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HEALTH CARE SYSTEMS AND THE PEOPLE: A FIVE-NATION STUDY IN THE EUROPEAN UNION

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Abstract The results of an exploratory five-nation survey of 2,239 adults interviewed on the telephone indicate general satisfaction with the health care system and less satisfaction with common welfare. In particular German respondents reported minor problems in their experiences with doctors with regard to communication and timing. Concerning health policy, French and Spanish respondents favoured more interventionist medicine, while Germans in particular preferred medicine as care. The public responsibility for care and the shifting of responsibility for future financial needs to employers and the public reveal a tendency that has been called corrupt. Overall, when evaluations and attitudes concerning health care and related policies were controlled for demographic factors, they were not particularly determined by social stratification, which indicates that the health system functions well in providing comprehensive care and securing the identity and integration of society. However, value orientations as a reflection of culture and the respective nationalities are strong determinants of health care systems. National identity confirms at the same time the validity of the comparative approach and the use of multivariate analyses.

Despite remarkable medical advances, all modern societies have developed major cost and organisational problems within their health care systems. Health care and health promotion have become significant domestic policy issues. The situation in Western Europe is no different. Notably German health care reformers call their system 'sick' and almost every other year they try to repair a supposedly bad system with patchwork health reform. In one of its first moves, the conservative French government wanted to double health care insurance to keep its system solvent. The Dutch have increasingly recognised that their system of high welfare accommodation, producing early retirement and longer life expectancy, is difficult to sustain financially. Zijderveld (1986), elaborating on the welfare system in its relation to culture, denounced the welfare system's corrupting tendency as an 'immorality' of the people in Northwestern Europe, and praised instead the higher morality of the 'American creed' and the American system.

Despite these alarm signals and positions, Western European nations have reasonably successful systems of care providing more or less comprehensive coverage, showing ever higher life expectancies for their populations, good incomes for health care personnel and, regardless of individual organisation, seemingly high satisfaction with the system, with the exception perhaps of the Spanish and British system.

With European integration, the issue of health care in Western European nations should receive considerable attention in politics as well as research. Actually, as far as the former is concerned, health care is not a major issue on the European agenda. But there appears to be increased activity in social

science research dealing with problems of formal organisation and health care delivery (Alber and Bernardi-Schenkluhn 1992; Altenstetter 1981; Field 1989; Graig 1993), social inequality (Fox 1989; Vagerö and Illsley 1992), health welfare provisions, and aggregate data analysis concerning health economy (Schneider et al. 1992). There is, however, very little information with regard to the behaviour and attitudes of the general population nor are there systematic comparative socio-cultural analyses. Even if the satisfaction of people with their national systems is high, suggesting that there is no need for a move towards a common European health policy, it is important to know and understand the experiences of and position taken by people toward major issues of health care between and within individual nations. Consequently, the West European Study of Health (WESH) was initiated by the Universities of Aachen, Antwerp, Düsseldorf, Maastricht, Nancy and Valencia as a comparative telephone survey of adults 18 years and older in Belgium, France, Germany, the Netherlands and Spain.

Theoretical frame of reference

The following analysis of WESH data, with random samples of adults from five Western European nations, will provide exploratory information concerning peoples' attitudes towards welfare and health care systems, experiences with doctors, and expectations of health care policy. The analysis will be based on a conception of health care systems approach which will stress dimensions of demographic structure, social stratification, culture and nation. Data as descriptors and responses of individuals will reflect systemic structures, and in the sequence of analysis will move from a lower level of demographic conditioning to a higher level of systemic control as identified in the concept of the nation.

Regardless of public concerns and statements of crises, the health system is still one of the pillars of the modern welfare society. It provides and guarantees basic needs for the population and does so at a comprehensive level with a strong notion of equity. Social welfare of this kind occurs in institutions such as education, law, politics and health. In historical terms, one may relate this to the principles of the French Revolution and the notion of equality in particular. In 1889 it was Bismarck who explicitly introduced a publicly guaranteed system of health care for the working poor. As Benedetto Croce (1932 : 266) remarked: 'A few physical needs should be met in order to pacify the minds and to break the will...' of socialists and workers. The system became immensely successful and now covers the majority of German and, since German occupation, also Dutch people. Regardless of Bismarck's political intention one may, in structural terms, and as verified by social scientists like Marshall (1977), Schmoller or Schumpeter around the turn of the century, relate this reform to the need of modern industrialised society to secure the integration of a basically stratified system. Within modern welfare societies health care has become a central concern to secure an optimum of equity in life chances (Lüschen, Cockerham and Kunz 1989b).

There are variances with regard to the latter. A country like the United States

of America does not provide equity in health care as part of respective welfare provisions (Anderson 1972); it has to call on the special charitable morals and institutions like university clinics to provide a minimum of health care for a group of uninsured people as large as 15 per cent of the population. In Western Europe, equity in care is secured at a comparatively much higher level. While smaller sectors of the population, such as in Germany and the Netherlands, may be able to secure some privileges in care, common care for the average citizen is still provided at a high level of equity regardless of the costs for the individual. The nations of Western Europe have secured such services through publicly guaranteed financial systems that are based on principles of the social security system. The United Kingdom, with its tax-financed National Health System, is the exception.

Regardless of uniformity in organisations and financing across national borders, and a common acceptance of principles of equity, health care systems display a high degree of national identity and uniqueness. On the one hand, such systems relate to each nation as a political entity in which resources are allocated, legal and administrative provisions are enacted, and where traditions and scientific accomplishments lead to an integrated system and a sense of national pride. The nation-state thus has a major bearing on the organisation of health care.

The nation may also mean a whole set of behavioural patterns, including a specific form of bureaucracy. French administrators, as Crozier (1964) observed, have distinctive traits: a difficulty of sustaining somewhat intimate face-to-face relationships, an accent on aristocratic values, and a preference for authoritarian solutions. The Dutch are quite critical of authority and disapprove of solitary decisions. The civic culture of the Germans is probably as petty bourgeois as any. The Belgians distrust central government, and the Spaniards display a conglomerate of regional cultures with their health system in considerable disarray. These and other features contributing to our variable 'nation' remain ultimately unexplored and leave the nation or nationality of the respective individuals in the state of a black box. Such a procedure is actually quite typical for cross-national comparative research (Scheuch 1989). While the nation-state is a powerful entity in any comparative research, whatever German or French may mean is composed of a number of structural levels. In this project and analysis our attempt will be to control for some of these levels, i.e., demographic, stratificational and cultural. These were selected for good reasons as they are related to the very topic of health, but they also serve the dual purpose of stripping nationality of some of the demographic, stratificational and cultural impacts that will leave the nation foremost as a political unit in the analysis. While there are express misgivings about the use of multivariate techniques in comparative analysis (Ragin 1987), in this special case and for this topic regression analysis will serve a useful purpose.

