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Healthcare provision and attitudes towards redistribution. A regional analysis across Europe

Giacomo Melli [a], Leo Azzollini[b] and Franco Bonomi Bezzo[c,d,e]

[a]Department of Sociology, University of Oxford, Oxford, UK; [b]Department of Sociology and Social Research, Center for Social Inequality Studies & Life Course Longitudinal Laboratory, University of Trento, Trento, Italy; [c]Department of Social and Political Science, University of Milan, Milano, Italy; [d]Institut National d'Études Démographiques, Paris, France; [e]University of Cape Town, Cape Town, South Africa

ABSTRACT

This study examines the relationship between the welfare state, individual social class, and views on redistribution. It is hypothesised that the manifestation of the welfare state at the regional level, proxied by the number of beds in hospitals, may attenuate the differences in attitudes towards redistribution between people from different social classes. To address this research question, data from Eurostat is employed in conjunction with data from the European Social Survey on public support and welfare services at the regional level (NUTS 2), comprising data from 16 European countries from 2008 to 2018. The findings of this study demonstrate that in regions where there is a higher availability of beds in hospitals, there is a greater degree in variation in attitudes towards redistribution across different social classes. Conversely, in areas with fewer beds in hospitals, social classes tend to exhibit a convergence towards a high level of support for redistribution. This highlights the central role of welfare state dynamics at the meso-level in influencing the relationship between socio-economic characteristics and attitudes towards redistribution.

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Introduction

The contemporary imbalances in the distribution of resources across the globe are somewhat perplexing, with societies adapting to the presence of

CONTACT Giacomo Melli giacomo.melli@sociology.ox.ac.uk Department of Sociology, University of Oxford, 42-43 Park End Street, Oxford OX1 1JD, UK

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inequality as if it were an unavoidable aspect of their economic landscape (Willis et al., 2022). In their effort to reconcile widening income gaps, individuals often revert deeply entrenched beliefs in concepts of fairness and meritocracy, thereby legitimising inequality and employing it as a psychological defence mechanism against perceived social threats (Butz et al., 2017; Du & King, 2022).

Understanding how the perceived presence, or absence, of the welfare state shapes attitudes towards redistribution is important for policymakers seeking to address rising inequality as a societal problem. The legitimation of inequality emerges as a critical concern, as it hampers public support for political responses and the effective implementation of redistributive policies (e.g., McCall, 2013).

While a substantial body of research has sought explanations based on self-interest, cognitive processes, or rational decision-making for the varying levels of concern about redistribution (Fernández & Jaime-Castillo, 2018; Schmidt-Catran, 2016), these explanations rooted in the Meltzer-Richard (Melzer & Richard, 1981) model fall short of providing a comprehensive understanding. The problematic assumption that individuals can accurately observe and comprehend the multiple facets of inequality is evident, as most ordinary individuals remain largely unaware of the nuanced details of how income is distributed and how inequality is on the rise (Gimpelson & Treisman, 2018). Scholars are gradually recognising attitudes towards inequality as subjective perceptions tightly linked with personal life experiences rather than being solely based on objective information. For instance, individuals with personal experiences of social mobility may construct beliefs that reinforce their perception of residing in a meritocracy (Alesina & La Ferrara, 2005), whereas those exposed to contextual inequality may develop systematic explanations for its existence (Sharazi & Biel, 2005).

Notwithstanding this evolving understanding, scholars often overlook the significance of the meso level, understood as the intermediate level between the macro-national context and the micro level of individual lived experiences, in shaping individuals' everyday experiences. At the meso level, the presence of the welfare state is more readily apparent. The prevailing reliance on national-level data has the effect of oversimplifying and neglecting the meso-level dimensions of lived experiences.

This study seeks to ask the following two questions: *how manifestations of the welfare state at the meso level shape and influence attitudes towards redistribution? How is this relationship intertwined with social class differences?* Specifically, we focus on the availability of beds in hospitals, a welfare component that is crucial for collective healthcare (Pecoraro et al., 2021; Siverskog & Henriksson, 2022) and is relevant for both self-rated health (Rocco & Suhrcke, 2012) and overall satisfaction with the healthcare system (Martinussen & Rydland, 2022).

The choice to focus on the meso level represents a significant contribution of the paper. To date, the majority of articles have examined how national-level dynamics, such as income inequality and welfare spending, differently influence attitudes towards redistribution across social strata (Edlund & Lindh, 2015; Fernández & Jaime-Castillo, 2018; Schmidt-Catran, 2016). This paper builds on these perspectives and joins the growing body of work highlighting the relevance of meso-level dynamics for political outcomes, considering their greater degree of proximity to the respondent (Azzollini, 2021; Bonomi Bezzo & Jeannet, 2023; Paulis & Van Haute, 2021; Pittau et al., 2010), and therefore offering more precise insights into how individuals define and understand inequality (Gugushvili et al., 2020; Xu & Garand, 2010). This approach has been rarely applied to attitudes towards redistribution (with the exception of Rueda and Stegmueller, 2016, who examine the relationship income and inequality in European regions) and welfare support. Hereunder, we elaborate on our approach linking social class, the availability of beds in hospitals and attitudes towards redistribution.

Social class and attitudes towards redistribution

At the individual level, our study examines the relationship between social class and attitudes towards redistribution. While a key strand of social science research has focused on income as the central predictor for redistributive attitudes (Bartels, 2009; Meltzer & Richard, 1981; Lupu & Pontusson, 2011; Schmidt-Catran, 2016), social class is considered as on par with income in predicting attitudes towards redistribution through the *self-interest approach* (Fernández & Jaime-Castillo, 2018), with other related predictors of attitudes towards redistribution being unemployment risks (Rehm, 2009) and skill specificity (Iversen & Soskice, 2001).

Social class is indeed widely regarded as the primary channel through which individuals find their own position in the social hierarchy (Durkheim 1933/1964; Putnam, 2000; Weber, 1922/1968). Moreover, social class has been considered as much more influential than income for political outcomes, such as party choice and electoral participation (Evans & Tilley, 2017), which are closely linked to redistribution, as amply documented in the class (non) voting literature (Evans & de Graaf, 2013; Hout et al., 1995; Korpi, 1983/2018; Lipset & Rokkan, 1967).

It remains unclear, however, through which mechanisms specifically does social class affects attitudes towards redistribution, and why it is considered on par with current income as a predictor, if not better (Fernández & Jaime-Castillo, 2018). We, therefore, highlight four main channels: income and poverty risks; labour market risks; and origin and destination class socialisation. First, social class has long been considered as a better predictor of lifetime income trajectory than current income is (Fernández

& Jaime-Castillo, 2018; Manza & Brooks, 1999). Members of lower social classes may be more inclined to support redistribution to smooth income risks over the life course, rather than solely focusing on current circumstances. Indeed, social class continues to be strongly associated with poverty risks, with members of more disadvantaged classes being disproportionately likely to experience poverty (Gioachin et al., 2023). Beyond monetary concerns, social class is secondly strongly linked to labour market risks (Rehm, 2009). Members of lower social classes are more likely to be unemployed (Rueda, 2005), to experience unemployment spells (Gangl, 2004, 2006), and to be precarious workers (Häusermann & Schwander, 2012; Kalleberg, 2009). In light of these considerations, members of lower social classes may prefer greater redistribution through a classic de-commodification pressure or the desire to be protected from market pressures (Esping-Andersen, 1990). In other words, members of lower social classes have more to gain from redistribution (Kulin & Svallfors, 2013), but also more to lose *in the absence* of redistribution. In contrast, upper classes may have more *to lose* from greater redistribution, as they are likely also to have more accumulated wealth – rather than only income – through intergenerational transfers (Hansen & Wiborg, 2019).

