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The Choice Agenda' in European Health Systems: The Role of 'Middle Class Demands'

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Abstract

Choice for patients, over varying aspects of health care, is becoming an increasingly common feature in European health care systems, especially in tax-funded health care systems. In this European 'choice agenda' we focus on the case of patients' choice of health care provider. Previous research draws on the expected quality and efficiency improvements as the main reform motivations. We put forward a political explanation, namely the satisfaction of the 'middle class' demand for health care use, who could alternative opt out to the private sector . To gather some evidence of the latter ewe explore the role and preferences of the middle class using survey data on a cross-section of European countries. Our findings suggest that the middle class, in countries implementing choice reforms has a pronounced preference for the availability of choice as a component of a quality health care system. The political impetus to satisfy this preference is consistent with the 'middle class' demand hypothesis.

Keywords: provider choice, health system satisfaction, tax funded health systems, middle class demands.

1. Introduction

A key tenet of European health and consumer protection strategy lies in strengthening patient involvement in decision making (European Union 2006). A dominant reform consistent with that goal is the furthering of patients' and users' choice of health care provider, such as hospital, clinic or general practitioner. The 'choice agenda' – the expansion of patient choice and individual responsibility – also extends to more detailed choices around specific treatments, inpatient, outpatient, treatment and choice of health care professional (Le Grand 2007). In general, the 'choice agenda' does not include choice in relation to the financing of care, such as options to purchase private insurance, except in some social health insurance type countries such as Germany and the Netherlands (Bartholomée & Maarse 2006, Lisac et al. 2010).

The general benefits of individual choice are well documented (see Iyengar 2010, Schwartz 2004). However, for a patient to benefit from provider choice specifically, health systems need to widen service diversity – in essence to offer a 'real' choice. From a provider perspective this means dealing with some level of competition in the organization of public services. The standard economics explanation of the benefits of such reforms argues that the empowerment of patients and provider diversity rewards more efficient production and improved quality (Kreisz and Gericke 2010). Based on this

rationale, provider choice suggests the potential for efficiency-driven re-organisation of the health care provision sector. Other benefits of choice include the potential to shift providers' motivation to be more patient-oriented and offer a personalised service, as well as to modernise technology and processes (Newman & Kuhlmann 2007).

In European publicly-funded health care systems, choice and its associated benefits are seen to be one way of maintaining popular support for the health care system, which is frequently a highly salient issue in electoral politics (Oliver 2006). Offering choice is also argued to reduce the risk of patients 'exiting' the system and opting for privately funded and provided services. For individuals with the economic capacity to supplement or substitute public care, the quality and accessibility of the public system has been found to constitute a key determinant of its continued use and support (Costa-Font and Jofre-Bonet 2008; Costa and Garcia, 2003).

We here broadly conceptualise this 'economically-able' group as 'middle class', drawing on the well-established body of literature on the role of the middle class in driving the public policy agenda dating back to Goodin and Le Grand (1987). Blomqvist, discussing choice and privatisation in the case of Sweden, also places the middle class as both the key proponent *and* beneficiary of choice reforms across public services (2004). According to

sociologists, the middle class strives to 'culturally' distinguish itself from 'others' (Bourdieu 2008) and choice in public services is one way to accomplish this. This is however in conflict with the goals stated by policymakers, who promote choice as a truly equitable way of organising pubic services because it is, in theory, available to all social groups, regardless of income or other characteristics (Milburn 2002). Critics of the introduction of choice have also argued that it is nothing more than an insidious way of introducing an American-style private system which places a large burden of responsibility onto the individual.

We argue in this paper that the motivation to appeal to the middle class is a key feature of the choice agenda, beyond the economic quality and efficiency arguments. Choice, in this sense, becomes part of the institutional toolkit that works to keep the middle class using and supporting the public health system. This is particularly relevant in National Health Service (NHS) systems where choice has traditionally been limited, relative to Social Health Insurance (SHI) systems where choice is traditionally institutionalised. We empirically explore this claim using cross-country survey data that captures public opinion in relation to health system characteristics in a set of European countries, including both NHS and SHI type health care systems (see table 1 for an overview of the countries).