It is an open question why national identity should express itself particularly through the health system. One can assume that it relates to the basic need of individual existence which, in moments of danger, requires immediate assistance that is typically organised from the local level up to the level of region

or nation. In this context, it is of some interest that the cosmopolitanism of health care is not far developed. As a case in point, the construction of a major health clinic at Aachen (Aix-la-Chapelle) in the so-called Euregio of Belgium, Germany and the Netherlands was justified by its expected attractiveness across the German border. Nothing of the kind materialised. Instead, national identity and pride resulted in the construction of similar clinics across the borders in Belgium and the Netherlands.

Of course, it is a matter of practicality whether the diffusion of services across borders and even regions is desirable for health care. The typical case of sickness needs local and immediate attention. A local identity and organisation of health care may thus prevail. The decentralisation of the German health system into more than 1,110 sickness funds and insurances may be more responsive to the needs of the population than a centralised unit administered by the European Union in Brussels. It is also interesting to note that the Single European Act (SEA) of 1987 provides for 'a high level of protection', 'harmonisation', and explicitly allows member states to continue national regulation in order to further 'public morality ... and the protection of health and life of humans'. However, as Immergut (1992) finds in her comparative study of France, Sweden and Switzerland, politics in health care often takes priority, and specific democratic provisions like referenda may even inhibit the progressive developments of appropriate health and welfare systems.

Whether the welfare society within such systems as health care is fraught with corruption, and whether we can talk about the immorality of particular people and within nations, as Zijderveld among others does, remains to be seen. The theoretical issue that it is not only social stratification (or differentiation and affluence) and national identity that drives the welfare system, but the generalisation of values as a matter of culture (Zijderveld 1986), raises an important issue beyond nationality, social structure and matters of inequality. The power of such impacts is apparent from Hofstede's cross-national study (1980) of respective industrial systems and the impact of culture. For health it is in a broader perspective related to religious systems as expressions of culture (Parsons 1960). The very fact that at the level of culture strong impacts can be expected is among others linked to the fact that health and health care deal with the most basic value in human life. But culture will relate for health not only to religion or religiosity but to value components, such as physical appearance, altruism (vs. individualism) and post-materialism. Such values, as expressed in individual attitudes, will help to explain and understand the differences between health care systems in modern societies of Western Europe. Comparative studies have addressed such issues with regard to political or civic culture (Almond and Verba 1963; Inglehart 1989), narcissism (Lasch 1979), problems of individuality (Inkeles 1983), European health care (Payer 1988) and the differences between American and German health cultures (Lüschen, Cockerham and Kunz 1987).

With regard to health as something of a finite resource in the ageing process, and as a result of respective biological conditions of the body, any model designed to explain and understand the health system has to control for age and

sex. Even in matters of health policy, it is safe to assume that the experiences of age and finiteness of existence, and the higher sensitivity towards health on the part of females will result in distinct positions. Cultural conventions and social traditions, often experienced as discrimination, extend beyond what first appears as a merely biological matter. But, in a hierarchy of cybernetic relations (Parsons), it remains a fact that age and sex have to be considered more in terms of conditioning, while culture and the nation are predominantly matters of control.

Overall, our model will assume quasi-causality from demographic over social structural (stratificational), cultural dimensions and nationality towards dependent variables, such as social welfare and health systems, experiences with care and expectations of health policy. Of course, the items selected for analysis dealing essentially with organisational and policy problems of health care will be determined by political dimensions such as the variable nation; but, if our argument concerning the sensitivity of demographic dimensions is correct, age and sex will have their bearing even on the health policy level.

Our research model as outlined in Table 1 suggests a number of propositions and a plethora of distinct hypotheses: health care systems and their evaluation are determined by age and sex; these may refer to positions, but age in terms of cohorts and sex as gender for health also imply structural conditions. For the level of social stratification and against the background of integrative needs of society, it is expected that variables of stratification show little overall impact and variance. They represent dimensions of life chances that welfare systems have tried to equalise (Lüschen, Cockerham and Kunz 1989b). On the level of culture or individual value orientation, principles like religiosity, post-materialism, altruism and appearance will affect issues of health and health systems. As far as nationality is concerned, this political entity will have a strong impact because of its late appearance in statistical procedures, and as a fourth step in regressions, it will show what was not explained by variables of the foregoing analysis. As matters of demography, stratification and culture have a national bearing, results of the foregoing steps in regression analysis will indicate to what degree that is so. However, as stated above, the variable nation will mainly address the political dimension of nation or the nation-state.

Method and data

1. *Sample and fieldwork.* The West European Study of Health (WESH) was conducted as a survey with a random sample of 686 adults in Germany (Northrhine-Westphalia) and 666 in the Netherlands. The survey also covered three smaller random samples: 156 in France (Lorraine), 380 in Eastern Belgium and 351 in Spain. Consequently, because of size and regional limitation in three of the five nations, the results are mainly exploratory. However, as far as cross-national research is concerned, so-called global indicators for a nation may provide valid information for certain items even from smaller samples. Comparability should not pose major problems of structural equivalence in an essentially similar system design in the five countries

Table 1
Model of Health System as Determined by Demographic Conditions, Social Stratification, Culture and Nation for Selected Health Indicators

Demographic Conditions>	Social Stratification>	Culture>	Nation>	System Indicators
Age	Occupation	Religiosity	Belgium	Welfare
Sex	Education	Altruism	France	Health system
	Income	Appearance	Germany	Doctor, communication
	Self-evaluated Social Status	Post-materialism	Netherlands	Doctor, timing
			Spain	Institutional finance

involved. The responses of individuals and regionally restricted samples should, however, safeguard us against Galton's problem of inferences for the systemic level.