The third and fourth rationales are linked to the two crucial features of social class identity: social class of origin and of destination (Durkheim 1933/1964; Grusky & Sørensen, 1998). Social class of origin powerfully shapes political beliefs and attitudes, such as party choice (Evans, 2000), political participation (Jeannet, 2022) and redistribution itself (Paskov & Weisstanner, 2022). Paskov and Weisstanner (2022) highlight how growing up in a working-class household 'play[s] a role in shaping material interests and consequently policy preferences' (p. 287), but also fosters feelings of solidarity through increased exposure to situations of economic hardship. Relying on European Social Survey data (2002–2018) for 24 countries, Paskov and Weisstanner (2022) show that working-class origins increase pro-redistributive attitudes even among those with an upper-class social destination. But even more so, the strongest pro-redistributive attitudes come from those with *both* working-class origins and destination (Paskov & Weisstanner, 2022): an occurrence which is a statistical regularity in social mobility research (Blau & Duncan, 1967; Breen & Jonsson, 2005; Erikson & Goldthorpe, 1992). Indeed, belonging to a more disadvantaged social class has its own socialisation processes: socio-occupational networks are crucial in shaping not only the perception of the socio-economic risks we have mentioned above, but also function as potential venues for industrial coordination and action (Edlund & Lindh, 2015; Fernández & Jaime-Castillo, 2018). This argument is substantiated by several empirical examinations which find that members of the working class are typically more pro-redistribution across

different countries and historical phases (Edlund & Lindh, 2015; Fernández & Jaime-Castillo, 2018; Kulin & Svallfors, 2013; Nieuwbeerta & de Graaf, 1999; Svallfors, 1997, 2004). As such, we expect that:

> Hypothesis 1: *Members of lower social classes are more in favour of redistribution than members of upper social classes*.

Relevance of the meso-level: beds in hospitals

Embracing a meso-level structural perspective, this work contends that individual attitudes towards redistribution are not solely shaped by personal circumstances, but are significantly influenced by perceptions of the welfare state in operation within their local context. Meso-level refers to all those intermediate levels between the individual and the macro. Meso-levels range from neighbourhoods to regions, from school to workplaces, from churches to sport clubs. In this paper, we do not consider any intimate meso-level. Our geographical unit of analysis are regions, the most common level at which health systems are administered in most countries. We argue therefore that the manifestation of the welfare state at the meso level is of crucial importance, with direct implications for citizens in their daily lives. The absence of infrastructures, or their inefficiencies, at the meso level, not only places economic and social strains on citizens' lives, impacting their day-to-day conditions, but also establishes a persistent scarcity of material resources in deprived communities. Furthermore, individuals' material deprivation is often exacerbated by a shortage of vital social resources in their surroundings. Acknowledging the well-established notion that cumulative experiences of deprivation can significantly impact residents' interactions, as emphasised by Jahoda et al. (1933) and Wilson (2011), is imperative for understanding the multifaceted effects of deprivation. Despite the significance of comprehending the civic and political life of deprived communities (Huckfeldt, 1979; Putnam, 2000), a noticeable gap in comprehensive research persists in this domain in terms of attitudes towards redistribution.

Indeed, the body of research on civic and political engagement considers meso-level socio-economic dynamics to be of central importance in shaping individual attitudes and behaviours. A number of studies conducted across the United States and Europe have highlighted how poverty (Huckfeldt, 1979), material disadvantage (Small, 2002; Wilson, 2011), and deprivation (Bonomi Bezzo & Jeannet, 2023; Dacombe, 2018; Lister, 2004) shape civic and political disengagement, as well as fostering political distrust (Stroppe, 2023) and support for radical right forces (Bolet, 2021; Cremaschi et al., 2024). Nevertheless, to our knowledge, a focus on the meso level has not been yet applied to study how individuals relate to attitudes towards redistribution. Adopting a Durkheimian perspective, which is the belief

that society has an existence of its own, separate from the individuals who comprise it, we build on this body of work to articulate that individuals' attitudes and beliefs depend not only on individual determinants but also on the socio-economic context in which they live their daily routine. We believe therefore this is the first paper investigating how meso-level experiences of the welfare state affect individuals' attitudes towards redistribution.

Therefore, our study examines how a specific socio-economic dynamic at the meso level, namely the scarcity (or availability) of beds in hospitals, shapes attitudes towards the state's role in reducing inequalities. Theoretically, this particular manifestation of the welfare state has been selected for four reasons. First, the availability of beds in hospitals at the meso-level is not influenced by differences in policy competencies across countries, as these will be present on the territory irrespectively of whether they are administered by the central government or by its subnational units (if any). This contrasts with other policies (such as employment or income support), which may not be necessarily managed at the meso level or may not be present at all. Second, and related, the availability of beds in hospitals is among the few healthcare variables that is consistently available across regions and time in Europe from institutional sources such as Eurostat. Third, the availability of beds in hospitals is considered in social-medical research to be something that is visible to citizens, insofar as it can influence their self-rated health (Rocco & Suhrcke, 2012), and also their broader satisfaction with the healthcare system (Martinussen & Rydland, 2022). Finally, the availability of beds in hospitals was clearly crucial in saving lives during the Covid-19 pandemic (Pecoraro et al., 2021), but also in the previous decade (Siverskog & Henriksson, 2022). In light of these considerations, the availability of beds in hospitals represents a ubiquitous, visible and impactful indicator of welfare services across European regions, and thus a good measure for analysing meso-micro interaction.

Interplay between individual social class and meso-level determinants

The link between lower social class and stronger pro-redistribution preferences is relatively well-established in the literature (Kulin & Svallfors, 2013; Paskov & Weisstanner, 2022). However, there is no consensus on how this individual relationship is moderated by socio-economic dynamics at the contextual level. The limited studies on this topic fall into two main theoretical camps: conflict (Edlund & Lindh, 2015) vs. convergence (Fernández & Jaime-Castillo, 2018), mirroring broader debates on income, inequality and redistribution (Schmidt-Catran, 2016). It is essential to clarify that both theories pertain to conflicting vs. converging pro-redistribution preferences

across social classes specifically in contexts marked by greater scarcity rather than in more affluent areas.

The first strand draws on conflict theory (Solt, 2008) and predicts that the existing socio-economic gradient in support for redistribution across the social hierarchy, whether based on income or social class, will deepen under adverse contextual socio-economic conditions (Karakoc, 2013). This effect is driven by the differential salience of material self-interest. When contextual socio-economic conditions are more disadvantaged, socio-economically disadvantaged individuals will have stronger incentives to support redistribution than when contextual conditions are more favourable, while better-off individuals remain relatively unaffected (Schmidt-Catran, 2016). Though primarily developed in the context of income, this logic can readily extend to social class. Poverty (Gioachin et al., 2023) and labour market risks (Rehm, 2009; Rueda, 2005) may be perceived as even more severe in contexts where care resources are limited, compounding the hardships (Paul & Moser, 2009). Edlund and Lindh (2015) find that a smaller welfare state and greater material inequality at the national level exacerbate the perceptions of social conflict between classes.

