REPORT ON THE FOURTH ISSP USER CONFERENCE – HEALTH AND HEALTH CARE

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The International Social Survey Programme (ISSP) is the largest regularly conducted international comparative sociological research program that uses a standardized survey measurement instrument, focusing each year on a specific topic of interest. The ISSP organized the fourth event in its series of user conferences on 24 November 2025, focusing on the "Health and Health Care" module, which has been fielded two times before, in 2011 and 2021.

The Health and Health Care module covers a wide range of health-related attitudes and behaviors. The survey examines health-related beliefs and how respondents evaluate the healthcare system's performance, including their perceptions of inequalities in it. Furthermore, it measures how satisfied the population is with the system's performance and the extent to which people trust the healthcare system and medical professionals. Attitudes towards the role of government in relation to health care are also an important topic in the survey. As attitudes can be influenced by respondents' own experiences, the questionnaire includes basic questions on health (e.g., chronic illnesses, unhappiness), health behaviors (e.g., frequency of smoking and physical activity), and healthcare utilization (health insurance, visits to doctors, hospital treatments, experience of unmet healthcare needs). The 2021 Health Care module was particularly important and timely in the context of the COVID-19 pandemic; therefore, the questionnaire also included specific questions related to trust in vaccination, the impact of the pandemic, and its management.

The first study presented at the conference by Manish Sinsinwar and Kshipra Jain ("Beyond Belief: How Religion and Secularism Forge Divergent Paths in Health Perception and Practice") investigated the role of religious belief systems in shaping health perceptions, behaviors, and policy attitudes across different sociopolitical and economic contexts using data from the ISSP 2021 Health

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and Healthcare II survey. Using a combination of bivariate and multivariate analytical methods, the study examined how religious affiliation (being Protestant, Catholic, Buddhist, Muslim, Hindu, Jewish, or Atheist) is associated with health-related behaviors (such as vaccination and treatment choices) and self-reported health status. It further evaluated how these factors correlate with attitudes toward healthcare policy, including access to services, redistribution through taxation, and inclusivity for marginalized groups.

The findings revealed that religious belief systems were significantly associated with variations in health behavior and trust in medical science. Jewish, Catholic, Protestant, and atheist respondents were more likely to perceive income-based inequalities in healthcare as unfair and report higher levels of gender equality, while Hindus and Muslims showed less agreement on these issues. Differences were also evident in health practices, with Hindus, Muslims, and Buddhists less likely to prioritize health over work and more likely to report low levels of physical activity. Statistical tests confirmed these differences, and multivariate analysis suggested that Hindu respondents, in particular, exhibited less progressive attitudes toward healthcare and weaker health consciousness. Overall, the study concluded that atheists and Christian groups tended to be more progressive and health-conscious than Hindu and Muslim populations, while also noting that these patterns may reflect broader country-level and cultural contexts, highlighting the need for deeper investigation.

The study by Gooding, Sno and Ganzeboom (2Stratification in Health: How the Intersection of Age, Gender, and Education Shapes Self-Rated Health Across 50 Years of the Life Course in Suriname and Beyond") examined the relationship between educational attainment and health outcomes across the life course, with a particular focus on age-related health trajectories and regional differences between the Global North and South. Building on well-established evidence that inequalities in morbidity and mortality are strongly stratified by socioeconomic status, the study conceptualized health as a dynamic process that evolves with age and is significantly shaped by educational experiences. Education was treated not only as a proxy for socioeconomic status but also as a fundamental determinant influencing health behaviors, access to resources, and long-term well-being.

The empirical analyses that were presented indicated that self-reported health declines with age for both men and women, but this decline is systematically less pronounced among individuals with higher levels of education. This suggests a protective effect of education, whereby more educated individuals maintain better health into older ages. Importantly, the magnitude of this protective effect varied across regions. Comparative evidence showed that educational gradients in health are steeper in the Global South than in the Global North, indicating that

education plays a more decisive role in mitigating health deterioration in less-developed contexts. At the same time, the data revealed minimal differences in health outcomes by education at younger ages, with disparities widening progressively over the life course.

The presentation further highlighted regional differences in baseline health and age structures. While the average age was similar between the North and the South, respondents in the North were older on average, reflecting broader demographic differences such as higher life expectancy. Additionally, overall health levels were higher in the North than in the South, reinforcing the importance of contextual factors in shaping health inequalities.