To obtain standardisation and equivalence, the interview schedule was first developed in German and in English. It was then translated from the German into Dutch, French and Spanish by native speakers of the respective languages. The pre-test versions were re-examined and the final version for each language was also tested against the English version. This procedure, according to our experience, guaranteed equivalent instruments in as far as they can be secured in cross-national research. The method of translation and re-translation, so often advocated, appeared neither feasible for translations into five languages nor does it provide, despite its seeming rigidity, a practical answer for matters of equivalence of meaning and function. Part of the questions were taken from a previous cross-national study of America and Germany (Lüschen, Cockerham and Kunz 1989a). A number of questions and closed answers represented validated indices, such as the Inglehart Scale for post-materialism or the Appearance Scale developed in a previous American-German health study (Cockerham, Kunz and Lüschen 1988).

Workshops were held with research teams in Belgium, France, Germany and the Netherlands to secure equal conditions in data collection. In Spain a commercial survey institute collected the data. Since external financing of research costs was limited,[1] and the internal resources at each institution were unevenly distributed, representativeness can only be claimed for the Netherlands and Northrhine-Westphalia in Germany. However, since the intent of the 5-nation project was exploratory and aimed to provide a theoretical and structural basis for future research, all nations are included.

Data were collected within three-to-four-month time periods in the winter of 1990–91 and in Spain in the autumn of 1991 respectively. The response rates were as follows: Belgium, 52.25 per cent (N=380); France, 62.4 per cent (N=156); Germany, 66.5 per cent (N=686); Netherlands, 49.1 per cent (N=666); Spain, 41.1 per cent (N=351); total responses, 54.64 per cent (N=2,239). Losses were due to refusals, prolonged absences, illnesses, deaths and language problems of the potential respondents selected from a given telephone household;

they were also affected by set time limits for the project. In Spain, in particular, data could only be collected for a restricted period of a few days due to problems of cost. Overall, the rates mentioned above are in the range of present experiences of survey research operations. Frequently only refusals are reported, which gives the impression that the majority of cases in a given unit of analysis is being included. However, absences, illnesses, language problems, as well as closures for scheduling reasons, do account for a substantial loss as well. In the WESH project, the latter accounted for 9.44 per cent, while total refusals finally amounted to 35.2 per cent. They were comparatively lower in Germany and higher in the Netherlands. Within households, randomness was secured by selecting the person 18 years and older who was the last to have her/his birthday (O'Rourke and Blair 1983).

A major criticism of telephone interviews is that there is no total coverage of or access to the population in respective nations. For all practical purposes, the exclusion of a small sector of a population is not biased in only one direction (Frey, Kunz and Lüschen 1990). Only very marginal groups, such as single-women households of blacks in the American South, have a telephone rate of less than 50 per cent and, as Friedrichs (1987) claims for Germany, there is no group with a telephone density below 90 per cent. The impact of such influences on respective results is low and negligible indeed. Of course, Spain, for Western Europe and within the present project, is the exception as it has only a telephone density of 75 per cent. In the four other countries the rate is well above 90 per cent.

The comparison by age group and sex with census data and those of our study by nation will suggest to the critical reader where this project and its results might be located.[2] As the figures show, the rate of women in the sample is slightly higher than in the population overall, and in terms of age the younger age groups 18–44 years are overrepresented, while the group of those 65 and older has a lower representation than it has in the population overall. Typically, populations in institutions are excluded in survey research. Thus, older people, due to their rate of institutionalisation (homes for the elderly, hospitalisation) show lower completion and response rates. For each nation there are slight deviations from these general patterns. Overall, the differences cannot only be explained by probabilistic reasons. The high rate of women in France may be due to interviewer effects, as the vast majority of interviews was conducted by female interviewers, and it may also be due to regional differences in the distribution of the sexes in rural-urban Lorraine. The difference for the group 65 and older in Belgium was due to the fact that in Flemish Eastern Belgium interviews were conducted with people from 18 to 65 years of age only. Seen overall, the higher rate of women may be due to lower mobility and lesser involvement in outside work, and hence being easier to get on the telephone. Regardless of such typical impacts, the sample of this exploratory study is sufficiently close to the demographic structure of the population in general.

2. *Variables and interview schedule.* Table 2a of means and standard deviations shows the independent and dependent variables used in the analysis. It also

Table 2a
Means and Standard Deviations (in italics) for Independent and Dependent Variables for Individual Nations and Total WESH-Sample

	BE (*N*=380)	FR (*N*=156)	GE (*N*=686)	NE (*N*=666)	SP (*N*=351)	Total (*N*=2239)	α	Variable
Independent								
1. *Demographic*								
Age in Years	42.03	45.07	45.89	43.12	43.73	44.01	—	AGE
	14.68	*17.08*	*16.74*	*15.85*	*17.11*	*16.28*		
Sex (0 = Male/1 = Female)	.54	.63	.51	.55	.52	.54	—	FEMALE
2. *Stratification*								
Maximum Occupation in	45.05	44.99	46.57	46.08	43.03	45.58	—	OCCMXEST
Household (Treiman Scale)	*11.98*	*14.79*	*12.70*	*11.17*	*12.39*	*12.29*		
Years of Education	12.37	11.41	11.34	12.37	—	11.91	—	EDYEARS
	3.53	*3.43*	*3.47*	*3.85*	—	*3.65*		
Family Income in ECU	25.71	20.29	27.86	23.25	—	25.18	—	INCOME
	9.20	*8.97*	*14.39*	*11.37*	—	*12.26*		
Self-evaluation	5.94	5.21	5.82	6.31	—	5.96	—	SESOSTAT
Social Status (1–10)	*1.45*	*1.43*	*1.50*	*1.32*	—	*1.46*		
3. *Value Orientations*								
Physical Appearance	3.21	3.22	3.09	3.13	3.04	3.12	.75	APPEAR
(5 items 1–4)	*.51*	*.44*	*.47*	*.44*	*.53*	*.48*		
Compassion (6 items 1–5)	4.21	4.34	4.36	4.25	—	4.29	.66	COMPASSN
	.43	*.39*	*.39*	*.39*	—	*.41*		
Post-materialism (1–5)	3.22	3.05	3.60	3.02	3.00	3.24	—	POSTMAT
	1.19	*1.28*	*1.31*	*1.27*	*1.06*	*1.27*		
Religious Orientation	2.79	2.54	2.74	3.18	—	2.89	—	RELORT
(1–5)	*1.03*	*1.03*	*1.01*	*.79*	—	*.99*		