The convergence perspective presents an alternative argument. Fernández and Jaime-Castillo (2018) conceptualise the self-interest approach in an opposite way. They argue that in more disadvantaged contexts, upper-class members become more supportive of redistribution, aligning their preferences with those of the lower classes. This argument hinges on the marginal costs of further redistribution: if redistribution levels are already high, further redistribution requires upper-class individuals to contribute an even larger share of their resources (Fernández & Jaime-Castillo, 2018). Empirically, they find support for their hypothesis: where the levels of redistribution and universalism are lower, upper-class members support redistribution considerably more than peers in higher redistribution contexts (Fernández & Jaime-Castillo, 2018, Figure 5, p. 1029). Conversely, working-class individuals maintain consistently pro-redistribution preferences, regardless of the irrespectively of contextual dynamics.

However, the authors do not directly address why members of the upper classes should be relatively more pro-redistribution when contextual socio-economic conditions are more disadvantaged. This argument aligns with the 'other-regarding' preferences literature in economics (Dimick et al., 2018), which suggests that dynamics of altruism (Andreoni, 1990; Schröder & Neumayr, 2023) and fear (Alesina & Rodrik, 1994; Engler & Weisstanner, 2021) can prompt more socio-economically advantaged citizens to support redistribution, even if it conflicts with their immediate self-interest. In the context of this study, it is possible that citizens in upper social classes may perceive that the lower availability of beds in hospitals in their region generates social conflict and increase their exposure to crime. Indeed,

Schmidt-Catran (2016), provides empirical evidence for this convergence pattern.

The studies mentioned above examine the impact of meso-level income inequality, while the current paper shifts the focus to meso-level welfare state inequality, particularly the distribution of healthcare resources within European regions. We argue that the mechanisms outlined in the conflict and convergence perspectives also apply to the cases discussed here.

Specifically, when communities face shortages in critical healthcare resources, such as hospital beds, especially during crises, the resulting inequities in access become both visible and personal (Shifa et al., 2021). In this context, the conflict theory posits that individuals in disadvantaged communities will feel a heightened sense of injustice and a stronger demand for redistribution, driven by the salience of material self-interest (Karakoc, 2013; Solt, 2008). In such communities, where healthcare resources are already scarce, conflict theory predicts that the strongest pro-redistribution preferences will be found among members of the lower social classes (Karakoc, 2013; Solt, 2008). The direct experience of being denied necessary medical care, or witnessing others in similar situations, can lead to negative attitudes towards inequality. This fosters a desire for more equitable resource distribution, as individuals see healthcare access as a fundamental right rather than a commodity. The material hardships resulting from insufficient healthcare services – such as longer waiting times, poorer quality care, or outright denial of care – can exacerbate feelings of social conflict. For lower-class individuals, the lack of access to healthcare is not just an inconvenience, but a direct threat to their well-being, thus intensifying their demands for more equitable distribution of resources. This group may feel that the system is rigged against them, fostering a sense of injustice that translates into a call for greater redistribution of both healthcare resources and wealth more generally (Karakoc, 2013).

In contrast, the convergence theory posits that in regions with more visible disparities – where wealthier areas have better access to hospital beds – members of the upper classes may become more supportive of redistribution, aligning their preferences with those of lower social classes (Fernández & Jaime-Castillo, 2018). This can occur because the upper classes may recognise that inequalities in healthcare access could exacerbate social conflict and insecurity, which, in turn, threatens their own well-being (Schmidt-Catran, 2016). From this perspective, disparities in healthcare access may increase fears of social instability and unrest (Alesina & Rodrik, 1994; Engler & Weisstanner, 2021), leading upper-class members to support redistribution despite the potential personal cost. Empathy for those in need (Andreoni, 1990; Schröder & Neumayr, 2023), combined with concerns about broader societal repercussions, can thus drive upper-class individuals to advocate for more equitable resource allocation.

For upper-class members, however, the effect of exposure to healthcare inequality may be more complex. In regions with more pronounced disparities in access – where wealthier areas have significantly better access to hospital beds – upper-class individuals may begin to shift their preferences towards more pro-redistribution stances. This convergence, as argued by Fernández and Jaime-Castillo (2018), could be driven by the recognition that healthcare inequality, if left unaddressed, might lead to broader societal instability (Dimick et al., 2018), which ultimately undermines the social and economic security that the upper classes depend on. Moreover, the upper classes may experience a growing sense of empathy for the struggles of the disadvantaged (Andreoni, 1990; Schröder & Neumayr, 2023), especially if they perceive inequalities as not just a product of personal failure, but of systemic neglect. This empathy, combined with a rational calculation of self-interest in a potentially destabilised society, could spur upper-class support for policies that promote more equitable healthcare access.

At the same time, the dynamic of upper-class members might reflect a nuanced balance between these two theories. In regions with better access to healthcare, upper-class individuals may not feel the same urgency for redistribution as the lower classes, as they themselves are less likely to experience direct deprivation. However, they may still feel a sense of solidarity with the disadvantaged, especially if they perceive healthcare access as part of a broader system of social fairness. In contexts where healthcare resources are more scarce, upper-class members might find themselves caught between empathy for the disadvantaged and concern for their own access to services. Thus, upper-class preferences might align more with the conflict theory (Karakoc, 2013; Solt, 2008) if they are increasingly exposed to the hardships faced by the lower classes, or with the convergence theory (Fernández & Jaime-Castillo, 2018) if they perceive redistribution as a way to mitigate broader societal risks.

The availability of beds in hospitals at the meso level, as a proxy for welfare state provision, can therefore significantly influence how different social classes perceive and respond to inequality. The extent of this exposure affects how each class internalises inequality and shapes their preferences for or against redistributive policies and welfare provision. For the upper classes, lower access to beds in hospitals – and healthcare in general – might tend to mitigate their positive attitudes towards inequality. When they experience scarce healthcare services, they may see this as a reflection of a poorly-functioning system that does not fully rewards success and sustains their privileged position. The upper classes may view the lack of availability of beds in hospitals in their communities as a failure of their meritocratic beliefs that inequality is justified. Their exposure to such scarce resources can increase empathy for those worse off than them and increase their support for policies aimed at increasing welfare provisions, as they are more likely to perceive healthcare inequality as a pressing issue.

Conversely, for people in the lower classes, limited access to beds in hospitals is a direct and tangible manifestation of inequality, reinforcing their critical attitudes towards social and economic disparities. When faced with healthcare shortages, these individuals have one more reason to perceive the system as failing to meet their basic needs, leading to frustration with inequality and consistent support for government intervention. A shortage of beds in hospitals justifies their perceptions of the structural barriers that prevent them from accessing quality healthcare, pushing them to advocate for expanded welfare provisions, such as increased funding for public hospitals and healthcare access for all. In light of the aforementioned considerations, we develop two competing hypotheses.

Hypothesis 2a (Conflict): *In regions where the availability of beds in hospital is lower, the gap in support for redistribution between social classes will be greater compared to regions with a higher availability of beds in hospitals*.

Hypothesis 2b (Convergence): *In regions where the availability of hospital beds is lower, the gap in support for redistribution between social classes will be narrower compared to regions with a higher availability of beds in hospitals*.

