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**Are Health Care ‘Choice – and – Competition’
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Abstract

Are choice and competition reforms only a route to improving economic efficiency or, do other goals buttress the so-called choice agenda? We here examine evidence of alternative explanations for drivers of choice reforms. More specifically, we explore whether there is evidence consistent with political incumbents' aspirations to satisfy middle (median) classes (voters), alongside providers capture and service modernisation agendas as potential drivers. We concentrate on health care sector reforms given its central role as a reference universal welfare service - and focus on eight European countries where there has been heterogeneous experimentation with choice and competition reforms. Our findings suggest that whilst competition and choice reforms are primarily driven by the attainment of micro-efficiency and modernisation goals, middle class politics and to a some extent provider interests, appear to also prompt choice reforms. Hence, we conclude that allocative efficiency is not the sole driver of choice reforms.

Keywords: health care systems, choice, modernisation, cost-containment, middle class politics, legitimacy, commercial interests.

Contents

- 1 Introduction** **4**
- 2 Background** **6**
 - 2.1 The “choice-and-competition” paradigm6
 - 2. 2. Extending the paradigm7
- 3 Evidence from Secondary Sources** **9**
 - 3.1 Cost-containment as a driver 10
 - 3.2 Administrative modernisation and legitimacy 11
 - 3.3 Middle class demand driver12
 - 3.4. Commercial interests as a driver of reform13
- 4 Evidence from Primary Sources** **14**
 - 4.1 Cost-containment and choice: the evidence15
 - 4.2 Private provider capture17
 - 4.3 Modernisation- improving the health care system 19
 - 4.4 Political drivers- the demand for choice 20
- 5 Conclusion** **25**
- References 27
- Appendix 30

1. Introduction

The key tenet of European health and consumer protection strategy is on all grounds to ‘increase the ability of citizens to take better, informed decisions’ (Council 2006). However, it is open to scrutiny how best to do so. A paradigmatic reform to attain such goals which has been particularly prevalent in Europe is that of furthering provider choice, often referred to as the “choice agenda” in media and academic debates (Jordan 2006). In practice, it encompasses the widening of provider diversity, which from a provider perspective implies the introduction of competition in the organization of public services¹. The textbook explanation for such reforms reads as follows: in the absence of collusion the empowerment of tax payers and service users (actual or potential) while rewarding provider performance to incentivise quality improvements - so that money follows the patients’ choice² - efficiency improvements, both allocative (cost reduction) and technical (quality improvements) can be attained³. Hence, provider choice is advocated as an efficiency driven re-organisation, although there are reasons to argue that choice might not automatically lead to efficiency gains.⁴ However, even if choice reforms are indeed efficiency driven, it is possible to envisage additional independent reasons to further pursue the choice agenda. Whether they can be seen as key drivers of health care reforms is an empirical question this paper will try to disentangle.

The choice agenda can be thought of as a means to modernise the monolithic organisation of public services, more precisely as a way of shifting power away from vested interests. More generally, by granting further choice to users it is possible to extend the

¹ More generally, this trend paves the way to some authors to document the existence of consumerism in health care, for example in the UK and Germany (Newman and Kuhlman, 2007).

² Economic theory predicts that under ideal conditions choice can improve *efficiency*, and hence objective and subjective *quality* and *the responsiveness* of health care services (Kreisz and Gericke 2010)

³ By extension, a political economy explanation is that provider choice reduces capture, such as physicians’ overwhelming power within the system.

⁴ We can think of three reasons. Firstly, information imperfections can make provider choices suboptimal and hypothetically individuals’ education attainment and social position might instead correlate with a demand for provider choice. Whether this case or not is an empirical question that will be addressed in the paper. Second, the overall sunk costs imposed by implementing the information systems required to offer patient choice may be non-negligible. That is, administrative cost from choice reforms should be balanced out against micro efficiency gains from information provision together with the costs of furthering the complexity of the system. Finally, the system should ensure that congestion does not hamper overall efficiency gains. Indeed, if the most efficient providers attract most patients, there might be provider bottlenecks in the short run.

influence of median voters beyond that of electoral support, which is of marked importance when citizens cannot vote only on health care matters.⁵ Furthermore, public sector involvement in health care depends on some form of interclass agreement, guided primarily by insurance motivations. In other words, collectively financed health systems are subject to considerable pressures to contain costs and at the same time keep the allegiance of the middle classes.⁶ This explains why quasi-market reforms in the United Kingdom attempt, at least in its theoretical design, to improve efficiency while being carefully designed not to hamper the equitable nature of the system (Milnes and Torsney 2003; Propper et al. 2006; Le Grand 2007). Nonetheless, similar reforms in Sweden and France are justified not so much by efficiency ends, but by the need to modernise the administration of health services, break the path dependency or existing policy inertia as well as to reduce incentives for provider capture as we show below. Therefore, at least at a conceptual level, it is possible to line up political motivations beyond efficiency which underpin the choice agenda.

This paper claims that there is more to choice reforms than an attempt to improve the efficiency of a health system. We argue that information imperfections in health care can undermine the case for a sole efficiency related driver in favour of other drivers such as modernization or middle class capture. The latter is especially the case in European health systems where there have been significant choice and competition reforms together with marked expenditure expansion. If cost-containment were the sole drivers underpinning choice reforms, choice would be accompanied by a system of financial incentives, as is the case in for example Germany. In contrast, choice reforms are found to exert an influence on power relationships underpinning the dynamics of welfare governance (Newman et al. 2008), as well as improve interclass and inter-temporal redistribution. Consistently with the latter, we hypothesize that the “choice agenda” is driven primarily by its role as a means to provide a solution to middle class political demands for reform, as well as, to a certain degree, to follow modernisation goals (e.g., it can provide a “blame” opportunity to close or restructure services). Similarly, we find evidence pointing out that choice can be associated with greater

⁵ The latter refers typically to the fact that middle classes are argued to have benefited disproportionately from the welfare state, perhaps giving rise to an unfair appropriation of public rents. Similarly, evidence shows that private health insurance (partial) opting does influence the support to publicly financed health systems (Costa-i-Font and Jofre-Bonet 2008).

⁶ Recent reforms are often argued to be primarily driven by an aim to constrain expenditure growth due to the technology induced expansion of health care demand, and to a lesser extent the ageing of European populations (Breyer et al. 2010).

equity, based on the argument that previously choice was generally only available to those who had the ability to pay. Through choice policies, such in the English NHS, the possibility to choose has been extended to all social groups (Milburn 2002).

