.3	-6.1	-1.9
LV	3.3	-2.1	-0.3	0.1
MT	0.9	2.5	4.0	-7.4
CY	2.6	-12.1	16.2	-6.2
BG	4.4	11.5	-9.5	-6.5
RO	0.5	4.4	1.9	-6.5
TR	4.6	-0.3	-8.1	3.4
ACC 13	5.2	-7.3	-5.1	7.2
EU 15	8.3	0.5	-8.1	-0.8
AC 10	4.3	2.5	-8.5	1.9
EU 25	7.7	0.8	-8.1	-0.5

Source: Eurobarometer 50.1, Q37/age; Candidate Countries Eurobarometer 2002.1, Q21/age: '*Irrespective of your answer, who do you think should mainly pay for taking care of elderly parents? — The elderly parents themselves, their children, or the State or other public authorities (e.g. local government, Social Security, etc).*'

Judging from their financing preferences for care, Europeans show a remarkable degree of inter-generational empathy and surprisingly little self-interest (*see Table 27*). In both the ACC 13 countries and the EU 15, older citizens are more in favour of shifting the burden of financing to the elderly than those in the youngest generation. They are also less likely than young people to advocate state financing as a means of externalising the cost of care to the tax-payer. Finally, they are not over-proportionately in favour of burdening children.[52] In 27 of the 28 European countries, shifting the cost of care to the elderly is more popular among the older generation than among the younger generation. In 11 of the 13 ACC and in 12 of the 15 EU Member States, the older generation is also more hesitant to let the tax-payer foot the bill. Concerning the obligations of children, the results are more mixed. Yet there are only a few countries where senior citizens distinctly outrun the young in advocating putting the burden on children. Marked differences (above three percentage points) are found in six of the acceding and candidate countries, as well as in Austria, France and Spain.

In summary, the findings lend little support to the idea that the growing age of the median voter automatically translates into a blockage of reforms aiming at more sustainable policies. At least in Europe, older citizens are willing to shoulder their part of the cost of care and they are reasonable and compassionate enough not to advocate externalising the cost to others more frequently than younger voters.

A very similar result shows up when we compare the financing preferences of retired people to those of economically active persons. Such a comparison shows pensioners to be more willing than working people to shift the burden of financing to elderly persons; in addition, they are less willing than economically active people (whom we should expect to fear a growing tax wedge) to support state financing. Again, the results are more mixed with respect to the option of having children pay the bill, but even here we find a lot of country-specific variation rather than a clear pattern that would fit the idea of a self-interested older generation ruthlessly putting burdens on future generations. This sustains the idea that interests are not firmly rooted in socio-structural positions, but are malleable enough to be actively shaped and constructed in the political process. Convincing voters even more of the importance of sustainable policies in ageing societies will become an important future task for policymakers throughout Europe.

[52] Once again, the fact that the aggregate average for the CC 13 countries is -7.3 is a statistical aggregation effect that should not be interpreted on substantive grounds, given the country-specific distributions.

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The European Foundation for the Improvement of Living and Working Conditions is a tripartite EU body, whose role is to provide key actors in social policymaking with findings, knowledge and advice drawn from comparative research. The Foundation was established in 1975 by Council Regulation EEC No. 1365/75 of 26 May 1975.

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