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LSE Europe in Question Discussion Paper Series

LSE 'Europe in Question' Discussion Paper Series

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LEQS Paper No. 82/2014

October 2014

LSE Annual Fund

LEQS is generously supported by the LSE Annual Fund

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Abstract

We examine the role of political economy drivers of the choice agenda in European health systems including middle class electoral support. Building on the reform trajectories and current institutional framework in eight western European countries where there have been significant choice reforms, we explore the preferences for choice and health system satisfaction in those countries. We find provider choice to be supported by middle class demands and health systems satisfaction, but weak evidence of other alternative political motivations for the expansion of provider choice. We conclude that in addition to efficiency improvements, provider choice is largely correlated with the demands for choice among the middle class. The provider choice agenda responds as much to political economy consideration as it does to efficiency arguments.

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

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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 that of furthering provider choice, which does not always encompass widening financing choice, often referred to as the 'choice agenda'. Provider choice refers to an expansive policy reform which furthers the choice set of certain aspects of care, such as decisions regarding inpatient and outpatient care. However, for a patient to benefit from choice, health systems need to widen their service diversity, which from a provider perspective entails the introduction of some level of competition in the organization of public services. A textbook explanation for the benefits of such reform would go as follows: the empowerment of potential choices rewards provider performance which incentivises a more efficient production and improved quality (Kreisz and Gericke 2010). Based on such rationale, provider choice can promise efficiency driven re-organisation of the care provision sector. Conversely, authors argue

that the increased reliance on 'provider choice' has led to the progression of 'consumerism' governing the relation between patients and the health care service, for example in the UK (Newman and Kuhlman 2007).

Nonetheless, in addition to 'consumerism' critiques, which mainly highlight a shift in the motivation of agents rather than on the outcomes, there are reasons to argue that 'choice reforms' are not automatically predicted to entail efficiency gains[1]. We are referring to political economy arguments, and more specifically the role of provider choice in reducing the potential for provider capture of health care regulators, and reducing physicians' overwhelming power within the health system. In addition, provider choice offers an alternative course of action for public sector involvement in health care to bypass traditional interclass agreements guided primarily by insurance motivations, and more generally to modernise the health system. Finally, the middle class hypothesis has been particularly articulated in regards in relation to the case of the English NHS, provider choice extends he possibility to choose to all social groups (Milburn 2002).

We argue in this paper that political economy explanations are important drivers of the choice agenda. We examine a range of hypothesised drivers of

[1] Possible limits to choice worth noting are imperfect information sharing and increasing complexity as well as potential bottlenecks in the short run.

the choice agenda in health systems, beyond the simple economic 'cost-containment' and efficiency argument. The drivers are examined in relation to European health care system trajectories, specifically to the distinctive reform patterns of tax funded National Health Service (NHS) compared to Social Health Insurance (SHI) systems. Not surprisingly, the 'choice agenda' is especially prominent in NHS type health care systems where choice has traditionally been limited. The empirical analysis hones in on a particularly prominent explanation – the middle class as a driver of choice reform. This departs from a well-established body of literature about the demands of the middle-class driving the public policy agenda dating back to Goodin and Le Grand (1987). Similarly, in the sociological literature the middle class is argued to be particularly prone to desire choice and in its quest to culturally distinguish itself from 'others' and maintain cultural belonging (Bourdieu 2008).

The remainder of the paper is structured as follows; the next section provides a background to, and discusses evidence on, the drivers of choice 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. Drivers of the European 'choice agenda'

An extensive literature offers views on the goals and drivers of choice and competition. This section discusses the range of suggested drivers and the previous evidence supporting their applicability in European health care systems.