The remainder of the paper is structured as follows: the next section discusses the role of the middle class in relation to other motivations for choice reforms in European health care systems. Next, methods and descriptive data are outlined, followed by results of the empirical analysis in section four. Section five provides a discussion of the evidence provided and implications for theory and policy while section six concludes.

2. The choice agenda in European health systems

Choice has been widely incorporated into public services across Europe, but in starkly different ways. A range of motivations have been put forward for this trend, and concerns have been raised over the long-term trajectories and the equitability of such policies. This section outlines the drivers of choice reforms and places the role of the middle class within the literature, with particular attention to evidence related to the countries later used in the empirical analysis.

Efficiency

At its core, the choice agenda positions citizens as consumers in fictitious markets. However, compared to the free market, introducing provider choice and competition in health systems relies on a set of more complex mechanisms (Le Grand & Bartlett 1993). General taxation can be thought of as

an implicit (public) price, yet unlike in a market system, its returns are complex to establish. A major challenge in identifying value is the capacity for judging health care quality, as shown in the United States where patients did not use information on quality of care to switch from hospitals with poor quality to those with high quality (Marshall et al. 2000). In a systematic review Fung et al (2008), came to a similar conclusion. In spite of this, a stream of studies on the English NHS have found evidence in favour of efficiency, quality and even wellbeing improvements following choice and competition in health care (Propper et al, 2008; Gaynor et al, 2010; Cooper et al. 2011, Zigante 2011). Similarly, evidence from Swedish hospitals suggests improvements in technical efficiency following the introduction of choice and competition (Gerdtham et al. 1999). Given this, it is conceivable that the incentives might operate through more complex mechanisms (Newman and Kuhlmann 2007, Frank and Lamiraud 2009).

The rationale for the efficiency argument is that it facilitates cost-containment over time, acknowledging that these cost pressures will vary between countries (Steffen 2010). In NHS style countries such as the UK, reforms have included choice of GP and more recently choice of hospital for elective surgery accompanied by waves of internal market competition (Department of Health 2003) but overall budget expansion persists. In Italy and Spain, where health care is devolved and provider choice has become policy in

certain regions, soft budget constraints have stimulated experimentation but not cost-containment (Durán et al. 2006, Costa-Font 2012 and Costa-Font and Pons-Novell 2007). Only in Sweden with a decentralised financing and provision structure, is choice conducive to cost-containment (Fotaki 2007). Concerns over rising expenditure in part explains why in social insurance countries some policies have instead restricted provider choice and introduced gate-keeping aspects to improve the targeting of health care utilisation, for example in Germany and France (Or et al, 2010).

Provider capture

Following Hacker (2005), the choice agenda can be argued to result in *provider capture,* where a focus on profitability leads providers to increase their rents at the expense of the rest of the health system. There is much to gain from involvement in the health care sector for a variety of private firms, including local health care providers as well as the international pharmaceutical and insurance industry (Evans 1997).

The countries in our sample show varying patterns of periods of contraction and expansion of private expenditure (OECD 2010). In both Sweden and the UK the emphasis on public provision has been maintained even though private providers are allowed to offer certain services paid for through the public system. In fact, Sweden as well as Belgium are the only countries

showing a steady increase in expenditure on privately provided services. In Spain, certain regions such as Catalonia, where the majority of providers are privately run, have followed a purchaser-provider split quasi market model with some level of competition (López et al. 2006). Similarly, in Italy, it is mainly the Lombardy region that promotes competition between public and private hospitals. Here the policies have resulted in some quality improvements which has in turn brought in patients from other regions (France and Taroni 2005; France et al. 2005).

Quality and responsiveness

Several countries have moved towards choice and competition reforms with the aim of addressing shortcomings in the health care system. Examples of shortcomings include excessive waiting times, lack of patient centeredness and overly bureaucratic procedures. In Sweden, a number of efficiency-enhancing choice policies have been introduced due to concerns about growing waiting times (Burström 2009). Similarly in the UK, the NHS has been subject to criticism for poorly addressing issues with access and excessive waiting times. This fed into the sequence of choice reforms; from initial choice policies in the late 1980s under Conservative governments, later followed by Labour's 'third way' policies which again expanded choice and competition (Greener 2003). On the other hand, Italy's scattered approach to choice and competition (mainly present in the northern region of Lombardy)

does not point towards quality and responsiveness pressures as drivers of reform (France and Taroni 2005).