Data and methods

We employ data from waves 4–9 (2008–2018) of the European Social Survey (ESS) Multilevel dataset. The dataset provides information about the European regions where respondents are located. Sample sizes for each wave are reported in Table A1. We conduct the analysis at the NUTS2 level, i.e., broadly speaking, regions. Given the availability of micro and macro data, we select 16 European countries: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Spain, Finland, France, Croatia, Hungary, Italy, Norway, Poland, Portugal, Sweden and Slovakia.

To measure attitudes towards redistribution, we focus on respondents' agreement with a very precise and direct question: 'The government should take measures to reduce differences in income levels'. The original variable is measured on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). We dichotomise the variable because of its distribution: around 23 per cent of the sample reports they Disagree Strongly, Disagree and Neither Agree to Disagree, while 77 per cent of the sample reports they Agree or Agree Strongly. Furthermore, the dichotomisation further eases the interpretation of the cross-level interactions. For the sake of robustness, we conduct a separate analysis using the original scale, and the results are comparable to those of the main analysis.[1]

The main contextual variable, which proxies for the level of welfare availability in the region, reports the rate over 1000 inhabitants of 'all beds in hospitals which are consistently maintained and staffed, and are immediately accessible for the care of admitted patients' (Eurostat, 2023). This data is

available from Eurostat (2023) through the 'eurouse' package in Stata (Neves, 2016). The availability of beds in hospitals is crucial for evaluating healthcare provision: it is one of the most immediately visible manifestations of local health welfare (Martinussen & Rydland, 2022; Rocco & Suhrcke, 2012), especially in emergencies (Shifa et al., 2021).

It is not possible to break this figure down by private or public hospital beds due to data constraints, but, as shown in Figure 3, in all included countries the proportion of beds in hospital publicly funded, typically exceeds 70 per cent and exhibits minimal fluctuation over time. Moreover, to further test the validity of our analysis, we use data from the French National Institute of Statistics and Economic Studies (INSEE) which provides the total number of hospital beds per NUTS2 region per 1000 inhabitants, as well as a breakdown of these figures by public and private provider. The analysis is replicated for France, with the measure provided by Eurostat replaced by this alternative measure. The results of this supplementary analysis are consistent with those of the primary analysis and are presented in the Supplementary Materials (Figures A3 and A4, and Table A9).

To measure respondents' socio-economic class, we employ the European Socio-Economic Classification (ESeC, Rose & Harrison, 2007) in its five-class version.[2] This is computed from the available variables using the 'iscogen' package in Stata (Jann, 2019). The categories are as follows: Salariat, Intermediate employee, Small Employers and Self-Employed, Lower Services, Lower Technical and Routine Occupations.[3] To rule out the effect of socio-demographic characteristics on support for redistribution, in all models we control for age, gender, income deciles as provided by the ESS, and level of education, using a seven-category ES-ISCED scale.[4] To account for the differences between European regions, in all models, we control for regional GDP at current market prices, population density, the rate of doctors per 1000 inhabitants in the region (in deciles), unemployment rate, and the Coefficient of Variation of GDP per capita (which captures between-region economic inequality, Lipps & Schraff, 2021). The final empirical sample comprises approximately 102,000 individuals. All analyses are weighted with *anweight* as provided by ESS. Descriptive statistics are presented in Table 1.

The analytical strategy proceeds in two parallel directions to cross-validate the hypotheses. Given the nature of the dependent variable, we first run logistic regressions with country and year-fixed effects and robust standard errors clustered at the regional level, where we test the moderating effect of the beds in hospitals rate on the relationship between social class and support for redistribution. It is noteworthy that the country and year-fixed effects account for the entire time-invariant and -variant unobserved heterogeneity at the national level. Consequently, they control for cross-national differences in how the healthcare regimes are financed and administered,

Table 1. Descriptive statistics.

Variable	Mean/percent	Std. dev.	Min	Max
High support for redistribution	77.17%	0.42	0	1
Social Class (ESeC)	3.77	1.81	1	6
Salariat	27.99%			
Intermediate employee	13.76%			
Small employers and self-employed	9.23%			
Lower services	13.10%			
Lower technical and routine occupations	25.58%			
NA	10.34%			
Household's total net income, all sources	4.09	3.24	0	10
Level of education (ES-EISCED)	3.49	1.97	0	7
NA	1.34%			
ES-ISCED I, less than lower secondary	16.89%			
ES-ISCED II, lower secondary	21.62%			
ES-ISCED IIIb, lower tier upper secondary	13.96%			
ES-ISCED IIIa, upper tier upper secondary	19.10%			
ES-ISCED IV, advanced vocational, sub-degree	8.51%			
ES-ISCED V1, lower tertiary education	7.08%			
ES-ISCED V2, higher tertiary education	12.51%			
Gender (1 = Female)	0.52	0.50	0	1
Age	48.70	18.09	18	99
Beds in hospitals per 1000 inhabitants	4.81	1.96	1.80	12.59
Deciles of rate of doctors per 1000 inhabitants	4.33	3.12	0	10
GDP at current market prices (Region)	5619.42	19869.24	13	59800
Population density (region)	282.98	664.83	3.3	7471.5
Unemployment rate by all ages in % (region)	11.26	6.60	1.3	38.5
Coefficient of variation GDP per capita (region)	1.75	2.14	0.05	10.70
N	101,564			

Note: Data from ESS multilevel rounds 4-9, weighted. Contextual information from Eurostat.

including differing policy competencies across the central government and subnational units (if any).

Second, to address the question of whether the influence of the contextual moderator is structural or dynamic, we use the Fairbrother (2014) decomposition technique, which allows us to exploit the longitudinal nature of contextual data. This method consists of including two variables in the models, the first of which takes the mean of the contextual variable over the period considered. The second measures the year-to-year variations around the mean, thus capturing its changes over time. By their very nature, the two obtained variables have zero correlation. We will therefore use three-level linear probability models, with individuals nested in region-years nested in regions. We then assess the moderating effect of the two structural variables on the relationship on interest.

Results

We first investigate the variation of support for redistribution across the countries under consideration. As illustrated in Figure 1, we can appreciate than in all countries but Denmark the proportion of individuals with high support for redistribution is larger than 50 per cent and in most cases larger

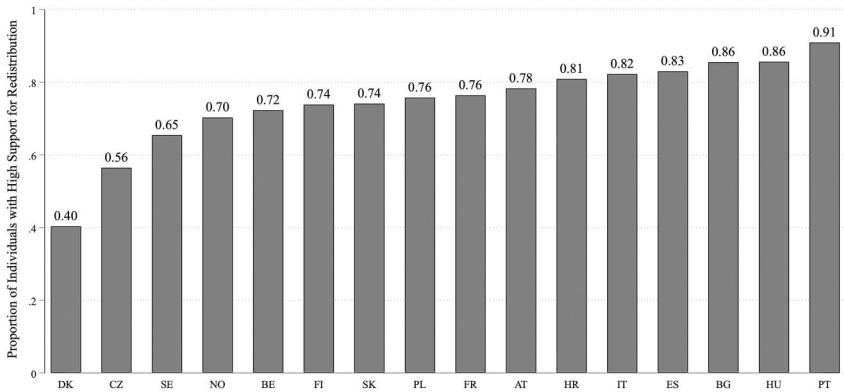

Figure 1. Proportion in country of individuals with strong or very strong support for redistribution.