This paper is structured as follows; in the next section we discuss the main drivers of the choice agenda in conjunction with definitions and delimitations. Section three reports the existing evidence from secondary sources from a sample of European countries examined. Section four explores primary evidence of the drivers of choice policies. Section five provides a concluding discussion of the evidence provided and implications for theory and policy.

2. Background

2.1 The “choice-and-competition” paradigm

In its core principles, the choice agenda impinges on citizen empowerment as fictitious market consumers. However, unlike in a free market, the price function is played out by general taxes, and hence the connection between public price and its returns is difficult to establish, and hence there are reasons to doubt that choice in publicly financed health services would always produce the same intended effects as that of standard markets. For health care, an additional difficulty lies in the consumer capacity for judging and evaluating quality of care, which stands as a requirement for the market fiction to operate. This does however not imply that choice fails completely to exert an incentive structure parallel to that of markets, but rather that the incentives operate through more complex mechanisms (Newman and Kuhlmann 2007). That is, the choice discourse can be seen as a move away from political accountability to one where ‘decision making is privatized’ into ‘consumerist action’ (Burström 2009).

In order to understand the anticipated effects of the so-called “choice and competition agenda”, and as we aim to do here, it is crucial to clarify the dynamics of the introduction of provider choice and how this can create incentives which has an influence in the way services are run. Key features are *who* makes the choice and what *body* is allowed competing. 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 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 (Cabiedes and Guilleen 2001). 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, it is neither possible nor desirable to disconnect the drivers of choice reform from those of competition reform.

2. 2. Extending the paradigm

A wide range of motivating factors for the rise of the choice agenda in public services can be discerned from the debate surrounding the topic. The literature coherently promotes choice as either intrinsically (Dowding and John 2009) or 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 a demand driven process, that is, the result of some form of internal policy innovation or policy learning from other countries experiences⁷. These environmental or informational spill-over effects can be considerable. External pressures, such as globalization and European integration, are understood to foster diffusion of reforms, yet re-interpretation (adoption and adaptation) takes place in each national and organizational context. Despite heterogeneity in traditions, culture and language, more advanced EU members 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).

The existing *institutional status-quo* of the health system is generally a feature that comparative studies disregard as providing different motivation of choice. When analysing choice the role of path dependency and the various reform trajectories appear to play a considerable role. Countries such as Belgium, France and Germany, with fragmented insurance funds, have traditionally had free choice of provider and to an extent have experimented with insurance choice. A high degree of diversity remains, which in part reflects provider and consumer capture under middle class politics; middle class accommodation to

⁷ Nordic reform has commonly served as a benchmark for reform in the UK, with the UK in turn being a reference point for Mediterranean countries (Cabiedes and Guilleen 2001).

the preference of a widespread coverage of basic care, has driven reform proposals. (Lisac et al. 2010). In NHS type systems choice is a more recent addition, and services has generally been more homogeneous⁸.

A core problem in health care provision is the *increasing* costs that do not necessarily result from static efficiency, but from dynamic or technology related transformations to the system, such as new and expensive treatments. This means that there are limits as to whether choice as a means to cut expenditure can be an effective policy and, as follows, limits to the possibilities to measure the effects of choice and competition on efficiency and expenditure. However, even if “policy makers have an efficiency impulse to offer larger numbers of choices and greater variety of health insurance products” (Frank and Lamiraud 2008: 550) it is clear that there are efficiency problems with extensive availability of options. Cost-containment is more obvious in the increase of cost-sharing and out-of-pocket payments prevalent in many countries and the, in some countries, increased competition in financing.

Another major driver of reform, as pointed out by Blomqvist (2004), is *middle class capture*, where the middle class is explicitly pinpointed as disproportionately benefiting from the choice agenda, and hence would support the political party that takes such a proposal into a political manifesto. However, this might well result from a specific Swedish experience, and if this is the case one might bifurcate the choice arguments: while competition is more likely to be driven by cost-containment, choice (between public providers, or choice of treatment), is more likely to be driven by politics, modernisation and legitimisation. Similarly, middle class capture arguments are also intertwined with *legitimation (or responsiveness)* arguments (Le Grand and Bartlett 1993). Choice reforms may bypass existing quality shortcomings, such as excessive waiting times, which nurture harsh critique towards the health care system in general. 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 *modernisation* device as well as providing opportunities for service legitimisation (Le Grand 2007). Modernisation as a driver is, more so than the legitimisation argument, positive towards managed involvement of private actors in the provision of health care. The arguments are however closely related and share the common ground of enforcing the responsiveness of the health care system.

⁸ Some evidence from the UK suggests that choice is likely to *improve* middle-class well-being (Zigante 2011).

One can further argue that choice is the result of *provider capture* and *commercial interests* as in Hacker (2005). It is clear that there is a lot to gain for private actors, include the power of local health care providers and the international pharmaceutical and insurance industry which stand to benefit from increased room for competition. Evidence would be consistent with increasing use of pharmaceutical treatments, or increasing role for private providers (Evans 1997).

3. Evidence from Secondary Sources

This section attempts to identify policy drivers by discerning secondary sources of the choice and competition reforms in health care in eight western European countries. The purpose is to identify any suggestive evidence of the presence of such drivers, other than the well-known efficiency and proposed “cost-containment” goal. Firstly, Table 1 provides overview of the institutional details that can influence the choice-and-competition reform agenda: dimensions of financing, provision and reliance on competition. 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 and have been selected for their broad representation of health care systems in Europe.

Table 1: Overview of choice and competition in eight European health care systems

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

Source: OECD Health Data 2010 Version: October 2010. Data from 2008

Our sample consists of countries with decentralised financing (Bismarckian); Belgium, France, Germany and Netherlands, which have long traditions of choice on the provision side and have in more recent years faced strong cost-containment problems. As a response,

Germany and the Netherlands in particular, have traditionally sought to introduce choice also on the financing side, in the shape of competition between insurance funds. Universality is however maintained through continued compulsory insurance. Also soft gatekeeping mechanisms have been introduced to contain costs. In contrast, in tax funded countries; UK, Sweden, Spain and Italy have traditionally offered little choice of provider, but have in recent years had a tendency to reform towards increasing levels of choice. This is noticeable principally in the UK and Sweden where the choice reforms have been a core point of debate since the early 1990s. The welfare discourse in Spain and Italy has been less focused on individual choice, but on territorial politics which in turn encompasses some but varying degrees of provider choice. Overall we find a gap between the traditional “choice” countries and tax financed systems has narrowed over time and below we discuss the divers of such reforms in more detail.