The role of the middle class

The middle class arguably benefits disproportionately from universally-provided services and benefits (Goodin and Le Grand 1987). This is seen to be linked to their ability to navigate services more effectively, enabled by higher levels of education and better social standing (e.g. connections). Even though the usefulness of a class based welfare analysis in modern welfare states has be questioned (Pierson1996), Korpi and Palme emphasised how we should instead revive the role of class when explaining the welfare state (2003). Korpi and Palme conceptualise class as defined through "membership groups with which individuals identify and the specific subcultures and norms of such groups" (2003: 427).

Several authors have highlighted the particular benefits for the 'middle class' of choice in public services. Blomqvist, argues in the case of Sweden, that the middle class has a distinct preference for consumer choice (2004) and has a strong influence on policy choices. This influential group not only demands better services but crucially has a tendency to exit the public system if quality becomes an issue (Costa-Font and Jofre-Bonet 2008).

The potential bias towards the middle class in choice policies has led to equity concerns, despite the fact that choice is frequently positioned as a policy that benefits everyone, regardless of income and education. According to Fotaki (2009) the ability of the middle class to make 'better choices' and hence benefit disproportionately, depends on several factors. Dixon argues that the ability to make use of the choices relies on capabilities such as knowledge of the system and ability to communicate effectively, as well as socio-economic factors such as funds to cover additional travelling (2003). Finally, social context can explain why individuals in similar groups assimilate into certain behaviours and to make active and 'good' choices (Bourdieu 2008).

3. Methods and data

The middle class preference hypothesis is empirically analysed using the World Health Survey (2002) and the Eurobarometer 72.2 Survey (2009). These datasets offer a rich set of variables, including individuals' perceptions of the national health care system, the demand for choice as well as demographic and satisfaction variables.

This paper uses survey data from eight European countries; which reflects a broad representation of health care systems in Europe. We compare a sample of four SHI system countries (Belgium, France, Germany and The

Netherlands) and four NHS countries (UK, Spain, Italy and Sweden). The countries differ in the size of the health system, the extent of patient cost-sharing, funding and territorial organisation. Importantly, in SHI countries, patient choice is embedded in the institutional setting of the health system whereas in NHS type countries choice is a more recent addition. Table 1 outlines the key features of the health care systems in our sample. The SHI countries spend more overall on health (as a proportion of GDP) tend to have a lower public expenditure compared to NHS type countries. Out-of-pocket payments and the role for private insurance vary significantly between the countries, with a higher (yet variable) prevalence of private insurance in SHI countries. Co-payments (or out-of-pocket payments) tend to be driven by spending on pharmaceuticals, dentistry and physiotherapy and reflect attempts to counter rising expenditure.

Our empirical strategy takes advantage of both within and between cross country variability. We firstly use the World Health Survey (WHS) (2002) to consider differences in how choice is perceived between countries and the relationship between the availability of choice and individual satisfaction with the health system. Table 2 illustrates the pattern of perceived freedom to choose between hospital and between care providers of all types – including general practitioners, where the most extensive choice is available – for each of the countries. There is substantial variation in the average ratings of the

perceived availability of choice between the countries, and the variation matches well the extent to which choice is available within each health care system, with Belgium in the top for both choice of hospital and choice of provider.

We base our further analysis, on preferences for choice, using the Eurobarometer 72.2 Survey (2009), on the assumption that individuals' perception of choice corresponds to the actual prevalence of choice, and this seems to be supported by the descriptive WHS data in table 2.[1] The Eurobarometer 72.2, Survey (2009) offers data on preferences regarding the health care system in general, as well as preferences specifically related to individuals' demand for choice when compared to other features of the health care system. The Eurobarometer Survey asks individuals what they consider to be the three most important criteria for quality health care from twelve criteria, including an option for 'other' (see table 3). The most commonly mentioned characteristics across the countries are 'well-trained staff', 'effective treatment' and 'no waiting lists' (mentioned by up to 65% of respondents). These are known to be components which individuals see as important or indeed necessary for a positive health outcome (Johannesson et al. 1998; Dawson et al. 2007). Choice of doctor or hospital is mentioned by on

[1] The perception of the availability of choice does not only depend on institutional features, but can also be affected by for example on geographical factors such as population density, and the organisation of specialist provider units.

average of 20% of respondents and varies across the country clusters; it is most common in Italy and least common in the UK. We identify middle class respondents using a range of social status indicators including income, education and employment status. Principally, a self-rated social status ('1' lowest and 10 'highest') variable is used as it incorporates national relative conceptions of social class and this reduces the need to equivalise the scale to account for cross-country differences (Banerjee and Duflo 2008).