Note: Data from ESS multilevel data, waves 4–9, weighted.

than 70 per cent. This corroborates our decision to dichotomise the variable. Nonetheless, there is considerable variation in the proportion of individuals supporting redistribution, with Southern and Eastern European countries showing the largest proportions. There is also considerable variation between regions in the availability of beds in hospitals, as shown in Figure 2. The distribution appears to be skewed to the left, with a limited number of regions having more than eight beds in hospitals per 1000 inhabitants.[5]

Figure 3 illustrates the percentage of funding derived from government schemes and compulsory contributory healthcare financing schemes on

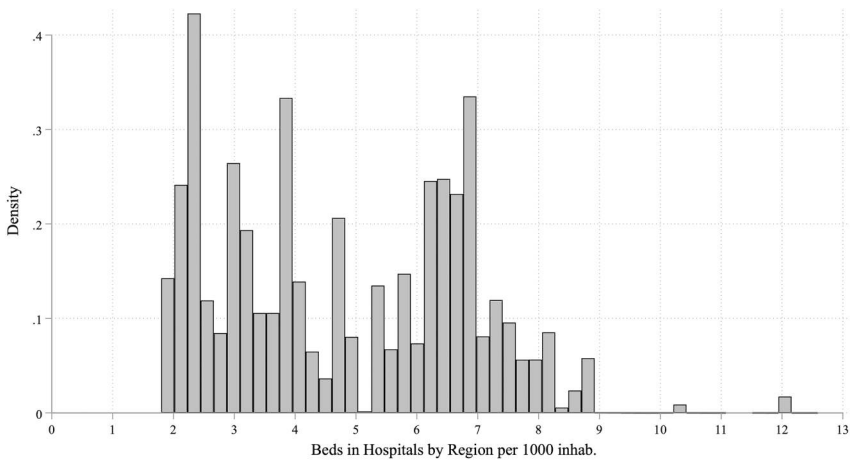

Figure 2. Histogram of beds in hospitals by region per 1000 inhabitants.

Note: Eurostat (2023).

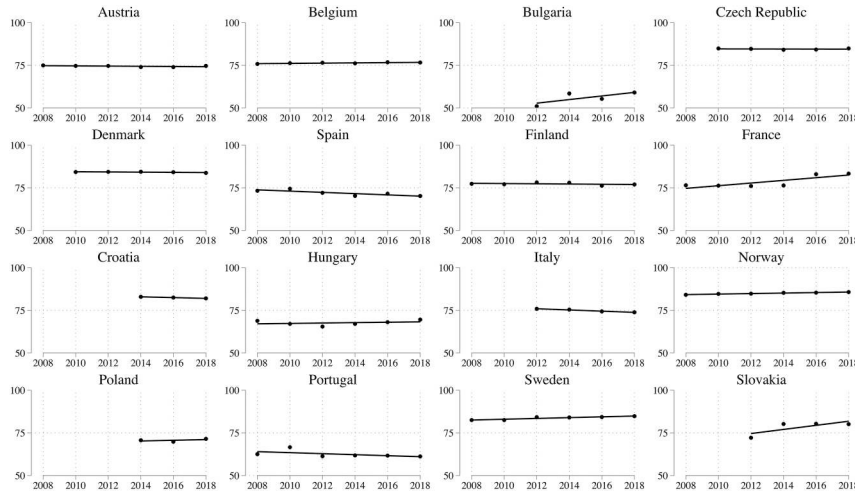

Figure 3. Government schemes and compulsory contributory health care financing schemes over all health financing scheme (%).

Note: Eurostat (2024). Computed as proportion on the sum of all financing schemes in million euros.

the total national healthcare system revenue of the countries included in our analysis (Eurostat, 2023). As can be observed, the figure in question represents a significant majority in most countries and demonstrates a relatively stable profile over the course of time. This indicates that the majority of funding for healthcare in the countries under consideration is derived from public sources.

Table 2 presents the results of logistic regressions for high support for redistribution on social class with region cluster-robust standard errors and weights. All models include country-fixed effects, while region-fixed effects are present in models 3 and 4. As anticipated, individuals in higher classes or those who are self-employed are less likely to support redistribution than individuals in lower classes (model 1). The results are consistent also when region fixed effects are added to the model, as evidenced by model 3. Upon computing predicted probabilities from model 1, it emerges that member of the working class have a predicted probability of reporting a high support for redistribution of 82.2 per cent, which is 8.1 percentage points higher than the 74.1 per cent probability of small employers and self-employed and 5.4 percentage points higher than the 76.8 per cent probability of members of the salariat class. Differences are minimal when region-fixed effects are included in the model.

The results provide support for Hypothesis 1, as we find a considerable social class gradient in preferences towards redistribution, with members of lower social classes being more likely to support redistribution. This finding is largely consistent with previous research (Kulin & Svallfors, 2013;

Table 2. Results of logistic regression for supporting redistribution.

Variables	(1) Odds ratios	(2) Odds ratios	(3) Odds ratios	(4) Odds ratios
Social Class (ref. Lower technical and routine occupations)				
NA	0.731***	0.864	0.731***	0.896
	(0.032)	(0.110)	(0.033)	(0.116)
Lower services	0.923	1.141	0.925	1.121
	(0.045)	(0.123)	(0.046)	(0.122)
Small employers and self-employed	0.617***	0.637***	0.610***	0.643**
	(0.035)	(0.086)	(0.035)	(0.089)
Intermediate employee	0.847***	1.169	0.849**	1.169
	(0.042)	(0.155)	(0.044)	(0.158)
Salariat	0.714***	0.917	0.715***	0.905
	(0.030)	(0.119)	(0.031)	(0.116)
Beds in hospitals in region per 1000 inhab.	1.033	1.067+	1.143	1.188
	(0.026)	(0.038)	(0.368)	(0.381)
Social Class * Beds in hospitals				
*NA * Beds in hospitals*		0.967		0.960
		(0.026)		(0.026)
*Lower services * Beds in hospitals*		0.959*		0.963+
		(0.021)		(0.020)
*Small employers and self-employed * Beds in hospitals*		0.995		0.991
		(0.026)		(0.027)
*Intermediate employee * Beds in hospitals*		0.937*		0.938*
		(0.026)		(0.026)
*Salariat * Beds in hospitals*		0.952+		0.954+
		(0.025)		(0.025)
Individual and Regional Controls	*Yes*	*Yes*	*Yes*	*Yes*
Country Fixed Effect	*Yes*	*Yes*	*Yes*	*Yes*
Region Fixed Effect	*No*	*No*	*Yes*	*Yes*
Constant	0.692	0.600+	0.361	0.299
	(0.160)	(0.158)	(0.693)	(0.574)
Observations	101,564	101,564	101,563	101,563
BIC	87857.96	87887.4	87133.15	87165.34

Note: All models control for age, gender, income, level of education, doctor rate, regional GDP, regional population density, regional unemployment rate, coefficient of variation of GDP per capita, year, country. Full table is Table A2 in the Supplementary Materials. Data from Multilevel ESS (2008-2018) and Eurostat. Standard errors clustered at the regional level. *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.1$

Nieuwbeerta & de Graaf, 1999; Paskov & Weisstanner, 2022; Svallfors, 1997, 2004), although it is important to note that it remains significant even when controlling for other forms of stratification, including household income and education, as well as when including fixed effects at both the national and regional levels, controlling for time-invariant unobserved heterogeneity also at a relatively fine-grained geographical level.