Firstly, in order to understand the anticipated effects of the 'choice agenda', it is crucial to clarify the dynamics of the introduction of provider choice and how it changes health care incentives. Key features are *who* makes the choice and what *body* is allowed to compete. The two questions allow us to distinguish between mixed markets and public competition; if purchasing choices are made by public agents (mediating between patients and providers) we have mixed markets, whilst if only choices are made by patients amongst competing public and private providers there is competition. Thus, the purchaser-provider split is a necessary but not a sufficient condition for managed competition, given that the mechanisms to create a market as well as a managerial strategy allowing the public and private providers to compete are absent. Freeman (1998) explores the political drivers of competition in European countries, and we here take a different stance as our key focus is on choice, in conjunction with competition.

However, we believe it is neither possible nor desirable to completely disconnect the drivers of choice reform from those of competition reform.

A wide range of stirring factors for the rise of the choice and competition agenda in public services can be discerned from the wider policy debate. On one extreme, some literature coherently promotes choice as either intrinsically (Dowding and John 2009) as well as instrumentally valuable (Le Grand 2007), which rationalises the variance within the political spectrum from traditional to paternalist libertarianism. Nonetheless, the introduction of choice, as an institutional reform, can be the outcome of a political demand. That is, the result of some form of a conveniently adapted policy transfers from other countries experiences (policy spill-over). Contextual triggers, such as globalization and European integration, might have laid the foundations for the diffusion of reforms, even when its re-interpretation (adoption and adaptation) is specific to each national and organizational context. Setting aside the heterogeneity of policy culture and language, some frontrunner countries (e.g., the United Kingdom) tend to act as blueprints for countries where there are strong and widespread aspirations to 'catch up with the rest of Europe', such as in Southern and Eastern Europe (Cabiedes and Guilleen 2001) which is often referred to as 'institutional arbitrage'.

2.1 Efficiency as a driver

In its core principles, the choice agenda impinges on citizen empowerment as fictitious market consumers. However, unlike in a free market, provider choice and competition in health systems enacts a set of more complex mechanisms. General taxation provides funding can be thought of as an implicit (public) price, yet unlike in a market system, its returns are complex establish. In particular, consumers' capacity for judging health care quality tends to be poor (Marshall et al. 2000). Indeed, US patients were found not to use information on quality of care to switch from hospitals with poor quality to those with high quality (Fung et al 2008). This implies that the efficiency improvements are unlikely to be rewarded following a market rationale. This does however not imply that choice fails completely to exert an incentive structure parallel to that of markets, or simply as a driver for reform, but rather that the incentives operate through more complex mechanisms (Newman and Kuhlmann 2007) which expand to the political arena as we argue in this paper.

That said, a stream of studies on the English NHS are currently providing growing evidence in favour of efficiency improvements following choice and competition in health care (Propper et al, 2008; Gaynor et al, 2010; Cooper et al. 2011) and evidence from Swedish hospitals suggests improvements in

technical efficiency following choice and competition (Gerdtham et al. 1999). Hence, there is evidence of micro-efficiency resulting from provider choice. Nonetheless, surprisingly there is scant evidence that choice alone contains costs resulting from an injection of 'market-like' incentives into the health care sector (Le Grand 2007). For example, the problems of implementing policies of provider choice in the English NHS has been discussed by Le Grand et al (1998) and Brereton and Vasoodaven (2010). This means that there are limits as to whether choice (and competition) as a means to cut expenditure can be an effective policy. Furthermore, even if "policy makers have an efficiency impulse to offer larger numbers of choices" (Frank and Lamiraud 2009: 550) it is clear that there are efficiency problems with extensive availability of options. The latter explains why some policies have restricted provider choice, such as in Germany and France (Or et al, 2012).