The binary and ordinal dependent variables (health system satisfaction in the WHS and preferences in the Eurobarometer survey) are modelled using logistic models (Agresti 2012).[2] The regression analysis of both datasets included a set of standard demographic covariates: age, gender, marital status, health variables (need, previous usage), employment, education and proxies for income. The models, reported in reduced form in table 4 and 5 are fully adjusted for these covariates. The full tables are available from the authors on request.

[2] The logit regressions assume a latent variable y* which is linearly related to the observed independent variables $y* = x_i + \varepsilon_i$ where x_i is a vector of observed covariates and ε_i is a random disturbance independent of the observed covariates. The observed dependent variable y equals 1 only if an unobserved variable y* is greater than an unobserved threshold, τ.

That is $y_i = \begin{matrix} 1\ if\ y_i^* > \tau \\ 0\ if\ y_i^* \leq \tau \end{matrix}$

4. Results

Firstly, we examined the effect of individual's rating of choice on the overall satisfaction using the WHS dataset. The ordered logit models reported in table 4 explores whether choice is a valued dimension in individuals satisfaction with the national health system. The specifications include a set of variables capturing demographic and socio-economic characteristics as well as indicators for previous interaction with the health service. Country dummies are added to the standard set of covariates and in this we aim to isolate the effect of the level of available choice on satisfaction with the health care system. The key variable of interest; 'rating of choice' is positive and significant across the specifications. Ordered logit odds ratios are reported, implying that when, for example, comparing the 'very bad' rating of choice to the 'very good' rating, the odds that the cases are found in a higher (compared to any lower) category of satisfaction with the health care system is 6.348 times larger for NHS countries. The results are overall consistent with expectations and suggest that availability of choice is at least implicitly a component relevant for satisfaction with the national health system.

Age exhibits a positive effect in explaining satisfaction while the results indicate that less educated are more satisfied with the health care system. Particularly noteworthy is that people in lower income quartiles are more

satisfied compared to the highest income quartile once we control for previous interaction with the health care system. The analysis was repeated on country samples which revealed that the positive effect of choice on satisfaction ratings is significant in all country samples except for Belgium[3]. Generally people with lower incomes rate the health care system higher, except in Sweden where income quartiles 1-3 rate the system lower than quartile 4. We find that only in Belgium, France, Sweden and the UK income exhibits significant differences.

Overall, the World Health Survey data indicates that choice ratings exert a positive effect on satisfaction with the health care system. This means that, across our sample, choice is a significant component to the views on the health care system, regardless of reform trajectory. Previous literature has identified individuals' satisfaction with the health care system as a key indicator of the responsiveness of the system (Coulter and Jenkinson 2005) and a proxy for the legitimacy of the health care system (Bergman 2002).

Next, in order to explore the preferences for choice as a function of social class and in relation to reform trajectory we use regression analysis of the Eurobarometer 72.2 data (2009). Our dependent variables, mentioning choice

[3] The insignificance of the Belgian sample is not surprising considering the institutional structure and reform trajectory. Private options and increased choice were implemented responding to demands stemming from the slow inclusion of cutting edge technology and medicines under the universal health insurance (Schokkaert & Voorde 2005).

of hospital and of doctor as features of a quality health care system (see table 3), are taken as indicators of demand for choice while the key independent variable 'self-rated social status' captures the effect of individuals' socio-economic group. Table 5 separates the two samples, NHS (Italy, UK, Spain and Sweden) from SHI countries (France, Belgium, Netherlands and Germany). We find that social status has a positive effect on both the dependent variables; choice of hospital and choice of GP, significant at the 1% level in the NHS group. A one unit increase in the social status rating increases the odds of mentioning choice of GP as a criterion for a quality health care system (i.e. going from 0-1) by 1.147. Similarly, for choice of hospital, the effect size is 1.153. In the SHI country group on the other hand, the demand for choice of doctor was negatively related to self-rated social status while the demand for choice of hospital was unrelated to social status. The ordinal self-rated social status variable (ranging from 1 to 10) was also entered as individual dummies for each of the categories, and as quartiles which indicated that the strongest effect was found in the third quartile in NHS countries.