3.1 Cost-containment as a driver

As discussed above, there is little evidence for choice alone containing costs, whereas competition is argued to inject “market-like” incentives into the health care sector (Le Grand 2007). The Bismarck type countries have a traditionally higher health expenditure, which has also increased considerably over time, partly due to wide availability of choice and direct access to specialists, which has resulted in excess usage. For example in the Netherlands, cost-containment has been the focus from the 1970s onwards, and reform has sought to promote competition between sickness funds, alongside expanding controls, rationing and expenditure caps (Schut et al. 2005). The Belgian system has faced similar cost-containment issues, but has kept choice as the key principle in all aspects, also for choice of treatment. Competition is encouraged on quality - but not price - between providers and mainly in provision (Corens 2007). Individuals are allowed to change insurance funds at regular intervals, but only about 1% make use of this option (Schokkaert and Voorde 2005). Similarly to the Belgian case, the French system has a tradition of user choice and has maintained this as a value throughout the system, with the addition of provider competition. France has however resisted any extensive introduction of competition in financing and the minor role played is argued to be in response to EU pressure (Steffen 2010).

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 (Cooper et al. 2011). The reforms have been accompanied by waves of internal market competition, aimed at improving levels of micro-efficiency in the NHS system, while maintaining a choice agenda in the reformation of the NHS (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 constraints remain which has stimulated experimentation but not cost-containment (Durán et al. 2006). 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 through 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 et al. 2006).

This initial survey reveals that our initial hypothesis; that there is more to the “choice-and-competition” agenda than cost-containment and efficiency, seems to be an appropriate assumption. The following sections discuss the other hypothesised drivers in terms of the present institutional evidence from secondary sources.

3.2 Administrative modernisation and legitimacy

Modernisation and legitimacy as drivers of choice reform are likely to be at play when we see status quo- in terms of financing and provision structure- maintained in the health care system, but with choice added to improve responsiveness and quality. The inclusion of private (particularly for profit) options is arguably less conducive to generate legitimacy for the public system and can be understood as modernisation attempts. Several of the health care systems surveyed have been forced to carry out significant reforms following public debate and critique of poor quality such as waiting times and unavailable treatments. It appears that modernisation pressures, and associated legitimacy crises are not exclusive to any particular type of health care system.

Several countries have moved towards choice and competition reforms following critique of the health care system. Firstly, in Sweden concerns of cutting 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 poor quality and lacking accessibility which fed into the sequence of choice reforms; from initial choice policies from the late 1980s by the Conservative governments, later followed by Labour ‘s “third way” policies which again expanded choice and competition⁹ (Greener 2003). However, in both cases the emphasis on public provision was maintained. On the other hand, in Belgium the growing importance of private and supplementary insurance during the 1990s was mainly caused by the (partly deliberate) delay in introducing new techniques, including new pharmaceuticals, in compulsory coverage (Schokkaert and Voorde 2005). In France choice is a traditional a source of legitimisation, but has not been expanded as a response to modernisation pressures, nor has competition (Steffen 2010). Italy’s scattered approach to choice and competition (mainly in the region Lombardy) does not point towards legitimisation or modernisation pressures (France and Taroni 2005).

Private cost-sharing and co-payments indicates less of a role for legitimisation as a driver as the alternative cost of going to the private sector decreases. Increased reliance on private expenditure has been most pronounced in Belgium, Spain and Sweden measured as the percentage of private expenditure (private insurance and co-payments). Sweden and Belgium are the only countries showing a steady increase in private expenditure, whereas the other countries of our sample show varying patterns of periods of contraction of private expenditure (OECD 2010).

3.3 Middle class demand driver

The middle class, in search of culturally distinct services, is argued to welcome increased choice within the public sector, enforcing the allegiance with the welfare state (Goodwin and Le Grand 1987). The risk of maintaining a rigid and traditional health system is that the middle class, eager to choose, will move to the private sector, downgrading public health care to a “second class” service.

⁹ Tony Blair’s famous assertion in the 1999 party conference speech was: “I want to go to the hospital of my choice, on the day I want, at the time I want. And I want it to be on the NHS” (See also (Blair 2001))

Blomqvist argues that the choice policies in Sweden represent a move away from the traditional Swedish model of welfare provision and essentially respond to middle class electoral politics (2004). Also Anell 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* (2005). The Swedish choice policies were intended to decrease waiting times, but to some extent including private GP as a publicly funded option (Bergmark 2008). Similarly in the UK, where choice and competition has been introduced in waves since the early 1990s (Greener 2003) it is conceivable that the target is, albeit equity debates, to incentivise the middle class to use the NHS rather than private options. The previous experience with for example schooling is that by allowing the middle class - consistently seeking culturally distinct options - to choose, support for public services is maintained.

It can be argued that the Bismarckian countries in general take a pro-middle class approach. Choice and easy access to specialists are features present traditionally, which in a indicates concern for the approval of the middle class, however, the lack of upward trend in the availability of choice and the lack of mention in the literature makes the argument less convincing.

3.4. Commercial interests as a driver of reform

In identifying the potential role of commercial interests as a driver of choice reforms the primary institutional evidence is the role of private options in health care provision (and financing) and the profitability of entering the health care market. The role of private options varies considerably between the countries of our sample, and is intertwined with auxiliary sectors such as the pharmaceutical industry.

In the Netherlands the system is denoted by extensive private involvement, particularly in terms of insurance (Bartholomé and Maarse 2006). The same applies to Belgium where the private sector gained ground following slow modernisation and un-inclusion of innovative treatments under the public system. The main factor for the increased usage of private insurance was rising cost-sharing, but it should be noted that in a comparative perspective Belgium still does not have a very large private presence in the health care market (Schokkaert and Voorde 2005). In Spain, on the other hand, the health system is decentralised and the availability of private providers varies between region states (comunidades

autonomas). Some region states such as Catalonia where the majority of providers are private have traditionally followed a purchaser provider split quasi market model with some level of competition (García Gómez and López Nicolás 2004; López et al. 2006). Again, 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).

There is clearly a large and increasingly important role for private providers and insurers (even though these are not our main concern) in several countries of our sample. However, this does not necessarily imply that commercial interests are a strong driver; the dynamic can be explained through other drivers such as modernisation and middle class interests.