One explanation lies in that cost-containment pressures vary between countries although a role played is argued to be in response to EU pressure (Steffen 2010). In contrast cost-containment as a motivation for reform in NHS style countries is, albeit present, less of a pressing issue. Denoting for the NHS style countries is emphasis on choice rather than competition. For instance in 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). Further, Sweden has a truly decentralised financing and provision structure, argued to be conducive to cost-containment where municipalities are in charge of channelling local taxes to health care (Fotaki 2007). Also in Italy (Anell 2005) and Spain, health care is devolved, but soft budget constrains remain which has stimulated experimentation but not cost-containment (Durán et al. 2006, Costa-Font 2012 and Costa-Font and Pons-Novell 2007). In both countries certain regions have experimented with competition; the Italian Lombardy region (1997 health care reform), aiming to improve quality of health care services and reduce costs though competition between public and private hospitals, and the Spanish region state of Catalonia where traditionally the majority of providers are private, a purchaser provider split quasi market model with some level of competition has been introduced (López-Casasnovas et al. 2006, López-Casasnovas et al, 2005).

Altogether, there is some evidence that there seems to be more to the 'choice (and competition) agenda' than cost-containment and efficiency, especially in tax funded health systems. The following subsections discuss the other hypothesised complementary drivers in terms of the present institutional evidence from secondary sources.

2.2 Provider interests and modernisation

Following Hacker (2005), the choice agenda can argued to result in *provider capture* to increase their rents at the expense of the rest of the health system. There is a lot to gain from involvement in the health care sector, for a variety of private actors; local health care providers as well as the international pharmaceutical and insurance industry. This argument is consistent with evidence would be consistent with increasing use role for private providers in choice reforms (Evans 1997). However, provider choice often does not necessarily involve a drastic expansion of private providers, instead might result in the strengthening of more efficiency run public providers.

Evidence suggests that the role of private options varies considerably between the countries of our sample and is intertwined with auxiliary sectors such as the pharmaceutical industry. Sweden and Belgium are the only countries showing a steady increase in private expenditure, whereas most other countries of our sample show varying patterns of periods of contraction and expansion of private expenditure (OECD 2010). In Spain, Spanish region states such as Catalonia where the majority of providers are privately run have traditionally followed a purchaser provider split quasi market model with some level of competition but does not apply across the country (López et al. 2006). Similarly, in Italy, it is mainly the Lombardy region that promotes

competition between public and private hospitals. The effects have resulted in some quality improvements and in turn the attraction of patients from other regions (France and Taroni 2005; France et al. 2005). Hence, although one could expect provider choice to give rise to some provider capture, the evidence does not point to shift in that direction.

Several countries have moved towards choice and competition reforms following a reaction to shortcomings in the health care system. Examples of shortcomings include excessive waiting times, lack of patient centeredness and overly bureaucratic procedures. Firstly, in Sweden concerns of cubing growing waiting times gave rise to efficiency enhancing policies, however without increasing the reliance on private options (Burström 2009). Similarly in the UK, the NHS has been subject to criticism for poorly addressing demands of access improvements which 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). In both Sweden and the UK the emphasis on public provision was maintained. On the other hand, Italy's scattered approach to choice and competition (mainly present in the northern region of Lombardy) does not point towards modernisation pressures as drivers of reform either (France and Taroni 2005).

2.3 The middle class and choice reform

A central driver of reform, as argued before is that of middle class capture. Blomqvist (2004) argues, in the case of Sweden, that the middle class is disproportionally benefiting from the choice agenda, and hence lending to a platform of support to the political elites that take such a proposal into a political manifesto. The middle class is argued to have a distinct preference for consumer choice (Fotaki 2009) and this influential group demands a special service and has a tendency to exit the public system if quality becomes an issue (Costa-Font and Jofre-Bonet 2008). The paper is based on the theoretical arguments in favour of the middle class as a key constituency for welfare reform (Goodin and Le Grand 1987; Loayza et al. 2012, Esping-Andersen 1990). The middle class is argued to benefit substantially from universally provided services and benefits, at times even more so than other social groups, due to their ability to manoeuvre the system as a result of their generally higher levels of education and societal standing (e.g. connections) (Goodin and Le Grand 1987). The later explains that pro-choice countries groups with higher education (and income) have easier access to specialist healthcare. Korpi and Palme (2003) forward an argument to revive the role of class when explaining the welfare state in response to Pierson's new politics of the welfare state (Pierson 2001). Together with potential provider capture, the middle class, can be pinpointed to create the condition for increased

choice within the public sector as a means to enforcing the allegiance with the welfare state (Goodin and Le Grand 1987). The risk of maintaining a rigid and traditional health system is that the middle class, can opt out downgrading public health care to a 'second class' service and reducing satisfaction with the health system (Costa-Font and Jofre-Bonet, 2008).