To analyse the effect of contextual levels of welfare availability on the relationship between social class and support for redistribution, a cross-level statistical interaction between social class and rate of beds in hospitals in the region was added to the model (Models 2 and 4). The results are statistically more significant only when region fixed effects are not included in

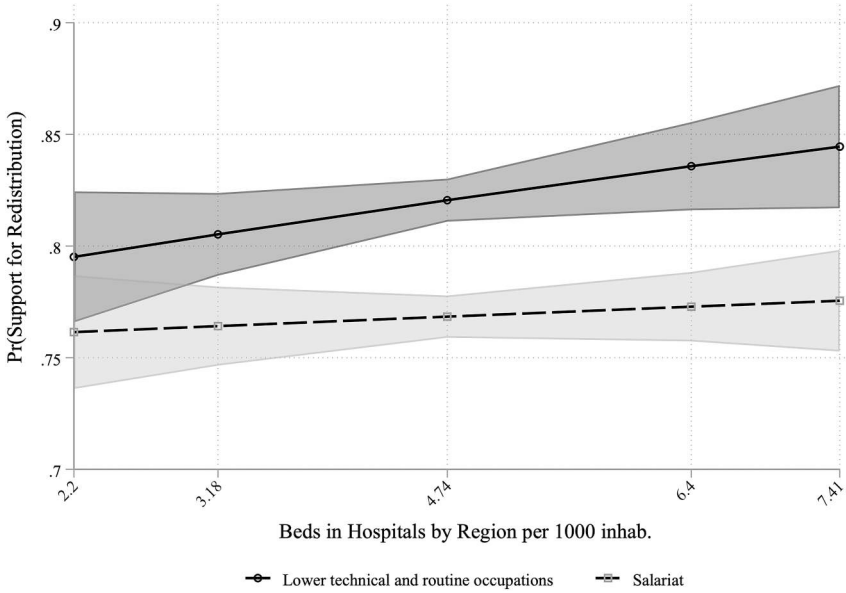

Figure 4. Predicted probability of support for redistribution, by social class and rate of beds in hospitals in Region.

Note: Data from European Social Survey Multilevel Data (2008–2018), weighted and Eurostat. Computed from models 2 in Table 2. The rate of beds in hospitals by region per 1000 inhabitants is considered at the 5th, 25th, 50th, 75th and 95th percentiles of its distribution.

the model. To facilitate the interpretation of the results, Figure 4 depicts the Marginal Effects at the Means from model 2 of Table 2.[6] For the sake of visual clarity, we present the figure with all classes in the Supplementary Materials. In regions where the supply of beds in hospitals is relatively limited, individuals tend to converge towards similar levels of support for redistribution, and differences between social classes are not statistically significant. Conversely, in regions with higher provision of beds in hospitals, there is a polarisation in attitudes. The differences between classes become significant, as working-class individuals show higher support in regions where more beds in hospitals are available. On the contrary, members of the salariat class show lower support for redistribution in regions with more developed welfare systems. Upon the inclusion of region-fixed effects in the model, the interactions lose significance. This may be attributed to the relatively low sample sizes observed in certain regions.[7]

To corroborate these results, we employ an alternative analytical strategy that leverages the longitudinal nature of contextual data (Fairbrother, 2014). In Table 3, we separate the structural and dynamic aspects of the rate of beds in hospitals in the region, by controlling for the average of the variable over the considered period of time (structural) and for the fluctuations around the average (dynamic). We run Multilevel Linear Probability Models with

individuals nested in region-years nested in regions and random effects for social class at the lower contextual level. The Intraclass Correlation is computed from the empty model and measures the proportion of the dependent variable's variation that is attributable to the fact that the individuals in the sample are clustered in groups. In our case, a multilevel approach is justified as the 6.2 per cent of the variance in support for redistribution is attributable to the fact that individuals are nested in regions, while 7.6 per cent is attributable to the fact that individuals are nested in region-years nested in regions.

As seen before, the effect of the rate of beds in hospitals on the outcome is not statistically significant in both its dimensions when we do not include the interaction with socio-economic class. However, once we include the interaction term, we can appreciate that the structural availability of welfare in the region significantly affects the correlation between social class and support for redistribution. As illustrated in Figure 5, individuals in regions with a higher structural availability of beds in hospitals exhibit a greater degree of polarisation in their support for redistribution based on their social class.[8] Working class members demonstrate significantly higher support than those in higher social classes, while in regions with lower structural welfare availability, the differences in support are negligible.

Conversely, the effect of changes in the availability of beds in hospitals on the relationship between social class and support for redistribution is limited. This may be attributed to the rigidity of this rate, which requires a considerable investment of state resources to vary and responds to long-term trends rather than annual fluctuations.

The results provide lend support to the convergence hypothesis (H2b), while rejecting the conflict hypothesis (H2a). The social class gradient in attitudes towards redistribution is less pronounced in regions where welfare services are worse, as indicated by the presence of fewer beds in hospitals. This is in contrast to regions where these conditions are more abundant. Notably, this pattern emerges when controlling for time-invariant unobserved heterogeneity at the national level, as well as several potential confounders at the meso level. Theoretically, this pattern lends support to different mechanisms proposed in the literature, such as material self-interest (Fernández & Jaime-Castillo, 2018), which posits that high-class individuals are less likely to support further redistribution when its levels are already high due to increasing marginal costs. However, this also extends to high-class citizens being more in favour of redistribution when meso-level healthcare conditions are worse due to altruism (Andreoni, 1990; Schröder & Neumayr, 2023), and/or fear (Alesina & Rodrik, 1994; Engler & Weisstanner, 2021). This outcome reinforces our argument that the meso-level serves as a critical vantage point for individuals to perceive and evaluate the presence and evolution of the welfare state within their daily lives.

Table 3. Results of multilevel linear regression for supporting redistribution with Fairbrother decomposition.

Variables	Model 1	Model 2	Model 3
Social Class (ref. Lower technical and routine occupations)			
NA	−0.043***	−0.003	−0.043***
	(0.008)	(0.019)	(0.008)
Lower services	−0.009	0.018	−0.009
	(0.007)	(0.015)	(0.007)
Small employers and self-employed	−0.077***	−0.067**	−0.078***
	(0.010)	(0.023)	(0.010)
Intermediate employee	−0.023**	0.024	−0.023**
	(0.008)	(0.019)	(0.008)
Salariat	−0.053***	−0.015	−0.053***
	(0.007)	(0.019)	(0.007)
Beds in hospitals (structural)	0.005	0.010*	0.005
	(0.004)	(0.005)	(0.004)
Beds in hospitals (dynamic)	0.018	0.018	−0.161**
	(0.053)	(0.053)	(0.056)
Social Class * Beds in hospitals (structural)			
*NA * Beds in hospitals (structural)*		−0.009*	
		(0.004)	
*Lower services * Beds in hospitals (structural)*		−0.006+	
		(0.003)	
*Small employers and self-employed * Beds in hospitals (structural)*		−0.002	
		(0.004)	
*Intermediate employee * Beds in hospitals (structural)*		−0.009*	
		(0.004)	
*Salariat * Beds in hospitals (structural)*		−0.008+	
		(0.004)	
Social Class * Beds in hospitals (dynamic)			
*NA * Beds in hospitals (dynamic)*			0.172
			(0.165)
*Lower services * Beds in hospitals (dynamic)*			0.009
			(0.138)
*Small employers and self-employed * Beds in hospitals (dynamic)*			0.358*
			(0.163)
*Intermediate employee * Beds in hospitals (dynamic)*			0.378**
			(0.128)
*Salariat * Beds in hospitals (dynamic)*			0.219*
			(0.110)
Individual and Regional Controls	*Yes*	*Yes*	*Yes*
Country Fixed Effects	*Yes*	*Yes*	*Yes*
Observations	105,993	105,993	105,993
Number of groups	143	143	143
Intercept	0.477	0.456	0.476
BIC	88933.75	88968.97	88969.77