4. Evidence from Primary Sources

This section complements the previous by examining primary empirical evidence for motivations of the ‘choice and competition agenda’ as discussed above. The aim is to identify empirical regularities rather than claiming to establish precise relationships from scantily available evidence. We examine data at different levels of aggregation (individual as well as national) to provide additional insights to the different drivers of choice in health care services.

Firstly, the bulk of the following evidence is to be interpreted in relation to the availability of choice, and the sequencing of choice reforms in each country as discussed above. Differences in the availability of choice can also be captured from individuals’ perceptions of the extent to which they are offered choice. For this the World Health Survey (WHS) provides useful evidence across the countries of our sample, for the year 2002. Table 2 illustrates the pattern of perceived freedom to choose health care provider in the countries, ordered by rating of choice of provider. Evidence appears to be consistent with the “objective” availability of choice in the respective countries discussed above, with Belgium in the top for both general choice and choice of hospital¹⁰. The perceived choice of health care provider, as opposed to hospital, includes primary care, which is where the most extensive choice is available.

¹⁰ The Bismarckian countries have a long tradition of choice, and aside from Germany they have the highest rating both for general choice of provider as well as choice of hospital. This is well in line with the objective availability of choice.

Importantly, there appears to be a rather substantial variation in the rating of the availability of choice between the selected countries, and to a large extent the variation matches the extent to which choice is prominent within the health care systems of the respective countries.

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

	Choice hospital	Standard error	Choice provider	Standard error
Belgium	4.195	0.040	4.514	0.048
France	3.904	0.035	4.468	0.068
Germany	3.294	0.039	4.229	0.063
UK	3.750	0.053	4.037	0.059
Netherlands	3.784	0.027	3.931	0.052
Italy	3.608	0.040	3.808	0.071
Sweden	3.268	0.079	3.622	0.076
Spain	3.231	0.018	3.546	0.024

Source: Authors calculation based on World health survey (2002)

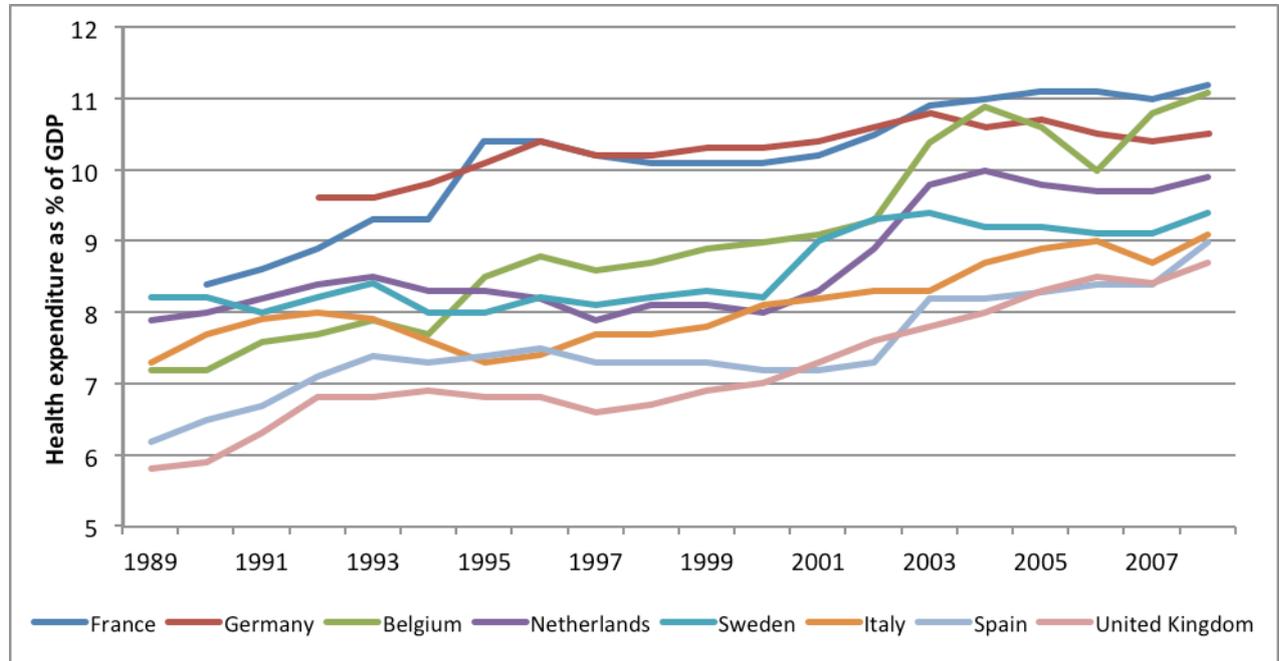
4.1 Cost-containment and choice: the evidence

Cost-containment as a driver, as discussed above, follows the standard economic theory of the allocative efficiency effects of market competition, in health care constrained by information asymmetries and wider administration costs. Even when disregarding market imperfections, we need to consider the fact that choice and competition reforms more often than not are accompanied with changes in technology, which may increase aggregate spending. This uncertain relation between spending and choice reforms lead to the key empirical question, whether the countries which have introduced provider choice exhibit similar or different patterns of health expenditure.

Figure 1 reveals that traditionally less integrated health care systems, which also tend to allow more provider choice, seems to exhibit historically higher expenditures. Total expenditure patterns suggest an expenditure expansion in all countries and particularly since the early-mid 1990s which was also the time when a large proportion of choice policies in NHS type countries were initiated. The initially higher expenditure and subsequent expansion in social insurance countries may partly be due to fee for service payments structures and easy access to specialists which has led to excess usage. Importantly, expenditure increases in UK, Spain and Italy, which have incorporated some levels of choice, appear to be even steeper after late