Finally, we note that the 'middle class' is not easily defined, particularly in the setting of an international comparison. The literature offers conflicting approaches; for example Korpi and Palme see class as defined through "membership groups with which individuals identify and the specific subcultures and norms of such groups" (2003: 427). A similar classic approach defines class as categories of individuals who share relatively similar positions or situations in for example employment relations (Goldthorpe 2000). Further, the ability of the middle class to make 'better choices' and hence benefit disproportionally, depends on several factors. The economics literature highlights education and income which enable individuals to make more informed and costly choices (Dixon et al. 2003). The sociological literature meanwhile focuses on theories of social capital, claiming that individuals are socialised into certain habits which are then enforced though learning from the social group that the individuals belongs to. Individuals in similar social groups assimilate into behaving in a certain way; in this context, to make active and 'good' choices (Bourdieu 2008).

3. Methodology and data

The middle class preference hypothesis is empirically analysed using the World Health Survey (2002) and the Eurobarometer 72.2 (2009) in which a rich set of variables of individuals' perceptions of the health care system, demand for choice, demographic variables and satisfaction variables, across the countries of our sample are available. This section discusses the case selection, data and empirical models.

3.1 Case selection

This paper uses survey data from eight European countries where there is evidence of choice reforms, consisting of a sample of NHS (tax funded) and SHI type health care systems for comparison. Given that path dependency and the various reform trajectories play a crucial role in defining policy options we focus on the trajectories of five tax funded systems where there have been some choice reforms. That said, one must acknowledge that there are different degrees of provider choice. Firstly, in our NHS system countries (England, Sweden, Italy and Spain) provider choice is a more recent addition, and services have generally been highly integrated and only in Italy and Spain we observe that regional organisation of the health system has have opened the door to provider choice in some regions only. We compare tax

funded countries to a sample of SHI system countries (Belgium, France, Germany and The Netherlands) that hold a long tradition of choice on the provision side, and in recent years, experimentation with some level of choice on the financing side, namely choice of insurance provider. Overall we find a gap between countries where 'choice' is embedded in the institutional setting of the health system and those where choice is a late addition through various reforms.

Table 1 provides an overview of the institutional features in the eight countries. The table shows dimensions of financing, provision and reliance on competition, factors which constrain or facilitate reform. The eight countries differ in the size of the health system, the extent of patient cost sharing, funding and territorial organisation, as well as the extent of public intervention. This reflects their broad representation of health care systems in Europe.

In the sample of SHI countries as expected we find they spend more as a proportion of GDP on health, tend to have a lower public expenditure and a higher satisfaction with the health care system (data from European Quality of Life Survey). Out-of-pocket payments and the role for private insurance varies significantly between the countries, with a higher (yet variable) prevalence of private insurance in SHI countries. The average satisfaction

mirrors spending to a certain extent, but it is clear that other variables influence. Co-payments (or out-of-pocket payments) tend to be driven by spending on pharmaceuticals, dentistry and physiotherapy and reflect strives to counter rising expenditure.

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

	Expenditure	Financing structure	General government expenditure	Private expenditure	Public expenditure	Co-payments
	% of GDP	Funding	% of total expenditure on health			
Belgium	11.1	Sickness funds	10.5	25.3	66.8	20.5
France	11.2	Sickness funds	5.2	22.2	77.8	7.4
Germany	10.5	Sickness funds	8.8	23.2	76.8	13
Italy	9.1	Centralised	77.1	22.8	77.2	19.5
The Netherlands	9.9	Sickness funds	5.1	16.5	75.3	5.7
Spain	9	Centralised	67.7	27.5	72.5	20.7
Sweden	9.4	Decentralised	81.9	18.1	81.9	15.6
UK	8.7	Centralised	82.6	17.4	82.6	11.1

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.