Table 2a
Continued

	BE (*N*=380)	FR (*N*=156)	GE (*N*=686)	NE (*N*=666)	SP (*N*=351)	Total (*N*=2239)	α	Variable
Dependent								
Welfare Society Integration (6 items 1–5)	2.75 *.66*	2.59 *.51*	3.10 *.63*	3.07 *.56*	2.31 *.62*	2.87 *.67*	.71	WSOCINT
Health System Evaluation (2 items 1–5)	3.78 *.74*	3.68 *.68*	3.69 *.76*	3.93 *.64*	— *—.72*	3.79	.54	HSYSEVAL
Communication Problems with Doctors (3 items 1–4)	1.39 *.52*	1.59 *.64*	1.76 *.73*	1.56 *.71*	— *—.69*	1.60	.71	DOCCOM
Timing Problems with Doctors (3 items 1–4)	1.75 *.73*	1.91 *.78*	2.32 *.89*	1.76 *.78*	2.36 *.89*	2.04 *.87*	.68	TIMING
Curative Medicine Preference (1–5)	2.91 *1.02*	3.47 *1.19*	2.47 *1.25*	2.77 *1.24*	3.06 *1.26*	2.79 *1.24*	—	CURATMED
Legal Right to Free Care (1–3)	2.39 *.74*	2.41 *.81*	2.42 *.86*	2.51 *.73*	— —	2.45 *.79*	—	FREECARE
Favour Institutional Financing (4 items 1–5)	3.27 *.61*	3.39 *.66*	3.36 *.72*	3.23 *.63*	— *—.67*	3.29	.59	INSTFIN

Table 2b
Correlations for Independent and Dependent Variables for WESH-Sample

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
1. AGE	—																
2. FEMALE	.055	—															
3. OCCMXEST	−.024	−.067	—														
4. EDYEARS	−.333	−.161	.509	—													
5. INCOME	−.128	−.117	.385	.325	—												
6. SESOSTAT	−.087	−.072	.233	.244	.218	—											
7. APPEAR	−.066	.219	−.067	−.073	.012	.063	—										
8. COMPASSN	.169	.158	.050	−.064	−.016	.034	.245	—									
9. POSTMAT	−.226	−.061	.144	.217	.139	.069	−.006	.020	—								
10. RELORT	.173	.129	−.037	−.085	−.111	.051	−.015	.130	−.176	—							
11. WSOCINT	.226	−.061	−.028	−.143	−.038	.052	.014	−.026	−.119	.199	—						
12. HSYSEVAL	.142	.043	−.083	−.086	−.049	.086	.114	.091	−.105	.171	.266	—					
13. DOCCOM	−.139	.000	−.006	.093	−.012	−.053	.017	.001	.111	−.092	−.089	−.155	—				
14. TIMING	−.139	.009	.066	.117	.061	−.038	−.025	.031	.152	−.107	−.183	−.187	.462	—			
15. CURATMED	−.109	−.009	−.112	−.113	.003	−.036	.092	−.009	−.068	−.017	.001	.043	−.079	−.085	—		
16. FREECARE	−.158	.029	−.018	−.008	−.037	−.032	−.014	.025	.099	−.034	−.167	−.068	.043	.042	.031	—	
17. INSTFIN	−.075	.144	−.218	−.186	−.182	−.105	.117	.131	.054	−.019	−.085	.043	.051	.042	.098	.116	—

contains the definition of variables. As a reliability check, it lists Cronbach's alpha for multiple indices. Factor analyses were also run to develop some of these indices and/or to check on the validity of multiple indices. They are not listed in detail but are available on request. Wherever it appeared appropriate, there are short references in the subsequent variable descriptions. Eigenvalues will be mentioned to provide additional information about the respective multiple indices. The last column in Table 2a contains the variable names as they are being referred to in the text. Table 2b lists the correlations for all variables.

Indices, such as the variable Welfare Society Integration (WSOCINT), were composed of six items to indicate the degree to which a societal system was felt to be socially just, fair in its distribution of goods and resourceful enough to guarantee the social welfare of its citizens, including health provision. These six items following the question 'Here are some statements about (Belgian/Dutch/French/German/Spanish) society. (Items 1–6 introduced.) Do you very much agree, agree, disagree, very much disagree?' were:

1. There is an adequate standard of living for everyone.
2. In this country everyone is treated equally.
3. Adequate health care is available to everyone who needs it.
4. Social differences are by and large equitable.
5. Economic profits are justly distributed in this country.
6. Everything considered, one can live very well in a country like (Belgium...)

The factor analysis indicated one factor across nations with the highest loading of .706 for item 2 and the lowest of .529 for item 6. The Eigenvalue generated results of 1.86 for France, 2.11 for the Netherlands, 2.59 for Germany and 2.64 for Belgium. In a similar fashion, all other indices were constructed and checked for validity via factor analysis and for reliability via Cronbach's alpha.[3]

Health System Evaluation (HSYSEV) indicating satisfaction with care provision was composed of two items following the question: 'Here are some statements which could describe your own health situation. (Items 1–2 introduced.) Do you very much agree, agree, disagree, very much disagree?'

1. I have access to first-rate hospitals and doctors.
2. In our health system I have the same rights as everybody else.

Among dependent variables that were supposed to indicate experience with and policies for the health care system, two indices were introduced to measure problems with doctors as the representatives of ambulatory care. These pertained to experience with communication problems (DOCCOM) and scheduling of and times wasted with appointments (TIMING). The questions asked were:

a) 'How often in your opinion and experience does it happen that ...
1. Your doctor does not recognise your health problems.
2. Your doctor does not understand when you approach him with your problem.

3. You in turn do not understand what he tells you and suggests?'
b) 'Have you in your contacts for your personal health care had problems such as those I read now to you? How often did it happen that ...
4. You had to wait unnecessarily before you were even given an appointment?
5. Your doctor didn't have enough time for you.
6. You had to wait too long in the waiting-room?'

Items 1, 2 and 3 composed the index DOCCOM; items 4, 5 and 6 the index TIMING. Eigenvalues for DOCCOM and TIMING were 3.4 and 1.3 respectively.

CURATMED was supposed to indicate the degree to which a policy of cure versus care was favoured in medicine. In a pattern to evaluate four items in their ranking order, a question was posed in the same way as the Inglehart Scale introduced in the interview schedule just before. The question was: 'Here are four policies in health care for which there is much interest in public. Please, tell me which of these according to your opinion is most important for you. Here are the four policies:

1. Health care for chronically ill.
2. Purchase of the latest medical technology.
3. Accommodation of mentally ill persons.
4. Organ transplants.