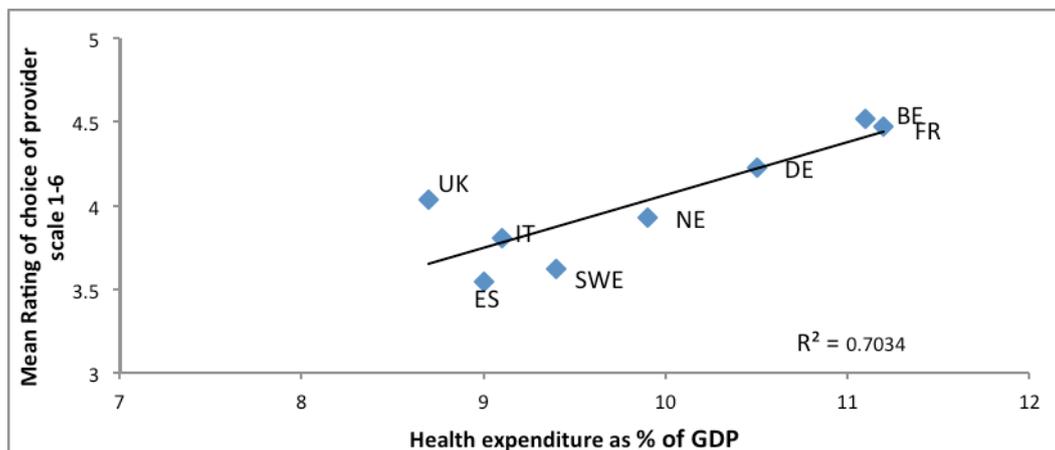
1990. In contrast, it is important to note that if anything, we observe a certain constriction in spending in social insurance type countries in the later years of the 2000s.

Figure 1: Total health expenditure as a percentage of GDP



Source: OECD Health Data 2010 - Version: October 2010

Figure 2: Average freedom to choose by country level health care expenditure.

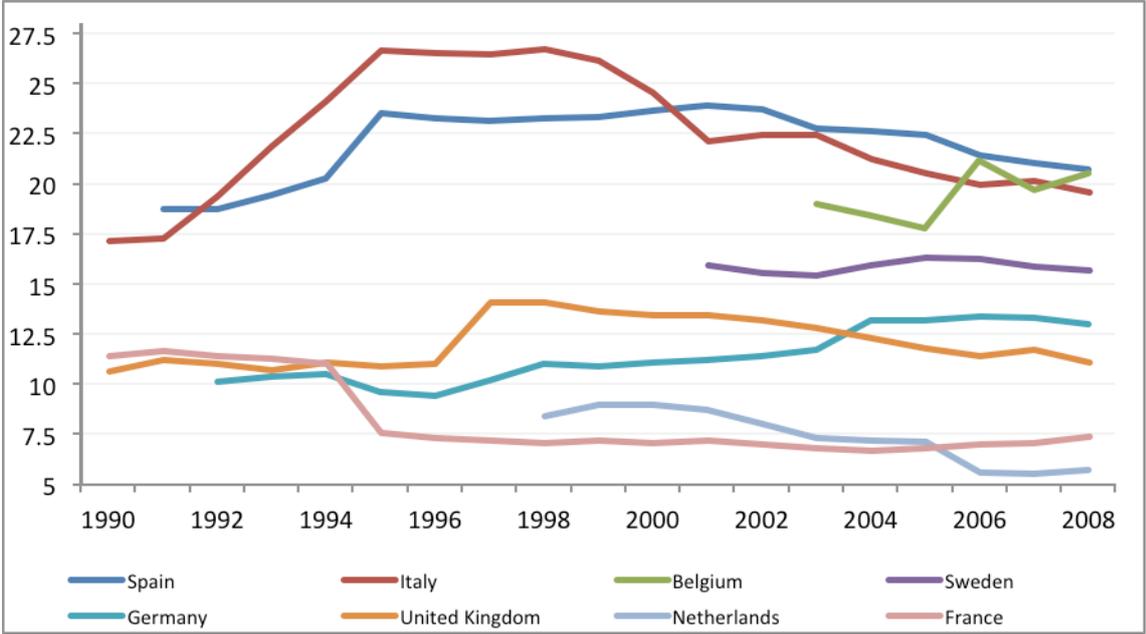


Source: OECD and World Health Survey, 2002.

Figure 2 exhibits an empirical relationship between individual's perception of their freedom to choose provider and health care expenditure in 2005 (from OECD as in figure 1). It appears that higher spending correlates well with higher perceptions of choice. However, a related note is the option of increasing the cost to the individual at the point of use. This can both

reduce demand and stimulate patients’ active participation in care choices. Cost sharing also emphasises the effect of individuals’ choices not only on the individuals benefits of health care consummated, but also on the underlying costs of health care services. Figure 3 explores trends in cost sharing in the forms of the percentage of out-of-pocket payments in total health expenditure. However, the out-of-pocket payments as part of total expenditure have stayed rather constant or even decreased in some countries, so increased shifting part of the cost of health care to individuals does not seem to have been used as a mechanism to promote cost-containment and incentive driven choice.

Figure 3 Trends Out of pocket health expenditure as a share of total expenditure (%)



Source: OECD Health Data 2010 - June

The development of health expenditure indicates that if cost-containment is a main driver, it is one of little success in the European countries of our sample. We move on to consider the empirical support for the other hypothesised drivers above.

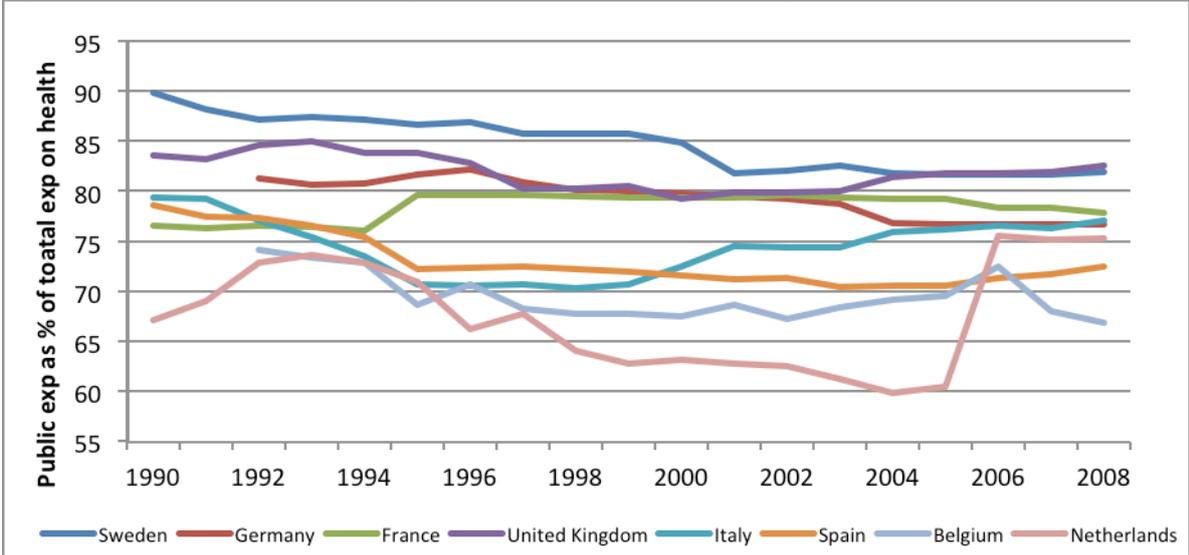
4.2 Private provider capture

Lobbying of private providers to expand their commercial interests if individuals “choose” private rather than public providers stands out as an additional explanation for the expansion of the choice agenda. In such a scenario private interest groups can reap rents that previously were reserved for public sector providers. Evidence supporting this theory is neither easily

available, nor easily interpretable as there may be lags and leads in the actual market capture of private providers, and entry barriers beyond the control of politicians.