The discussion raised important methodological and substantive issues, including the comparability of educational measures across regions and the potential underestimation of education effects in the South due to incomplete or non-equivalent qualifications. The presentation also pointed to the need to account for differences in life expectancy when interpreting age-health profiles. Overall, the findings underscored that education is a key determinant of health across the life course, with its protective effects being both age-dependent and context-specific, and particularly pronounced in regions with lower overall levels of development.

The study by Sigrún Ólafsdóttir and Bernice A. Pescosolido ("Healthcare and the Social Contract: Trust, Satisfaction, and Inequality Across Nations") addressed the comparative positioning of Iceland in cross-national analyses of social and health inequalities, with a particular focus on why it does not consistently appear among the top-performing countries despite its generally favorable socio-economic profile. The central research question was whether Iceland constitutes an outlier in patterns of stratification, and, if so, how this deviation may be empirically identified and interpreted within a broader comparative framework.

The discussion highlighted a key methodological constraint in cross-national research: the limited number of countries available for analysis, which restricts the feasibility of applying multilevel modeling techniques.

Multilevel approaches typically require a sufficiently large number of higher-level units (countries) to reliably estimate contextual effects. In this case, the small sample of countries undermined the statistical power and robustness of such models, necessitating alternative analytical strategies.

As a solution, the presentation proposed the use of pooled analysis, in which individual-level data from multiple countries are combined into a single dataset. Within this framework, Iceland can be examined as a specific case by introducing country indicators or interaction terms to test whether its patterns significantly diverge from the pooled average. This approach allowed for the identification

of country-specific effects even in the absence of a fully specified multilevel structure, thereby providing a pragmatic compromise between methodological rigor and data limitations.

Substantively, the presentation suggested that Iceland's unexpected ranking may reflect unique institutional, demographic, or cultural characteristics that differentiate it from other countries in the sample. However, rather than assuming exceptionalism, the analytical strategy emphasized the need to empirically test whether Iceland's coefficients or outcome distributions significantly deviate from the general pattern observed across countries.

In conclusion, the presentation underscored both the substantive and methodological importance of carefully assessing outlier cases in comparative research. It advocated for flexible analytical designs that can accommodate data constraints while still allowing for meaningful cross-national comparisons, and positioned Iceland as a potentially informative case for understanding variation in social and health inequalities.

The study by Nazim Habibov, Alena Auchynnikava, Yunhong Lyu and Lida Fan ("What factors explained willingness to pay more taxes to improve public healthcare in the COVID-19 era: Learning from the International Social Survey Programme") examined the factors influencing individuals' willingness to pay more taxes to improve public healthcare using data from the COVID-19 period and drawing on the 2021 data from the Health and Health Care module of the ISSP. The study was motivated by the observation that the pandemic highlighted weaknesses in healthcare systems and raised questions about public support for increased healthcare funding. The authors formulated several hypotheses focusing on how perceptions of health problems (whether structural or behavioral), satisfaction with healthcare, trust in institutions, and personal experiences with COVID-19 shaped individuals' willingness to contribute financially to better public healthcare.

The empirical analysis showed that trust in healthcare systems was the most significant predictor of willingness to pay, indicating that individuals who believed in the effectiveness and reliability of healthcare institutions were more inclined to support additional funding. An increase in COVID-19 mortality was also associated with higher willingness to pay, suggesting that greater exposure to the severity of the pandemic heightened awareness of healthcare needs. Conversely, individuals less satisfied with healthcare systems were less willing to contribute, reflecting possible skepticism about how additional resources would be used. The study further found that beliefs about the causes of health problems mattered: individuals who attributed health issues to structural factors, rather than individual behavior, were more supportive of increased public spending on healthcare.

The results also highlighted the role of personal behavior and attitudes. Pro-health behaviors, such as vaccination uptake, were positively associated with willingness to pay, and trust in COVID-19 vaccines emerged as a particularly strong predictor. This suggests that individuals who align with public health recommendations were more likely to support collective solutions. Cross-country differences were evident, with variation in willingness to pay reflecting institutional contexts and differing levels of trust and healthcare performance across countries.

The key insights emphasized that, beyond economic capacity, attitudinal and institutional factors play a central role in shaping public support for healthcare funding. Trust, both in healthcare systems and in broader institutions, acts as a crucial mechanism linking individual perceptions to policy preferences. The findings imply that improving transparency, effectiveness, and communication in healthcare systems could increase public willingness to finance them. Additionally, the study contributed to the literature by providing evidence from the COVID-19 period, showing how a global health crisis can influence public attitudes toward collective healthcare financing and reinforce the importance of institutional trust in shaping policy support.