Regardless of the fact that these are all important policies, which one is most important for you? Which do you consider least important? Which of the two that remain is more important for you?' The variable CURATMED is thus composed as a bipolar scale from curative medicine to medicine as care. In the 5-point scale a value of 3.0 denotes the neutral point.

Adequate health care as a citizen's right at no cost versus health care as one's own responsibility was measured as FREECARE over a 3-point scale following the question and respective response items: 'Some say that everybody should have a right to adequate and free health care. Others say that everybody is responsible for him/herself. Which of the following positions is closest to your opinion?'

— Adequate and free health care is a right. (=3)
— Everybody as far as health care is concerned is responsible for him/herself. (=1)
— Both, cannot decide. (=2) (Item not asked)

The future policy to finance rising costs was measured by a question with six items as follows: 'There are continuously rising costs that have to be provided for health care and the whole health system. Who should pay more for this in the future? Please, tell me whether you strongly agree, agree, disagree, strongly disagree with the following policies?'
1. Employers should pay more for sick-pay.

2. The federal government should pay more out of general taxes.
3. The individual citizen should pay higher health care fees.
4. Payments for health insurance should be raised for employers.
5. Cities and communities should pay more out of their taxes.
6. In case of illness the deductible for the individual should be raised.

The factor analysis generated two factors labelled INSTFIN for institutional financing by government, communities or employers, and SELFFIN for financing of future increases by respective individuals themselves. The following analysis uses only the factor INSTFIN composed of items 1, 2, 4 and 5.

As most of the independent variables are self-explanatory, only a few comments appear to be needed for respective definitions: OCCMXEST indicates the highest occupational prestige of a member in a given household. Typically this meant the husband's or wife's occupation, whichever was higher, or the occupation of parents with whom students or grown-up children still live. EST referred to the fact that in a few cases an estimate of occupational position was computed for respective countries predicting such a position from variables like education, age, household size, whichever variable in a given country provided the best predictions.[4]

SESOSTAT on a 10-point scale measured via self-evaluation the status individuals would assign to themselves (1 = lowest, 10 = highest); this index, modified in the direction of the scale, was adopted from the 1987 ISSP on 'Social Inequality'.

Value orientations indicate dimensions of culture as stated by individual respondents. For Physical Appearance (APPEAR) tested with a 4-point scale (from very important = 4, to not important at all = 1), the question was 'How important is it for you

1. to have a good appearance;
2. to look attractive to the opposite sex;
3. to have a healthy complexion;
4. to have a good posture;
5. to fix yourself up so that you like yourself?'

COMPASSN, for compassion, was indicated by the question 'I would now like to read some statements to you that you might have experienced as important or unimportant in your life. Please tell me whether these are very important, important, unimportant or very unimportant for you. How important is it for you ...

1. to work for environmental causes;
2. to enjoy life;
3. to fulfil one's obligations;
4. to have compassion for others;

5. to really enjoy silent moments;
6. to get ahead in life;
7. to work for the community;
8. to facilitate equality in society;
9. to do whatever one likes;
10. to live as consciously as possible?'

While the question was supposed to generate two more factors beyond the factor of altruism, it produced two factors only: we called compassion agreement with items 1, 3, 4, 5, 7 and 10 of the above; showing an Eigenvalue of 2.98, it extended beyond what could be referred to as altruism. It included high loadings for (5) the enjoyment of silent moments and (10) to live as consciously as possible. Compassion seemed to catch the overall meaning of that index; in a different meaning it appears to reveal the Christian command 'to love thy neighbour like yourself'. Only that index will be used in the analyses, while the factor of egocentrism with a low Eigenvalue showed little predictive power.

POSTMAT was employed in the 4-item short version of the materialism–postmaterialism scale developed by Inglehart (1989), and measured the degree of post-materialism on a 5-point scale; i.e., a value of 3.0 would denote the neutral point in between the dichotomous orientations.

RELORT, a 5-point scale from very religious (=5) to not religious at all (=1), indicated the degree of religious commitment to one's faith. It was obtained by asking: 'As a (Catholic, Protestant...), would you call yourself very strong (=5), strong, somewhat strong, not very strong, not strong at all (=1)?'

Table 2a shows that the Germans on average have the oldest population, the highest occupational status and the highest family income. They are also the most post-materialistic and, together with the Dutch, have relatively the best impression of welfare and justice in their society, while that indicator does not score highly for the Spanish who gave the worst evaluation. Compared to the welfare system, the health care system fares much better and obtains a reasonably high approval rating in the four nations. Information for Spain was not obtained. Communication problems with doctors as well as problems of scheduling and timing in ambulatory care stand out in the reports of the German sample. Only the Spanish appear to be equally dissatisfied. CURATMED produced an interesting result. Overall, there is a tendency to favour care rather than cure, which is the position taken by the Germans in particular. Deviations from that position are the French and somewhat less so the Spanish, both of whom show higher regard for cure than care. It is a result that matches general experience and is also reported by Lynn Payer (1988) in her four-nation study of medical practice with reference to the Cartesian philosophy of the French.

Due to missing data, the Spanish will not be included in most of the subsequent analysis. However, it is worth noting at this point and by their mean values that the Spanish register more dissent in terms of the welfare society and equity than the other four nationalities.

Means of independent and dependent variables were listed in Table 2a. Table 2b shows overall correlations in ranges that are of no concern for further analysis which will be pursued mainly with regressions. Regression analyses are supposed to indicate the impact of social stratification variables, of value orientations as elements of culture, with control for age and sex, to lay bare the meaning and impact of nationality on indices of welfare and health systems, on experiences with doctors as the main representatives of ambulatory care, and finally on issues of health policy including preferences for financing the system.

Results

1. *Assessing the welfare society and the health care system.* The evaluation of welfare systems in terms of integration and equity received modest results across the five nations with the extremes being Germany (best) and Spain (worst). In terms of the mean 3.1 for Germany, it is only barely above the neutral point, and similar to the Netherlands with 3.07. The other nations show results of 2.8 (Belgium), France (2.6) and Spain (2.3) which are clearly if not overwhelmingly negative, i.e., disagreeing with the respective statements.