The health system related variables, included in all specifications in table 5, explain some of the variation while socio-demographic variables are overall insignificant or weakly significantly related to the health system characteristics. Interestingly, the overall rating of the health system,

comparing 'very good' to 'fairly good' is positive for NHS systems and negative in SHI countries. Lower satisfaction seems to lead to more desire for choice, but only in NHS countries, indicating that choice may be seen as a solution to quality issues. Gender is generally insignificant, although men in NHS countries are more likely to mention choice of doctor. Similarly for age, occupational status and marital status, small effects are found. In summary, demand for choice on average is weaker in NHS countries, however more likely to be located in groups of respondents which can be defined as middle class.

5. Discussion

The empirical analysis provided evidence supporting the idea of the middle class as a group which views choice as an important facet of a quality health care system. The middle class may prefer choice both for intrinsic reasons, i.e. they 'like' to have control and autonomy (Iyengar 2010) and it may form an integral part of middle class identity as suggested by Bourdieu (2008). On the other hand, the availability of choice may be viewed as a tool for assessing a quality service, which is more responsive to individual preferences and needs. There may be an overlap with political ideology, in which choice and the associated competition between providers is seen as an important system wide tool for improved efficiency and quality. What we mean by this, is that

in relation to other motivations for provider choice reform in European health systems, including efficiency and quality and consumer responsiveness, these may constitute reasons for the identified middle class demands for choice.

The reform trajectories in the European countries we analysed allowed us to contrast various 'levels' of availability of choice as institutionalised in the system. We found a strong association between the availability of choice and individual satisfaction with the health care system. This relationship may not be causal, and importantly, when we distinguish by health system type, we only find such an association among middle range income groups within tax-funded NHS systems. This implies that demands for provider choice tend to be higher when the institutional default offers less choice. A caveat worth noting is that, although our data supports a relationship between the perceived levels of choice and actual levels of choice, this relationship has not always been seen in other studies. For example, in the UK, surveys have found that only around half of patients surveyed in 2010 recall being offered a choice of hospital (Dixon, 2010).

One implication of our results is that satisfying the middle class preference for choice can be a way for tax-funded health care systems to maintain support from this key group. In progressive tax systems, the middle class subsidise the disproportionate use of health care by individuals in more deprived

income groups (Goodin & Le Grand 1987). If perceived quality is low, beyond the threshold pushing middle class patients to opt for self-funded private care or private insurance, the public system risks losing support from this key constituency (Costa-Font and Jofre-Bonet, 2008). Hence, we argue that choice of provider is valuable in that it allows middle class users, who value having a choice, choose a service of high enough quality to remain in the public system. Consequently, instead of being a risk factor for increased privatisation and weakening of public welfare, we argue that choice can instead be a factor that might serve to maintain middle class use of publicly-funded services and strengthen the role of the public health system. Nonetheless it should be noted that private providers, funded through the public system, are not likely to be affected by this process, and the role for private providers within the public system may become more important where choice is a key feature.

This results are consistent with our middle class hypothesis, namely that, given middle class preferences for choice, the offer of provider choice presents an institutional device to keep the middle class using the NHS, who otherwise might opt out to the private sector (Costa-Font and Jofre-Bonet, 2008). In contrast, in SHI countries, provider choice is integral to the health insurance system and is therefore not a reason to opt out. In line with this, Anell (2005) argues that the reason for the introduction of choice constitutes a political

strategy to attain the support of the middle class to wider reform proposals. At the same time, in some countries the introduction of provider choice is wrapped up with efforts to decentralise provision and funding of care. This reform strategy is also thought to lead to greater individual influence over the health service and hence part of the benefits of choice policies overlap with those of these other modes of decentralised public provision (López-Casanovas, et al 2006)(.Finally, one must acknowledge that the provider e choice agenda by providing the opportunities for public service legitimisation (Le Grand 2007), it can serve as a 'means to and end' of reforming public services.