3.2 Empirical model and assumptions

The empirical strategy takes advantage of within and between cross country variability. We firstly consider the relation between availability of choice and individual satisfaction with the health system and secondly the individuals'

demand for choice relative to other health care system features. Individuals' satisfaction with the health care system in the country of residence is a common indicator for the responsiveness of the system (Coulter and Jenkinson 2005) and can be seen as a proxy for the legitimacy of the health care system as a public service (Bergman 2002). Choice has previously been identified as improving overall wellbeing under most conditions (Iyengar 2010) and specifically in the case of choice of hospital in England (Zigante 2011). The latter found that groups with lower income and lower education that state a higher demand for choice. An overall significant relation between choice and satisfaction is a necessary condition for the validity of the ensuing regression modelling of middle class demand for choice. Even though choice is not particularly high on the list of health system characteristics, we hypothesise that it is a key contributor to overall health system satisfaction. In sum, given a positive relation between choice and satisfaction, if there is a middle class gradient to choice preferences we should see this in NHS countries, where choice has traditionally been limited and has been promoted as part of a 'choice agenda' over the past 20 years, but not in SHI countries.

The empirical modelling approach relies on a set of assumptions. Firstly, a key assumption is that individuals' perception of choice has a correspondence

to the actual prevalence of choice[2], for each of the countries of our sample and is not significantly biased between social groups. It is not clear from the literature what extent the availability of choice is reflected in the perceptions of users, for example in the UK surveys have found that around half of the patients recall being offered a choice of hospital (Dixon, 2008).

In order to account for the categorical nature of the dependent variables we model the relationships using logistic models with binary or ordinal dependent variables (Agresti 2012). 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, $y_i = \begin{matrix} 1\ if y_i^* > \tau \\ 0\ if\ y_i^* \leq\ \tau \end{matrix}$

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.

[2] The latter can be problematic when respondents seem to "perceive" much choice in a system where in fact there is hardly any choice at all; this could be related to the fact that some countries changed from strict gatekeeping to a situation where patients can choose their doctor. Hence, we do acknowledge that this ai an imperfect measure of choice.

3.3 Data and descriptive statistics

We use two survey data sources which allow us to identify individuals' views on choice in the health care system. Firstly, the World Health Survey (WHS) data identifies structural difference in how choice is perceived between countries (2002). Table 2 illustrates the pattern of perceived freedom to choose health care providers in general and hospitals more specifically in the countries. There is a substantial variation in the rating of the availability of choice between the countries, and the variation matches well the extent to which choice is prominent within the health care systems of the respective countries, with Belgium in the top for both general choice and choice of hospital. The perceived choice of health care provider, as opposed to hospital, includes primary care, which is where the most extensive choice is available. The higher ratings of choice of other care providers compared to choice of hospital stems from the more specialised nature of hospital care which implies a higher technological and knowledge based constraint on individual choice. The average satisfaction with the national health care system and the rating of the freedom to choose provider are weakly yet positively correlated[3].

[3] Satisfaction of the health care system is treated as a proxy for quality, which does not change the results when not included in the specification.