The regression analysis (see Table 3) in four steps for this index indicates that in the four countries women are more critical and that older people are more positive in evaluating the welfare dimension of their society. Betas are particularly high for age and these results are highly significant. Items indicating stratification are certainly weaker than WSOCINT, centred strongly around equality and the distribution of goods, would have suggested. Indeed, the indicators that measure a more materialistic, economic dimension (income, occupation) are not significant, while education is on the critical and negative side, as Wilensky (1976) would have suggested. The hierarchy expressed in the self-evaluation of one's status relates favourably towards the welfare system; obviously this variable tends to have a bias towards a dimension of higher satisfaction with one's status conditions and life chances. One should also observe that the *r*-square does not increase much after inclusion of stratification variables.

The increase of the *r*-square is quite different for variables denoting dimensions of culture through individual value orientation. Religious orientation strongly correlates with a positive outcome, while compassion and post-materialism is, at a slightly lower level, negative. Appearance is not particularly relevant in explaining welfare system integration. As the means already suggested, the impact of nationality is significant, with Belgium, France and the Netherlands showing considerably lower betas than Germany. Of some relevance is perhaps that POSTMAT increases in significance if controlled for nationality.

Table 4 with regressions for the evaluation of the health care system does not show a particularly high explained variance. The general result is obviously a fairly high acceptance rating of health care across groups and nations, with

Table 3
Regression Analysis (beta-coefficient) for Welfare Society Integration (WSOCINT) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP	STEP 2	STEP 3	STEP 4
FEMALE	−.091***	−.103****	−.119****	−.109****
AGE	.231****	.199****	.166****	.152****
OCCMXEST		.013	.028	.019
EDYEARS		−.118***	−.112***	−.099***
INCOME		−.010	.008	.014
SESOSTAT		.089***	.075**	.055*
APPEAR			.024	.058*
COMPASSN			−.072**	−.097****
POSTMAT			−.087***	−.123****
RELORT			.169****	.155****
BELGIUM				−.247****
FRANCE				−.218****
NETHERL				−.093***
R^2	.060	.076	.116	.187

*$p \leq .05$; **$p \leq .01$; ***$p \leq .001$; ****$p \leq .0001$.

some negative results for occupation and more positive attitudes among older, higher status, more religious people and, in particular, those who highly value their appearance. Beyond the relatively high mean for HSYSEVAL, the even distribution across variables is a strong indicator of the assessed quality of health care across the four nations. With some distinction, the Dutch value their system most.

2. *Experiences with the health care system: communication and timing with doctors.* Two indicators were supposed to measure respondents' experiences with doctors in the ambulatory sector of the health system. The expectation was that stratificational variables would show effects at this point, i.e., the implied hypothesis was that those weaker in the system of social stratification would experience more problems with doctors.

As the means already indicated, communication problems with doctors are not particularly frequent. The average is positioned between 'never' and 'rarely'. There are stronger complaints about timing, i.e., the fact that one could not get an appointment, the doctor did not allocate enough time or that one had to wait unnecessarily long. Still, on average complaints add up to only 'rarely'. As Tables 5 and 6 show, older people report fewer communication and timing problems with their doctors. The differences show strong betas and high

Table 4
Regression Analysis (beta-coefficient) for Health System Evaluation (HSYSEVAL) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP 1	STEP 2	STEP 3	STEP 4
FEMALE	.037	.036	−.009	−.009
AGE	.140****	.144****	.113****	.126****
OCCMXEST		−.096***	−.087**	−.088**
EDYEARS		−.009	.002	.007
INCOME		−.015	−.006	−.005
SESOSTAT		.129****	.105****	.084***
APPEAR			.103****	.099****
COMPASSN			.033	.048
POSTMAT			−.049*	−.032
RELORT			.132****	.109****
BELGIUM				.039
FRANCE				−.004
NETHERL				.119****
R^2	.022	.043	.075	.086

Table 5
Regression Analysis (beta-coefficient) for Communication Problems with Doctors (DOCCOM) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP 1	STEP 2	STEP 3	STEP 4
FEMALE	.005	.009	.012	.016
AGE	−.139****	−.117****	−.096***	−.114****
OCCMXEST		−.029	−.037	−.042
EDYEARS		.098**	.094**	.096**
INCOME		−.030	−.041	−.039
SESOSTAT		−.073**	−.069**	−.064**
APPEAR			.011	.036
COMPASSN			.029	−.001
POSTMAT			.072**	.043
RELORT			−.063*	−.056*
BELGIUM				−.219****
FRANCE				−.082***
NETHERL				−.117****
R^2	.019	.029	.040	.078

Table 6
Regression Analysis (beta-coefficient) for Timing Problems with Doctors (TIMING) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP 1	STEP 2	STEP 3	STEP 4
FEMALE	.033	.044	.054*	.062
AGE	−.145****	−.123****	−.093***	−.129****
OCCMXEST		.035	.018	.015
EDYEARS		.075*	.063*	.061*
INCOME		.029	.018	.019
SESOSTAT		−.078**	−.071**	−.044
APPEAR			−.028	.003
COMPASSN			.057*	.009
POSTMAT			.136****	.079**
RELORT			−.070**	−.035
BELGIUM				−.266****
FRANCE				−.137****
NETHERL				−.291****
R^2	.022	.035	.062	.141

significance levels. Moreover, they are not much affected by the subsequent introduction of variables in steps 2 and 3. Only the dummies for nation produce an effect as the beta for age increases. In step 2 of both regressions, stratification variables show few significant variances. People with more education report more problems with doctors. In contrast, those with a higher status self-evaluation report fewer. Income as well as occupation, the most obvious variables in terms of life chances, show no significance. It is the clearest indication that the implied hypothesis of socially weaker people receiving less attention in their care is not supported by respondents' perception. The higher complaint rate of those with more education probably indicates not only their sensitivity but their constantly critical attitude to the system.

Step 3 of the regressions indicates that elements of culture show more variance than stratificational variables. Those scoring high on post-materialism complain in particular about timing problems. Those with stronger religious orientation seem to have fewer communication problems with their doctors and fewer with timing as well. Step 4 discloses what was already apparent in the mean values. German doctors, with regard to communication as well as timing, get comparatively worse reports than doctors in the other nations. It is both communication and timing that stand out with rather stronger differences in

betas comparing reports about German doctors to those in Belgium, France and the Netherlands. In terms of betas and explained variance, TIMING is the bigger problem in respondents' experience, and in particular for Germans.

Overall, problems with doctors do not markedly stand out in individual responses. This result confirms what previously appeared in the relatively positive evaluation of the health system (HSYSEV). What is theoretically a more important result is the low impact of dimensions of stratification, in particular as far as those in weaker positions are concerned.