Note: All models control for age, gender, income, level of education, doctor rate, regional GDP, regional population density, coefficient of variation of regional GDP per capita, regional unemployment rate, year, and country. Random slopes (social class) included with unstructured covariance. Random Effects parameters reported in the Supplementary Materials, with full table in Table A3. Data from Multilevel ESS (2008-2018), weighted and Eurostat. Standard errors clustered at the regional level. *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.1$

Our third finding and contribution refers to the geospatial characteristics of the meso-micro relationship: both our Region Fixed Effects regressions and the Multilevel Models with the Fairbrother (2014) decomposition

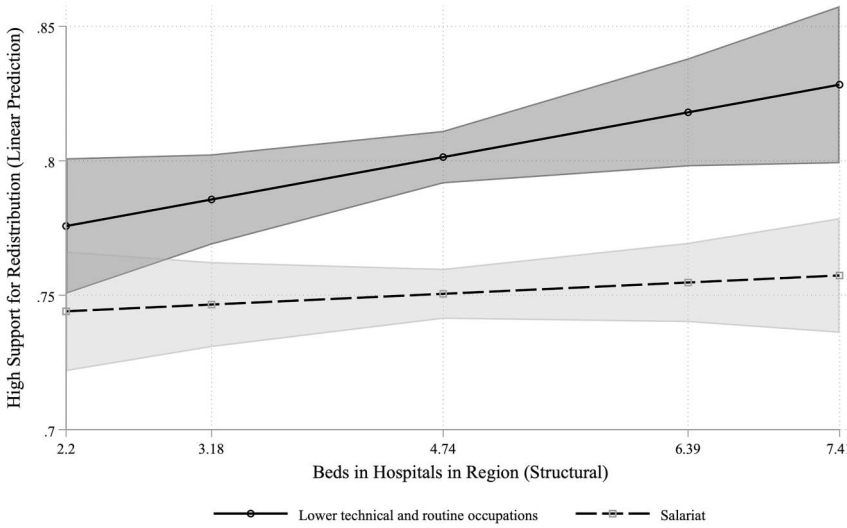

Figure 5. Predicted probability of support for redistribution, by social class and structural regional beds in hospitals per 1000 inhabitants.

Note: Data from European Social Survey Multilevel Data (2008-2018), weighted and Eurostat. Computed from Model 2 in Table 3. The rate of beds in hospitals per region is considered at the 5th, 25th, 50th, 75th and 95th percentiles of its structural distribution.

highlight that the meso-micro interaction is driven by differences between regions, rather than within regions. This is clearly indicated by the interaction being only significant in the linear regression models without Region Fixed Effects, and by the significant interaction between the cross-sectional component of the meso-level variable and social class.

The findings of this study demonstrate that social stratification in redistribution preferences is not merely a reactive response to meso-level trends in welfare state provisions. While the temporal limitations of our data may mask the potential influence of meso-level trends on individuals' support for redistribution, our data effectively captured the economic crisis of 2008 and subsequent years, providing valuable insights into the transformative potential of meso-level socio-economic dynamics.

In less deprived European regions, individuals in lower classes may perceive their economic standing as relatively disadvantaged within the meso-level context, which may motivate them to advocate for redistribution policies as a means to rectify economic disparities. The availability of adequate welfare services at the meso level may play a crucial role in shaping these attitudes. Residents in more affluent areas may have confidence in existing provisions, which could result in a reduced perceived need for additional redistribution. Moreover, cultural variations in values and social norms

pertaining to wealth, inequality and societal responsibility across regions may contribute to differences in attitudes towards redistribution.

Conversely, our findings indicate that individuals from higher social classes residing in more affluent areas tend to exhibit lower support for redistribution compared to their counterparts in economically deprived areas. A number of factors contribute to this noteworthy pattern. A higher satisfaction with one's current socio-economic status, derived from a sense of financial security and confidence in the existing economic structure, may result in a resistance against additional redistribution, driven by concerns about increased taxation. The belief in the inherent fairness and meritocracy of the economic system, coupled with the perception of diminishing returns on the utility of additional income, may further reinforce the reluctance to endorse wealth redistribution among individuals in more affluent regions. Furthermore, concerns about the potential for disincentives to economic productivity and the impact on motivation for success and entrepreneurship could contribute to the reluctance among the more affluent individuals in these regions to endorse further income redistribution measures.

Robustness checks

Our choice to dichotomise the dependent variable is based on its distribution, where only 23 per cent of the sample reports they Disagree Strongly, Disagree and Neither Agree or Disagree (collectively), while the remaining 77 per cent of the sample reports they Agree or Agree Strongly with the 'government should take measures to reduce differences in income levels' statement. Nonetheless, for purposes of robustness, a replicated analysis with the dependent variable treated as continuous is available in the Supplementary Materials (Tables A5, A7 and A8), to which we refer within the Data and Methods section of the manuscript. The results of this robustness check support the main analysis.

Additionally, from a theoretical standpoint, contextual characteristics at the national level are highly relevant. However, our main focus is to gauge the meso and meso-micro effects with a regional perspective. Hence, as discussed in the methods section, we include country and year-fixed effects to account for time-invariant heterogeneity at the national level, and common cross-country trends. Their inclusion allows to control of cross-national differences in the financing and administration of health care systems, including the varying policy responsibilities of central governments and sub-national units (if any). Table A14 presents a robustness check in which country and year-fixed effects are replaced with country-year-fixed effects. This allows us to account for time variant and invariant country characteristics, such as public expenditure on health, from the analysis. The results are consistent with the main analyses. Furthermore, given that public expenditure on

health fluctuates very little over the period considered, as shown in Figure 3, it is not surprising that there are no substantial differences between this robustness check and the analyses conducted in the main text, which is reassuring for the main analysis in the manuscript.

Discussion

How does social class affect attitudes towards redistribution across European countries? What roles do manifestations of the welfare state at the meso level play in this relationship? The aim of this study has been to examine the influence of specific manifestation of the welfare state at the meso level, proxied by the availability of beds in hospitals in European regions, on attitudes towards redistribution in 16 countries over a 10-year period. Theoretically, we moved from a Durkheimian perspective, and hypothesised that individuals' attitudes and beliefs depend not only on their individual position within the socio-occupational hierarchy (Evans & de Graaf, 2013, 2017; Korpi, 1983/2018; Putnam, 2000; Weber, 1922/1968), but also on the context in which they are embedded and their daily routines, by focusing specifically on a manifestation of the welfare state that is visible and impactful for citizens' lives (Martinussen & Rydland, 2022; Rocco & Suhrcke, 2012). This approach diverges from the prevailing literature, which typically focuses on national socio-economic dynamics as moderators, such as inequality and the size of the welfare state spending (Edlund & Lindh, 2015; Fernández & Jaime-Castillo, 2018; Schmidt-Catran, 2016), to focus instead on the potentially more relevant (Jahoda et al., 1933) and relatively unexplored in this context (Bolet, 2021; Bonomi Bezzo & Jeannet, 2023) meso-level drivers. At this intermediate level of geographical aggregation, we contend that the scarcity of beds in hospitals has a substantial impact on attitudes towards income redistribution. Given the considerable variation in the number of beds in hospitals across European countries, our analysis considers the differences between regions within the same country.