Table 2: Mean rating of freedom to choose, 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
Italy	3.608	0.04	3.808	0.071	3.849	0.036
Netherlands	3.784	0.027	3.931	0.052	3.196	0.031
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 estimates from rating of survey questions of the World health survey (2002)

Second, the Eurobarometer 72.2, (2009) offers data on preferences regarding the health care system. Along with a range of socioeconomic indicators, the Eurobarometer survey asks individuals what they consider to be the most important criteria for quality health care (see table 3). Respondents are asked to choose *three* out of the eleven criteria (there is also an 'other' category).[4]

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 closely linked to the ultimate outcome of an interaction with the health system – an improved or restored health status and are known to be components which individuals see as important or

[4] Of the following criteria, which are the three most important criteria when you think of high quality healthcare in your country? Proximity of hospital and doctor, Free choice of doctor, Respect of a patient's dignity, Medical staff that is well trained, A clean environment at the healthcare facility, Treatment that works, Free choice of hospital, Healthcare that keeps you safe from harm, No waiting lists to get seen and treated, A welcoming and friendly environment, Modern medical equipment. Respondent may select up to three answers.

indeed necessary for a positive health outcome (Johannesson et al. 1998; Dawson et al. 2007).

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

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

Source: Eurobarometer 72.2 2009 Estimates are percentage rating varying from 0-100.

Choice of doctor or hospital is mentioned by on average 20% of respondents. Interestingly, hospital choice is most frequently mentioned in SHI countries, where choice should be available to most patients. The mentioning of choice of doctor varies across the country clusters, most common in Italy and least in the UK. Finally, in order to identify the middle class a range of social status indicators are used. Primarily, a self-rated social status ('1' lowest and 10

'highest') variable is used. Since national conceptions of social class are relative within each society, a self-rated variable means there is no need to equivalise the scale to account for cross-country differences (Banerjee and Duflo 2008). The ordinal self-rated social status variable (ranging from 1 to 10) is entered into the regressions both as a z-score transformed variable and as individual dummies for each of the categories.

4. Results

Firstly, we have examined the determinants of the individual's rating of choice on the overall satisfaction using the WHS dataset to understand whether choice is a valued dimension in rating a health system. The specification includes a set of measures that proxy socio-economic status and other socio-demographic characteristics. 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 as reported in Table 4.

Table 4: Ordered Probit Regression Analysis of legitimacy of health care systems

		Basic	Health variables	NHS	SHI
Freedom to choose health care provider	Very Bad (1) (ref cat)				
	Bad	2.013***	2.064***	2.005***	7.993*
	Moderate	3.014***	2.990***	3.051***	4.679
	Good	4.113***	4.149***	4.299***	6.893**
	Very good (5)	6.143***	6.028***	6.348***	9.167**
Household expenditure (quartile)	1st (ref cat)				
	2nd	1.077	1.017	1.068**	0.951
	3rd	0.939	0.889	0.989	0.627*
	4th	0.830	0.777***	0.829**	0.732**
Health status	Very Bad (1) (ref cat)				
	Bad	0.815	0.767*	0.769	
	Moderate	1.041	0.968	1.028	0.780
	Good	1.422***	1.313	1.352	1.391
	Very good (5)	2.109***	1.936	2.012*	1.846
Sex	Male (ref cat)				
	Female	1.018	1.027	1.009	1.088
Age		1.019***	1.018***	1.022***	1.003
Years in formal education		0.976***	0.978***	0.976***	1.012
Current job	Government employee (ref cat)				
	Non-government employee	0.897*	0.859***	0.920	0.778***
	Self-employed	0.828	0.798	0.917	0.500*
	Employer	0.676*	0.737	0.567***	1.657
	Not working for pay	1.043	1.033	1.119***	0.803**
Marital status	Never married (ref cat)				
	Currently married	0.892*	0.890**	0.882**	1.090
	Separated	1.074	1.091	1.054	3.015
	Divorced	0.750*	0.730*	0.945	0.656**
	Widowed	0.871***	0.887*	0.925	0.756
	Chohabiting	0.860	0.858	0.720	1.102
Country	Belgium	5.344***	9.682***		3.614***
	France	5.319***	5.019***		1.462***
	Germany	1.507***	1.416***		0.747***
	Italy	0.990	1.018	1.061***	
	Netherlands	2.597***	2.522***		
	Sweden	2.526***	2.647***	2.764***	
	UK	3.191***	3.201***	3.293***	
	Spain (ref cat)				
Health system Interaction	Spending on health care		0.927***	0.501	0.945***
	Spending on insurance		0.930	0.962	0.893
	Hospital stay		0.922***	0.979	0.900
Cut 1		-0.923	-1.078	-0.852	-1.396
Cut 2		0.327	0.170	0.353	0.113
Cut 3		1.792	1.653	1.999	0.749
Cut 4		4.225	4.038	4.431	3.098
Number of observations		4043	3629	3017	612
Pseudo R-square		0.058	0.0554	0.059	0.040