3. *Three issues of health care policy.* Key issues in health care policy pertain to the general medical orientation of the system and to the rights understood as matters of finances and comprehensive, optimal care. The former is an issue closely related to welfare benefits and entitlements to care in the original sense, on the one hand, and an interventionist, scientifically and technological oriented, system, on the other. There is a third dimension of prevention and health promotion that has recently received attention among policy-makers. In a respective tripartite set of questions, the latter was not being recognised and did not measure well as factor analysis showed. Thus, that dimension was not used in the analysis. Rather, CURATMED in a bipolar fashion measures the extent to which people favour high-tech medicine over traditional care within the system. As the means in Table 2a show, there is a clear tendency among people to opt for care rather than cure; however, as the means show, this varies from country to country.

Table 7 in respective regressions shows that older people and women are more in favour of a policy towards care, strongly supported by those with better education and, to a degree, by post-materialists. In turn, those who highly value appearance in particular support an interventionist policy of CURATMED. Again, nationality provides a clear division. French, Belgian and Dutch people are more inclined to favour CURATMED than Germans. Indeed, the Betas and levels of significance are high, and controlling for demographic, stratificational and cultural variables show a strong preference for interventionist medicine by nation, when compared to Germany as the standard.

Table 8 shows regressions for the legal right to have FREECARE that do not result in a high explained variance for the *r*-square (.048). However, there appears to be one startling result. Older people with a high beta and level of significance support free care to a lesser degree than those who are younger. People with higher education, although showing a lower beta, indicate the same. Some, albeit not particularly strong, support comes from those ranking highly on post-materialism and on compassion. It is also of some interest that there is not much difference between nations, with only the Dutch significantly supporting the policy of free care more than the Belgians, French and Germans. It is an interesting result in terms of the support that the modern welfare state and society enjoy among the people of the respective nations and West European societies.

Further support for the shift of responsibility for health care towards non-private resource and institutions is found in the means shown above in Table 2a

Table 7
Regression-Analysis (beta-coefficient) for Curative Medicine Preference (CURATMED)) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP 1	STEP 2	STEP 3	STEP 4
FEMALE	.000	−.021	−.046	−.056*
AGE	−.108****	−.153****	−.165***	−.157****
OCCMXEST		−.058*	−.045	−.039
EDYEARS		−.153****	−.138****	−.150****
INCOME		.056*	.054*	.049
SESOSTAT		−.012	−.021	−.001
APPEAR			.102****	.081***
COMPASSN			−.002	.009
POSTMAT			−.088***	−.057*
RELORT			−.002	.008
BELGIUM				.117****
FRANCE				.212****
NETHERL				.088**
R^2	.012	.041	.057	.098

Table 8
Regression-Analysis (beta-coefficient) for Legal Right to Free Care (FREECARE)) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP 1	STEP 2	STEP 3	STEP 4
FEMALE	.035	.021	.025	.024
AGE	−.159****	−.188****	−.182****	−.174****
OCCMXEST		.036	.023	.022
EDYEARS		−.063*	−.071*	−.067*
INCOME		−.046	−.048	−.047
SESOSTAT		−.029	−.028	−.042
APPEAR			−.042	−.042
COMPASSN			.056*	.063*
POSTMAT			.073**	.084***
RELORT			−.009	−.026
BELGIUM				−.004
FRANCE				.002
NETHERL				.079**
R^2	.026	.033	.042	.048

Table 9
Regression-Analysis (beta-coefficient) for Favour Institutional Financing (INSTFIN) over four steps of selected demographic, stratification and value orientation variables plus dummy for nation (basis Germany)

	STEP 1	STEP 2	STEP 3	STEP 4
FEMALE	.147****	.109****	.085***	.085***
AGE	−.080***	−.137****	−.132****	−.141****
OCCMXEST		−.108***	−.119****	−.119****
EDYEARS		−.119****	−.118****	−.122****
INCOME		−.099***	−.108****	−.109****
SESOSTAT		−.033	−.041	−.028
APPEAR			.049*	.053*
COMPASSN			.129****	.116****
POSTMAT			.079***	.068**
RELORT			−.034	−.020
BELGIUM				−.052*
FRANCE				.005
NETHERL				−.074**
R^2	.027	.093	.122	.126

and in the regressions of Table 9. It is at this point that almost all variables introduced show some significant relationship to what we have called INSTFIN, i.e., institutional responsibility for future increased health care costs. From local to state government and employers, they are all expected to carry a greater share in future health care. Women favour that more, the aged with an impressively high beta again less. All stratificational variables, except SESOSTAT, show with increased status lower support for INSTFIN. Indeed, the result is strong in betas and level of significance. The value orientations of compassion, post-materialism and appearance show in that order significant support for shifting future financial burdens away from the individual to the institutional level. In terms of nationality, the French and Germans show greater support for this position than the Dutch and Belgians. However, the differences are not strong and they appear only after demographic, stratificational and value orientation variables have been controlled for, while the differences between nations are barely shown in the means of Table 2a.

Summary and discussion

The health system in Western Europe as an integrated part of modern welfare society apparently performs well in the five nations of Western Europe with the potential exception of Spain: while satisfaction with existing conditions of health care is obvious, respondents to different question still expressed their opinion that the European Union should get involved in health care as well.

Because of the superficiality of this information, such an outcome and implied policy structure should not be understood as a demand for the integration and central direction of health systems.[5] On the contrary, there appears to be a definite identification with the respective national systems which, according to the results and the impact of the variable nation, are actually less centralised than one would expect.

Three main results and one obvious outcome of factors determining health care and related policies were found: the obvious and predicted factor relates to age and sex. Both are strong determinants of attitudes toward the health system, with the aged indicating greater acceptance, while females hold more critical positions towards both the health system and the welfare society.

The first main result pertains to matters of social stratification. In particular variables implying more hierarchies of life chances show little impact, although there is more criticism of the health system by those higher in occupation and of attempts to divert future expenditure to employers and the public by those lower in status. The strongest predictor for stratification is education. What is quite obvious is that better educated people play the role of guardians in the system (Wilensky 1976). They are critical of the welfare society and direct their criticism to the personnel rather than the health system itself. They are opposed to greater public involvement in future health budgets, against the right to free care and they strongly favour care over cure in the system. The latter is probably one of the biggest surprises of this project. People who evaluate their own social status more highly are positively related to more optimistic outcomes in the welfare society, health system and doctor's evaluation: they give the impression of being on the positive side of events. Overall, social stratification is not a strong determinant in Western European health care systems. Quite obviously, the health systems fulfil the expected function of social integration.