Our empirical results suggest that there is a correlation (not causal association) between middle class preferences for choice and the institutional structures in NHS health care systems. We can hence not, based on the present data, claim that the middle class is a direct *driver* of reforms. Instead, we argue that, as in most countries, improvement of the health care system is perceived as an electoral asset and expanding provider choice increases the chance of obtaining the support of the middle class, this presents an opportunity for political incumbents to claim credit for health policy reform. Electoral politics and the drive for (re-)election is not the only dynamic behind the transfer of preferences into policy; public opinion also influences the behaviour of politicians already elected (Page and Shapiro 1983). Narud and

Esaiasson discuss this facet as 'between elections democracy', emphasising the importance of voter input also outside of elections (2013).

6. Conclusion

Political motivations of the 'choice agenda' in European health care systems – beyond the discussions around quality and efficiency – are both largely under-researched, and of primary strategic importance. In this paper we provide some evidence consistent with the hypothesis that 'choice reforms' are associated with the demands for health care service improvement by e middle classes in NHS countries. This finding is consistent with Le Grand (2007) and others' discussion of choice as a middle class concern. Indeed, provider choice appears to be an institutional device to keep the middle class using (and hence supporting) the health system. We can conclude that political motivations aimed at keeping the support for the public health system in Europe are central to understanding the introduction of choice reforms, their benefits and challenges. Future research need to understand better how the median class impact of the expansion of NHS services and in keeping the middle classes in the system rather than opting out to using private health insurance.

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Table 1: Institutional features influencing choice and competition in eight European health care systems (2008)

		Financing structure	Expenditure	Co-payments	General government expenditure	Private expenditure	Spending on pharmaceuticals
			% of GDP	% of total expenditure on health			
Social health insurance	Belgium	Sickness funds	11.1	20.5	10.5	25.3	16.3
	France	Sickness funds	11.2	7.4	5.2	22.2	16.5
	Germany	Sickness funds	10.5	13.0	8.8	23.2	15.1
	Netherlands	Sickness funds	9.9	5.7	5.1	16.5	11.5 (1)
National health service	Italy	Tax based centralised	9.1	19.5	77.1	22.8	19.3
	Spain	Tax based centralised	9.0	20.7	67.7	27.5	21.0
	Sweden	Tax based decentralised	9.4	15.6	81.9	18.1	13.4
	UK	Tax based centralised	8.7	11.1	82.6	17.4	12.2

Source: OECD Health Data 2010 Version: October 2010. Data from 2008
Notes: **Private expenditure** includes out-of-pocket payments, private insurance programmes, charities and occupational health care. **General government** expenditure is incurred by central, state/regional and local government authorities, *excluding* social security schemes, including are non-market, non-profit institutions that are controlled and mainly financed by government units. **Co-payments** comprise cost-sharing, self-medication and other expenditure paid directly by private households including co-payment or co-insurance or deductibles. **Public expenditure** includes expenditure incurred by state, regional and local government *and* social security schemes.

Table 2: Mean rating of freedom to choose in 2005, by country

	Choice of hospital	SE	Choice of provider	SE	Satisfaction with health care system	SE
Belgium	4.195	0.04	4.514	0.048	4.304	0.027
France	3.904	0.035	4.468	0.068	4.104	0.029
Germany	3.294	0.039	4.229	0.063	3.595	0.032
Netherlands	3.784	0.027	3.931	0.052	3.196	0.031
Italy	3.608	0.04	3.808	0.071	3.849	0.036

Spain	3.231	0.018	3.546	0.024	3.554	0.012
Sweden	3.268	0.079	3.622	0.076	3.811	0.036
UK	3.75	0.053	4.037	0.059	3.882	0.034

Source: Authors calculation based on World health survey (2002). Survey questions on choice of hospital (Q7428) and provider (Q7325) on a scale from: (1) Very bad to (5) Very good. Satisfaction with health care system (Q7021) on a scale from: (1) Very dissatisfied to (5) Very satisfied.