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

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 choice is at least implicitly a component to account for in judging the health system, and hence we interpret this evidence as consistent with the idea that political incumbents can operate upon to garner support, especially when health is regarded as a key public policy responsibility across European countries (Eurobarometer, 2009). Needless to say, due to the cross-sectional nature of the data we cannot establish causality and hence the coefficients should be interpreted as correlations.

As expected, 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 that people in lower income quartiles are more satisfied compared to the highest income quartile once we control previous interaction with the health care system. When interacting the rating of choice and the income quartiles an interesting difference between the NHS

and a SHI group becomes evident. Whilst there is a linear relationship across income groups between choice demands and satisfaction in SHI countries, in NHS system there is a curve-linear relation in the interaction terms. The 3rd income quartile is where we find the strongest association consistently with the middle class argument for choice. The analysis was repeated on country samples which revealed that the positive effect of choice rating on satisfaction is significant in all country samples except for Belgium[5]. 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. Next, considering the demand for choice in relation to reform trajectory we use regression analysis of the Eurobarometer 72.2 data (2009). We focus on 'demand for choice' (of hospital and doctor) as dependent variables and the key independent variable 'self-rated social status' captures the effect of individuals being in a higher

[5] 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.

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.

Health system related variables explain some of the variation while socio-demographic variables are overall insignificant or weakly significantly related to the healthy system characteristics. Interestingly, the overall rating of the health system, comparing 'very good' to 'fairly good' is positive in NHS and negative in SHI. Lower satisfaction hence leads to more desire for choice, only in NHS countries. 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 little effects are found.

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

		Choice of doctor NHS	Choice of doctor SHI	Choice of hospital NHS	Choice of hospital SHI
Self-rated social status		1.147***	0.911**	1.153***	1.028
Difficulty meeting payments		1.093	0.947	1.375***	1.037
Female		0.838*	1.077	1.113	0.930
Age		1.016	1.014	1.001	1.021*
Age squared		1.000	1.000	1.000	1.000
Overall health care quality	Very good	Reference category			
	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	Reference category			
	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*
Occupational status	Self-employed	1.036	1.102	1.503	0.979
	Managers	Reference category			
	White collar	1.431	0.916	2.156	1.000
	Manual workers	1.342*	0.789*	1.533***	1.073
	House persons	1.393	1.227	1.397*	1.285*
	Unemployed	1.066	1.180	1.670	1.206
	Retired	1.243	1.112	1.581*	1.003
	Students	1.118	0.565**	2.425***	0.797
Marital status	Married	Reference category			
	Cohabitating	0.762	0.953	0.971	0.904
	Single	0.981	1.048	0.952	1.000
	Divorced or separated	1.020	0.927	0.999	0.926
	Widow	1.358*	0.859	0.762	1.179
	Other	1.111	1.203	0.624	0.806
High education (yes)		0.920	1.024	0.893	0.874
Access to IT		0.791**	1.088	1.169	0.901
Owns home (yes)		0.993	1.168*	1.082	1.124
Area type	Large town	1.314**	1.324***	0.931	1.149
	Mid-sized town	1.171	1.059	0.936	0.875
	Rural	Reference category			
Italy		1.210		0.820	
Spain		2.128***		0.708**	
Sweden		1.370**		0.590***	
UK		Reference category			
France			0.616***		0.706***
Germany			0.714***		0.427***
Netherlands			0.546***		0.510***
Belgium		Reference category			
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.