This study explored the relationship between the meso-level context, rather than the macro-national context, and individual attitudes towards redistribution. We used social class as the key predictor for redistributive preferences (Manza & Brooks, 1999), diverging from conventional income-based measures. Consistent with the prevailing narrative in the political sociology literature, social class provides a more precise representation of individuals' position in the stratification of opportunity and disadvantage in their region of residence. Consequently, it is more appropriate to examine political attitudes (Fernández & Jaime-Castillo, 2018).

Our main empirical findings are three-fold, and so are our contributions. First, at the individual level, the results support Hypothesis 1, indicating a significant social class gradient in preferences towards redistribution, with

members of lower social classes being more likely to support redistribution. Second, in the ongoing debate between conflict (Edlund & Lindh, 2015 – polarisation happens where socio-economic characteristics are bad) and convergence (Fernández & Jaime-Castillo, 2018 – polarisation happens where socio-economic characteristics are good) on the moderating effect of contextual socio-economic characteristics, our findings provide support for the latter, as we find high convergence between social classes in regions with low welfare provision. As a third finding, our analyses highlight that the interaction between MESO and micro levels is predominantly influenced by structural regional disparities rather than dynamic welfare variations within regions over time.

Theoretically, this pattern points to the importance of socialisation mechanisms. It is consistent with a body of research that has underlined how meso-level socio-economic dynamics, such as inequality and unemployment (Azzollini, 2023; Fairbrother & Martin, 2013), can take more than a generation to consistently shape attitudes.

One of the limitations of this paper relates to its geographical scope. The geographical units employed may be considered too broad. It is conceivable that health infrastructure at the provincial or commuting zone levels may be even more influential than the regional level in shaping the individual relationship between social class and attitudes towards redistribution. However, the Eurostat data on beds in hospitals does not include contextual variables for geographical units below the NUTS2 level. Therefore, while recognising the potential insights a more granular provincial-level analysis could offer, our methodological approach strikes a judicious balance, leveraging large comparative cross-sectional datasets while maintaining a focused examination of the meso-level.

Another potential issue arises from the repeated cross-sectional nature of the ESS dataset. An alternative approach to test our hypotheses would be to assess whether the same individual over time reacts to changes in the number of beds in hospitals in their region in terms of their redistribution preferences. However, this would necessitate the use of longitudinal datasets that are, however, predominantly country-specific and for only a limited number of countries, which would impair the considerable geospatial diversity we can leverage with over 75 country-years and 632 region-years. The identified limitations serve as a call to future research to further analyse sub-national policy dynamics and their impact on redistributive attitudes. In conclusion, adopting a meso-level perspective on welfare state provision may reveal new insights into the classic debate on stratification and redistribution, thereby enhancing our broader understanding of how inequalities are either mitigated or reproduced in the circular relationship between the socio-economic and political domains.

This emphasis on differences at the meso level broadens our understanding of the role of regional characteristics, such as the availability of health services, in shaping to the overall landscape of redistribution preferences. Our findings indicate that individuals' stances on redistribution are not solely reflective of their social class, but are also significantly influenced by the socio-economic environment in their respective regions. This nuanced perspective illuminates the multifaceted nature of individuals' attitudes towards redistribution, offering a more comprehensive understanding that incorporates both individual and contextual factors at the meso level. Ultimately, this work contributes to refining the narrative around redistribution preferences by acknowledging and unravelling the complex interplay between micro and meso-level influences.

The findings of this study indicate that public policy regarding redistribution should consider meso-level factors in addition to individual characteristics. Since investments in local health and welfare services can influence attitudes towards redistribution, policymakers should prioritise funding for these services in regions where support for redistribution is lacking. Moreover, addressing socio-economic disparities between regions is crucial. While social class influences attitudes towards redistribution, our paper reveals that contextual factors also play a significant role. Policies aimed at reducing inequality and fostering economic development in disadvantaged regions could promote greater support for redistribution. Overall, understanding regional dynamics can help assess policy effectiveness and ensure alignment with the preferences of various regions.

Notes

1. Reported in Tables A5, A7, and A8 of the Supplementary Materials.
2. The European Socio-Economic Classification (ESeC) facilitates cross-European comparative analysis. The system classifies occupations based on two key dimensions: the specificity of the human assets and the difficulty of monitoring. This enables the organisation of occupations into nine classes. The aggregated version is used in five classes. The 'Salariat' class encompasses large employers, higher and lower grade professional, administrative and managerial occupations, and higher-grade technician and supervisory occupations. The 'Lower technical and routine occupations' class includes lower grade white collar workers, skilled workers, and semi- and non-skilled workers. Further information can be found in Rose and Harrison (2007).
3. In the main analysis, we include individuals without social class as a separate category. Please refer to Tables A12 and A13 in the Supplementary Materials for the results with the aforementioned individuals excluded.
4. Robustness checks excluding education as an individual covariate are reported in Tables A10 and A11 in the Supplementary Materials.
5. As detailed in the 'Data and Methods' section, Eurostat does not provide any information regarding the source of funding for these beds in hospitals (i.e.

whether they are in private, public, public-private hospitals). However, this distinction is available from the French National Institute of Statistics and Economic Studies (INSEE). Table A9 in the Supplementary Materials presents a replication of the empirical analysis for France, utilising the available funding data. When we include only beds in public hospitals the results are very similar to the ones when we include all beds in hospitals. When we include only beds in private hospitals the results differ. We think this should not be cause of concern, as Figure 3 illustrates that in all countries included in the analysis, the percentage of public financing of national health systems is above 50%, and in the majority of countries, it is above 75%. Therefore, the overall analysis represents the lower bound of the effect. This robustness check provides support for the conclusion that the variable included in the main analysis of the paper is an adequate proxy for welfare manifestation (public) at the meso level.

6. Average Marginal Effects are reported in Table A4 of the Supplementary Materials.
7. In Table A6 of the Supplementary Materials, we present the same models without controlling for the number of doctors in the region, as this variable is potentially collinear with our main meso-level explanatory variable. The results match those presented here.
8. Average Marginal Effects are reported in Table A4 of the Supplementary Materials.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability statement

Some of the data applied in the analysis in this publication is based on the ESS Multilevel Data. The data is provided by Eurostat, and prepared and made available by Sikt - Norwegian Agency for Shared Services in Education and Research, Norway. Neither Eurostat nor Sikt are responsible for the analyses/interpretation of the data presented here. Access to the data is granted upon completion of a registration process with both the European Social Survey and Eurostat.

Notes on contributors

Giacomo Melli (https://orcid.org/0000-0002-5335-5935) is a DPhil Candidate in Sociology at the University of Oxford, where he is affiliated with Trinity College, Oxford.

Dr. Leo Azzollini is an Assistant Professor of Sociology at the Department of Sociology and Social Research of the University of Trento, where he is affiliated with the Center for Social Inequality Studies.

Dr. Franco Bonomi Bezzo is a Research Fellow at La Statale, University of Milan, and he is affiliated with the *Institut national d'études démographiques* (INED) in Paris and to the Southern Africa Labour and Development Research Unit (SALDRU) at the University of Cape Town.

ORCID

Giacomo Melli http://orcid.org/0000-0002-5335-5935

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