Firstly we consider, as possible evidence of this phenomenon at an aggregate level, patterns of public expenditure's share in total expenditure. A decrease in public expenditure can be viewed as indicative of increased private activity, interpreted as a shifting of expenditure from public to private. Evidence from Figure 4 illustrates the trends in public expenditure as a part of total health expenditure; the average change in public expenditure is a drop of 3.2% from 1990 to 2008.

Figure 4: Trends Public health expenditure as a share of total expenditure on health (%)

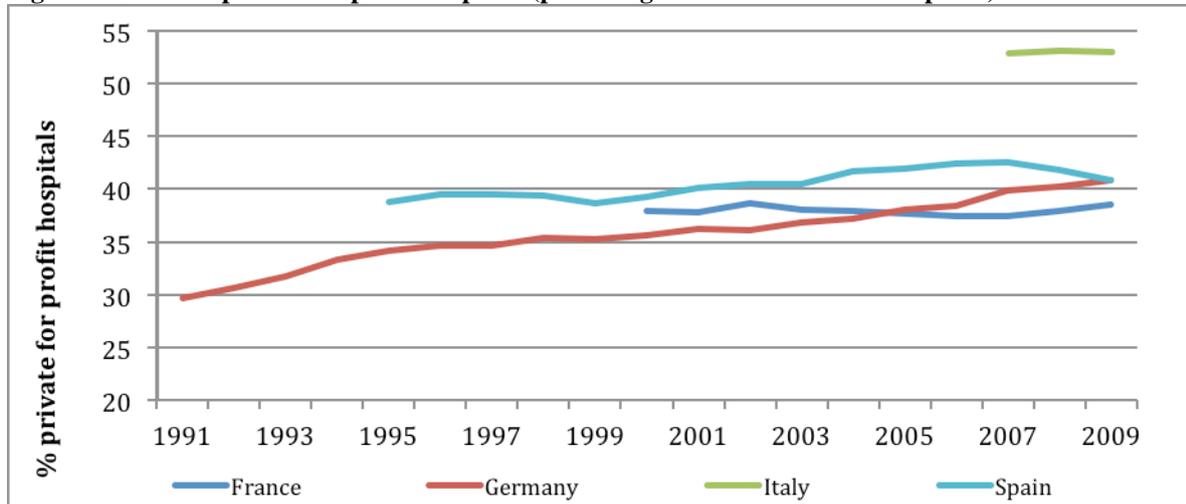


Source: OECD Health Data 2010 - Version: October 2010

In order to establish whether the drop is simply a shifting of expenditure to individuals through out-of-pocket payments we consider the total of public expenditure and out-of-pocket payments (see figure 3). Overall the total is remaining steady or increasing, but in Germany, France and to some extent Spain, the total exhibits a downward trend, opening up the space for private expenditure, mainly from private insurance. It should however be noted that the drop is minor, less than 5 % in Germany between 1990 and 2008 (OECD Health Data 2010). Data on the development of private provision is scarce on a cross-national level. OECD offers data on the number of hospitals; public, private for profit and not for profit, unfortunately only for a subset of our sample. As illustrated in figure 5, the development of private provision in the hospital sector does not indicate any dramatic changes, except

possibly for Germany where the share held by private for-profit hospitals has increased by 10% over 20 years.

Figure 5: Share of private for profit hospitals (percentage of total number of hospitals)



Source: OECD Health Data 2010 - Version: October 2010 (no data available for Sweden, UK and Belgium)

4.3 Modernisation- improving the health care system

The need for modernisation of the health system as a catalyst for choice reform is clearly discernable in many countries, through the public discourse of choice as a way of making the health care system more responsive to individual preferences and more in tune with the overall development in European societies. Evidence is not conclusive as to whether choice and competition leads to efficiency or quality improvements and the reasoning suffers from the pitfalls discussed more in length above; information, behaviour and incentive problems. An stream of studies on the English NHS are currently providing growing evidence in favour of quality and efficiency improvements following choice and competition in health care (See for example Cooper et al. 2010; Cooper et al. 2011). Some international secondary evidence is available, for example on positive effects on technical efficiency in Swedish hospitals (Gerdtham et al. 1999). However, on the whole quantitative evidence for modernisation is precarious, as the choice of indicator inevitably carries value judgements. Possible indicators range from efficiency measures, quality indicators such as mortality and morbidity, waiting times and subjective satisfaction with the care provided. Modernisation can also be something considerably more intangible, where a subjective indicator can be useful (See also Wendt et al. 2010). In figure 6 we use a satisfaction with care indicator, and found that the more choice (subjectively) available, the higher is the overall satisfaction with the health care system is.