Table 3: Percentage mentioning criteria for a quality health system, by country in 2009

	Belgium	France	Germany	Netherlands	Italy	Spain	Sweden	UK	Total
Well-trained staff	50.94	47	62.65	63.42	43.17	54.28	65.77	59.87	56.25
Effective treatment	32.91	34.71	39.62	39.36	36.25	28.39	35.32	40.04	36.07
No waiting lists	19.01	21.53	13.79	37.87	33.37	46.31	39.3	27.43	28.82
Choice of doctor	**27.29**	**23.6**	**25.11**	**32.21**	**36.73**	**22.81**	**27.56**	**21.17**	**26.95**
Proximity	20.99	40.81	15.22	21.37	11.83	28.39	56.02	13.76	25.29
Modern equipment	26.4	30.29	31.69	16	21.83	20.32	24.38	23.39	24.74
Dignity	33.89	24.58	27.46	21.37	15.87	23.01	14.63	12.42	21.97
Safety from harm	17.34	15.14	34.55	22.76	22.88	18.23	4.48	29.16	21.46
Clean	13	19.27	22.19	12.92	19.9	11.85	10.65	29.84	17.8
Choice of hospital	**26.11**	**20.26**	**14.25**	**14.81**	**12.5**	**10.36**	**8.26**	**14.05**	**15.03**
Friendly staff	11.13	8.06	1.89	4.47	10	3.98	4.78	6.64	6.12
Don't know	0.39	0.39	0.2	0.7	1.35	0.6	0.2	2.98	0.82
Other	0.89	0.1	0.46	0.99	0.58	1.99	0.6	0.1	0.69

Source: Eurobarometer 72.2 2009

Table 4: Satisfaction with health care, Ordered Logit Regression using World Health Survey 2005

Dependent variable: Satisfaction with the health care system

		Health variables	NHS	SHI
Freedom to choose health care provider	Very Bad (1) (ref cat)			
	Bad	2.064***	2.005***	7.993*
	Moderate	2.990***	3.051***	4.679
	Good	4.149***	4.299***	6.893**
	Very good (5)	6.028***	6.348***	9.167**
Respondent's spending on health care		0.927***	0.501	0.945***
Respondent's spending on health insurance		0.930	0.962	0.893
Respondent had previous hospital stay		0.922***	0.979	0.900
Country	Belgium	9.682***		3.614***
	France	5.019***		1.462***
	Germany	1.416***		0.747***
	Italy	1.018	1.061***	
	Netherlands	2.522***		
	Sweden	2.647***	2.764***	
	UK	3.201***	3.293***	
	Spain (ref cat)			
Cut 1		-1.078	-0.852	-1.396
Cut 2		0.170	0.353	0.113
Cut 3		1.653	1.999	0.749
Cut 4		4.038	4.431	3.098
Number of observations		3629	3017	612
Pseudo R-square		0.0554	0.059	0.040

Note: * Significant at 10% level; ** Significant at 5%, *** Significant at 1%. Standard errors are clustered at country level.

Table 5: Demand for choice in NHS versus SHI countries, logistic regressions on Eurobarometer 72.2

Dependent variables:		Choice of doctor	Choice of doctor	Choice of hospital	Choice of hospital
		NHS	SHI	NHS	SHI
Self-rated social status		1.147***	0.911**	1.153***	1.028
Overall health care quality	Very good				
	Fairly good	1.251***	0.841***	1.060	0.911
	Fairly bad	1.130	0.850	0.935	1.083
	Very bad	0.881	0.553	0.843	1.145
Experience with health care system		0.785**	1.012	0.814*	0.994
Hospital care: probability of harm	Very likely				
	Fairly likely	0.881	1.196	0.795	1.142
	Not very likely	0.7045*	1.091	0.742	1.045
	Not at all likely	0.660	0.968	0.594	1.494*
Area type	Large town	1.314**	1.324***	0.931	1.149
	Mid-sized town	1.171	1.059	0.936	0.875
	Rural				
Italy		1.210		0.820	
Spain		2.128***		0.708**	
Sweden		1.370**		0.590***	
UK					
France			0.616***		0.706***
Germany			0.714***		0.427***
Netherlands			0.546***		0.510***
Belgium					
Number of observations		3760	4359	3760	4359
R-square		0.0171	0.0308	0.0317	0.0216

Note: * Significant at 10% level; ** Significant at 5%, *** Significant at 1%. Standard errors are clustered on countries.