5. Discussion

This paper has examined the wider motivations for provider choice in European health systems. It has done so by providing an empirical analysis of institutional trajectories and survey data evidence. Evidence reveals a strong link between availability of choice and individual satisfaction with the health care system. The link was stronger among middle range income groups in tax funded (NHS) countries. The link between the middle class and choice in the health system was further supported by the evidence of middle class preferences for choice from the Eurobarometer survey (2009). This indicated that in NHS countries the middle class view choice as an important part of a quality health care system, in contrast to SHI systems where there is a non-existent or in fact negative social gradient to the demand for choice.

In explaining such results one can be argue that preference for choice tend to be more extreme where the institutional default offers less choice, namely in tax systems and where, individuals can opt out to the private sector if the system fails to offer the requested choice. The latter is especially the case of the middle class (Costa-Font and Jofre-Bonet, 2008). In contrast in SHI countries; provider choice is part of the insurance.

As argued initially, the 'choice agenda' tends to incorporate some degree of competition, with potentially diverging drivers and motivations. While provider competition is more likely to be driven by cost-containment, in contrast provider choice (between public providers, or choice of treatment), is more plausibly driven by middle class demand as a precondition for reform (Le Grand and Bartlett 1993). Choice reforms may bypass existing health system shortcomings, such as excessive waiting times, which can nurture a harsh critique towards the health care system in general. Indeed, furthering choice may generate increased public support for state provided health care and increase individuals' trust in, and continued use of, public health care. Similarly, the choice agenda can be argued to act as a *reform precondition* by providing the opportunities for service legitimisation (Le Grand 2007).

Other literatures have dealt with the process of policy makers being influenced, actively or passively, by particular constituencies (Finseraas and Vernby 2011), and proceed under the hypothesis of interlinked preferences and policy outcomes in the case of consumer choice reform. Nevertheless, no attempt is here made to disentangle the dynamics with which the preferences of the well-off translate into policy change. Needless to say, we are not arguing there is evidence of a sort of public demonstration of middle class people taking to the streets ("What do we want? Choice! When do we want it? Now!"). Instead, in the context of political competition where the

improvement of the NHS is perceived as a political asset, we argue that expanding choice increases the chance of obtaining the support of the middle class and hence for political incumbents to claim credit for health policy reform. The assumption here is that public opinion matters for elected politicians' behaviour (Page and Shapiro 1983). Arguably, this is especially the case of tax based system where systems are politically managed.

Alternative explanations include Anell (2005) who argues that the reason for the introduction of choice was political and ideological rather than a response to a clear demand from patients and citizens more broadly. Yet, other evidence suggests that the Swedish choice reforms where intended to decrease waiting times by integrating , private GP's in the public network (Bergmark 2008). Similarly in the UK, where choice reforms aimed at incentivise the middle class to keep using the NHS rather than going private (Greener 2003).

6. Conclusion

This paper has sought to explore of the claim that alternative political economy explanations underpin the 'choice agenda' in European health care systems *beyond* the most commonly cited driver and motivation, namely cost-containing and micro-efficiency. We focus on provider choice in National Health Service (NHS) countries and we provide empirical evidence suggestive of 'choice reforms' are consistent with the public need of responsiveness, and more specifically to the demands of the middle classes in NHS countries, consistently with Le Grand, (2007) discussion of choice as a middle class obsession. Importantly, we show that choice on its own has been shown not to be conducive to cost-containment unless coupled with provider competition which has lately been a reform with the purpose of curbing rising expenditures through efficiency improvements.

Our evidence is consistent with the argument that middle class demands for health care choice are a key driving force across the models of care. The role of choice demands is not largely noticeable in Italy and Spain given that middle class find themselves purchasing complementary private health insurance instead. Further research should follow up the development of datasets that allow identifying the longer term effects of choice reforms and support from different socio-economic groups.

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