4.4 Political drivers- the demand for choice

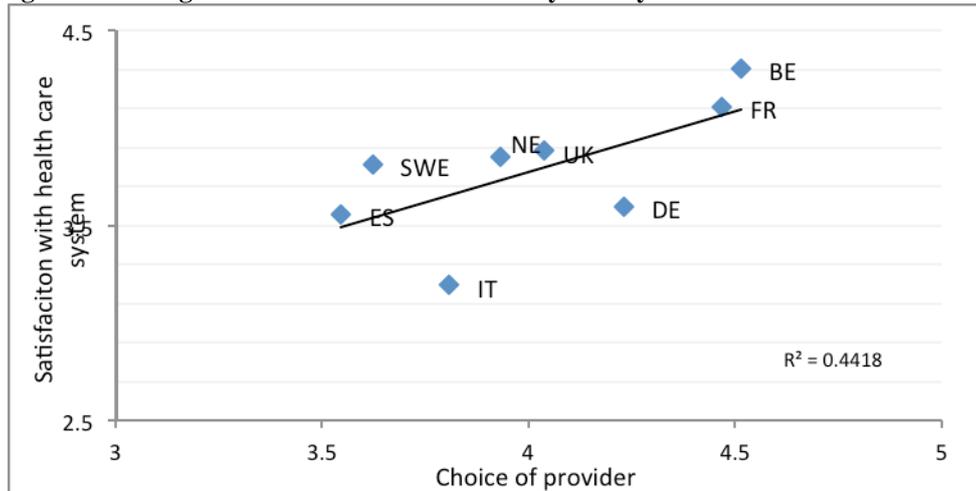
Aspirations to increase or maintain the general legitimacy of the health care system and to secure the support of middle class voters are the key *political* drivers of choice reform. These drivers crucially depend on demand for choice among the general population and particular of the more well-off middle class – i.e. choice reform resulting from individual demand, which is aggregated through the political process in the form of institutions and policies. In order to empirically assess these demand oriented drivers we use the World Health Survey (2002) ¹¹ in which we can make use of a rich set of variables of individuals' perceptions of the health care system, demographic variables and satisfaction variables, across the countries of our sample. The WHS data provides an opportunity to explore how choice contributes to the overall satisfaction with the health care system, under the assumption that public opinion matters for elected politicians' behaviour (Page and Shapiro 1983). 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).

Starting with a descriptive graph of the relation between average satisfaction with the national health care system - and the rating of the freedom to choose provider - we find a rather weak yet positive correlation. Germany is placed as an outlier with its relatively low satisfaction and extensive availability of choice. At a first glance the figure 6 indicates that there might be something to the hypothesis of choice being a source of legitimacy in health care systems, or at least correlated with. ¹²

¹¹ Details on survey questions and the world health survey in general are outlined in appendix.

¹² Reverse causality cannot be rejected in the present analysis, however it does not seem more likely that health care system that enjoy relative legitimacy should be more prone to increasing choice.

Figure 6: Average satisfaction with health care system by freedom to choose.



Source: World Health Survey 2002. (Average rating of satisfaction with health care system, and average rating of availability of choice of provider, by country)

We first consider the “legitimacy hypothesis”, i.e. whether there is an overall link between satisfaction and choice before moving on to exploring whether individuals of the middle classes is more satisfied from choice, to a higher degree than other social groups- assessing the “middle class electoral politics hypothesis”. Firstly we regress the individual’s rating of choice on the overall satisfaction, while controlling for a range of demographic and health covariates that account for need.¹³ We also include country dummies to account for country level variation 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 3.

¹³ Individual or household income is not available in the WHS. Throughout total household expenditure is here taken as a proxy for income.

Table 3: Ordered Probit Regression Analysis of legitimacy of health care systems

Dependent variable: Satisfaction with health care system								
Rating of choice	0.265***	0.223***	0.223***	0.241***	0.219***	0.230***	0.245***	0.219***
Health status	0.159***	0.169***	0.169***		0.177***		0.111**	0.161***
Male	0.027	0.014	0.014		-0.006	-0.012		0.017
Age	0.009***	0.010***	0.010***		0.009***	0.008***		0.012***
Income quartile	1st	0.176***	0.126***	0.126***		0.134***	0.194***	0.142***
	2nd	0.219***	0.169***	0.169***		0.172***	0.213***	0.188***
	3rd	0.121***	0.081*	0.081**		0.091**	0.094**	0.089**
4th (reference category)								
Education level	0.01	-0.038**	-0.038***		-0.050***	-0.019*	-0.089***	
Unemployed	-0.069	-0.045	-0.045		-0.096	-0.048		
Country dummies	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Clustered standard errors	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Cut 1	0.426***	-0.317*	-0.317	-1.288***	-0.471***	-0.978***	-1.187***	-0.111
Cut 2	1.063***	0.318*	0.318	-0.658***	0.169	-0.350**	-0.557*	0.522***
Cut 3	1.866***	1.133***	1.133***	0.081	0.924***	0.458*	0.248	1.336***
Cut 4	3.230***	2.545***	2.545***	1.449***	2.318***	1.861***	1.642***	2.747***
Number of observations	4390	4390	4390	5679	5653	4407	4391	4390
Pseudo R-square	0.038	0.055	0.055	0.05	0.062	0.051	0.048	0.055

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. As the regressions are run as an ordered probit model, the coefficients cannot be directly interpreted, but they can generally be taken as indicative of the strength of the effect as when running the regressions as an ordinary least square (OLS) model the resulting coefficients are comparable¹⁴. The results are overall consistent with expectations, and it is particularly noteworthy that people in lower income quartiles are more satisfied compared to the highest income quartile once we control for health need and socio-demographics. This relation is further explored and discussed in detail below. We can further deduct that less educated are more satisfied with the health care system, and also this will be traced for each country¹⁵. We repeated the analysis for each country which revealed that the positive effect is significant in all country samples except for Belgium.

¹⁴ All regression tables are available upon request from the authors.

¹⁵ The changing sign of the education variable in the first specification; being positive yet clearly insignificant, implies that the level of education is correlated with national education standards, as it becomes significant when country dummies are introduced.

Table 4: Ordered probit Regression Analysis of legitimacy of health care systems, by country

Dependent variable: Satisfaction with health care system

		Belgium	France	Germany	Italy	Netherlands	Sweden	UK	Spain
Rating of choice		0.122	0.290**	0.176**	0.285***	0.142*	0.155***	0.343***	0.238***
Health status		0.077	0.373***	0.197*	0.050	0.185**	0.421***	0.361***	0.130***
Male		0.179	-0.232	0.147	-0.225	-0.025	0.176	0.161	0.029
Age		0.006	0.006	-0.001	0.001	-0.002	0.014***	0.015***	0.014***
Income quartile	1	-0.077	0.367	-0.011	-0.236	-0.034	-0.374*	0.581	0.160***
	2	0.593**	0.631**	-0.060	-0.107	-0.192	-0.021	0.613**	0.200***
	3	0.319	0.278	-0.238	0.034	-0.165	-0.151	0.495	0.108*
	4				(reference category)				
Education level		0.071	0.076	-0.008	-0.119	0.019	-0.011	0.032	-0.034*
Unemployed		-0.402	-0.339	-0.419	-0.122	-0.270	-0.158	0.287	0.118
Cut 1		-0.138	1.104	-0.282	-1.013	-0.928	0.749	2.435	0.241
Cut 2		0.224	1.857	0.349	-0.166	0.025	1.572	2.956	0.843
Cut 3		0.543	2.475	0.707	0.444	0.346	2.100	3.363	1.848
Cut 4		1.987	3.823	2.178	1.987	1.782	3.293	4.639	3.325
Number of observations		141	171	243	194	374	223	164	2880
Pseudo R-square		0.036	0.060	0.025	0.031	0.013	0.084	0.095	0.047

Note: * Significant at 10% level; ** Significant at 5%, *** Significant at 1%

The insignificance of the Belgian sample is not surprising considering the institutional structure and reform trajectory.¹⁶ 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. 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. The overall lower satisfaction among high income earners can be taken to support the arguments of (Blomqvist 2004). We would hence expect the middle class to be the demanding social group and NHS type health care systems to be more responsive to the views of the public. We find that only in Belgium, France, Sweden and the UK income exhibits significant differences. In Sweden, individuals in the highest quartile are more satisfied with the health care system than individuals in the lowest quartile.