Secondly, constructs indicating cultural elements through personal value orientations are stronger determinants of the welfare and health systems, including the respective policies pursued, than stratification. Those who scored highly on post-materialism and compassion are negative about an integrated and equitable welfare society; both favour the right to free care and shifting the cost of health budgets to the public and employers. Post-materialists seek care rather than curative medicine, and they also report more timing problems with their doctors. In contrast, people committed to their religion are more accepting of existing conditions in both the welfare society and health system.

A third major outcome is the strong impact of nationality on almost every indicator. Taking Germans as the standard, the Belgians, French and Dutch are far more critical of their welfare society, while they are less critical of their doctors both with respect to communication and timing, and stress cure more than care. The Belgians like the Dutch favour less public finance in the future: and yet there is an anomaly as the Dutch at the same time insist most on the right to free care. Regardless of slight deviations in individual results, the impact of nationality is strong and perhaps involves some uncontrolled elements of cultural identity as well as socio-economic differences. This effect

mainly belongs, however, to national identity as a matter of a political unit which has a long tradition in the nation-states of Europe. The fact that it stands out in matters of health systems is probably as much an outcome of the actual fact that through adequate health care, the identity and integration of the system was and is secured. Moreover, health systems have often been a matter of national pride. Results like these signalise that European integration in this sector has to recognise national identity as well as solutions to health care that regarding social insurance or mixed systems are fairly close in their organisation and yet have unique national features of their own.

On the most general level of comparative cross-national analysis, and in terms of stratification and cultural systems, the four health systems for which we had sufficient data indicate their location not so much in contexts of social hierarchies and life chances of individuals but in the dimensions of culture; beyond the respective individual beliefs, education also indicates that dimension. Moreover, it is very clear that national identities in health care systems have a meaning beyond the apparent realm of power and influence. This is also the outcome of analyses (not reported here) which show that a trans-national transfer of medical services and products sought across the border in the three-country EUREGION is practically non-existent. This is not bad news for European integration. It may actually mean that health care for the common person is something very private, nearby and predominantly regional as many decentralised tendencies in health care systems indicate. Such intimacy may, of course, also explain why people's attitudes reflect few of the concerns about health care as expressed and felt by policy-makers, certain interest groups or general public opinion.

The demands upon the system will probably grow rather than decline. Whether that should be interpreted as a corrupting tendency (Zijderveld 1986) is a moral question. The results of the present analysis dealing with the future financing of health care strongly suggest that the tendency of shifting costs towards the public and away from private responsibility may even grow. In a process of change described as medicalisation, immediate needs of care will be met and public systems are expected to deliver. But beyond such needs, a whole range of psycho-social medical requirements and preventive medicine will have to be met by activities and responsibilities that may form a 'third pillar' of welfare (von Ferber 1989) beyond that of social security and health care. One can only guess that this will professionally incorporate such disciplines as education, nutrition, psychology, sociology, health and physical education. At that level, a higher degree of cross-European integration may be possible, since this new health culture embodies a notion of cosmopolitanism, cross-national identity and a true integration of mind, body and soul that so far cultural traditions, conceptions of the human being in the world, Christianity and other religious systems have held back from. While for the immediate needs of health care there will be even and equitable life chances in the welfare state, this new health culture may result in a life-style that could generate and, in Bourdieu's terms (1979), again 'produce' new forms of differentiation and stratification.

Notes

1. Besides the resources of the participating institutes and universities, funding was provided by a grant from the Ministerium für Wissenschaft und Forschung (MWF) in Düsseldorf and by NIVEL, the Dutch Research Institute for Primary Health Care in Utrecht.

2. Distribution by age groups for five nations, the total of nations and for the sample of WESH by nation and total of nations (in percentages):

	18–44		45–64		65 plus	
	Population	WESH	Population	WESH	Population	WESH
Germany	49.4	52.1	31.8	33.2	18.8	14.6
Netherlands	56.5	63.4	26.5	24.1	17.0	12.5
Belgium	52.0	64.6	29.2	27.7	18.8	7.7
France	53.6	56.8	27.9	28.4	18.5	14.8
Spain	53.8	57.0	28.9	31.3	17.3	11.7
Total	52.1	58.7	29.4	28.9	18.5	12.4

Distribution by sex for five nations, total of nations and for the sample of WESH by nation and total of nations (in percentages):

	Male		Female	
	Population	WESH	Population	WESH
Germany	48.2	49.4	51.8	50.6
Netherlands	49.4	44.7	50.8	55.3
Belgium	48.9	46.3	53.7	51.1
France	78.7	37.2	51.3	62.8
Spain	49.1	47.9	50.9	52.1
Total	48.7	46.4	51.3	53.6

3. Indices are typically the result of two or more items that were measured by 5-point Likert Scales (5 = very much agree to 1 = very much disagree) or by 4-point ordinal scales (4 = very often to 1 = not at all). Indices after respective factor analysis and analysis for Cronbach's alpha were computed by means of scales. Whether to accept and use an index was also based on Eigenvalues.

4. A number of analyses indicated that the variable OCCMAXEST, for highest occupational status within a household, turned out to be a better predictor, and a stronger determinant of social status for that matter, than the occupational status of respective respondents. Among others, against the background of prolonged diffuse statuses of those growing numbers still in tertiary education, this differential effect appears to be entirely reasonable.

5. In a question about how important they considered the pursuit of specific policies within the European Union to be, 85 per cent called health policy to be important or very important. It ranked right at the top together with environmental and agricultural policies. This result, not pursued further in WESH, could mean any number of things; among others, the generally high attention matters of health get under all circumstances. Moreover, the complexities of policies at that level cannot easily be understood in a population survey and would need careful operationalisation and an extensive set of questions. As WESH focused on the collection of data on health behaviour and health care as experienced by individuals, even if they were considered reflections of systemic dimensions, policy analysis and organisation received only scant attention. That should not imply that this level and method of analysis cannot be pursued, rather to the contrary. However, a policy analysis of health care and its organisation should preferably seek information through elite interviewing of experts, selected group representatives, policy-makers and through the collection of data by means other than survey methods.

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