Satisfaction with the health care system appears to be closely connected with the perceptions of choice, which can be interpreted as legitimacy being positively related to the availability of choice in the system (if we take individual's perceptions as close to the real situation). Building on this finding, the effect of choice on the legitimacy of the health care system can be assessed for Blomqvist's (2004) group of particular interest; *the middle class*. In the WHS

¹⁶ Belgium also has the smallest sample.

data we can identify middle class individuals through three channels; income, education and occupation. By interacting the perception of choice with each of the middle class indicators we can assess the joint effect of a higher choice rating within the middle class sample, on the legitimacy of the health care system. Firstly, regression results suggest a positive effect of being in middle class occupation and median income on health system satisfaction.

Table 5: Overview middle class indicators, sign of coefficient (positive or negative relation) and significance.

	Middle class indicators			Income quartiles			
	Occupation	Education	Income (> median)	1	2	3	4
All countries	Positive	Insignificant	Positive	Insignificant	Insignificant	Insignificant	Insignificant
Belgium							
France							
Germany							
Italy	Positive	Positive		Negative			
Netherlands							
Spain							
Sweden						Negative	Positive
UK			Negative				Negative

Standard errors are clustered on countries. Denoted as significant if significant at 10% level.

As displayed in Table 5, middle class electoral politics seem to be at play in Italy where both occupation and education are positive and significant whereas being in the lowest income quartile is negative. Sweden displays the same pattern but with weaker evidence, where the coefficient for being in the fourth and highest quartile is positive and significant, whereas being in the third quartile is negative and again significant. So far the theory of the importance of legitimacy in NHS style tax funded health care systems, and the role of the middle class as argued by Blomqvist (2004) seem confirmed. However, when considering the results for the UK the picture becomes blurred; the coefficients for above median income and the fourth income quartile are negative and significant. This implies that there is a negative effect on legitimacy when choice increases- for middle class individuals. The UK results are in line with other findings (Zigante 2011) and as it would seem here, also channel legitimacy as a response to more choice. In sum, the evidence for middle class electoral politics identified through the WHS is weak and isolated to two countries; Sweden and Italy. Legitimacy in contrast seems to be bolstered through choice policies; this is found both across all Europe and in individual countries, except for Belgium.

5. Conclusion

This paper has sought to explore empirical evidence on the main theoretical explanations for the choice agenda in European health care systems *vis-a-vis* the most commonly cited driver and motivation; the cost-containing properties of choice and competition based on micro-efficiency arguments. Our findings suggest firstly importance of the conceptual difference of choice policies and competition policies; where competition and quasi-market solutions respond to a higher extent to micro-efficiency arguments, but competition reform does not necessarily coincide with increased choice. Secondly, the role of demand for reform is found to be driven by either critique of poor quality (modernisation, legitimisation) or the desire for a socially or culturally distinct service responsive to the demands of the middle classes.

The key insight that it is necessary to separate the drivers of choice and competition policies means that the idea of cost-containment as the uniquely important driver is easily falsifiable. Choice on its own has been shown not to be conducive to cost-containment – whereas competition has lately been introduced in many countries with the purpose of curbing rising expenditures through efficiency improvements.

Responsiveness to the electorate's demands for health care reform was identified as a key driving force across the models of care. The role is least noticeable in Italy and Spain, where limited choice is suggestive that the middle class with demands for choice, tend to partially opt out by purchasing private health insurance. The institutional evidence for Sweden and the UK indicate a mixed message. In Sweden the highest income earners has a positive effect on satisfaction with the health care system from more choice, whereas in the UK the effect is the opposite. This can potentially be explained by the distinct characteristics of the income distribution in the countries, with Sweden's being considerably more horizontal.

Similar to demands of the middle classes, choices reforms driven by modernisation demands and politicians strive to legitimise the public health system have been found important in countries such as Sweden and Belgium, as well as in the UK. Connected is the role of private providers and insurers as an option for individuals and evidence of a de-legitimation of the public system. In Germany and other social insurance type systems the role of private

insurance and private providers has increased consistently over the years, often as in France due to increasing cost-sharing.

The role of private sector capture is within the scope of this paper hard to establish, and here more research has important contributions to make. Administrative modernisation seems to be an important factor for choice policies, but should not be considered in isolation. Instead, we find evidence consistent with the idea that choice reforms aim at attaining public service legitimacy, and this is particularly relevant for health care and more specifically among the middle classes, given that its insurance role draws heavily on the individual's ability and willingness to choose.

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Appendix

World Health Survey, questions and variables

WHS 2002 Individual questionnaire rotation A

Choice ratings:

1) Provider: Q7325 For your [child's] last visit, how would you rate the freedom you had to choose your [health care provider]?

1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad

2) Hospital: Q7428 For your [child's] last hospital stay, how would you rate the freedom you had to choose the health care providers that attended to you [your child]?

1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad

Satisfaction with the health care system:

Q7021 In general would you say you are very satisfied, fairly satisfied, neither satisfied nor dissatisfied, fairly dissatisfied or very dissatisfied with the way health care runs in your country.

1. Very satisfied 2. Fairly satisfied 3. Neither satisfied or dissatisfied 4. Fairly dissatisfied 5. Very dissatisfied

Satisfaction with own health:

Q8002 How satisfied are you with your health?

1. Very dissatisfied 2. Dissatisfied 3. Neither satisfied nor dissatisfied 4. Satisfied 5. Very satisfied

Income: (total household expenditure was taken as a proxy for income as no question on income is asked in the WHS)

Q0800 In the last 4 weeks, how much did your household spend in total?

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